STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345243	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Redwood Health & Rehab	**5939 Reddman Road , Charlotte, North Carolina, 28212**

(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 onsite recertification and complaint investigation survey was conducted 5/04/2026 through 5/07/2026. Additional information was obtained offsite 5/08/2026 through 5/11/2026. Therefore, the exit date was changed to 5/11/2026. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID# 230770-H1.	E0000		05/26/2026
F0000	INITIAL COMMENTS An unannounced onsite recertification and complaint investigation survey was conducted 5/04/2026 through 5/07/2026. Additional information was obtained offsite 5/08/2026 through 5/11/2026. Therefore, the exit date was changed to 5/11/2026. Event ID# 230770-H1. The following intakes were investigated 2982455, 2970383, 2739526, 2662134, 2594619, 2575395, 2565414. 1 of the 23 complaint allegations resulted in deficiency.	F0000		05/26/2026
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	F0812	F812 – Food Procurement, Storage, Preparation & Service – Sanitary On 5/4/2026, Immediate corrective action was completed by the facility dietary manager. The dented cans were removed from use and discarded. The wet nested divided plates were removed from the dishwashing area, rewashed, sanitized, and allowed to air dry completely prior to restacking. The cardboard box containing pound cakes was discarded. The walk-in freezer storage area was reorganized to ensure food and non-food items are stored away from cooling units, fans, condensation lines, and any areas with potential moisture exposure. The facility Maintenance director installed wooden blocks underneath the cooling unit to prevent items from being placed under the cooling fan. On 5/4/2026 the facility Dietary Manager and regional dietary consultant completed a 100% audit of	06/05/2026

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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F0812 SS = E	Continued from page 1 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 discard dented canned goods stored for use, failed to dry divided plates prior to stacking, and failed to discard a wet cardboard box of pound cakes covered in frozen condensation. These practices occurred in 1 of 1 walk-in freezer, 1 of 1 dishwashing area, and 1 of 1 dry storage area and had the potential to affect food served to residents. The findings included: An initial tour of the main kitchen occurred on 5/4/26 at 9:58 AM with the Dietary Manager. The following concerns were identified: -A 108 ounce (oz.) can of applesauce with a large dent on the rim and side, a 6.62 pound (lb.) can of mandarin oranges with a small dent on rim, and a 7 lb. can of vanilla pudding with a small dent on the rim were stored in the dry storage area for use. -A cardboard box containing 12-pound cakes was stored under the main cooling fan in the walk-in freezer; the box was dark in appearance and covered in frozen condensation. -Six divided plates were stacked wet (wet-nested) in the dishwasher area. An interview with the Dietary Manager on 5/7/26 at 2:05 PM revealed she in-serviced the kitchen staff on proper drying of dining supplies, inspecting cans for dents, and proper storage in the freezer. The Dietary Manager stated the staff sometimes would not pay attention and would forget correct kitchen practices. She stated the cardboard box in the walk-in freezer belonged to the Activities department and she found sometimes those boxes were not placed in the right spot in the walk-in freezer to prevent the condensation from dripping on the box. The Dietary Manager stated Activity staff had access to the freezer and the box was placed in the incorrect spot on the shelf. She stated she wanted dented cans to be pulled from rotation to send back to the distributer for credit. An interview with the Administrator on 5/7/26 at	F0812	Continued from page 1 all canned goods in dry storage to ensure no cans were dented, swollen, punctured, leaking, rusted, or otherwise compromised, as well as a 100% audit of dishwashing, drying, and storage practices was completed to ensure dishes, trays, and divided plates were clean, sanitized, fully air dried, and not wet nested and 100% audit of freezer storage areas was completed to ensure food items were stored appropriately and protected from potential moisture contamination. No additional concerns requiring resident intervention were identified. On 5/4/2026 the facility Dietary manager and regional dietary consultant completed education to all dietary staff and department heads with access to dietary storage areas regarding proper canned food inspection, damaged can identification, wet nesting prevention, proper dish drying and storage, appropriate freezer storage practices, infection prevention, and food sanitation standards. All newly hired dietary staff will be educated upon hire during orientation by the facility Dietary Manager. On 5/5/2026, the Administrator educated all department managers that only dietary staff are permitted to organize and store food products in the walk-in freezer. Activity-related food items or other department-related food products must be stored only in approved locations and may not be placed in dietary storage areas without dietary department oversight. Any newly hired department managers will be educated by the Administrator during facility orientation. The facility Dietary Manager or designee will conduct ongoing sanitation audits daily for 2 weeks, weekly for 4 weeks, and monthly for 2 months. Audits will include dry storage inspection, damaged can identification, wet nesting observation, dish drying/storage review, freezer storage inspection, and food integrity checks. Any concerns identified during monitoring will be corrected immediately, and additional staff education will be provided as indicated. Audit results will be reviewed by the Administrator or designee and presented to the Quality Assurance Performance Improvement Committee monthly for 3 months to evaluate trends, determine effectiveness of corrective actions, and identify whether additional interventions are needed to maintain ongoing compliance. Responsible Party: Dietary Manager / Administrator	06/05/2026

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F0812 SS = E	Continued from page 2 2:50 PM revealed he had the expectation for staff to properly store items in the walk-in freezer and divided plates needed to be stored correctly. He indicated kitchen staff who assist with unloading the food distribution truck would be educated on proper can storage in the dry storage area.	F0812	Continued from page 2 or Designee Completion Date: 6/5/2026	06/05/2026
F0684 SS = D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is NOT MET as evidenced by: Based on observations, record review, and Nurse Practitioner, resident and staff interviews, the facility failed to provide clinical assessment and treatment when a resident first reported that he was burned after he accidentally spilled his cup of hot noodles on himself for 1 of 3 residents reviewed for quality of care (Resident #70). Findings included: Resident #70 was admitted to the facility on 1/31/15 and readmission on 1/02/25 with diagnosis that included multiple sclerosis, paraplegia, muscle weakness, and contracture of muscles to lower extremities. Review of physician order dated 7/25/24 revealed Hydrocodone (pain reliever used to treat moderate to severe pain) 5-325 milligrams (MG) one (1) tablet by mouth every 12 hours as needed for pain. Review of annual Minimum Data Set (MDS) assessment dated 3/01/26 revealed Resident #70 was cognitively intact and had been assessed as being independent for eating, personal hygiene, mobility, and transfers. Resident #70 also required minimal assistance for toileting, supervision assistance for dressing, and partial assistance for showering. Resident #70 was also as coded as use	F0684	F684 – Quality of Care On 5/1/2026, Resident #70 was assessed by licensed nurse #3 following identification of injury/skin alteration concern. Skin assessment was completed and findings were documented in the resident's medical record. Physician and Nurse Practitioner were notified of resident's status and assessment findings. Treatment orders were obtained and implemented as ordered by nurse #3. Wound care follow-up was initiated, and residents were referred/continued for routine wound care and monitoring as appropriate by rounding wound NP. On 5/4/2026, Medication Aide #1 and Nurse #4 received immediate re-education by the Director of Nursing (DON) regarding facility expectations for resident injury reporting, timely licensed nurse assessment, physician/NP notification, incident reporting, and documentation. Education included the requirement for immediate reporting of any resident injury, burn, skin alteration, accident, or change in condition to the licensed nurse and/or nursing supervisor. Education also included timely completion of nursing assessment, notification of physician/NP when indicated, implementation of treatment orders, completion of incident reporting, and documentation in the medical record. On 5/4/2026, the DON reviewed all incidents from the previous 30 days involving burns, injuries, skin alterations, resident accidents, and changes in condition to verify timely nursing assessments, physician/NP notification, appropriate treatment follow-up, and complete documentation. No additional concerns were identified. On 5/4/2026, The DON began education for all licensed nurses, certified nursing aides, and medication aides, including agency staff regarding the facility's incident response process and quality of care expectations. Staff were instructed that any resident injury, burn, skin alteration, accident, or change in condition must be reported immediately to the licensed nurse and/or nursing supervisor. Licensed nurses were instructed to complete an immediate resident assessment, notify the	05/29/2026

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F0684 SS = D	Continued from page 3 of manual wheelchair for mobility. An interview with Resident #70 on 5/06/26 at 2:15 PM revealed on the evening of 4/30/26 sometime after supper probably between 6:00 PM to 7:00 PM he was putting his fork into a cup of hot noodles, and his hand accidentally hit the cup and spilled the cup of noodles onto him. He stated he immediately started to clean himself up, removed his wet clothes, dried himself off and draped a gown over himself. He revealed at first he could tell his skin on the lower right side of his stomach and his right upper thigh appeared red but then a few minutes later the areas appeared more irritated and were burning a little, so he went out to the hall and found Medication Aide #1 on the medication cart. Resident #70 stated that he told Medication Aide #1 about what had happened and that he had burned himself and she asked him why he did not tell the first shift nurse and that he should have told them and that he could tell the second shift nurse (Nurse #4) who was covering both halls. He revealed he then asked for his as needed pain medication due to the pain from his burn being a level 8 out of 10 (numeric scale for pain with 0 being no pain and 10 being the worst pain) and Medication Aide #1 administered him his pain medication which helped with the pain. He stated later that evening he spoke with Nurse #4 and told her about what had happened and that he had been burned, and she also asked him why he did not notify the first shift nurse and that he should have notified the first shift nurse and then walked away. Resident #70 stated at first he was shocked Nurse #4 had not even asked to look at his burns but his pain medication had started working, and he was not feeling any pain or discomfort from his burns, so he did not mention it again until he notified the first shift nurse (Nurse #3) the following morning on 5/01/26. He revealed once he told Nurse #3 about what had happened and about the burns, Nurse #3 immediately assessed his burns, contacted the NP and provided treatment. Resident #70 stated the NP followed up with him later that same day and continued with his same treatment, instructed him to notify staff if he saw any signs of drainage or infection, and reminded him if he was feeling any pain to request his pain medication as needed. An interview conducted with Nurse Aide (NA) #2 on 5/06/26 at 3:15 PM revealed he typically worked second shift (3:00 PM to 11:00 PM), had been scheduled to work second shift on the evening of 4/30/26, and was assigned to Resident #70's hall. NA #2 stated he did not recall Resident #70 telling	F0684	Continued from page 3 physician/NP as indicated, obtain and implement treatment orders as appropriate, complete incident reporting prior to the end of shift, and document all follow-up in the resident's medical record. All staff not educated on 5/4/2026 will be educated by the DON or designee by next scheduled shift. All newly hired staff will be educated by the DON or designee upon hire during orientation. Beginning 5/6/2026 the DON or designee started conducting ongoing audits 3 times per week for 4 weeks, weekly for 4 weeks, and monthly for 2 months. Audits will include random skin assessments of 30 residents to ensure all noted skin impairments have appropriate documentation, follow up, and treatment orders implemented as necessary. Audit results will be reviewed by the Administrator or designee and presented to the Quality Assurance Performance Improvement Committee monthly for 3 months to evaluate trends, determine effectiveness of corrective actions, and identify whether additional interventions are needed to maintain ongoing compliance. Completion date: 5/29/2026	05/29/2026

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F0684 SS = D	Continued from page 4 him during his rounds that night about him spilling his noodles or about the burns and if Resident #70 had told him he would have notified the nurse. An interview with Medication Aide #1 on 5/06/26 at 3:25 PM revealed she typically worked second shift (3:00 PM to 11:00 PM) and was scheduled on the evening of 4/30/26 and assigned to work the medication cart for Resident #70's hall. She stated on the evening of 4/30/26 sometime between 7:00 PM and 8:00 PM while working the medication cart, Resident #70 approached her and stated that earlier he had gotten burned when he accidentally spilled his cup of hot soup noodles on himself. She revealed she asked him if he had told the first shift nurse what happened and Resident #70 stated no, the first shift nurse had already left by the time he had got everything cleaned up. Medication Aide #1 stated that she told him he should have notified the first shift nurse and that the second shift nurse on the 200 hall was also covering his hall and for him to tell her. She revealed Resident #70 had an order for as needed pain medication due to his medical conditions and requested his pain medication for a pain level of 8 out of 10 due to burning himself. She stated that she administered Resident #70 his pain medication. Medication Aide #1 revealed she never assessed or provided treatment for Resident #70's burns that night and did not recall whether she informed Nurse #4 about the burns. She stated she did recall seeing Resident #70 speaking with Nurse #4 later that evening but could not hear what they were speaking about and was never told that night of any new orders for medications or treatments. Medication Aide #1 revealed she remembered completing rounds on Resident #70 later that evening and he stated his pain was good and the medication was effective. Review of the April 2026 Medication Administration Record (MAR) revealed on 4/30/26 at 8:38 PM Resident #70 was administered Hydrocodone 5-325 MG 1 tablet by mouth every 12 hours as needed for pain by Medication Aide #1 for a pain level of 8 out of 10. Pain medication was effective. A telephone interview conducted with Nurse #4 on 5/11/26 at 2:30 PM revealed she typically worked as a second shift nurse (7:00 PM to 7:00AM) and was scheduled to work on the night of 4/30/26. She stated she was scheduled as the nurse and working the cart on the 200 halls but was overseeing Medication Aide #1 who was working Resident #70's	F0684		05/29/2026

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F0684 SS = D	Continued from page 5 hall. She revealed she was familiar with Resident #70 and might have spoken to him that night but did not recall him ever telling her about him accidentally spilling his cup of hot soup noodles onto himself causing him to get burned. She stated she believed that had she been told she would have assessed Resident #70, called the physician, and documented the incident. Nurse #4 revealed she spoke with Medication Aide #1 that night about resident blood sugars but never about Resident #70 getting burned. Review of nursing progress note written by Nurse #3 dated 5/01/26 revealed Resident #70 showed Nurse #3 scald wounds sustained previous night when “hot soup noodles” accidentally spilled onto his right thigh (8 inch by 3-inch wound and a 3 inch by 1-inch wound) and lower right side of abdomen (6 inch by 2-inch wound). Nurse #3 notified NP and wound nurse and received treatment orders. Nurse #3 thoroughly washed wound and applied new treatment orders. Review of incident report written by Nurse #3 dated 5/01/26 revealed Resident #70 showed Nurse #3 scald wounds sustained previous night when “hot soup noodles” accidentally spilled to his right thigh (8 inch by 3-inch wound and a 3 inch by 1-inch wound) and lower right side of abdomen (6 inch by 2-inch wound). Nurse #3 notified NP and wound nurse and received treatment orders. Nurse #3 thoroughly washed wound and applied new treatment orders. An interview with Nurse #3 on 5/06/26 at 3:35 PM revealed he typically worked first shift (7:00 AM to 7:00 PM) and was scheduled to work on the morning of 5/01/26 and assigned to Resident #70’s hall. He stated on the morning of 5/01/26 sometime between 8:00 AM and 9:00 AM he was administering Resident #70 his morning medications when Resident #70 informed him that the previous evening he was attempting to eat a cup of hot soup noodles and accidentally hit the cup with his hand and spilled the hot soup noodles onto himself and had gotten burned. He revealed Resident #70 stated that after he cleaned himself up, he went to the second shift Medication Aide #1 and informed her what had happened and that he had gotten burned and that she asked Resident #70 why he didn’t tell the first shift nurse before they left and that he would need to tell the second shift nurse. He revealed Resident #70 requested his as needed pain medication for the pain from his burns and Medication Aide #1	F0684		05/29/2026

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F0684 SS = D	Continued from page 6 administered the medication and it was successful. Nurse #3 stated Resident #70 later informed the second shift nurse (Nurse #4) who was covering that hall and that she also asked why he did not inform the first shift nurse what happened and that he should have informed first shift but that she never physically assessed him or treated the burns or contacted the physician. Nurse #3 revealed after hearing this he immediately assessed Resident #70 and found that he had a burn to his lower right abdomen that was red and appeared as if a blister had popped and what he believed to be two wounds to his right upper thigh that appeared the same. He stated he immediately notified the NP and received new treatment orders. He revealed he then washed Resident #70's wounds, applied the new treatments, administered his as needed pain medication for a pain level of 5 out of 10, entered treatment orders into system, completed incident report, and documented incident in progress notes. Nurse #3 stated that he did check on Resident #70 a little while later and observed the dressings were intact and his pain medication was successful with no complaints of pain. Review of physician progress note written by the NP dated 5/01/26 revealed Resident #70 reported he had spilled hot soup noodles on himself by accident last night and sustained burns to his right abdomen and right upper thigh. Upon exam, Resident #70 was assessed to have stage 2 burns (partial-thickness burn is a burn that affects the outer layer of the skin (epidermis) and part of the underlying dermis) to his right lower abdomen and right upper thigh that had been treated and was currently dressed with dry dressing with no evidence of drainage, infection or swelling. Wound Care NP would assess burns during routine rounds next week to make further recommendations. Resident #70 endorsed mild pain at burn site and advised he had an order for as needed pain medication that could be administered for burn pain. Continue new orders for thermal wound care to right upper thigh and right lower abdomen. Review of physician order written by NP for Resident #70 dated 5/01/26 revealed thermal wound care to right upper thigh and right lower abdomen with betadine paint (fast drying topical treatment used to kill germs and prevent infection in skin wounds), Dermasyn (provides moist environment for maximum healing to skin wounds and burns) ointment and covered with dry dressing.	F0684		05/29/2026

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F0684 SS = D	Continued from page 7 Review of physician progress note written by the NP dated 5/04/26 revealed Resident #70 was seen for follow-up of recent second-degree thermal wound to right upper thigh and right lower side of abdomen to assess healing and assure no evidence of wound infection. Upon exam, abdominal wound was noted to be open with a deep red base and areas of yellow crusting. Given the location of wounds in areas more prone to increased moisture and friction, there was concern for potential secondary infection. Recommended treatment plan revealed the following: discontinue current treatment orders for both burns due to potential for impaired healing, initiate Clindamycin (antibiotic used to treat or prevent serious bacterial infections) 300 MG one (1) tablet by mouth 3 times daily for 7 days for wound infection, apply Silvadene (topical antibiotic cream used to treat serious skin infections associated with second-third degree burns) cream 1% to affected areas once a day (day shift) for wound care, increase as needed pain medication from every 12 hours to every 8 hours as needed, placed consult request for Wound Care NP evaluation on 5/06/26 (routine weekly rounds) for further assessment and recommendations, continue wound hygiene and monitor closely for any signs or symptoms of infection. Review of physician orders written by NP for Resident #70 dated 5/04/26 revealed the following: Hydrocodone Acetaminophen 5-325 MG one (1) tablet by mouth every 8 hours as needed for treatment of pain. Clindamycin 300 MG 1 tablet by mouth 3 times daily for 7 days for wound infection Silvadene cream 1% applied to affected area (right upper thigh and right lower abdomen) once a day (day shift) for wound care An interview conducted with the NP on 5/06/26 at 10:15 AM revealed he was familiar with Resident #70. He stated on the morning of 5/01/26 he received a telephone call from Nurse #3 stating the previous evening Resident #70 had accidentally spilled a cup of hot soup noodles on himself and had some burns to his lower right abdomen and right upper thigh and they appeared red and as if blister had opened. He revealed he gave orders to clean both burns and treat with betadine, medicated cream, and cover with dry dressing and to	F0684		05/29/2026

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F0684 SS = D	Continued from page 8 administer Resident #70's as needed pain medication if needed and that he would be in to assess burn that morning. The NP stated on 5/01/26 he assessed Resident #70's burns and felt they were stage 2 and continued with the current treatment order to be completed daily during day shift. He revealed Resident #70 stated only some mild pain from the burns and he reminded him that he had an order for pain medication every 12 hours that he could request as needed. The NP stated he followed up with Resident #70's burns on 5/04/26 and they appeared a little worse with a red base and yellow crustiness so he changed the treatment order to an antibiotic cream specifically for burns to be administered daily during day shift, ordered an antibiotic to prevent infection, and changed his as needed pain medication to every 8 hours as needed instead of every 12 hours due to new treatment orders. He revealed Resident #70 was also evaluated today by the Wound Care NP and they agreed to keep the treatment order the same and will continue to see him weekly until the burns have healed. The NP stated as of right now there were no signs of infection present in Resident #70's burns and he has not complained of any severe pain and has only requested his as needed pain medication sporadically with a documented pain level of 5 and medication seemed to be working effectively. He revealed he was not notified and to his knowledge neither was the on-call service notified of Resident #70's incident or his burns on the evening the incident occurred and although in his opinion it would not have changed the degree of the burn he still would have liked to have been notified or at least on-call to have been notified so they could have had an initial assessment of the burn after it occurred and treatment recommended. Review of Wound Care NP progress note dated 5/06/26 revealed Resident #70 being seen for initial evaluation. He received burns from accidental spilling of hot soup noodles onto right thigh and right abdomen, both areas with dermis (middle layer of skin) and scabbed areas, some trace erythema (redness) on edges, and received antibiotic. Resident #70 reported some drainage, but none seen on assessment. Wound to right thigh measured 16 centimeters (cm) by 4.5 cm by 0.1 cm and wound to right abdomen measured 6 cm by 3 cm by 0.1 cm. Continue current treatment course. An interview and observation with Resident #70 on 5/06/26 at 2:15 PM revealed he believed his burns were starting to heal, nursing staff were providing	F0684		05/29/2026

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F0684 SS = D	Continued from page 9 his treatment daily, the NP continued to follow-up with him weekly, and he had also been seen and treated by the Wound Care NP. Resident #70 stated he had some mild to moderate pain from the burns from time to time but once he received his as needed pain medication the pain would stop. Observation of Resident #70 burns on his lower right abdomen and right upper thigh revealed both areas covered with dry dressing, dated, and initialed. An interview conducted with the Director of Nursing (DON) and Regional Nurse Consultant on 5/07/25 at 3:30 PM revealed both were familiar with Resident #70. The DON stated she was not made aware of the incident with Resident #70 and the burns until 5/04/26 due to being out of town and then was only notified that Resident #70 had spilled his cup of hot soup noodles on himself by accident and received burns to his stomach and thigh. The DON revealed she was not aware of staff being told after the incident occurred on 4/30/26 and not assessing or treating the burns until the following morning. The Regional Nurse Consultant stated that she was made aware of the incident on 5/01/26 while at the facility and had spoken with Resident #70 who had told her a similar version of how he had accidentally spilled the cup of hot soup noodles onto him and caused him to get burned but could not recall him telling her the specifics about the staff and not providing care. She stated when she saw Resident #70 on 5/01/26 his wounds had been treated, and he had no complaints of pain. The Regional Nurse Consultant stated she expected that nursing staff should immediately report to their supervisor any incidents involving residents as soon as they are made aware, nursing staff should physically assess any reports of resident injury as soon as they are made aware, nursing staff should notify the physician of any incidents as soon as they are made aware, and nursing staff should always document any incidents involving residents as soon as possible. The DON agreed with the expectations from the Regional Nurse Consultant and stated that Medication Aide #1 should have assured that Nurse #4 was notified of the incident and Nurse #4 should have physically assessed Resident #70's burns, notified the physician for further recommendations, applied any treatments as ordered, and documented the incident. An interview conducted with the Administrator on 5/07/26 at 4:00 PM revealed he was familiar with Resident #70. The Administrator stated he believed he was made aware on 5/01/26 of Resident #70	F0684		05/29/2026

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F0684 SS = D	Continued from page 10 accidentally spilling his cup of hot soup noodles onto himself causing him to get burned and having to receive treatments for his burns. He revealed he was not aware that Resident #70 had told Medication Aide #1 and Nurse #4 the previous night when the incident happened and that he was not physically assessed or provided care until the following morning. He stated nursing staff were aware to notify their supervisors immediately when notified of any type of incident or injury involving a resident, to immediately physically assess residents once they were notified of an incident or injury, to notify the physician for further recommendations and treatment orders, and to complete incident reports and document the reported incidents or injury in a timely manner. The Administrator stated Medication Aide #1 should have made sure Nurse #4 was aware of Resident #70's incident and his burns and once notified Nurse #4 should have physically assessed Resident #70 immediately, notified the physician for further treatment recommendations, completed an incident report and documented the incident and injury in a nursing progress note.	F0684		05/29/2026
F0849 SS = D	Hospice Services CFR(s): 483.70(n)(1)-(4) §483.70(n) Hospice services. §483.70(n)(1) A long-term care (LTC) facility may do either of the following: (i) Arrange for the provision of hospice services through an agreement with one or more Medicare-certified hospices. (ii) Not arrange for the provision of hospice services at the facility through an agreement with a Medicare-certified hospice and assist the resident in transferring to a facility that will arrange for the provision of hospice services when a resident requests a transfer. §483.70(n)(2) If hospice care is furnished in an LTC facility through an agreement as specified in paragraph (o)(1)(i) of this section with a hospice, the LTC facility must meet the following requirements: (i) Ensure that the hospice services meet professional standards and principles that apply to individuals providing services in the facility, and to the timeliness of the services. (ii) Have a written agreement with the hospice that is	F0849	Resident #101 is no longer a resident of the facility and is deceased; therefore, no direct resident corrective action or ongoing resident monitoring could be completed. On 5/4/2026, The Director of Nursing (DON) completed a 100% audit of all current hospice residents to verify the following Hospice election documentation was present in the medical record, MOST forms and/or advance directives were current and available, Emergency contact information was accurate in the electronic medical record, Hospice agency contact information was readily accessible to nursing staff, Hospice coordination documentation was present and current, Resident hospice status was clearly identified in the electronic medical record. Any identified concerns were corrected immediately, including updating contact information, ensuring hospice documentation was present, and clarifying hospice communication processes as needed. Audit also included a review of all Hospice resident incident reports and changes in condition for the last 30 days to ensure notification of Hospice provider was completed for appropriate coordination of care. On 5/27/2026, the DON began re-education to all licensed nursing staff, including agency staff, regarding hospice coordination requirements, including timely hospice notification for changes in	05/28/2026

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F0849 SS = D	Continued from page 11 signed by an authorized representative of the hospice and an authorized representative of the LTC facility before hospice care is furnished to any resident. The written agreement must set out at least the following: (A) The services the hospice will provide. (B) The hospice's responsibilities for determining the appropriate hospice plan of care as specified in §418.112 (d) of this chapter. (C) The services the LTC facility will continue to provide based on each resident's plan of care. (D) A communication process, including how the communication will be documented between the LTC facility and the hospice provider, to ensure that the needs of the resident are addressed and met 24 hours per day. (E) A provision that the LTC facility immediately notifies the hospice about the following: (1) A significant change in the resident's physical, mental, social, or emotional status. (2) Clinical complications that suggest a need to alter the plan of care. (3) A need to transfer the resident from the facility for any condition. (4) The resident's death. (F) A provision stating that the hospice assumes responsibility for determining the appropriate course of hospice care, including the determination to change the level of services provided. (G) An agreement that it is the LTC facility's responsibility to furnish 24-hour room and board care, meet the resident's personal care and nursing needs in coordination with the hospice representative, and ensure that the level of care provided is appropriately based on the individual resident's needs. (H) A delineation of the hospice's responsibilities, including but not limited to, providing medical direction and management of the patient; nursing; counseling (including spiritual, dietary, and bereavement); social work; providing medical supplies, durable medical equipment, and drugs necessary for the palliation of pain and symptoms associated with the terminal illness and related	F0849	Continued from page 11 condition, EMS transfer, hospitalization, significant change, or death; verification of resident goals of care and MOST/advance directive forms; accurate emergency contact verification; and documentation of hospice communication in the medical record. All licensed nursing staff not educated on 5/27/2026 will be educated prior to their next shift by the DON or designee. All newly hired staff will be educated during orientation by the DON or designee. The Director of Nursing/designee will monitor ongoing compliance through audits of current hospice resident records, who have documented incidents and or concerns to ensure that hospice services were notified each time and to audit for MOST Form accuracy of residents wishes and ensure they are present in the EMR. Audits will be completed weekly for 4 weeks and monthly for 2 months. Any concerns identified during audits will be corrected immediately. Additional education and/or counseling will be provided as indicated. Audit results will be reviewed by the Administrator, Director of Nursing, and/or designee and reported to the QAPI Committee monthly for 3 months. The QAPI Committee will review findings for trends, evaluate effectiveness of corrective actions, and determine whether additional interventions are needed to maintain ongoing compliance with hospice coordination, resident rights, goals of care, and communication requirements. Responsible Party: Director of Nursing/designee Completion Date: 5/28/26	05/28/2026

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F0849 SS = D	Continued from page 12 conditions; and all other hospice services that are necessary for the care of the resident's terminal illness and related conditions. (I) A provision that when the LTC facility personnel are responsible for the administration of prescribed therapies, including those therapies determined appropriate by the hospice and delineated in the hospice plan of care, the LTC facility personnel may administer the therapies where permitted by State law and as specified by the LTC facility. (J) A provision stating that the LTC facility must report all alleged violations involving mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of patient property by hospice personnel, to the hospice administrator immediately when the LTC facility becomes aware of the alleged violation. (K) A delineation of the responsibilities of the hospice and the LTC facility to provide bereavement services to LTC facility staff. §483.70(n)(3) Each LTC facility arranging for the provision of hospice care under a written agreement must designate a member of the facility's interdisciplinary team who is responsible for working with hospice representatives to coordinate care to the resident provided by the LTC facility staff and hospice staff. The interdisciplinary team member must have a clinical background, function within their State scope of practice act, and have the ability to assess the resident or have access to someone that has the skills and capabilities to assess the resident. The designated interdisciplinary team member is responsible for the following: (i) Collaborating with hospice representatives and coordinating LTC facility staff participation in the hospice care planning process for those residents receiving these services. (ii) Communicating with hospice representatives and other healthcare providers participating in the provision of care for the terminal illness, related conditions, and other conditions, to ensure quality of care for the patient and family. (iii) Ensuring that the LTC facility communicates with the hospice medical director, the patient's attending physician, and other practitioners participating in the	F0849		05/28/2026

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F0849 SS = D	Continued from page 13 provision of care to the patient as needed to coordinate the hospice care with the medical care provided by other physicians. (iv) Obtaining the following information from the hospice: (A) The most recent hospice plan of care specific to each patient. (B) Hospice election form. (C) Physician certification and recertification of the terminal illness specific to each patient. (D) Names and contact information for hospice personnel involved in hospice care of each patient. (E) Instructions on how to access the hospice's 24-hour on-call system. (F) Hospice medication information specific to each patient. (G) Hospice physician and attending physician (if any) orders specific to each patient. (v) Ensuring that the LTC facility staff provides orientation in the policies and procedures of the facility, including patient rights, appropriate forms, and record keeping requirements, to hospice staff furnishing care to LTC residents. §483.70(n)(4) Each LTC facility providing hospice care under a written agreement must ensure that each resident's written plan of care includes both the most recent hospice plan of care and a description of the services furnished by the LTC facility to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, as required at §483.24. This REQUIREMENT is NOT MET as evidenced by: Based on observation, record review, and interviews with the Responsible Party (RP), staff, Nurse Practitioner (NP), and hospice staff, the facility failed to ensure effective communication and coordination of care occurred with the hospice provider. On 6/29/25, Resident #101, who was under the care of hospice, fell in his room and was assessed by Nurse #1, assisted back to bed and then sent to the Emergency Department (ED) for evaluation. The hospice on call provider was not notified by facility staff before Emergency Medical Services (EMS) was	F0849		05/28/2026

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F0849 SS = D	Continued from page 14 called. This deficient practice affected 1 of 4 sampled residents reviewed for coordination of hospice services (Resident #101). The findings included: The Hospice Facility and Services Agreement contract dated 4/30/19 stated, “With respect to the management of the resident’s terminal illness, the facility shall notify Hospice immediately of any significant change in the Patient’s status (mental, social, emotional, or physical), clinical complication that suggest a need to alter the plan of care; a need to transfer the Patient out of the Facility; or the Patient’s death regardless of the time or the day since a Hospice staff member is available (24) twenty four hours a day, every day.” Resident #101 was admitted to the facility on 4/18/25 under hospice services with diagnoses which included protein-calorie malnutrition (when the body does not receive enough protein and calories to maintain proper health and functioning), and ascorbic acid deficiency (a deficiency caused by low vitamin C levels). Resident #101’s care plan dated 4/21/25 revealed a focus area for hospice services with expected decline in condition due to terminal progressive disease related to protein calorie malnutrition. Interventions included notifying the Medical Director and hospice of complications as indicated. Resident #101’s admission Minimum Data Set (MDS) assessment dated 4/24/25 revealed he was severely cognitively impaired and received hospice care. Resident #101 required substantial and maximal assistance to set up assistance from staff for all Activities of Daily Living (ADL). A review of Resident #101’s physician’s orders revealed an order dated 4/24/25 for hospice due to protein-calorie malnutrition. The order read to notify Hospice 24 hours a day, seven days a week of any change in condition or question/concern. A review of a document entitled “Interact Transfer Form” dated 6/29/25 and signed by Nurse #1 revealed Emergency Contact #2 was called and notified of the transfer to the hospital. The reason for transfer to the ED was due to altered mental status. A nursing progress note dated 6/30/25 and written by Nurse #1 revealed after a fall on 6/29/25, Resident #101 appeared lethargic and was observed	F0849		05/28/2026

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F0849 SS = D	Continued from page 15 head to toe with no wounds or bruises noted and Resident #101 was assisted back to his bed. Resident #101 was restless and repeatedly stated he was having difficulty breathing. A pulse oximetry (a non-invasive test that measures the oxygen saturation level in the blood and heart rate) reading was obtained and noted to be in the low 60s (normal range is between 95% and 100%) and oxygen was applied immediately. The nursing progress note continued that due to Resident #101's continued lethargy and low oxygen saturation, EMS was contacted and he was transported to the hospital via ambulance for further evaluation and treatment. The note indicated that the RP and nurse supervisor were notified. There were no physician orders documented to send Resident #101 to the ED for evaluation on 6/29/25. A telephone interview with Nurse #1 occurred on 5/7/26 at 12:37 PM. She stated she couldn't remember exact details from 6/29/25 but did generally recall Resident #101. Nurse #1 stated the Former Nurse Supervisor that night called EMS, and she stayed with Resident #101 in the meantime. She stated Resident #101's oxygen saturation was low and just because he used hospice services didn't mean he didn't need to be treated although she did not specifically recall if Resident #101 utilized hospice services. Nurse #1 stated she did not call hospice or the NP, but the Former Weekend Supervisor did. A telephone interview with the Former Weekend Supervisor on 5/8/26 at 1:23 PM revealed he was not assigned to Resident #101 on the night of 6/29/25 and that Nurse #1 was. He stated he did not assist with calling EMS for Resident #101 but knew he was sent out of the facility for evaluation at the ED. The Former Weekend Supervisor stated he did not remember many details about what happened on 6/29/25 but knew he did not complete any paperwork or make any calls to hospice, the on-call service for the NP, or the RP regarding Resident #101. A phone interview with Hospice Nurse #1 on 5/6/26 at 3:40 PM revealed the hospice agency was not contacted about Resident #101's fall on 6/29/25. She stated Resident #101 was documented in their EMR as not wanting any aggressive treatment. Hospice Nurse #1 stated she reviewed the coordination notes in their system call log and it revealed no calls or notes regarding Resident #101 that night. Hospice Nurse #1 stated they became aware of his hospitalization the following day on	F0849		05/28/2026

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F0849 SS = D	Continued from page 16 6/30/25 because Resident #101's RP called stating he was sent to the hospital and did not know which one. She stated generally hospice should be called for any change in condition. Hospice Nurse #1 stated their on-call service would track the call, coordinate with the RP or family to see what their wishes were and typically a nurse from the hospice agency would be sent out to evaluate. She stated a MOST form was signed on 7/2/25 after Resident #101's hospitalization on 6/29/25 indicating no further hospitalizations. In a telephone interview with Resident #101's RP on 5/6/26 at 1:16 PM she revealed Resident #101 did not want to go to the hospital for treatment. She stated Emergency Contact #2 was called instead of her on 6/29/25. The RP stated she had recently become Emergency Contact #1 for Resident #101 due to a change in health status concerning Emergency Contact #2. She stated the facility called Emergency Contact #2 and stated Resident #101 was being sent to the ED for evaluation. The RP stated the facility did not call hospice for any orders or evaluation of Resident #101 and as a result, a MOST (Medical Orders for Scope of Treatment) form was signed indicating Resident #101 did not want to be hospitalized when he returned from the ED. The RP stated she also placed a sign in Resident #101's room indicating his wishes to not be hospitalized again. A review of Resident #101's Electronic Medical Record (EMR) revealed Emergency Contact #2 was labeled as "Emergency Contact #2," but listed first on the form and Emergency Contact #1 was labeled as "Emergency Contact #1," but listed second on the form. A review of Resident #101's hospital records dated 6/30/25 revealed Resident #101 was sent by EMS for treatment after a fall with a fever and low oxygen saturation. Resident #101 was found to have a fractured rib, pneumonia, and osteomyelitis (a bone infection) in one toe. Broad spectrum antibiotics were initiated but were stopped due to comfort measures wishes as directed by the RP. Resident #101's hospital records also revealed hospice was contacted by hospital staff and confirmed only comfort measures were desired at that time per the RP and Resident #101 would be discharged back to the facility when transport became available. Resident #101 was discharged from the hospital back to the facility 7/01/25. An additional review of Resident #101's EMR revealed a MOST form signed on 7/2/25 indicating	F0849		05/28/2026

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F0849 SS = D	Continued from page 17 "Comfort Measures. Keep clean, warm and dry. Use medication by any route, positioning, wound care, and other measures to relieve pain and suffering. Use oxygen, suction, and manual treatment of airway obstruction as needed for comfort. Do not transfer to hospital unless comfort needs cannot be met in current location." A telephone interview with the Former Director of Nursing (DON) on 5/8/26 at 2:20 PM revealed that generally, if the nurse on duty was not familiar with any resident, she would expect them to call the provider and provide care for the resident's safety. She stated she did not recall the exact details of Resident #101's fall and transfer to the ED on the night of 6/29/25 but stated unless his EMR stated to not call 911 due to hospice services, she expected Nurse #1 to call the provider and let hospice know. The Former DON was not sure when hospice was contacted for Resident #101 but stated she recalled doing some education to the nursing staff about hospice coordination. A telephone interview with the former Administrator on 5/11/26 at 1:45 PM revealed he did not recall Resident #101 or the coordination of care the night of 6/29/25 but stated the Former DON expected providers to be called and indicated education for staff was probably completed on hospice coordination by the Former DON.	F0849		05/28/2026
F0919 SS = D	Resident Call System CFR(s): 483.90(g)(1)(2) §483.90(g) Resident Call System The facility must be adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area from- §483.90(g)(1) Each resident's bedside; and §483.90(g)(2) Toilet and bathing facilities. This REQUIREMENT is NOT MET as evidenced by: Based on record review, observations and interviews with residents, Responsible Party, and staff, the facility failed to ensure the call light system was functioning properly for 3 of 27 residents who required assistance for activities of daily living (Resident #5, Resident #19, and Resident #48).	F0919	On 5/4/2026, the Administrator supplied residents #5, #19, and #48 with temporary hand bells to ensure they had the ability to summon staff assistance as needed. The Maintenance Director immediately evaluated, repaired, and tested the affected call bells to ensure proper operation. On 5/4/2026, The Maintenance Director completed a 100% facility-wide audit of resident call light systems, including bedside call lights, bathroom call systems, hallway indicator lights, and central console notification functionality. No other issues with call lights were identified. On 5/27/2026, the Director of Nursing (DON) initiated education with all Licensed nursing staff and nurse aides, including agency staff regarding the requirement to verify that residents have access to a functioning call light or alternate communication device, to report any malfunctioning call system immediately, and to ensure residents are provided with a method to always summon staff assistance. All nursing staff not educated on 5/27/26 will be	05/28/2026

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0919 SS = D	Continued from page 18 The findings included: a. Resident #5 was admitted on 8/14/24. The quarterly Minimum Data Set (MDS) assessment dated 4/7/26 revealed Resident #5 was assessed as moderately cognitively impaired. An observation of the call light for Resident #5's room and an interview with the resident occurred on 5/4/26 at 11:00 AM. The light in the hallway above the Resident #5's door did not light up when the call light was pressed. Resident #5 stated he was not aware the call light was not working and had been waiting for a staff member to provide ice water and take money to get a soda for him out of the drink machine. He stated he might have to yell if he needed assistance since his call light was not working. There was not a manual hand bell present for Resident #5's use. An interview with Unit Manager #1 occurred on 5/4/26 at 11:10 AM. She stated she was not aware there was an issue with Resident #5's call light. Unit Manager #1 went to Resident #5's room to test call light. She stated she had no idea the call light was not working and provided a hand bell to Resident #5 and immediately notified maintenance to address the issue. b. Resident #19 was admitted to the facility on 3/29/26. The significant change MDS assessment dated 2/12/26 revealed Resident #19 was moderately cognitively impaired. An observation of the call light for Resident #19's room and an interview with Resident #19 occurred on 5/4/26 at 11:50 AM. When Resident #19's call light was pressed it did not light up in the hallway above the door. Resident #19 stated he did not know that the bell was not working. There was no hand bell present in Resident #19's room. c. Resident #48 was admitted to the facility on 3/17/26. The admission MDS assessment dated 3/20/26 revealed Resident #48 was moderately cognitively impaired. An observation of Resident #48's call light and interview with Resident #48's Responsible Party (RP)	F0919	Continued from page 18 educated prior to their next shift. All newly hired nursing staff will be educated by the DON/designee during orientation. On 5/27/2026, the Administrator educated all Maintenance staff regarding timely response to reported call light concerns, documentation of repairs, and completion of preventive maintenance tasks related to the resident call system. All newly hired maintenance staff will be educated by the Administrator or designee during orientation. Systemic changes by the Administrator included implementing a preventive maintenance schedule in the Technology Enhanced Life Safety System (TELS) electronic building management platform for monthly testing of resident call light systems. The Maintenance Director or designee will maintain documentation of testing, identified concerns, corrective actions, and repair completion. The Administrator is responsible for communicating this requirement to the maintenance director. The Maintenance Director or designee will conduct call light audits as follows: Daily audits of 5 resident rooms on each unit for 2 weeks, Weekly audits of 5 resident rooms on each unit for 4 weeks, Monthly audits of 10 resident rooms on each unit for 2 months. Audits will include verification of call light functionality, bathroom call system functionality, hallway indicator light response, central console notification, timely completion of repairs, and availability of alternate communication devices when needed. Any concerns identified during audits will be corrected immediately. Findings will be documented and submitted to the Administrator and/or Director of Nursing for review. The Maintenance Director or designee will report audit findings to the Quality Assurance and Performance Improvement Committee monthly for 3 months. The QAPI Committee will review the findings to determine effectiveness of corrective actions, identify any trends or patterns, and determine whether additional interventions are needed to maintain sustained compliance. Responsible Party: Maintenance Director/designee, Director of Nursing/designee, Administrator Completion Date: 5/28/26	05/28/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345243	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/11/2026

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F0919 SS = D	Continued from page 19 occurred on 5/4/26 at 11:45 AM. When the bell was pressed, the light in the hallway did not turn on. Resident #48's RP stated she was not aware the call light was not working. There was no hand bell present in Resident #48's room. An interview with Nurse #2 on 5/4/26 at 11:03 AM revealed it was her first day at the facility and she did not know there was any issue with the call lights not lighting up in the hallway. An interview with Nurse Aide (NA) #1 on 5/4/26 at 11:05 AM revealed she did not know there was any issue with the call lights not lighting up in the hallway. An interview with the Maintenance Director occurred on 5/7/26 at 9:24 AM. He stated he was notified by Unit Manager #1 of call lights not lighting up in the hallway on 5/4/26. He was not aware of the call lights not functioning for Resident #5, Resident #19, and Resident #48's rooms before 5/4/26 and no staff had reported any issues. A follow-up interview with the Maintenance Director on 5/7/26 at 1:10 PM was conducted. The Maintenance Director stated any staff member could place a request in the online system for maintenance. He stated staff would frequently stop Maintenance staff members in the hallway with requests. The Maintenance Director stated the Maintenance department did random call light checks often and the nonfunctioning call lights were not identified before 5/4/26. An interview with the Maintenance Assistant on 5/7/26 at 1:35 PM revealed the Maintenance staff did random rounds to check on the call lights in resident rooms, but he was not aware of any of the call lights not working before 5/4/26. An interview with the Director of Nursing (DON) was conducted on 5/8/26 at 4:03 PM. She stated she was not aware of the call lights not working in Resident #5, Resident #19, and Resident #48's rooms before 5/4/26 but stated if there was a concern regarding call lights not working after hours, staff could borrow a call light from an empty room and put a request in the online maintenance request system. The DON stated nursing staff could also give any resident a physical hand bell to use, alert the staff of the use of the physical hand bell, and then put in a request in the online maintenance request system. An interview with the Administrator on 5/7/26 at	F0919		05/28/2026

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F0919 SS = D	Continued from page 20 2:58 PM revealed he did not know the call lights in Resident #5, Resident #19, and Resident #48's rooms were not working before 5/4/26 and he had the expectation that all staff would make a request to fix call lights in the online maintenance request system as soon as the issue was identified.	F0919		05/28/2026