STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345134	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pelican Health Randolph LLC	**4801 Randolph Road , Charlotte, North Carolina, 28211**

(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 from 9/8/25 through 9/17/25. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID# 1D594C-H1.	E0000		10/03/2025
F0000	INITIAL COMMENTS An unannounced recertification and complaint investigation survey was conducted 9/8/25/25 through 9/17/25. Event ID # 1D594C-H1. The following intakes were investigated 799793,799798, 799800, 799802, 799803, 799804, 799805, 799806, 799807, 799808, 799809, 799810, 799814, 799815, 799818, 799820, 799821, 256903, 2575431, 2579401. 17 of the 50 complaint allegations resulted in deficiency. The posting of the 2567 was delayed due to issues with IQIES on 10/01/25 which delayed Quality Assurance (QA) review of the report that is completed prior to posting.	F0000		10/03/2025
F0558 SS = D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is NOT MET as evidenced by: Based on observations, resident and staff interviews, the facility failed to ensure a dependent resident could access the call light device for 1 of 2 residents reviewed for accommodation of needs (Resident #5). The findings included: Resident #5 was admitted to the facility on 7/3/2024	F0558	The facility failed to ensure the call bell was within reach for Resident #5. On 9/10/2025 Nursing Assistant (NA) #1 placed the call bell within reach for resident #5. The Director of Nursing (DON) educated NA#1 and #3 on providing call light prior to leaving Residents room on 9/10/25. On 9/11/2025 the Administrator and the Director of Nursing did an audit of all current residents to ensure Residents had access to their call lights/bells while they were in their rooms. No other call lights were noted out of reach. On 9/10/2025, the Director of Nursing/designee began education with all staff, including agency staff, on the call light/bell policy, and ensuring residents had access to call lights/bells while they were in their rooms. The DON/Designee will ensure all staff, new staff and agency staff are educated on call bells being	11/19/2025

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

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F0558 SS = D	Continued from page 1 with diagnoses that included cervical spinal cord injury and quadriplegia. The quarterly Minimum Data Set (MDS) assessment dated 8/7/2025 revealed Resident #5 was cognitively intact. The MDS indicated Resident #5 was unable to use upper and lower extremities and required maximum assistance for all activities of daily living. An observation was conducted on 9/10/2025 at 2:15 PM of Nurse Aide (NA) #1 providing catheter care to Resident #5. The call button was not in view during the observation. NA #1 completed catheter care and began to exit Resident #5's room without providing Resident #5 with a call button. Surveyor asked if Resident #5 had a way to call staff for assistance. NA #1 looked behind Resident #5's nightstand and retrieved the call button. NA #1 set the call button on the right side of Resident #5's head and asked him to press the button. Resident #5 pressed the button with the right side of his head. NA #1 checked to see if the indicator light was activated on the outside of Resident #5's room prior to leaving the room. An interview was conducted with NA #1 on 9/10/2025 at 2:45 PM. NA #1 stated that she did not normally work with Resident #5; however, was familiar with the special call button and Resident #5 used his head to activate the button. NA #1 stated she was distracted by completing catheter care for survey observation and forgot to give Resident #5 his call button prior to Surveyor asking about the call button. Another observation was conducted on 9/10/2025 at 8:10 PM. While Surveyor stood in the lobby of the facility, Resident #5 was heard yelling for help from his room at the end of the hall. Upon entry to Resident #5's room, the call button was observed hanging off the right side of his bed, out of Resident #5's reach. NA #3 was observed in the hall transporting a resident in a wheelchair. NA #3 entered Resident #5's room, asked Resident #5 how he could assist and gave Resident #5 his call button. NA #3 assisted Resident #5 in removing dentures and confirmed that Resident #5 could access his call button. An interview was conducted with Resident #5 on 9/8/2025 at 11:00 AM. Resident #5 stated that staff did not like to give him his call button. Resident #5 stated that he	F0558	Continued from page 1 within residents reach before they can accept an assignment. Newly hired staff will receive this education during the orientation process. An Ad Hoc Quality Assurance Performance Improvement meeting was conducted on 10/3/2025 with the Medical Director, the Administrator, the Director of Nursing, Registered Nurse Unit Manager to review facility deficiency. To ensure compliance continues, the DON/ designee will audit Residents access to call lights/bells, 10 random rooms, weekly for 12 weeks, the DON will be responsible for sharing the findings of those audits to the Quality Assurance and Performance Improvement committee monthly for three months. Date of Compliance 10/17/25	

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F0558 SS = D	Continued from page 2 could not care for himself because he was paralyzed from the chest down to his feet and that he depended on staff for assistance. An interview with NA #3 revealed that he was assigned as Resident #5's NA. NA #3 reported he forgot to give Resident #5 his call button because he was trying to get all his residents in bed, and he knew that he would return to Resident #5 shortly after placing another resident in bed. NA #3 stated that he normally gave Resident #5 his call button prior to leaving Resident #5's room. An interview was conducted with the Director of Nursing (DON) on 9/12/2025 at 1:45 PM. The DON stated she expected staff to be attentive to residents' environment and ensure that each resident had access to call for assistance if needed. DON stated that NA #1 and NA #3 should have given Resident #5 his button prior to leaving Resident #5's room. During an interview with the Administrator on 09/12/2025 at 2:05 PM, she stated she expected staff to ensure each resident had a call bell in reach prior to leaving the room.	F0558		
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 protection of the resident's property from loss or theft.	F0584	The facility failed to fill the gaps around the packaged terminal air conditioners (PTACs) to separate the exterior environment from the interior of the residents' rooms and failed to secure the seal around the PTACs for rooms #108, #110, #135, #151. On 9/15/2025, the Maintenance Director repaired room #108, #110, #135, #151 gaps around PTAC units. On 9/15/2025, the Maintenance Director completed a 100% audit of all resident room PTAC units for gaps. Any areas identified were corrected at that time. On 9/16/2025, the Regional Maintenance Director completed a 100% audit of all resident room PTAC units to ensure gaps were sealed. All gaps were sealed. The Maintenance Director was educated by the Administrator to ensure no gaps were permitted around the PTAC units in resident rooms. All facility staff will be educated by the Administrator/Designee on reporting any environmental concerns including gaps around PTAC units to Administrator or Maintenance Director. All newly hired maintenance directors will be educated by the Administrator on this process.	11/19/2025

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F0584 SS = E	Continued from page 3 §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is NOT MET as evidenced by: Based on observations, residents and staff interviews, the facility failed to fill the gaps around the packaged terminal air conditioners (PTACs) to separate the exterior environment from the interior of the residents' rooms and failed to secure the seal around the PTACs (rooms #108, #110, #135, #151) for 4 of 8 rooms on 3 of 4 halls reviewed for homelike environment. The findings included: a. An observation conducted on 9/12/25 at 9:32 AM in Room 151 revealed the PTAC unit did not align against the wall and there was an approximately one-inch gap across the top of PTAC unit where the remaining insulation was observed to be in a crumbled condition. Through the gap daylight from the exterior of the building was visible from the interior of the resident room. b. An observation conducted on 9/12/25 at 9:43 AM in Room 108 revealed the PTAC unit did not align with the wall across the top of the unit. The PTAC unit stuck out approximately one inch from the wall which created a gap where the resident room was not sealed from the	F0584	Continued from page 3 An Ad Hoc Quality Assurance Performance Improvement meeting was conducted on 10/3/2025 with the Medical Director, the Administrator, the Director of Nursing, Registered Nurse Unit Manager to review facility deficiency. To ensure continued compliance, the Maintenance Director/Designee will audit PTAC units in 7 rooms per week for 12 weeks. The Maintenance Director will be responsible for sharing the findings of those audits to the Quality Assurance and Performance Improvement committee monthly for three months. Date of Compliance 10/17/25	

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F0584 SS = E	Continued from page 4 outside. Through the gap daylight from the exterior of the building was visible from the interior of the resident room. c. An observation conducted on 9/12/2025 at 9:48 AM in Room 135 revealed there was a two-inch gap across the top of the PTAC unit and the wall. The PTAC unit was not aligned with the wall and the top portion of the unit leaned inwards towards the room. There was a large open area on the right side of the unit where the unit was not sealed to the wall. There were wet, soiled towels and sheets at the time of the observation with brown stains on them, present underneath the PTAC unit. d. An observation on 9/12/25 at 9:58 AM in Room 110 revealed the PTAC unit had a two-inch gap across the top of the unit and the wall. The insulation in the gap was observed to be crumbled as evidenced by smaller pieces of the insulation in the vicinity of main piece of insulation. A second observation of rooms 108, 110, 135, and 151 and facility tour with the Maintenance Director, Regional Maintenance Director, and the Administrator occurred on 9/12/25 at 10:58 AM. The PTAC unit placement in each resident room remained unchanged from the first observation. The Maintenance Director, Regional Maintenance Director and the Administrator explained they were not aware of the PTAC unit gaps in rooms 108, 110, 135, or 151. During the facility tour, the Regional Maintenance Director indicated the PTAC unit electrical cords had been replaced recently and the PTAC units were removed from the wall and put back into place. The PTAC units had a middle, top and bottom screw attachment and after the plugs were replaced, only the middle screws were secured when the units were re-installed. The Regional Maintenance Director indicated the PTAC unit in room 135 was leaning to the point that water was leaking form the unit and that was why there were towels and sheets underneath the PTAC unit. An interview with the Administrator on 9/12/25 at 11:15 AM revealed she expected the PTAC units to be installed correctly in residents' rooms and that the Maintenance staff would make the repairs in the appropriate rooms.	F0584		
F0600 SS = D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse,	F0600	The facility failed to protect a resident's right to be free from resident to resident sexual abuse when Nurse Aide #7 and Floor Technician #1 observed Resident #22, touched resident #27 inappropriately. Resident #27 was assessed by licensed nurse on 6/9/25 with no symptoms of injury and did not exhibit signs of mental anguish. Resident #22 was placed on every 15 minute checks until	11/19/2025

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F0600 SS = D	Continued from page 5 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. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is NOT MET as evidenced by: Based on observation, record review, resident, responsible party, and staff interviews, the facility failed to protect a resident's right to be free from resident to resident sexual abuse when Nurse Aide #7 and Floor Technician #1 observed Resident #22, a male resident, "fondle" a severely cognitively impaired female resident (Resident #27) when he placed his hand under her shirt near/on her bare breast. Resident #27 did not have the cognitive capacity to consent to this intimate sexual contact. This deficient practice affected 1 of 3 residents reviewed for resident-to-resident abuse (Resident #27). The findings included: Resident #22 was admitted to the facility on 5/21/2020 with diagnoses which included encephalopathy (a broad term for any brain disease that alters brain function or structure) and cognitive communication deficit. A quarterly Minimum Data Set (MDS) assessment dated 3/19/2025 indicated Resident #22 was cognitively intact. Resident #22 propelled himself independently in his wheelchair. A Nurse Practitioner progress note dated 6/3/2025 at 7:55 AM indicated Resident #22 was alert and oriented to person, place and time. Resident #22 was stable with no acute concerns. A Psychiatric-Mental Health Nurse Practitioner follow up assessment note dated 6/3/2025 at 10:13 AM revealed Resident #22 was alert and oriented to person, place, time and situation. Resident #22's concentration/attention span, immediate, recent and remote memory were within normal limits. Resident #22's abstract reasoning was assessed as within normal	F0600	Continued from page 5 6/11/2025 when he was able to be further assessed by psychiatry services and did not demonstrate further inappropriate behavior. On 6/9/25 all residents with a BIM's of greater than 10 were interviewed by Social Worker to ensure that no other resident had complaints of being touched inappropriately. No other resident voiced concern. Skin Assessment was completed by Director of Nursing/designee on 6/9/25 for all residents with a BIM's score of less than 10 to identify any signs of inappropriate touch/abuse. None were noted. Resident #22 was placed on 1:1 monitoring every shift by the assigned licensed nurse on 10/2/25 to monitor for any abnormal behaviors and location of resident until alternate placement can be obtained. On 6/9/25 all staff including agency staff were educated on the abuse policy by Director of Nursing/designee which included resident to resident abuse and inappropriate touch. On 10/2/25 staff reeducation began by the Director of Nursing (DON) on the abuse policy, which included resident to resident inappropriate touching. All staff, including agency staff not educated on 10/2/25 will be educated prior to start of next shift. Newly hired staff will be receive this abuse education during the orientation process by the DON/Designee. An Ad Hoc Quality Assurance Performance Improvement meeting was conducted on 10/3/2025 with the Medical Director, the Administrator, the Director of Nursing, Registered Nurse Unit Manager to review facility deficiency. To ensure continued compliance, the Social Worker/designee will interview 5 residents per week for 12 weeks to ensure this deficient practice does not occur and Director of Nursing/designee will review 5 resident skin checks weekly for resident who are unable to be interviewed. The Administrator will be responsible for sharing the findings of those audits with the Quality Assurance and Performance Improvement committee monthly for three months. Date of Compliance 10/17/25	

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F0600 SS = D	Continued from page 6 limits. A review of Resident #22's active care plan as of 6/9/2025 indicated the resident had no care plan related to sexually inappropriate behaviors. Resident #27 was admitted to the facility on 11/3/2021 with diagnoses which included a history of a cerebral infarction, dementia, and cognitive communication deficit. A quarterly MDS assessment dated 4/9/2025 indicated Resident #27 had both short- and long-term memory deficits and severely impaired cognitive skills for daily decision making. She could feed herself with set up/supervision but otherwise required total assistance with all Activities of Daily Living (ADL). Resident #27 was dependent on staff for mobility as she could not propel herself in a wheelchair. A review of the 24-hour Initial Allegation Report dated 6/9/2025 at 11:55 AM indicated a Nurse Aide (NA) (NA #7) had notified the Administrator that a male resident (Resident #22) had been observed fondling a female resident (Resident #27). The NA immediately separated the residents and notified the Administrator. The State Agency was notified on 6/9/2025 at 12:37 PM. Local law enforcement was notified on 6/9/2025 at 1:30 PM. The initial report was signed by the Administrator. A review of a local Law Enforcement Incident Report dated 6/9/2025 at 4:12 PM revealed on 6/9/2025 at 1:20 PM the reporting person (the facility Administrator) reported the victim (Resident #27) had been sexually battered by the known suspect (Resident #22). Resident #22 had used his hand to fondle the outer exterior area of Resident #27's upper private regions. Resident #27 had various cognitive developments, physical disability, and poor health/illness. The case was exceptionally cleared (the law enforcement agency had identified an offender and gathered sufficient evidence to support an arrest and charge, but an external factor beyond the agency's control prevented the arrest or formal prosecution of the offender) on 6/12/2025 as Resident #27/Resident #27's representative chose not to prosecute Resident #22. A Psychiatric Mental Health Nurse Practitioner follow up assessment note dated 6/10/2025 at 10:03 AM revealed Resident #27 was alert and oriented only to person. Resident #27 appeared to be calm and relaxed while sitting in her wheelchair. Staff reported no mood issues, no behavioral issues and no new concerns. Resident #27's concentration/attention were assessed as	F0600		

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F0600 SS = D	Continued from page 7 impaired. Resident #27's immediate memory, recent memory and remote memory were all assessed as impaired. Plan was to follow up in 4 weeks. A social services note dated 6/11/2025 at 11:07 AM indicated Resident #27 had been observed over the past couple of days participating in activities, laughing and watching television. Overall, Resident #27's mood appeared to be good. A review of the 5 Day Investigation Report dated 6/13/2025 at 12:25 PM indicated the Administrator was notified on 6/9/2025 at 11:55 AM by Nursing Aide (NA) #7 that she had observed Resident #22 sitting in the hallway rubbing Resident #27's breast. NA #7 immediately removed Resident #27 from the situation and notified the Administrator. Resident #22 was immediately taken to the Administrator's office and interviewed. A review of the interview statement dated 6/9/2025 indicated Resident #27 stated he did not fondle Resident #22 but was rubbing her arm because she was rubbing his arm. Resident #22 was asked if Resident #27 had given him permission to rub her arm and Resident #22 did not answer the question and stated he had rubbed her arm because she had rubbed his arm. The interview statement was signed by the Administrator, the Director of Nursing and the Social Worker. Resident #22 was placed under constant supervision by the Administrator or Receptionist from the time of the incident until he went on 15 minute checks by nursing staff for 48 hours. A review of the every 15 minute checks log indicated Resident #22 was on 15 minute checks from 6/9/2025 at 3:00 PM to 6/11/2025 at 3:30 PM. A written witness statement dated and signed on 6/9/2025 from NA #7 revealed she had witnessed Resident #22 touching Resident #27's breast. She observed that Resident #22 had looked around to see if anyone saw him. NA #7 immediately removed Resident #27 from the situation and immediately reported the incident to the Administrator. NA #7 stated she did not observe Resident #27 touch Resident #22. Resident #27 had her hands in her lap and did not seem to pay attention to Resident #22 at all. A written witness statement dated and signed on 6/9/2025 from Floor Technician #1 described he was cleaning the floor and observed Resident #22 touching on Resident #27 after rolling his wheelchair up next to Resident #27. Floor Technician #1's statement indicated Resident #27 was not observed touching Resident #22 and she kept her hands to herself. Floor Technician #1's statement indicated NA #7 was also a witness and had reported the incident to the Administrator. A skin check was performed on Resident #27 on 6/9/2025 at 1:00 PM and no concerns were noted. Included in the 5 Day Investigation were	F0600		

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F0600 SS = D	Continued from page 8 Brief Interview for Mental Status (BIMS) assessments dated 6/9/2025 that indicated Resident #22 had moderate cognitive impairment and Resident #27 had severe cognitive impairment. An interview on 9/9/2025 at 11:48 AM with NA #7 indicated Resident #27 was always very confused and was placed at the nurse's station for supervision on a daily basis if not with a staff member or in an activity. Resident #27 was unable to self-propel her wheelchair and was dependent for all care. NA #7 observed on 6/9/2025 before lunch that Resident #22 had propelled his wheelchair next to Resident #27 to sit closely on her right side. Both residents were facing forward toward the rooms across from the nurse's station. NA #7 stated she was checking on the resident in the room across from where Resident #22 and Resident #27 were seated. She stated she observed from the room Resident #22 look up and down the hall as if to see if anyone was watching, then he placed his left hand on Resident #27's right leg and moved his hand up and under Resident #27's shirt toward her breast. NA #7 stated she exited the room immediately and told Resident #22 to stop and asked what he was doing. Resident #22 initially stated nothing then he said he was touching Resident #27 because she was touching him. NA #7 stated Resident #27 was not observed touching Resident #22 and had her hands in her lap. NA #7 stated she was unsure if Resident #27 even knew Resident #22 was sitting beside her. NA #7 believed Resident #22 knew what he was doing especially since he had looked around to see if anyone could see him. NA #7 indicated she was unsure if Resident #22's hand touched Resident #27's breast but stated Resident #27 did not wear a bra under her shirts. NA #7 immediately separated Resident #22 and Resident #27 and notified the Administrator. Resident #22 was placed under continuous supervision. NA #7 stated the only other witness was Floor Technician #1 who had been working down the hallway. NA #7 stated she and Floor Technician #1 had both provided written witness statements. NA #7 indicated she had not noted any changes in Resident #27 after the incident, and she seemed at her baseline. On 9/9/2025 at 2:07 PM a telephone call was placed to Floor Technician #1 who was no longer employed at the facility. The call disconnected after 3 rings. A re-dial attempt resulted in the same disconnection. Subsequent attempts to reach Floor Technician #1 resulted in the calls being disconnected. An interview attempted on 9/8/2025 at 2:09 PM with Resident #27 revealed she was alert but could not provide any information or answer questions in a	F0600		

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F0600 SS = D	Continued from page 9 logical manner. She smiled and spoke in a nonsensical way and could not be understood. A telephone interview on 9/8/2025 at 3:23 PM with Resident #27's Responsible Party (RP) revealed she was contacted very quickly regarding Resident #27 being fondled by Resident #22 on 6/9/2025. She stated she spoke with the local Law Enforcement Officer who responded to the call and had been asked if she wished to pursue charges against Resident #22. The RP chose not to prosecute Resident #22. The RP stated she understood that inappropriate contact could occur in the nursing home setting and there had been no injury. The RP felt the facility staff had intervened quickly and kept Resident #27 safe. Resident #27 had not shown any change in her baseline behavior during RP visits. An interview with Resident #22 on 9/8/2025 at 2:55 PM revealed he recalled the incident when he was accused of inappropriately touching a female resident. He indicated he knew exactly who the female resident was (Resident #27). Resident #22 stated he did nothing wrong, just patted Resident #27 on the arm twice. He indicated he now only spoke to a female resident if spoken to first. He stated he no longer sat with Resident #27 or the other female residents as he once did. An observation on 9/11/2025 at 11:45 AM revealed Resident #22 on the unit and interacting with other male residents and staff. An interview on 9/9/2025 at 3:59 PM with Nurse #1 revealed she knew Resident #22 well. Nurse #1 indicated Resident #22's cognition could fluctuate on a daily basis. She stated she had never witnessed any inappropriate sexual touching between Resident #22 and the female residents. Nurse #1 reported she also cared for Resident #27. Nurse #1 stated Resident #27 required "almost total dependent care." She stated staff always kept Resident #27 under close supervision as she was not ambulatory, could not propel herself in her wheelchair and was consistently confused. Nurse #1 indicated she had never seen Resident #27 touch anyone inappropriately and did not believe Resident #27 would have initiated any physical contact with Resident #22. An interview on 9/10/2025 at 1:03 PM with Nurse Aide (NA) #8 revealed she had not observed or heard of any other inappropriate sexual behavior involving Resident #22. NA #8 stated Resident #22's cognition and behavior did fluctuate from day to day. She believed the interaction between Resident #22 and Resident #27 was an isolated event.	F0600		

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F0600 SS = D	Continued from page 10 An interview on 9/10/2025 at 4:30 PM with the Administrator indicated Resident #22 was not cognitively intact and his cognition fluctuated often. She did not feel resident to resident abuse had occurred due to Resident #22 having a BIMS score that indicated he had moderate cognitive impairment on the day of the event. She stated the responding Law Enforcement Officer had told her Resident #22 was confused and there was nothing he could do with the accusation. She stated she felt staff had acted appropriately and separated the residents immediately. Resident #22 had been interviewed, his statement taken and placed on one to one supervision while waiting for the police. Staff had performed skin checks on Resident #27 and other cognitively impaired residents with no concerns noted. Resident interviews regarding abuse were conducted with cognitively intact residents with no concerns noted. Staff witness statements were obtained. The Administrator stated there was not a Plan of Correction as their investigation had not substantiated abuse. A follow up interview on 9/12/2025 at 2:45 PM with the Administrator indicated she felt Resident #22 was not in his right mind when he inappropriately touched Resident #27 on 6/9/2025. She stated Resident #22's cognition fluctuated on a daily basis. She stated she did not believe abuse had occurred due to both residents being cognitively impaired at the time of the incident. On 9/12/2025, several attempts to reach the Former Director of Nursing by phone were unsuccessful.	F0600		
F0609 SS = D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator	F0609	The facility failed to report an allegation of resident to resident abuse to Adult Protective Services (APS) for resident #27. On 9/15/2025 the Administrator reported the allegation of abuse to the Department of Social Services. On 9/15/2025 100% of the facility reportable incidents (FRI) from the past 90 days were reviewed and reported to the Department of Social Services by the Administrator. No other FRI's were noted to have not been reported to the appropriate departments. On 9/12/2025 Regional Nurse Consultant educated the Administrator on the abuse policy which included notifying Adult Protective Services through the Department of Social Services. The Administrator educated the Director of Nursing on this process in the	11/19/2025

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F0609 SS = D	Continued from page 11 of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is NOT MET as evidenced by: Based on record review and staff interviews, the facility failed to report an allegation of resident to resident sexual abuse to Adult Protective Services (APS) for 1 of 3 residents reviewed for resident to resident abuse (Resident #27). The findings included: The facility's abuse policy revised on 10/20/2022 indicated all alleged violations involving abuse are reported immediately, but no later than 2 hours after the allegation is made, to APS where state law provides for jurisdiction in long-term care facilities in accordance with State law. Resident #27 was admitted to the facility on 11/3/2021. The 24-hour Initial Allegation Report dated 6/9/2025 at 11:55 AM indicated a Nurse Aide (NA) #7 had notified the Administrator that a male resident (Resident #22) had been observed fondling a female resident (Resident #27). The State Agency was notified on 6/9/2025 at 12:37 PM. Local law enforcement was notified on 6/9/2025 at 1:30 PM. The initial report was signed by the Administrator. The 5 Day Investigation Report dated 6/13/2025 at 12:25 PM indicated the Administrator was notified on 6/9/2025 at 11:55 AM by NA #7 that she had observed Resident #22 sitting in the hallway rubbing Resident #27's breast. The incident was not reported to the Department of Social Services/APS. The 5 Day Investigation Report was signed on 6/13/2025 by the Administrator. An interview with the Administrator on 9/12/2025 indicated she did not know she was required to report allegations of abuse to Adult Protective Services or	F0609	Continued from page 11 absence of the Administrator on 9/12/25. Any newly hired Administrator and DON will receive this education during the orientation process by the regional consultant. An Ad Hoc Quality Assurance Performance Improvement meeting was conducted on 10/3/2025 with the Medical Director, the Administrator, the Director of Nursing, Registered Nurse Unit Manager to review facility deficiency. To ensure continued compliance, the Administrator/designee will audit all reportable's and notify Adult Protective Services through the Department of Social Services as they occur. Audits will be conducted weekly for twelve weeks. Notifying Adult Protective Services through the Department of Social Services will be monitored by the Administrator and the Administrator's finding will be reported to the Quality Assurance and Performance Improvement committee monthly for three months.	

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F0609 SS = D	Continued from page 12 she would have done so.	F0609		
F0628 SS = D	Discharge Process CFR(s): 483.15(c)(2)(iii)(3)-(6)(8)(d)(1)(2); 483.21(c)(2) §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with	F0628	The facility failed to notify the Ombudsman of the discharge of Resident #88. On 9/15/2025, the Regional Nurse Consultant notified the Ombudsman, via email, of all residents discharged from the facility from 6/1/2025- 9/15/2025 which included Resident #88. On 10/1/2025, the Administrator notified the Ombudsman, via email, of all residents discharged from the facility from 6/1/2024-9/23/2025, which included Resident #88. On 9/15/2025, the Regional Nurse Consultant provided education to the Administrator that the Ombudsman must be notified of all discharges from the facility. Facility Administrator educated newly hired Social Service Director of the requirement to notify the Ombudsman of all facility discharges on 9/29/25. Any newly hired Administrator or Social Service Director will receive this education during the orientation process by Regional Consultant. An Ad Hoc Quality Assurance Performance Improvement meeting was conducted on 10/3/2025 with the Medical Director, the Administrator, the Director of Nursing, Registered Nurse Unit Manager to review facility deficiency. To ensure continued compliance with regulation, the Administrator/ Designee will audit all resident discharges to make sure they are reported to the Ombudsman at least monthly, the Administrator will report the finding to the Quality Assurance and Performance Improvement committee monthly for three months. Date of Compliance 10/17/25	11/19/2025

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F0628 SS = D	Continued from page 13 paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and	F0628		

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F0628 SS = D	Continued from page 14 submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies-	F0628		

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F0628 SS = D	Continued from page 15 (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). This REQUIREMENT is NOT MET as evidenced by: Based on record review and staff and Ombudsman interviews, the facility failed to notify the Ombudsman in writing of the resident's discharge home for 1 of 3 residents reviewed for discharge (Resident #88). The findings included: Resident #88 was admitted to the facility on 6/20/25. A nursing note dated 7/22/25 at	F0628		

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F0628 SS = D	Continued from page 16 10:11 AM stated Resident #88 was discharged from the facility to his home on 7/22/25 at 10:00 AM with his family member. Education on self-care provided and understanding was verbalized. A review of Resident #88's electronic medical record (EMR) revealed no transfer or discharge notice was issued to Resident #88. A telephone interview on 9/10/25 at 10:41 AM with the Ombudsman revealed she had not received a transfer or discharge list from the facility since May 2025 and was not familiar with Resident #88's discharge home. A telephone interview on 9/12/25 at 3:36 PM with the former Social Worker (SW) revealed she was employed at the facility from June 2025 to the end of August 2025 and was still in training for her position during that time. The former SW indicated she did not send notifications of transfers or discharges to the Ombudsman and did not know about this requirement. The former SW indicated the Administrator handled the details for transfers and discharges in the facility. A telephone interview on 9/15/25 at 3:35 PM with the Administrator revealed the facility currently did not have a SW, but she had the expectation that the facility would communicate with the Ombudsman a list of transfers and discharges. The Administrator indicated she has since been in contact with the Ombudsman and sent her transfer and discharge lists. A telephone interview on 9/17/25 at 1:13 PM with the former Director of Nursing (DON) indicated that Resident #88 had been at the facility for long term antibiotic treatment, which he completed and had a planned to discharge home. She indicated the former SW was responsible for communicating information to the Ombudsman regarding all transfers and discharges.	F0628		
F0658 SS = D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is NOT MET as evidenced by: Based on observations, record review, and family and staff interviews, the facility failed to provide treatment to a resident's bilateral legs for arterial and venous ulcers (an ulcer due to inadequate blood supply) as specified in the physician orders for 1 of 2 residents reviewed for arterial and venous wounds (Resident #2). In addition, the facility failed to	F0658	1.The facility failed to provide treatment to resident #2 bilateral legs for arterial and venous ulcers as specified in the physician orders. The facility failed to ensure transportation was arranged for Resident #97 to attend a scheduled appointment with a Gastroenterologist. The wound nurse received a clarification order from vascular surgeon for treatment to resident #2's bilateral legs on 9/16/2025. Resident #97 no longer resides in the facility. On 9/16/2025- 100% of treatments orders were reviewed by the Director of Nursing to ensure facility treatment orders included how the wound would be cleansed during the dressing change. The Administrator audited the transportation book on 9/15/2027 for the past 3 months to account for any missed appointments; no other appointments were missed without valid reason.	11/19/2025

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F0658 SS = D	Continued from page 17 ensure transportation was arranged for a resident to attend a scheduled appointment with a Gastroenterologist (doctor who specializes in gastrointestinal issues). This occurred for 1 of 3 residents reviewed for medical appointments (Resident #97). The findings included: Resident #2 was admitted to the facility on 03/20/25 diagnoses which included peripheral vascular disease, peripheral arterial disease, edema, and muscle weakness. Review of Resident #2's quarterly Minimum Data Set (MDS) assessment dated 06/27/25 revealed he was cognitively intact and required assistance with most activities of daily living. The assessment also indicated he had wounds to his bilateral lower extremities and required wound care. Review of Resident #2's care plan dated 03/31/25 and revised on 07/31/25 revealed a focus area for the resident having skin impairment upon admission of bilateral lower extremities. The goal was for the resident's wounds to resolve without complications. The interventions included: Enhanced barrier precautions Refer to wound physician as needed Treatment as ordered Weekly skin observations Review of a physician order dated 04/07/25 read: bilateral unna boots (a semi-rigid compression bandage often called a boot made of zinc oxide-impregnated gauze that hardens as it dries, applied from the foot to below the knee to treat venous leg ulcers) from toes to knees per vascular surgeon appointment on 04/07/25, resident is to have wound cleanser to bilateral lower legs, wrapped with unna boots from toes to knees, then apply self-adherent wrap, changed on Mondays and Thursdays every day shift and as needed (PRN) for soiled or off. An observation on 09/10/25 at 12:01 PM of wound care performed by the Wound Nurse on Resident #2 was made. The Wound Nurse gathered her supplies and proceeded into Resident #2's room to provide his wound care to	F0658	Continued from page 17 On 9/15/2025 the Director of Nursing educated all licensed nurses, including agency nurses, on following the treatment order for cleansing wounds as directed by the medical practitioner, and to clarify wound orders with the provider if order is unclear. Any staff not educated on 9/15/25 were educated prior to the start of their next assigned shift. All newly hired licensed nurses, including agency nurses, will be educated during the orientation process by the Director of Nursing/Designee. On September 15, 2025, the Administrator educated the current Transporter and the Director of Nursing that residents must be taken to their appointments unless they are missed for a reason. Licensed Nurse Manager/Supervisor will be responsible for scheduling appointments for residents that require Emergency Medical Transportation. The Director of Nursing made the Licensed Nurse Managers/Supervisors aware of this responsibility on 9/15/25. Any newly hired transporter and Nurse Managers will receive this education during the orientation process by the administrator/designee. The Administrator made the facility transporter aware of the responsibility for scheduling outside resident appointments. The Administrator is to ensure that residents attend appointments as scheduled. An Ad Hoc Quality Assurance Performance Improvement meeting was conducted on 10/3/2025 with the Medical Director, the Administrator, the Director of Nursing, Registered Nurse Unit Manager to review facility deficiency. To ensure continued compliance the Director of Nursing/designee will observe nurses providing wound care 3 times a week for 4 weeks, then weekly for 8 weeks to ensure the Nurses are following the treatment order for cleansing wounds and the Director of Nursing will report the finding to the Quality Assurance and Performance Improvement committee monthly for three months. The Administrator will monitor the transportation log weekly to ensure all residents are taken to their appointments as scheduled unless there is a valid reason for appointment cancelation and the Administrator will report the finding to the Quality Assurance and Performance Improvement committee monthly for three months Date of Compliance 10/17/25	

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F0658 SS = D	Continued from page 18 his bilateral lower legs. Upon entering the room, Resident #2 was sitting in his recliner with his feet dependent on the floor and there was no dressing on his bilateral legs. The Wound Nurse instructed Resident #2 to sit back in his recliner and lift the foot rest of his recliner. Resident #2 lifted his foot rest and the Wound Nurse proceeded to put a clean towel under his right foot on the foot rest. The Wound Nurse with gloves on dabbed the open ulcers on his leg with wound cleanser-soaked gauze and then proceeded to apply the unna boot to the right leg. The right leg was not cleaned with wound cleanser to clean the dry skin patches noted on his lower right leg before the Wound Nurse applied the unna boot. The unna boot was completed on the right leg and the self-adherent wrap (a brand of self-adherent wrap, a type of elastic bandage that sticks only to itself, not to skin, hair or other materials) wrapped around the unna boot for mild compression and taped into place. The Wound Nurse then moved to the left leg and placed a clean towel under the leg and proceeded with gloves on and dabbed the open areas with the wound cleanser-soaked gauze and then proceeded to apply the unna boot to the left leg. The left leg was not cleaned with wound cleanser to clean the dry skin patches noted on his lower left leg before the Wound Nurse applied the unna boot. The unna boot was completed on the left leg and the self-adherent wrap wrapped around the unna boot for mild compression and taped into place. An interview was conducted with Wound Nurse on 09/11/25 at 3:46 PM. The Wound Nurse stated she was not used to doing Resident #2's wound care and said she "didn't feel comfortable doing his wounds" on 09/10/25. The Wound Nurse further stated she had been taught when doing unna boots to only cleanse the open areas so that is what she had done. She indicated the order for the wound care was not clear to her and she should have called the surgeon's office and clarified the order so she would know if the entire lower legs had to be cleansed with wound cleanser or just the open areas. An interview was conducted with the Director of Nursing (DON) who also served as the Infection Preventionist (IP). The DON reported that she started in October 2024 as the IP. The DON stated the Wound Nurse should have cleansed Resident #2's? the entire lower extremities prior to applying the unna boots and further stated if the Wound Nurse was not clear about the orders she should have contacted the surgeon's office and clarified the order. The DON indicated she expected the Wound Nurse to follow the physician's order for wound care.	F0658		

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F0658 SS = D	Continued from page 19 An interview with the Administrator on 09/12/24 at 2:23 PM revealed it was her expectation for the Wound Nurse to follow the physician's order when performing wound care on Resident #2. She stated if the Wound Nurse was not clear about the orders she should have contacted the surgeon's office and clarified the order prior to providing wound care to Resident #2. 2. Resident #97 was admitted to the facility on 11/15/24 with diagnoses that included generalized muscle weakness and dysphagia (difficulty swallowing food or liquids) and was discharged on 3/07/25. Resident #97's admission minimum data set (MDS) assessment dated 11/22/24 revealed she was severely cognitively impaired, dependent for all care and mobility and was coded for having a feeding tube. A care plan dated 11/27/24 revealed Resident #97 had a goal to remain free of side effects or complications related to tube feeding. A review of Resident #97's electronic medical record revealed a physician's order entered on 1/5/25 for a GI consultation (medical consultation with a gastroenterologist). There was no physician progress note that explained the need for the consultation. Review of the facility appointment book revealed Resident #97's name written in on 1/15/25 at 10:40 AM for a "gastro" appointment and "EMS" (Emergency Medical Services). On 9/10/25 at 9:59 AM a phone interview with Family Member #1 revealed she was aware that Resident #97 had missed her gastroenterology appointment, but no explanation was given as to why transportation had not been set up for the appointment. A phone interview on 9/11/25 at 3:42 PM with the appointment scheduler at the gastroenterologist's office revealed Resident #97 had an appointment on 1/15/25 at 11:00 AM and no one showed up for the appointment or had called to cancel it. She indicated Resident #97 did not have any other appointments scheduled with their office. An interview with the facility Transportation Scheduler on 9/15/25 at 1:39 PM revealed he did not schedule appointments for residents but did schedule transportation to appointments. He indicated his process was to look through the facility appointment book daily and make transportation arrangements for	F0658		

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F0658 SS = D	Continued from page 20 residents who had appointments scheduled. The Transportation Scheduler did not recall Resident #97, did not recall making transportation arrangements for her to attend her appointment on 1/15/25 and did not know why she didn't get scheduled for transportation. The Transportation Scheduler indicated that if he saw an appointment in the book with EMS written beside it, he didn't do anything as he didn't schedule for EMS transportation and did not know who was supposed to be doing the scheduling for EMS transportation. He further voiced he transported residents to dialysis appointments in the facility van and used contracted transportation services for all other appointments. An attempt made on 9/16/25 at 11:11 AM to speak with former Social Worker #2 who was employed at the time of the missed appointment on 1/15/25 was unsuccessful. An interview on 9/17/25 at 11:28 AM with the former Assistant Director of Nursing (ADON) who was the ADON at the time of the missed appointment and the current Director of Nursing revealed she recalled Resident #97 but did not recall any issues with her feeding tube and didn't know why she was not scheduled for transportation to her appointment. She indicated the Social Worker would make appointments for residents and write them in the appointment book and the Transportation Scheduler would make the necessary transportation arrangements. A phone interview with the Administrator on 9/15/25 at 3:46 PM She indicated she was not the administrator at the time of Resident #97's missed appointment on 1/15/25 but her expectation was residents would have transportation scheduled to not miss appointments. The Administrator revealed it would have been the Social Worker at the time who scheduled appointments and wrote them in the appointment book. Attempts to speak with the former Medical Director on 9/12/25 at 11:22 AM and 9/16/25 at 11:40 AM were unsuccessful.	F0658		
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	F0684	The facility failed to identify, assess, and obtain wound care orders for Resident #89. Resident #89 is no longer resides at the facility On 9/15/2025 a skin assessment was conducted for all current residents' by the Director of Nursing. No new areas were identified. On 9/16/2025 the Director of Nursing began to educate	11/19/2025

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F0684 SS = D	Continued from page 21 professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is NOT MET as evidenced by: Based on record review, family member, staff, Nurse Practitioner, wound care physician, and Assisted Living Facility Executive Director interviews, the facility failed to identify, assess, and obtain wound care orders for a wound on the left ankle for 1 of 5 residents reviewed for wound care (Resident #89). The findings included: Review of Resident #89's hospital discharge summary dated 02/06/2025 revealed Resident #89 would be discharged to the facility but had no documentation of any wounds when discharged from the hospital. Resident #89 was admitted to the facility on 02/06/2025 with diagnoses that included: diabetes mellitus (DM), and vascular dementia. Review of the facility's admission nursing assessment dated 02/06/2025 at 9:15 PM by Nurse #3 revealed Resident #89 had bilateral upper extremity bruising and bruising to her left ankle. Review of the facility's admission nursing note dated 02/06/2025 at 9:15 PM by Nurse #3 revealed Resident #89 arrived at the facility via wheelchair. Resident #89 was alert and oriented, pleasant with calm affect, and able to make her needs known. Scattered bruising was noted to Resident #89's bilateral upper extremities (arms) and Resident #89's left ankle was covered with a brace, and some was bruising noted. Review of Resident #89's physician orders from 02/06/2025 to 02/24/2025 revealed there were no physician orders for wound care. The admission Minimum Data Set (MDS) assessment dated 02/07/2025 and the discharge MDS dated 02/24/2025 revealed Resident #89 had moderately impaired cognition and required moderate assistance with bathing, and maximum assistance with toileting, dressing, bed mobility, and transfers. The 5-day admission MDS and the discharge MDS revealed Resident #89 had no pressure	F0684	Continued from page 21 current Licensed Nurses and Nurse Aides on identification, reporting and documentation of any open skin issues with any resident. The Director of Nursing/Designee will ensure treatment orders are in place for any newly identified skin issues during the clinical morning meeting. All current Licensed Nurses and Nurse Aides, newly hired nurses and nurse aides will receive this information prior to their first shift, in addition, all nursing agency employees will receive this information prior to working their first shift at facility. An Ad Hoc Quality Assurance Performance Improvement meeting was conducted on 10/3/2025 with the Medical Director, the Administrator, the Director of Nursing, Registered Nurse Unit Manager to review facility deficiency. To ensure continued compliance, the DON/designee will audit 5 random skin assessments weekly for 12 weeks, the Director of Nursing will report the finding to the Quality Assurance and Performance Improvement committee monthly for three months Date of Compliance 10/17/25	

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F0684 SS = D	Continued from page 22 ulcers or wounds. Review of the daily skilled nursing notes dated 02/08/2025, 02/11/2025, 02/12/2025, 02/13/2025, 02/14/2025, 02/15/2025, 02/16/2025, 02/17/2025, and 02/19/2025 revealed Resident #89 had no skin conditions. Review of the Physical Therapy note dated 02/13/2025 at 2:32 PM by the Director of Rehabilitation revealed Resident #89 was assessed for her left lower extremity brace for fit and comfort. The brace was adjusted for fit due to it being too tight. The Director of Rehabilitation doffed (removed) the brace to inspect Resident #89's skin. Resident #89's skin was intact. The Director of Rehabilitation reviewed the hospital records to see any indications for the brace; no indications for the brace were found. The Director of Rehabilitation telephoned Resident #89's family member to inquire about the brace. The family member stated that Resident #89 had an old fracture in September 2024, and the brace was provided by her orthopedic doctor. The family member stated that Resident #89 could bear full weight on both legs and only used the brace occasionally. Review of Resident #89's weekly skin assessment dated 02/17/2025 by Nurse #3 revealed no abnormal skin issues were identified. There was not a weekly skin assessment documented on 2/24/25. Review of Resident #89's care plan dated 02/17/2025 revealed Resident #89 was at high risk for pressure ulcer development and skin impairment related to advanced age, chronic health conditions, cognitive impairment, dry fragile skin, immobility, and impaired healing from diabetes. The interventions included to assess Resident #89 for risk of skin breakdown, assist with turning and positioning, keep skin clean and dry, utilizing pressure reducing mattress, and perform weekly skin assessments. The care plan did not reveal any abnormal skin conditions, pressure ulcers, or wounds. Review of a nursing note dated 02/24/2025 at 4:09 PM by Nurse #3 revealed Resident #89 was discharged to an assisted living facility. There was no documentation about any abnormal skin conditions, pressure ulcers, or wounds.	F0684		

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F0684 SS = D	Continued from page 23 Multiple unsuccessful attempts were made to contact and interview Nurse #3. An interview was conducted with Nurse Aide (NA) #2 on 09/11/2025 at 1:13 PM who routinely worked on the hallway where Resident #89 resided. NA #1 stated that he did not recall or remember anything about Resident #89. An interview was conducted with NA #3 on 09/11/2025 at 3:15 PM who routinely worked on the hallway where Resident #89 resided. NA #2 stated that she did not remember Resident #89. An interview was conducted with the facility's Wound Nurse on 09/11/2025 at 3:46 PM. The Wound Nurse stated she was not aware that Resident #89 had any skin issues or areas of breakdown. The Wound Nurse explained that she had not seen or treated Resident #89 for any type of skin concerns or wounds. An interview was conducted with the Wound Care Physician on 09/09/2025 at 2:15 PM. The Wound Care Physician stated that she had not been consulted to evaluate or treat Resident #89 for any wounds. The Physician explained that she had not seen or treated Resident #89 for any type of skin concerns or wounds and Resident #89 had never been on her wound care case load. An interview was conducted with the Director of Rehabilitation on 09/11/2025 at 4:10 PM. The Director of Rehabilitation stated that Resident #89 had a left ankle brace due to an old left ankle fracture. The Director of Rehabilitation stated that she had worked with Resident #89 on one occasion to adjust her brace because Resident #89 would have periodic swelling to her lower extremities and she wanted to make sure the brace fit correctly. The Director of Rehabilitation stated that she removed the brace and inspected Resident #89's skin and her skin was intact on 02/13/2025. The Director of Rehabilitation explained that she adjusted the brace which was a little too tight and she applied the brace to Resident #89's left ankle. The Director of Rehabilitation also stated that Resident 89's family member had told her that she only wore the brace occasionally, could bear full weight on	F0684		

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F0684 SS = D	Continued from page 24 both legs and had no specific restrictions. Multiple unsuccessful attempts to contact the previous DON were made. A telephone interview was conducted with the Nurse Practitioner (NP) on 09/15/2025 at 10:38 AM. The NP stated that she did not recall Resident #89 having any wounds or skin alterations. The NP stated that the nursing staff would have notified her of any abnormality with Resident #89's skin assessment and she would have consulted the wound care physician for further care and treatment. Review of the facility's Discharge Summary dated 02/24/2025 at 3:05 PM by the former Social Worker #2 revealed Resident #89 was discharged to an assisted living facility. There was no documentation about any abnormal skin conditions or wound care orders. A telephone interview was conducted with the former SW #2 on 09/11/2025 at 4:33 PM. SW #2 stated that she did not remember Resident #89. Review of Resident #89's assisted living facility's progress note entered by a Medication Aide dated 02/25/2025 at 4:46 PM revealed Resident #89 was admitted on 02/24/2025 with an open wound on her left foot. The assisted living facility was not made aware of the wound and Resident #89's family had not been made aware of the wound. The Medication Aide no longer worked for the assisted living facility and could not be contacted for interview. Review of the assisted living facility's physician order dated 02/25/2025 revealed an order for Home Health to evaluate and treat Resident #89's left heel wound. During an interview with the Family Member on 09/10/2025 at 7:45 AM, the Family Member stated when Resident #89 was discharged from the facility to an assisted living facility on 02/24/2025, the nurse at the assisted living facility observed Resident #89 had	F0684		

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F0684 SS = D	Continued from page 25 an open wound to the back of her left ankle. The Family Member stated the wound was about the size of a fifty-cent piece with a dark center. The Family Member also revealed the wound was deep through several layers of skin and there was clear drainage coming from the wound. The Family Member further explained that Resident #89's sock was stuck to the wound. The Family Member stated that there was no mention of the left ankle wound in Resident #89's discharge paperwork and the skilled nursing facility had not been treating the wound and had not notified her that Resident #89 had developed a wound while in the facility. The Family Member stated that the assisted living facility's physician stated to the family member that Resident #89's wound was a diabetic wound. The Family Member stated that she did not know when the wound developed. The Family Member also revealed that Resident #89 had broken her left ankle about a year ago and had been fitted with an ankle brace which she still wore occasionally. An interview was conducted with the Executive Director of the assisted living facility on 09/15/2025 at 4:35 PM. The Executive Director also stated that the nurse that admitted Resident #89 to the assisted living facility was no longer employed with the facility, and she was unable to contact her. The Executive Director further revealed that Resident #89's medical record revealed that Resident #89 was admitted to the facility on 02/24/2025 with a wound on her left foot and remained in the assisted living facility and home health nursing services provided Resident #89's wound care that was required.	F0684		
F0687 SS = D	Foot Care CFR(s): 483.25(b)(2)(i)(ii) §483.25(b)(2) Foot care. To ensure that residents receive proper treatment and care to maintain mobility and good foot health, the facility must: (i) Provide foot care and treatment, in accordance with professional standards of practice, including to prevent complications from the resident's medical condition(s) and (ii) If necessary, assist the resident in making appointments with a qualified person, and arranging for transportation to and from such appointments.	F0687	The facility failed to assess resident's feet to determine if nail care was needed, ensure resident's toenails were trimmed and podiatry services were arranged for Resident #3 and Resident #2. Residents #3 was seen by an outside podiatrist on 9/29/2025. Resident #2 allowed facility nurse to cut his toenails on9/15/2025. On 9/15/2025 the Director of Nursing audited 100% of current residents' feet to ensure that no other residents were affected. The Director of Nursing and Administrator ensured that any resident in need of podiatry services was on the list to be seen on the next in-house podiatry visit. No other resident was identified to be in need of outside podiatry services. On 9/15/2025 the Director of Nursing (DON) began to	11/19/2025

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F0687 SS = D	Continued from page 26 This REQUIREMENT is NOT MET as evidenced by: Based on observations, staff, resident, and Nurse Practitioner (NP) interviews and record review, the facility failed to assess resident's feet to determine if nail care was needed, ensure resident's toenails were trimmed and podiatry services were arranged for 2 of 2 residents reviewed for foot care (Resident #3 and Resident #2). The findings included: 1. Resident #3 was admitted to the facility on 11/01/2024. Resident #3 had diagnoses which included cerebral infarction (occurs when blood flow to the brain is interrupted causing damage to brain tissue) with hemiplegia (a condition that causes paralysis on one side of the body), and diabetes mellitus (DM). Resident #3's care plan dated 02/17/2025 and revised on 08/03/2025 revealed Resident #3 was care planned for activities of daily living (ADL) self-care performance deficits related to her disease processes. The goals included total staff assistance in all aspects of daily care to ensure all needs were met. Interventions included staff to provide grooming and personal hygiene. Review of Resident #3's quarterly Minimum Data Set (MDS) assessment dated 08/08/2025 revealed Resident #3 was severely cognitively impaired and was rarely/never understood. The MDS also revealed Resident #3 was dependent for all ADL. Review of Resident #3's weekly skin assessments from 05/01/2025 through 09/12/2025 revealed no notation that her toenails were long and thick and needed trimmed. Review of the facility's podiatry clinic schedule for 08/18/2025, revealed Resident #3 was not seen by the podiatrist. Review of the facility's podiatry clinic schedule for 10/28/2025 revealed Resident #3 was not scheduled to see the podiatrist. There were no consultation reports or notations in Resident #3's Electronic Medical Record (EMR) that she had been seen by a podiatrist. An observation of Resident #3's feet was conducted on	F0687	Continued from page 26 educated the current nurses and nurse aides, including agency staff, to identify, report and document any residents' requiring foot care/podiatry services. Any resident in need of podiatry services will be reported to the facility Social Service Director. Social Service Director will be responsible for ensuring podiatry services are provided for residents in need of services. Newly hired Social Service Director was made aware of this responsibility by the Administrator on 9/9/25. Any licensed nurses, nurse aides and agency staff not educated on 9/15/25 will be educated prior to the start of their next shift. Newly hired nursing staff and agency staff will receive this education during the orientation process by the DON/designee. An Ad Hoc Quality Assurance Performance Improvement meeting was conducted on 10/3/2025 with the Medical Director, the Administrator, the Director of Nursing, Registered Nurse Unit Manager to review facility deficiency.. For continued compliance, the DON/Designee will observe 10 random residents' feet for need for podiatry services. The Director of Nursing will report the finding to the Quality Assurance and Performance Improvement committee monthly for three months Date of Compliance 10/17/25	

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F0687 SS = D	Continued from page 27 09/08/2025 at 3:10 PM. Resident #3's toes revealed thick, long toenails that extended ½ inch beyond the tip of her toes and were curled downward. Resident #3 also had a light brown crusty material located underneath her toenails. An interview and observation of Resident #3's feet were conducted with Nurse #1 on 09/11/2025 at 9:25 AM. Nurse #1 stated that Resident #3 toenails were too long and very thick and beginning to curl downward. Nurse #1 also revealed that Resident #3 would need to be seen by the podiatrist because she was diabetic. An interview was conducted with the Director of Nursing (DON) on 09/11/2025 at 11:01 AM. The DON stated that she was unaware that Resident #3 needed to see the podiatrist. The DON also stated that the facility's Social Worker (SW) was responsible for scheduling residents for podiatry services, but the facility had not had a SW for about a month, and some residents may not have gotten placed on the upcoming podiatry schedule. The DON also explained that the podiatry clinic was held every 3 months. The DON indicated she expected all residents to receive podiatry services when needed. An interview was conducted with the Administrator on 09/15/2025 at 9:01 AM. The Administrator stated that she expected all residents to receive podiatry services as needed and depending on the situation, the resident could be sent out for an outpatient podiatry appointment, if need. An interview was conducted with the Nurse Practitioner (NP) on 09/15/2025 at 10:38 AM. The NP stated that she was not aware that Resident #3's toenails were long and thick, but she did try to check all diabetic resident's feet during her assessments. The NP also stated that the nursing staff should not attempt to cut or trim Resident #3's toenails but should have had Resident #3 seen by the podiatrist. The NP stated that all diabetic residents should be referred to the podiatrist for care and treatment of their toenails. 2. Resident #2 was admitted to the facility on 03/20/2025 with diagnoses which included polyosteoarthritis, peripheral vascular disease,	F0687		

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F0687 SS = D	Continued from page 28 peripheral arterial disease, and muscles weakness among others. Resident #2's care plan dated 03/31/2025 and revised on 07/31/2025 revealed Resident #2 was care planned for requiring assistance with activities of daily living (ADL) related to chronic health conditions, congestive heart failure and muscle weakness. The goal was for the resident to maintain his current level of function as able through the review date. The interventions included provide ADL assistance as needed, independent for transfers, provide setup for meals and independent for bed mobility. Review of Resident #2's quarterly Minimum Data Set (MDS) assessment dated 07/10/2025 revealed Resident #2 was cognitively intact.. The MDS also revealed Resident #2 required substantial to moderate assistance with bathing and showering and personal hygiene. Review of Resident #2's weekly skin assessments from 03/21/2025 through 08/22/25 revealed no notation that his toenails were long and thick and needed trimmed. Review of the facility's podiatry clinic schedule for 08/18/2025, revealed Resident #2 was not seen by the podiatrist. Review of the facility's podiatry clinic schedule for 10/28/2025 revealed Resident #2 was not scheduled to see the podiatrist. There were no consultation reports or notations in Resident #2's Electronic Medical Record (EMR) that he had been seen by a podiatrist. An observation of Resident #2's feet was conducted on 09/08/2025 at 11:58 AM. Resident #2's toes revealed thick, long pointed toenails that extended ¼ inch beyond the tip of his toes and were jagged on most of his toes. Resident #2 also had a light brown crusty material located underneath his toenails. An interview was conducted with Resident #2 on 09/09/2025 at 11:00 AM. Resident #2 stated he would like for his toenails to be trimmed but said he could not get down to reach his toes and trim them. Resident #2 stated he could ask his sister to cut them but said he would prefer for the facility staff to cut them for him or be seen by a podiatrist to get them cut. An interview and observation of Resident #2's feet was conducted with Nurse #1 on 09/11/2025 at 2:06 PM. Nurse #1 stated that Resident #2 toenails were long and very thick. Nurse #1 also revealed that Resident #2 would need to be seen by the podiatrist even though he was not diabetic because they were too thick to be cut by	F0687		

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F0687 SS = D	Continued from page 29 the nurse. An interview and observation was conducted with the Director of Nursing (DON) on 09/12/2025 at 3:37 PM. The DON stated that she was unaware that Resident #2 needed to see the podiatrist. The DON also stated that the facility's Social Worker (SW) was responsible for scheduling residents for podiatry services, but the facility had not had a SW for about a month, and some residents may not have gotten placed on the upcoming podiatry schedule. The DON also explained that the podiatry clinic was held every 3 months. The DON indicated she expected all residents to receive podiatry services when needed. An interview was conducted with the Administrator on 09/15/2025 at 9:01 AM. The Administrator stated that she expected all residents to receive podiatry services as needed and depending on the situation, the resident could be sent out for an outpatient podiatry appointment, if needed. An interview was conducted with the Nurse Practitioner (NP) on 09/15/2025 at 10:38 AM. The NP stated that she was not aware that Resident #2's toenails were long and thick, but she did try to check all resident's feet during her assessments. The NP also stated that the nursing staff should not attempt to cut or trim Resident #2's toenails if they were thick but should have had Resident #2 seen by the podiatrist. The NP stated that all residents with thick toenails should be referred to the podiatrist for care and treatment of their toenails.	F0687		
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 observation, record review, resident and staff interviews, the facility failed to provide safe	F0689	On 5/18/2025 and 9/10/2025 the facility failed to provide safe mechanical lift transfers when a mechanical lift bar struck resident #56 in the forehead resulting in a hematoma and for resident #5 when Nurse Aide (NA) #2 and NA #5failed to lock toe lift wheels prior to transfer. The facility corrected the incident for resident #56 when the incident happened 5/18/25 by educating the clinical staff on mechanical lifts, the two staff members involved no longer work for the facility. Resident #5 was transferred from wheelchair to bed without injury. Resident #56 was assessed by the nurse and transported to the hospital for further assessment. On 9/10/25 nurse aide (NA) #2 and #5 were reeducated by the Director of Nursing on mechanical lift transfers, which included ensuring toe lift wheels are locked prior to transferring resident when using mechanical lift. On 9/15/2025 the Director of Nursing observed	11/19/2025

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F0689 SS = D	Continued from page 30 mechanical lift transfers when the lift swung and hit the resident on the forehead resulting in a hematoma (collection of blood outside of a blood vessel) (Resident #56). In addition, staff failed to follow manufacturer guidelines for the use of a mechanical lift (Resident #5). This affected 2 of 3 residents reviewed for free of accident hazards, supervision and devices (Resident #56 and Resident #5). The findings included: A review of the undated Safe Lifting of Residents policy revealed that floor based and overhead full-body sling lifts (i.e. mechanical lift) required a minimum of two person assist, and the manufacturer's guidance/instructions would be followed on all other types of lifts. 1. Resident #56 was admitted to the facility on 6/18/2021 with diagnoses which included quadriplegia (a condition when a person experiences the partial or total loss of function and feeling in all four limbs and torso), history of seizure, history of traumatic brain injury and chronic respiratory failure. An annual Minimum Data Set (MDS) assessment dated 4/18/2025 indicated Resident #56 was cognitively intact. Resident #56 had impaired range of motion (ROM) in all extremities. Resident #56 could feed herself and perform oral hygiene with set up assistance using her left hand but was dependent with all other Activities of Daily Living (ADL). Resident #56 was dependent for all transfers which required a mechanical lift. Resident #56 was not taking an anticoagulant on 5/18/2025 as this medication had been on hold since 5/6/2025 due to the pre-surgical protocol for a planned surgery later in May 2025. A review of Resident #56's care plan dated 4/23/2025 revealed a focus area for a risk to fall related to deconditioning and quadriplegia with a goal of Resident #56 being free of falls through the review period. Interventions included anticipating and meeting the resident's needs, always have the call bell within reach and resident needed 2 persons with bed mobility and transfers. A nursing note dated 5/18/2025 at 9:20 PM revealed Nurse #4 was called into Resident #56's room on 5/18/2025 at 7:31 PM and observed Resident #56 lying on the floor near her bed with the mechanical lift pad underneath her. Nurse Aide (NA) #5 stated there was a mechanical lift failure during the transfer so Resident	F0689	Continued from page 30 100% of residents requiring the mechanical lifts for transfer by the Director of Nursing to ensure no other deficient practice. The audit revealed no other residents were affected by this deficient practice. 3. On 9/10/ 25 the Director of Nursing began education with the Nurses and NA's on the use of mechanical lifts which included ensuring the mechanical lift wheels are locked prior to transfer and to observe the lift swing bar location to ensure it does not strike residents during transfer. Director of Nursing/Designee will review newly admitted resident transfer status and change of transfer status in clinical meeting. DON/Designee will educate staff on new admits requiring mechanical lift in addition to current residents that have a status change requiring mechanical lift transfer. The Director of Nursing/designee will provide training to all staff including new Nurses and NA's during orientation as well as agency staff prior to picking up shifts at this facility. 4. An Ad Hoc Quality Assurance Performance Improvement meeting was conducted on 10/3/2025 with the Medical Director, the Administrator, the Director of Nursing, Registered Nurse Unit Manager to review facility deficiency. To ensure continued compliance, the Director of Nursing will complete 2 random audits Nurses and NA's transferring residents with mechanical lifts weekly x12 weeks. The Director of Nursing will report the findings to the Quality Assurance and Performance Improvement committee monthly for three months Date of Compliance 10/17/25	

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F0689 SS = D	Continued from page 31 #56 was eased/lowered to the floor. Resident #56 was observed with a hematoma on her forehead. Resident #56 reported she did not fall, she was lowered to the floor and said the hematoma on her forehead was obtained when the mechanical lift hit her in the head. No other apparent injury noted at the time of the assessment. Neurological checks were initiated. The Nurse Practitioner (NP) was notified at 7:35 PM and provided orders to send Resident #56 to the hospital for evaluation. The Responsible Party (RP) was contacted. Emergency Medical Services (EMS) arrived and transported Resident #56 to the hospital at 8:00 PM. A telephone interview on 9/12/2025 at 11:13 AM with Nurse #4 revealed she had been called to the Resident #56's room on the evening of 5/18/2025. Nurse #4 stated when she arrived in the room, Resident #56 was on the floor, lying on the mechanical lift sling. NA #5 reported the battery had failed on the mechanical lift and NA #5 had lowered Resident #56 who was still in the sling attached to the mechanical lift to the floor. Resident #56 stated she did not fall, that the mechanical lift had swung and hit her in the forehead. Nurse #4 immediately noted the hematoma on Resident #56's forehead and notified the provider who gave orders to send Resident #56 to the hospital. Nurse #4 stated she did not know if NA #5 had performed the mechanical lift transfer alone as she had been called after Resident #56 was already on the floor. An Incident Witness Statement dated 5/18/2025 taken by the former Director of Nursing from NA #5 indicated he was transferring Resident #56 back to bed with the assist from another NA (NA #6). When the mechanical lift battery died and while trying to maneuver the lift machine, the geriatric recliner fell over and the resident hit her head on the lift machine. NA #5 lowered Resident #56 to the floor due to the battery being dead. The statement was signed by the former Director of Nursing. A telephone interview on 9/10/2025 at 5:11 PM with NA #5 indicated he had previously worked at the facility. He stated he recalled Resident #56. When NA #56 was asked about what happened on 5/18/2025 with the mechanical lift, NA #5 disconnected the call. A redial attempt was not answered. Several attempts to reach NA #5 again were not successful. An Incident Witness Statement dated 5/18/2025 taken by the former Director of Nursing from NA #6 indicated that NA #6 was not present during the transfer of Resident #56 on the noted incident date (5/18/2025). The statement was signed by the former Director of	F0689		

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F0689 SS = D	Continued from page 32 Nursing. A telephone interview on 9/11/2025 at 11:04 AM with NA #6 revealed she was previously employed at the facility and recalled Resident #56. NA #6 stated on 5/18/2025 in the evening, NA #5 had come to the room where NA #6 and the Scheduler (who was working as an NA at that time) were assisting another resident. NA #6 told NA #5 that she would help him with Resident #56 and the mechanical lift transfer when she had finished care with the resident she was currently with. She stated a few minutes passed and NA #5 was back at the doorway and stated he needed help quickly with Resident #56. NA #6 went to the doorway of Resident #56's room and observed Resident #56 on the floor. NA #5 was the only staff member in the room. NA #6 immediately called Nurse #4. NA #6 stated that NA #5 had asked her to say she was with him during the mechanical lift transfer but NA #6 stated she would not do that. NA #6 found out that NA #5 had told the Director of Nursing (DON) that NA #6 had been with him during the mechanical lift transfer. NA #6 stated she provided her own statement to the DON that she had not been present during the mechanical lift transfer with Resident #56. An interview on 9/12/2025 at 9:15 AM with the Scheduler indicated on the evening of 5/18/2025 she was with NA #6 performing care with another resident when NA #5 had asked for assistance with Resident #56. NA #5 had been told to wait for assistance. The Scheduler and NA #6 had just finished care when NA #5 came back asking for help. The Scheduler went to Resident #56's room and observed Resident #56 on the floor, lying on the mechanical lift sling. No other staff was present in the room. She noted the injury to Resident #56's forehead and Nurse #4 was notified. The Scheduler stated NA #6 had been assisting her the entire time and was not involved in the mechanical lift transfer for Resident #56 on 5/18/2025. A review of the hospital emergency department records dated 5/18/2025 at 8:41 PM indicated that both Emergency Medical Services (EMS) and Resident #56 reported that Resident #56 had been hit in the head by the mechanical lift while being transferred back to bed by the mechanical lift. Resident #56 had been lowered to the floor and stayed on the floor until EMS arrived and transported Resident #56 to the hospital. Resident #56 had an obvious hematoma to her forehead and complained of a headache of 7 on a 0 to10 pain scale. Resident #56 was not on any anticoagulants, had no nausea or vomiting and denied seeing double. Resident #56 did not lose consciousness during the incident. A review of the Computed Tomography (CT) of the head and	F0689		

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F0689 SS = D	Continued from page 33 CT of the facial bones dated 5/18/2025 at 9:19 PM indicated soft tissue swelling of the forehead and a hematoma on the forehead. No acute fracture of the maxillofacial bones noted. No intracranial hemorrhage or other injuries were noted. No new orders were noted. A nursing note dated 5/18/2025 at 11:45 PM indicated Resident #56 had returned to the facility from the hospital. There were no new orders regarding care of the hematoma on Resident #56's forehead. A Nurse Practitioner progress note dated 5/19/2025 at 8:17 AM indicated Resident #56 had been sent to the hospital on 5/18/2025 after being hit in the head by the mechanical lift during a mechanical lift transfer. A Computed Tomography (CT) scan was performed and no acute fracture noted. The small hematoma on her forehead was being monitored and pain management provided as needed. A nursing note dated 5/19/2025 at 9:52 PM indicated Resident #56 was alert and oriented with no acute distress noted. The bruise remained on Resident #56's forehead but no complaints of pain or discomfort when touched. Resident #56 continued on neurological checks and all were within normal limits. No other concerns noted. A telephone interview on 9/15/2025 at 2:43 PM with the Nurse Practitioner (NP) revealed she had been called on 5/18/2025 and notified of the mechanical lift transfer accident. Resident #56 had been sent to the hospital and returned to the facility later that night. The NP had seen Resident #56 on 5/19/2025, 5/21/2025 and 5/27/2025 to monitor the status of the forehead hematoma, Resident #56's cognition and neurological status. Nursing continued to perform neurological checks during this time and provided pain management as needed. An interview on 9/8/2025 at 11:03 AM with Resident #56 revealed she required a mechanical lift transfer into the geriatric recliner when she chose to get out of bed. Resident #56 stated a few months ago there had been a mechanical lift accident when Nursing Aide (NA) #5 had tried to use the lift by himself. On the evening of the accident, Resident #56 stated she had requested to get back into bed after sitting up in the geriatric recliner. NA #5 had used the mechanical lift without a second staff member present. Resident #56 stated the mechanical lift battery had stopped working and NA #5 was trying to move the sling closer to the bed which got caught on the geriatric recliner and caused the bar to swing and hit Resident #56 in the forehead resulting	F0689		

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F0689 SS = D	Continued from page 34 in a hematoma. NA #5 lowered Resident #56 to the floor and went to seek assistance. Resident #56 stated she was transferred to the hospital for an assessment. Resident #56 indicated she now knew two staff members were required for mechanical lift transfers at all times. Resident #56 stated since the accident there have always been two staff members present when using the mechanical lift. An interview on 9/9/2025 at 3:59 PM with Nurse #1 revealed she was not working when the mechanical lift accident occurred but she had heard about it. Nurse #1 stated staff had been educated over and over regarding proper mechanical lift procedure and that two trained staff members should be present for all mechanical lift transfers. An Interdisciplinary Team (IDT) note dated 5/19/2025 indicated the IDT met and discussed educating staff on the importance of ensuring that the mechanical lift battery was fully charged and worked properly prior to transferring a resident as NA #5 had reported the battery stopped working when he was transferring Resident #56 on 5/18/2025. An interview on 9/10/2025 at 3:02 PM with the Administrator revealed that two issues were investigated regarding the mechanical lift accident. The first issue was whether or not there were two staff members present for the mechanical lift transfer performed on 5/18/2025 with Resident #56. The Administrator stated NA #5 had reported in his statement that NA #6 had been present. NA #6 reported in her statement that she had not assisted with the mechanical lift transfer and was not in the room at the time of the mechanical lift accident. The Administrator indicated that until 9/8/2025, Resident #56 had always told the Administrator that there were two staff members in the room on 5/18/2025 when the mechanical lift was used. When the Administrator spoke with Resident #56 on 9/8/2025, Resident #56 stated there was only one staff member present. The second issue addressed during the investigation was that NA #5 indicated that the battery on the mechanical lift had stopped during the mechanical lift transfer and had slowly lowered Resident #56 to the floor. The Administrator stated the mechanical lift had been inspected and no obvious issues were noted but the facility had deemed that the lift not to be used in the future to be extra cautious. The Administrator stated the facility developed a Plan of Correction (POC) to reeducate staff regarding mechanical lift use and the need for staff to check if the battery was fully charged prior to use to ensure resident safety.	F0689		

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F0689 SS = D	Continued from page 35 A follow-up interview on 9/12/2025 at 2:45 PM with the Administrator revealed there should be two staff members present for all mechanical lift transfers and staff should check to ensure the battery is fully charged prior to use. An interview on 9/12/2025 at 2:30 PM with the Director of Nursing (DON) indicated she was not working in the facility at the time of the mechanical lift accident. The DON stated there should always be two staff members assisting with a mechanical lift transfer. Several attempts to reach the former Director of Nursing (DON) were unsuccessful. 2. Review of the mechanical lift user manual without a date provided by the facility, revealed in section 7.1 titled “Lifting the Patient”, Step 1. With the legs of the base open and locked, use the steering handle to push the patient lift into position. Step 2. Lower the patient lift for easy attachment of the sling. “WARNING”: The legs of the lift must be in the maximum open position and the shifter handle locked in place for optimum stability and safety. Resident #5 was admitted to the facility on 7/4/24 with diagnoses which included cervical spinal cord injury and quadriplegia. The quarterly Minimum Data Set (MDS) assessment dated 8/7/2025 revealed Resident #5 was cognitively intact. The MDS indicated Resident #5 was unable to use upper and lower extremities and required maximum assistance for all activities of daily living. Resident #5’s care plan dated 9/8/25 included the goal to provide assistance with activities of daily living (ADL) related to quadriplegia. The interventions included Resident #5 requires a mechanical lift for all transfers and the use of two people. An observation of a mechanical lift transfer for Resident #5 was conducted on 9/10/25 at 11:30 AM. Nurse Aide (NA) #2 and #5 were observed as they transferred Resident #5 from his wheelchair to his bed using a mechanical lift. NA #5 locked the wheels to Resident #5’s wheelchair as NA #2 positioned the mechanical lift around Resident #5’s wheelchair without	F0689		

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F0689 SS = D	Continued from page 36 widening/opening or locking the base of the mechanical lift. The mechanical lift was pushed tightly around Resident #5's wheelchair causing the base of the lift to get stuck in the wheelchair. NA #2 and NA #5 attached Resident #5's mechanical lift sling support to the mechanical lift. NA #1 and NA #2 tried to move the lift to Resident #5's bed and could not pull the mechanical lift away from Resident #5's wheelchair. The East Unit Manager maneuvered Resident #5's wheelchair from side to side to release the wheelchair from the mechanical lift. NA #1 and NA #2 transferred Resident #5 from the mechanical lift to his bed without widening the mechanical lift base or locking the base of the mechanical lift. An interview was conducted on 09/12/2025 at 5:45 PM with NA #5. NA #5 reported while using a mechanical lift and transferring residents, the base of mechanical lift should be widened as needed for the size of the chair and the wheels to the mechanical lift should be locked. NA #5 reported she connected the sling to Resident #5 and guided his legs while NA #2 controlled the lift and did not think to look at the lift to assure the base was in a widen position or if the wheels were locked while connecting the resident to the lift. A phone interview was conducted on 09/15/2025 at 3:22 PM with NA #2. NA #2 stated the procedure when transferring a resident using a mechanical lift should include widening the base of the mechanical lift, placing the lift around the wheelchair and locking the wheels to the lift. NA #2 reported she could not recall opening the base or locking wheels to the mechanical lift. An interview was completed on 09/12/2025 at 6:06 PM with the East Unit Manager. The East Unit Manager stated she recalled pulling Resident #5's wheelchair from side to side because the mechanical lift was tight around the wheelchair. The East Unit Manager stated if the base was in widened position, she could have removed the wheelchair with more ease. The East Unit Manager reported she did not think to widen the base of the mechanical lift or lock the wheels to the mechanical lift at the time. An interview with the Director of Nursing (DON) on 09/12/2025 at 5:30 PM revealed the staff were just educated on 05/21/2025 regarding Mechanical lift	F0689		

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F0689 SS = D	Continued from page 37 transfers. The DON stated NA #2, NA #5, and the East Unit Manager should have widened the base and locked the wheels to the mechanical lift when transferring Resident #5 on 09/10/25 at 11:30 AM. An interview was conducted on 09/12/2025 at 2:18 pm with the Administrator. The Administrator stated staff received education about mechanical lifts and transfers upon hire and on an as needed basis. The Administrator stated she expected staff to follow the policy for mechanical lift transfers.	F0689		
F0690 SS = D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is NOT MET as evidenced by:	F0690	The facility failed to empty urinary drainage bag and secure urinary catheter tubing with anchoring device for Resident #5. On 9/8/25 Nurse Adie (NA) emptied the foley catheter. On 9/10/2025 the Director of Nursing added an anchor to Resident #5's catheter bag. On 9/10/2025 the Director of Nursing did a 100% audit of all residents with catheter bags to ensure foley catheter bags were emptied and anchor device was on. No other residents with catheters were noted to be in need of anchor or bag to be emptied. On 9/15/2015 the Director of Nursing began to educate the nurses and NA's, including agency staff on proper emptying of catheter bags and proper anchoring of catheter bags. All new admissions and orders for current residents will be reviewed by the Director of Nursing/Designee in clinical meeting to ensure orders are in place for emptying foley bag each shift and catheter securement device is in place. Any staff not educated on 9/15/25 were educated prior to next shift. All newly hired nurses and NA's, including agency staff, will be educated on this process during the orientation process by the DON/designee. An Ad Hoc Quality Assurance Performance Improvement meeting was conducted on 10/3/2025 with the Medical Director, the Administrator, the Director of Nursing, Registered Nurse Unit Manager to review facility deficiency. To ensure continued compliance, the Director of Nursing will complete 2 random catheter bag audits to ensure catheter bags are not over filled and are properly anchored weekly x12 weeks. The Director of Nursing will report the finding to the Quality Assurance and Performance Improvement committee monthly for three months Date of Compliance 10/17/25	11/19/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345134	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pelican Health Randolph LLC	4801 Randolph Road , Charlotte, North Carolina, 28211

(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
F0690 SS = D	Continued from page 38 Based on observations, record review, and staff interviews, the facility failed to empty urinary drainage bag and secure urinary catheter tubing with anchoring device to prevent trauma to urinary opening or dislodgment of the catheter. The deficient practice occurred for 1 of 2 residents reviewed for urinary catheter care (Resident #5). The findings included: Resident #5 was admitted to the facility on 7/4/24 with diagnoses which included cervical spinal cord injury and neurogenic bladder (a disorder or problem with the nerve control of continence and voiding function). The quarterly Minimum Data Set (MDS) assessment dated 8/7/2025 revealed Resident #5 was cognitively intact. The MDS indicated Resident #5 was unable to use upper and lower extremities and required maximum assistance for all activities of daily living. He was documented as having an indwelling urinary catheter. Resident #5's care plan dated 9/8/25 included the goal to provide urinary catheter to Resident #5 for neurogenic bladder. The interventions included catheter anchor/securement device, and provide catheter care every shift. An observation was conducted on 9/08/2025 at 1:22 PM. Resident #5's urinary bag was 100% full and hanging below his bladder level on the left side of Resident #5's bed on a hook. The urine drainage bag capacity was 2000 milliliters, and urine was observed backed up halfway in the tubing. An interview with Resident #5 was conducted on 9/08/2025 at 1:23 PM. Resident #5 stated that he had seen staff come in his room once or twice a day to empty his urine bag. Resident #5 reported he had not noticed urine in the urine drainage tubing. Resident #5 reported that he had not noticed a device to secure the urinary device tubing in place and could not tell if the urinary device was pulling. On 9/8/2025 at 3:15 PM another observation revealed Resident #5's urinary drainage bag was empty. An observation was conducted on 9/09/2025 at 12:30 PM when the Medication Aide (MA) #1 provided catheter care to Resident #5. Resident #5 had an indwelling urinary catheter connected to a bedside urinary drainage bag that was half full. Resident #5's urethral opening had a healed split at the base of the urethra opening.	F0690		

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F0690 SS = D	Continued from page 39 There was no observation of a leg strap or urinary anchor to secure the indwelling catheter tubing in place. The MA #1 emptied the urine drainage bag when she completed the catheter care. An interview was conducted with the MA on 09/09/2025 at 12:50 PM. The MA stated Resident #5 had not had a catheter anchor when she provided catheter care in the past. MA #1 reported Resident #5 had an issue with catheter becoming dislodged when the catheter was placed last year which caused a slit at the urinary opening. The MA reported that the staff try to empty Resident #5's urine bag during rounds if full and at the end of each shift. MA reported she tried to ensure that Resident's #5's urinary devices was not pulling on Resident's #5 urinary opening when providing care. MA #1 reported she was not aware that Resident #5 required a urinary catheter anchor and would make sure she adjusted the urinary device tubing to assure the catheter tubing did not cause tension on Resident #5's urethral (urinary opening). A follow-up observation was conducted on 09/10/2025 at 1:03 PM of Resident #5's indwelling urinary drainage system when the Wound Nurse provided Resident #5's wound care with the assistance of the West Unit Manager. The bedside drainage bag was positioned below his bladder hanging on the side of his bed. The urine bag appeared to be a quarter full, and Resident #5 did not have a leg strap or anchor in place to secure the urinary catheter tubing. The West Unit Manager confirmed that there was not a urinary securement device on Resident #5. The nurse assigned to Resident #5 on 9/10/25 from 7:00 AM to 3:00 PM was unable to be interviewed during the survey. The Wound Nurse was accompanied to Central Supply room on 09/11/2025 at 8:38 AM where one urinary leg strap and three adhesive urinary securement devices were observed. An observation on 9/11/2025 at 10:15 AM revealed Resident #5 had a leg strap securement device to his left leg to secure urinary catheter tubing. An interview was completed with Wound Nurse on 09/11/2025 at 3:46 PM. The Wound Nurse stated she had been assigned to Resident #5 in past and was only assigned to complete Resident #5's wound care for 09/10/2025. The Wound Nurse reported that the assigned nurse for Resident #5 should obtain a urinary securement device from Central Supply and apply to	F0690		

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F0690 SS = D	Continued from page 40 Resident #5. An interview was completed with Nurse Aide (NA) #3 on 09/10/2025 at 3:45 PM. NA #3 confirmed he was assigned to Resident #5 and reported he would empty urine collection bags during his rounds every 2 hours and would empty urine bag prior to transferring Resident #5 to avoid extra tension pulling on Resident #5's catheter tubing. NA #3 stated he had not noticed a securement device for Resident #5's catheter tubing and just made sure the urinary catheter tubing was not pulling on Resident #5's urinary opening. An interview with the Director of Nursing (DON) was conducted on 9/11/2025 at 2:40 PM. The DON reported she began working at the facility in October 2024 and 9/10/2025 was her first day as DON. The DON stated that the nurse aides should empty the urinary bags when they round every 2 hours and at the end of the shift. The nurses were expected to follow the medical orders and care plans. The DON stated that since Resident #5 had an order and care plan for a catheter anchor/securement device, the nurse should have placed the anchor or delegated to a nurse aide to place the anchor on Resident #5. A phone interview with Nurse Practitioner #1 was completed on 9/15/25 at 5:13 pm. Nurse Practitioner #1 stated Resident #5 was followed by urology for chronic urinary tract infections (UTI) and neurogenic bladder. Nurse Practitioner stated Resident #5 had not had urinary device dislodgement since she began working with the resident January 2025. A phone interview was completed with the Medical Director on 09/16/2025 at 11:31 AM. The Medical Director stated that he wrote an order for catheter leg anchor because it was best practice to have a urinary securement device to prevent injury to urethra and prevent the urinary catheter from becoming dislodged when Resident #5 was repositioned. The Medical Director reported that a full urinary bag would add more tension to the urinary catheter tubing that could add to the potential for trauma and the potential for stagnant urine to backflow into the bladder.	F0690		
F0693 SS = D	Tube Feeding Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)(5) §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous	F0693	On 9/10/2025 at 2:06pm the facility failed to properly label enteral feed bag for Resident #3. On 9/11/2025 the Director of Nursing acquired the proper enteral feed tube labeled and ensured it was on the enteral feed bag. On 9/11/2025 the Director of Nursing did a 100% audit	11/19/2025

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F0693 SS = D	Continued from page 41 endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is NOT MET as evidenced by: Based on observations, record review, and staff interviews, the facility failed to follow procedure for labeling a continuous gastrostomy tube (a tube surgically placed in the stomach to provide nutrition, hydration, and medications) feeding. This deficient practice was for 1 of 2 residents reviewed for enteral (the administration of nutrients directly into the gastrointestinal tract through a tube) feeding management (Resident #3). The findings included: Resident #3 was admitted to the facility on 11/01/2024. Resident #3 had diagnoses which included chronic respiratory failure with hypoxia, diabetes mellitus (DM), and gastrostomy tube status. A review of Resident #3's Physician orders revealed: 1. 01/20/2025 Nothing by mouth (NPO). 2. 01/30/2025 Change enteral feeding pump tubing, solution, and piston syringe (used for flushing gastrostomy tubes) nightly. 3. 01/30/2025 Water flush of 200 milliliters every 3 hours via feeding pump. 4. 04/07/2025 Enteral nutritional feeding continuously via gastrostomy tube at 45 milliliters (ml)/hour (rate	F0693	Continued from page 41 of all residents with enteral feeds to ensure any resident requiring enteral feedings had proper labeling of enteral feed bag. No other concerns were noted. On 9/10/2025 the Director of Nursing began to educate all nurses, including agency nurses, on proper labeling of enteral feed bags. Assigned Licensed Nurse administering the enteral feed is responsible for labeling feed bag. Director of Nursing/Designee is responsible for ensuring the enteral feed bag is labeled correctly. Any nurse not educated on 9/10/25 will be educated prior to start of next shift. Any newly hired nurses, including agency, will be educated on this process during orientation by the DON/designee. An Ad Hoc Quality Assurance Performance Improvement meeting was conducted on 10/3/2025 with the Medical Director, the Administrator, the Director of Nursing, Registered Nurse Unit Manager to review facility deficiency. To ensure continued compliance, the Director of Nursing/designee will complete 2 random enteral feed bag audit weekly x12 weeks to ensure proper labeling. The Director of Nursing will report the findings to the Quality Assurance and Performance Improvement committee monthly for three months Date of Compliance 10/17/25	

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F0693 SS = D	Continued from page 42 of infusion for the continuous feeding). A review of Resident #3's care plan dated 02/17/2025 and revised on 08/03/2025 revealed a plan for risk of malnutrition due to gastrostomy tube as the primary source of nutrition. The stated goal was to prevent weight loss. Interventions included elevated head of bed at 45 degrees during and thirty minutes after tube feed. Monitor for any signs of aspiration (fever, shortness of breath), dislodged feeding tube, infection at g-tube site, g-tube malfunction, abnormal lung sounds, abdominal pain or distension, constipation or fecal impaction, diarrhea, or nausea and vomiting. Review of Resident #3's quarterly Minimum Data Set (MDS) assessment dated 08/08/2025 revealed Resident #3 was rarely/never understood, had severely impaired cognitive skills for daily decision making, and was dependent for all activities of daily living. The MDS also revealed Resident #3 was unable to eat by mouth and received all her nutrition through her gastrostomy tube. An observation of Resident #3 was conducted on 09/08/2025 at 11:47 AM. Resident #3 was lying in bed with the head of bed elevated. Resident #3's enteral feeding was infusing at 45 ml/hour via a feeding pump. The enteral feeding bag contained a light tan liquid and was labeled with 09/08/2025. No other information was noted on the enteral feeding bag. An additional observation of Resident #3 was conducted on 09/09/2025 at 1:06 PM. Resident #3 was lying in bed with the head of bed elevated. Resident #3's enteral feeding was infusing at 45 ml/hour via a feeding pump. The enteral feeding bag contained a light tan liquid and was labeled with 09/09/2025 and Resident #3's room number. No other information was noted on the enteral feeding bag. An observation and interview were conducted on 09/10/2025 at 2:06 PM with Nurse #1 who was assigned to Resident #3 on 09/08/2025, 09/09/2025, and 09/10/2025 during the 7:00 AM to 3:00 PM shift. Nurse #1 stated that night shift changed the tube feeding solution, the tubing, and the piston syringe every morning at 6:00 AM. Nurse #1 stated that the night shift nurse had asked her to label Resident 3's tube feeding during her shift report, but she had not had time to label the	F0693		

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F0693 SS = D	Continued from page 43 feeding yet. Nurse #1 stated that all tube feedings should have a white label on the bag or bottle which included the resident's name and room number, the type of feeding solution, if any additives were added, the name of the nurse who prepared the tube feeding, and the rate and method of infusion. Multiple unsuccessful attempts were made to contact the night shift nurse. An interview was conducted with the Director of Nursing (DON) on 09/11/2025 at 11:47 AM. The DON stated that she was new to the facility and that she had recently put together a list of responsibilities for the night shift which included changing tube feeding set ups and proper labeling of the tube feeding set up. The DON stated that all tube feedings should be labeled with the resident's name and room number, the type of feeding solution and the rate and method of infusion, and the name of the nurse who prepared the feeding set up. The DON further stated that she expected all tube feeding preparations be labeled appropriately. An interview was conducted with the Nurse Practitioner (NP) on 09/15/2025 at 10:38 AM. The NP stated that she was not aware that Resident #3's enteral feeding had not been labeled. The NP stated that all enteral feedings should be labeled with the type of nutritional formula used and if any additives or medications were added to the feeding solution. The NP further explained that it was important to note the type of feeding the residents were receiving because some residents were diabetic and required a special diabetic formula for their enteral feeding.	F0693		
F0695 SS = D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is NOT MET as evidenced by:	F0695	The facility failed to ensure that Resident #3 received proper oxygen delivery . On 9/11/2025 the Director of Nursing corrected the LPN on Resident #3. On 9/11/2025 the Director of Nursing audited all residents on Oxygen to ensure they were receiving oxygen per physicians order, no other deficient practice was found. Between 9/11/2025 and 9/12/2025 the Director of Nursing began to educate the Nurses on ensuring residents on oxygen had LPM as ordered by physician. All new resident admissions to the facility on oxygen and any new order for oxygen therapy will be reviewed during	11/19/2025

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F0695 SS = D	Continued from page 44 Based on observations, record reviews, and staff and Nurse Practitioner (NP) interviews, the facility failed to ensure oxygen was delivered at the prescribed rate for 1 of 4 residents reviewed for respiratory care and services (Resident #3). The findings included: Resident #3 was admitted to the facility on 11/01/2024. Resident #3 had diagnoses which included chronic respiratory failure with hypoxia and cerebral infarction (occurs when blood flow to the brain is interrupted causing damage to brain tissue) with hemiplegia (a condition that causes paralysis on one side of the body). Review of Resident #3's electronic medical record (EMR) revealed a physician's order dated 01/29/2025 for oxygen at 2 liters per minute (LPM) via nasal cannula continuously. Review of the care plan revised on 08/03/2025 revealed Resident #3 was at risk for respiratory complications secondary to chronic respiratory failure with hypoxia requiring supplemental oxygen. The interventions included to administer oxygen as ordered and to observe for signs and symptoms of respiratory complications. Review of Resident #3's quarterly Minimum Data Set (MDS) assessment dated 08/08/2025 revealed Resident #3 was rarely/never understood and the Brief Interview for Mental Status (a cognitive screening tool used to assess a resident's memory and orientation) (BIMS) assessment was unable to be conducted. Resident #3's cognitive skills for daily decision making was severely impaired. The MDS also revealed Resident #3 was dependent for all activities of daily living (ADL). The MDS indicated Resident #3 was receiving oxygen. Observations of Resident #3 were completed on 09/08/2025 at 11:49 AM, 09/09/2025 at 2:45 PM, 09/10/2025 at 12:12 PM, and 09/11/2025 at 7:59 AM. During each of the observations Resident #3 was observed in bed with her nasal cannula in her nostrils and the oxygen concentrator was set at 1 LPM. An interview was completed on 09/11/2025 at 9:01 AM with Nurse #1 who was assigned to care for Resident #3 on 09/08/2025, 09/09/2025, 09/10/2024, and 09/11/2025 during the 7:00 AM to 3:00 PM shift. Nurse #1 stated that all residents receiving oxygen should have a physician's order for oxygen which would include the	F0695	Continued from page 44 the morning clinical meeting to ensure LPM is being delivered per physician order. Any nurse, newly hired nurses, including agency, will be educated prior to starting their next or first shift by the DON/designee. An Ad Hoc QAPI was conducted on 10/3/2025 with the Medical Director, the Administrator, the Director of Nursing, Registered Nurse Unit Manager to review facility deficiency. To ensure continued compliance, the Director of Nursing/designee will complete an audit of 5 random residents weekly x12 weeks to ensure their LPM's are as ordered by physician The Director of Nursing will report the finding to the Quality Assurance and Performance Improvement committee monthly for three months Date of Compliance 10/17/25	

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F0695 SS = D	Continued from page 45 flow rate. Nurse #1 also stated the flow rate on the oxygen concentrator should be set as ordered by the physician. Nurse #1 further stated she reviewed Resident #3's physician's orders and stated that Resident #3 should be on 2 LPM of continuous oxygen via her nasal cannula. Nurse #1 further explained that she had not checked Resident #3's oxygen flow rate on the morning of 09/11/2025 and she did not remember checking Resident #3's oxygen flow rate on 09/08/2025, 09/09/2025, or 09/10/2024. Nurse #1 stated that she should have checked Resident #3's oxygen flow rate every morning during her initial assessment to ensure Resident #3 was receiving the correct prescribed rate of oxygen. An interview was completed on 09/11/2025 at 11:01 AM with the Director of Nursing (DON). The DON stated Resident #3 was dependent with all ADL and she was unable to change the flow rate on the oxygen concentrator. The DON stated she expected the nursing staff to check the physician's order for the prescribed oxygen flow rate and check to make sure residents were receiving the correct oxygen flow rate. The DON further explained that four days of observations for an incorrect oxygen flow rate was not acceptable nursing practice. A telephone interview was conducted on 09/15/2025 at 9:01 AM with the Administrator. The Administrator stated she expected all staff to follow the physician's order for oxygen settings. A telephone interview was conducted with the Nurse Practitioner (NP) on 09/15/2025 at 10:38 AM. The NP stated all residents receiving oxygen required an active physician's order for the prescribed liters per minute of oxygen they were to receive. The NP further stated nursing staff should follow the physician's orders for providing oxygen including the correct prescribed flow rate.	F0695		
F0880 SS = D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.	F0880	1.On 9/10/2025 the facility failed to follow our Enhanced Barrier Precautions (EBP)policy when Nurse #2 failed to don (put on) a gown when administering a gastrostomy tube, and nurse aide (NA) 1 did not don a gown to provide care to a urinary catheter for resident #5. Additionally, the facility failed to follow our policy on hand hygiene policy and our dressing policy when the wound nurse failed to clean and sanitize her hands while preparing for a wound dressing after encountering unclean surfaces for staff nurse #2, NA#1 and wound nurse. No signs and symptoms of infection were observed with resident #72 resident #5	11/19/2025

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F0880 SS = D	Continued from page 46 §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents	F0880	Continued from page 46 2. On 9/12/2025 the Director of Nursing did a 100% audit of residents with Enhanced Barrier Precautions, to ensure no other residents were affected by this deficient practice and staff had access to personal protective equipment (PPE) when caring for residents with EBP. No other concerns were noted. 3. On 9/10/25 education began by the Director of Nursing to the nurses and NAs, including agency staff, on EBP and infection control to include proper hand hygiene after encountering unclean surfaces and during wound care and dressing changes. In addition, on 9/12/2025 EBP signs were placed on the doors entering the rooms for residents needing EBP's. The Director of Nursing/Designee will review newly admitted residents and new orders for current residents in clinical meetings to ensure any resident admitted with or acquiring a new wound or device has an order for EBP and appropriate PPE. Any staff not educated on 9/10/25 will be educated prior to the start of their next shift, including agency staff. All newly hired nurses, NA's, and agency will be educated on this process during the orientation process by the DON/designee. 4. An Ad Hoc Quality Assurance Performance Improvement meeting was conducted on 10/3/2025 with the Medical Director, the Administrator, the Director of Nursing, Registered Nurse Unit Manager to review facility deficiency. The Director of Nursing/designee will complete audits weekly for 12 weeks to ensure staff have the appropriate PPE to provide care for residents on EBP and observe 10 random staff members weekly for 12 weeks for hand hygiene performed after encountering unclean surfaces and during wound care and dressing changes. The Director of Nursing will report the findings to the Quality Assurance and Performance Improvement committee monthly for three months Date of Compliance 10/17/25	

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F0880 SS = D	Continued from page 47 identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is NOT MET as evidenced by: Based on observations, record reviews and staff interviews, the facility failed to follow their Enhanced Barrier precaution policy when Nurse #2 did not don (put on) a gown to administer medications via gastrostomy (tube in the stomach) tube and Nurse Aide (NA) #1 did not don a gown to provide care to a urinary catheter for Resident #5. Additionally, the facility did not follow their hand hygiene policy or their clean dressing policy when the Wound Nurse failed to clean and sanitize her hands while preparing for a wound dressing after coming in contact with unclean surfaces. The deficient practice occurred for 3 of 10 staff (Nurse #2, NA #1, and Wound Nurse) observed for infection control. The findings included: The findings included: 1. Review of the facility's infection control policy titled, Enhanced Barrier Precautions (EBP) dated 03/28/2024 read in part, "Criteria for implementing EBP include residents with indwelling medical devices including feeding tubes. EBP will be utilized to provide targeted gown and glove use during high-contact resident care activities to reduce the transmission of multidrug-resistant organisms (MDROs) within the facility". An observation on 09/10/2025 at 4:01 PM revealed Nurse #2 sanitized her hands and put on clean gloves but did not put on a gown to administer medications to Resident #72 via his gastrostomy tube (g-tube) (a tube surgically placed in the stomach to deliver nutrition, fluids, and medications). The EBP sign was posted above	F0880		

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F0880 SS = D	Continued from page 48 Resident #72's bed and there was no personal protective equipment (PPE) located in or outside of Resident #72's room. An interview was conducted with Nurse #2 on 09/10/2025 at 4:10 PM. Nurse #2 stated that she did not see the EBP sign located above Resident #72's bed. Nurse #2 further stated that the EBP sign should be placed on Resident #72's door so the sign could be seen when entering the room. Nurse #2 stated that she knew about EBP, but she did not realize caring for feeding tubes required the use of gowns. An interview was conducted with the Director of Nursing (DON) who also served as the facility's Infection Preventionist on 09/11/2025 at 11:47 AM. The DON stated that she was aware of the regulation and the Center for Disease Control's (CDC) recommendations for EBP. The DON explained that she was new to the facility, and the previous DON had taken all the EBP signs off of the resident's doors and placed them above the resident's beds due to privacy concerns. The DON further explained that the previous DON had also removed all of the PPE which had been located in the hallways to a storage room on each hallway. The DON further stated that she was in the process of placing all EBP signs on the resident's doors and returning the PPE to the hallways so the staff would have easier access to the PPE. The DON further explained that she expected staff to follow EBP guidelines for appropriate PPE usage. Multiple unsuccessful attempts were made to contact the previous DON. A telephone interview was conducted with the Administrator on 09/15/2025 at 9:15 AM. The Administrator stated that she knew about the regulation concerning EBP and that she expected staff to follow the guidelines on the EBP signage. The Administrator further explained that she did expect the facility to be in compliance with all infection control regulations including the implementation of EBP. 2. Review of the facility's infection control policy titled, "Enhanced Barrier Precautions (EBP)" dated 03/28/2024 read in part, "Criteria for implementing EBP include residents with indwelling medical devices including feeding tubes and indwelling catheters. EBP will be utilized to provide targeted gown and glove use	F0880		

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F0880 SS = D	Continued from page 49 during high-contact resident care activities to reduce the transmission of multidrug-resistant organisms (MDROs) within the facility." An observation on 09/09/2025 at 12:30 PM revealed Nurse Aide (NA) #1 sanitized her hands with soap and water but did not put on gown to provide urinary catheter care for Resident #5. There was no available personal protective equipment (PPE) observed inside or outside Resident #5's room. The EBP sign was on the wall behind the head of Resident #5's bed. NA #1 read aloud the EBP sign after she completed the catheter care. An interview was completed with NA #1 on 09/09/2025 at 12:50 PM. NA #1 stated that after she read the EBP sign above Resident #5's bed, she had forgotten to put on a gown before providing catheter care. NA #1 stated she normally would obtain gown and any other PPE from the Central Supply room before providing care to Resident #5. An interview with the Director of Nursing (DON) who also served as the facility's Infection Preventionist was completed on 09/12/2025 at 2:17 PM. The DON stated she was aware of the EBP policy and NA #1 should have worn a gown while providing urinary catheter care. An interview with the Administrator on 09/12/2025 at 2:25 PM revealed that she expected NA #1 to follow the EBP policy and infection control regulations to prevent the spread of any multidrug-resistant organisms. 3. Review of the facility's policy without a date, titled "Clean Dressing" included "Clean technique involves meticulous handwashing, maintain a clean environment by preparing a clean field, using clean gloves and preventing direct contamination of materials and supplies. Review of the facility's infection control policy without a date titled, "Hand Hygiene" read in part: "Alcohol-based hand sanitizers are the most effective products for reducing the number of germs on the hands of health care providers." "Specific Procedures/Guidance" 1. All staff are responsible for following hand hygiene procedures: d. After contact with inanimate objects (including medical equipment) in the immediate vicinity of the resident.	F0880		

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F0880 SS = D	Continued from page 50 An observation was conducted on 09/10/25 at 10:30 AM of wound care being provided to Resident #93 for her sacral pressure wound. The Wound Nurse was observed preparing wound supplies outside of Resident #93's room on top of the treatment cart. The Wound Nurse applied alcohol-based hand sanitizer to both hands, opened drawer of the treatment cart and placed a wax paper barrier on top of treatment cart. Next, she opened two other drawers to remove a stack of gauze, wound cleanser, one calcium alginate dressing, and one 4 x 4-inch border gauze dressing. The Wound Nurse filled a 30 milliliter (ml) medicine cup with wound cleanser. The Wound Nurse did not sanitize her hands after gathering supplies and touching the outside of the treatment cart and the Wound Nurse used her ungloved index and middle fingers to press the gauze down into the wound cleanser. The Wound Nurse proceeded into the room with her supplies on wax paper and laid the supplies on the wax paper onto the overbed table. The overbed table had visible spills that had not been cleaned prior to placing the supplies on the table. The Wound Nurse washed her hands with soap and water and donned gown and clean gloves and proceeded to use the wound cleanser-soaked gauze she had prepared with her two fingers without gloves to clean the inside of Resident #93's sacral wound. The Wound Nurse then proceeded to use gauze to dry the wound and to apply the calcium alginate in the wound and secured it with a bordered foam dressing. The Wound Nurse then gathered her supplies and trash, doffed her gloves and gown, washed her hands with soap and water and left the resident's room. An interview was conducted with Wound Nurse on 09/11/2025 at 3:46 PM. The Wound Nurse stated that her hands were cleaned with alcohol-based hand sanitizer prior to preparing the wound care supplies. The Wound Nurse reported she had always prepared her wound cleanser and gauze solution without gloves and that "it had never been a problem in the past". The Wound Nurse reported she wore gloves to complete Resident #93's wound care once she was in the resident's room. An interview was conducted on 09/12/2025 at 2:17 PM with the Director of Nursing (DON) who also served as the Infection Preventionist (IP). The DON reported that she started in October 2024 as IP. The DON stated that the Wound Nurse should have sanitized her hands and worn gloves when touching wound cleanser solution to clean the residents' wounds.	F0880		

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F0880 SS = D	Continued from page 51 An interview with the Administrator on 09/12/2025 at 2:23 PM revealed that she expected the Wound Nurse to follow infection control and clean dressing policies and procedures to prevent the spread of any multidrug-resistant organisms.	F0880		
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 observations, resident, and staff interviews, the facility failed to ensure the call light system was functioning properly for 1 of 2 residents who required assistance for activities of daily living (Resident #66). The findings included: Resident #66 was admitted on 7/31/17 with diagnoses including cerebral infarction, hypertensive heart disease and dysphagia. Review of quarterly Minimum Data Set (MDS) assessment dated 6/9/25 revealed Resident #66 was assessed as cognitively intact and needed partial assistance from staff with bed to chair and toilet transfers. In addition, the quarterly MDS assessment indicated he was occasionally incontinent of bowel and coded Resident #66 as having an indwelling catheter. Review of the care plan focus area for activities of daily living revised on 6/18/25 described Resident #66 as requiring assistance with his activities of daily living (ADL). Interventions put in place included partial assistance with transfers, supervision assistance with bed mobility and bathing. An observation of the call light for Resident #66 was	F0919	The facility failed to provide Resident #66 with a hand bell to utilize due to call bell system failure. On 9/10/2025 the Administrator provided Resident #66 a hand bell to use in place of electric call bell. On 9/10/2025 the Administrator and Director of Nursing did a 100% resident audit of all residents to ensure they had a working call bell or a handbell and knew how to use it. On 9/11/2025 the Director of Nursing began to educate the nurses and Nurse Aides (NA) to ensure that all residents had a properly working call bell or hand bell. The admitting nurse will be responsible for assessing resident's ability to use call bell and/or hand bell. If resident is unable to use any type of handheld device, a soft touch call pad (pancake touch pad) will be provided. All staff began education to ensure that call bell and/or hand bell were within resident reach on 9/11/25 by Director of Nursing. Any staff not educated on 9/11/25 will receive this education prior to start of next shift. All newly hired staff, including agency staff, will be educated during the orientation process. An Ad Hoc Quality Assurance Performance Improvement meeting was conducted on 10/3/2025 with the Medical Director, the Administrator, the Director of Nursing, Registered Nurse Unit Manager to review facility deficiency. To ensure compliance continues, the DON/ designee will audit Residents access to call lights/bells, 10 random rooms, weekly for 12 weeks, the DON will be responsible for sharing the findings of those audits to the Quality Assurance and Performance Improvement committee monthly for three months. Date of Compliance 10/17/25	11/19/2025

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F0919 SS = D	Continued from page 52 made on 9/10/25 at 8:42 PM. The call light at the bedside was engaged. The light above the room entry door lit up but no alarm sounded. The communication panel at the nurse's station lit up, but no sound was audible when the bedside alarm was engaged. There was not a manual hand bell present for Resident #66's use. An interview was conducted on 9/10/25 at 8:42 PM with Nurse Aide (NA) #8. NA #8 stated the call bell system at the facility had not worked correctly for quite some time. She explained the system was supposed to ring or alarm at the room when the call bell was engaged and the light up on the panel at the nurse's station and the light above the door of each room was supposed to go off, but they didn't always work. NA #8 stated she just rounded very two hours to check on the residents since the bells did not work correctly. An interview with Resident #66 on 9/10/25 at 8:43 PM revealed he was able to locate and engage the call light at the bedside but did not hear a noise when he pressed the button. He stated that sometimes it took a long time for staff to respond to help him when he pressed his call light. He was not aware that his call bell did not make a sound to alert staff. Resident #66 also stated he had never had a manual handbell to use to call staff for assistance. An interview with Nurse #1 on 9/12/25 at 11:30 AM revealed the call system in the facility had been giving them trouble for quite a while and was not working properly. She stated the system did not work properly in certain rooms such as Resident #66's room. She stated since the system was not working properly, the staff just checked on the residents when rounding. An interview was conducted on 9/11/25 at 9:36 AM with the Regional Maintenance Director. The Regional Maintenance Director explained the facility had been having issues with the call bell system for quite some time with certain rooms not lighting up and other rooms not making alarm sounds. He explained they were in process of obtaining quotes from three different companies to replace and upgrade the system in the building. He stated after the quotes were obtained, he would then forward the quotes to his upper management for approval. The Regional Maintenance Director explained he used TELS (a web-based maintenance software) and if there were concerns, any staff member could alert the Maintenance staff when there was a concern. The Regional Maintenance Director indicated the call bell system was an ongoing concern in the building.	F0919		

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F0919 SS = D	Continued from page 53 A review of three quotes from different call bell companies was completed. These quotes were obtained on 8/20/25, 8/28/25, and 9/12/25. A facility tour was conducted on 9/12/2025 at 10:58 AM which included the Maintenance Director, Regional Maintenance Director, Administrator and Administrator in Training. The concerns with the call bell system in Resident #66 room were discussed. The Surveyor brought to the group's attention that no manual handbell was placed in Resident #66's room. A telephone interview was conducted on 9/15/2025 3:29 PM with the Administrator. She stated she expected any staff member to report any concerns regarding the call bell system to Maintenance. The Administrator stated she was aware the call bell system was not functioning correctly and stated residents would be given a hand bell to use to call staff. She also stated they were working on quotes to replace the call bell system.	F0919		
F0925 SS = E	Maintains Effective Pest Control Program CFR(s): 483.90(i)(4) §483.90(i)(4) Maintain an effective pest control program so that the facility is free of pests and rodents. This REQUIREMENT is NOT MET as evidenced by: Based on observations, record review and resident, staff and Pest Control Technician interviews, the facility failed to maintain an effective pest control program to prevent the presence of roaches and/or flies that were observed in 1 of 1 conference room, 1 of 1 lobby, 2 of 2 resident hallways (East and West hallways), and 4 of 4 resident rooms (Rooms 108, 109, 113, and 134). The findings included: A review of the pest control Commercial Services Agreement dated 12/24/24 revealed service for roaches, common ants, rats and mice and common spiders, and the service would occur two times per month. A review of the semi-monthly pest control service report dated 7/30/25 read: Inspected and serviced interior as requested. Left monitor boards (glue traps), applied gel bait throughout requested areas. The service report noted a recommendation to add/repair door sweep to address a door gap and indicated it was the customer's responsibility. The door was not	F0925	1. The facility failed to secure gaps between the inside and the outside of PTAC's in some rooms which allowed insects to enter the building unseen. On 9/29/2025, the Pest Control company came and sprayed for insects in Resident #23's, Resident #6's, and Resident #66's rooms and throughout the facility, as well as numerous flies noted in the lobby area. On 9/15/2025, the Maintenance Director repaired room #108, #110, #135, #151 gaps around PTAC units. The facility's Pest Control Technician was called out to the facility on 9/11/25 to spray for insects, including flies. On 9/15/2025 the Maintenance Director completed a 100% audit for resident room PTAC units for gaps. If any areas were identified, all areas were corrected. On 9/16/2025 the Regional Maintenance Director completed a 100% audit of resident room PTAC units to ensure gaps were sealed. All gaps were sealed. On 9/19/2025 the Maintenance Director and the Administrator audited 100% of the residents rooms for insects, none were found The Maintenance Director was educated by the Administrator to ensure no gaps were permitted around the PTAC units in resident rooms. The facility's Pest Control contract was updated from twice a month to weekly visits. Any newly hired maintenance staff will be educated by the Administrator during the orientation	11/19/2025

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F0925 SS = E	Continued from page 54 specified, and no pest activity or problem areas were noted. A review of the semi-monthly pest control service report dated 8/12/25 read: Inspected and services business as requested, general pest treatment throughout interior of business, inspected requested rooms, left monitoring boards, inspected kitchen areas, and common areas for general pest activity. The service report noted a recommendation to add/repair door sweep to address a door gap and indicated it was the customer's responsibility. The door was not specified, and no pest activity or problem areas were noted. A review of the semi-monthly pest control service report dated 8/19/25 read: Treated business per scope. The service report noted a recommendation to add/repair door sweep to address a door gap and indicated it was the customer's responsibility. The door was not specified, and no pest activity or problem areas were noted. a. An observation of the East hallway next to the housekeeping closet on 9/08/25 at 11:18 AM revealed a roach approximately one inch long, dark brown, thin, and had antennae that were approximately half an inch long crawling along the baseboard. The roach crawled under the door of the housekeeping closet. b. An observation of the conference room, which was located on the East Hallway next to resident rooms on 9/09/25 at 2:23 PM revealed a roach crawling across the table. The roach was pea-sized, dark brown and had antenna. c. An observation of the West Hallway on 9/10/25 at 10:34 AM revealed a roach approximately two inches long, dark brownish red, with wings and antennae approximately one-inch-long crawling across the floor. The West Unit Manager attempted to kill the roach with her shoe when it crawled up the wall. d. An observation of room 134 on 9/10/25 at 11:32 AM revealed a roach crawling across the floor and disappearing underneath the Packaged Terminal Air Conditioner (PTAC) unit affixed to the outer lower wall of the room. The roach was approximately one inch long, dark brown with wings and antennae approximately half an inch long. e. An observation of the front lobby on 9/10/2025 at 2:19 PM revealed several flies, too numerous to count, flying around the lobby area around residents who were sitting in their wheelchairs.	F0925	Continued from page 54 process. An Ad Hoc Quality Assurance Performance Improvement meeting was conducted on 10/3/2025 with the Medical Director, the Administrator, the Director of Nursing, Registered Nurse Unit Manager to review facility deficiency. To ensure continued compliance, the Maintenance Director/Designee will audit PTAC units in 7 rooms per week for 12 weeks and 7 random areas in the facility for insects weekly for 12 weeks. The Maintenance Director will be responsible for sharing the findings of those audits with the Quality Assurance and Performance Improvement committee monthly for three months. Date of Compliance 10/17/25	

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F0925 SS = E	Continued from page 55 f. An observation of room 113 on 9/10/25 at 8:24 PM revealed a roach approximately two inches in length on the floor next to Resident #23's nightstand. The roach was dark brown, approximately one inch in length with antennae approximately one inch in length. g. An observation of room 109 on 9/11/25 at 9:12 AM revealed a large roach crawling on the floor along the baseboard. The roach was dark brown, approximately one inch in length with antennae approximately one inch in length. An interview on 9/10/25 at 8:24 PM with Resident #23 who lived in room 113 revealed there were always roaches and bugs in the facility and his room, especially at night. An interview on 9/12/25 at 9:32 AM with Resident #6 revealed he had been seeing lots of roaches near his PTAC unit, but none were observed at this time. An interview and observation in room Resident #66 on 9/12/2025 at 9:43 AM revealed a glue trap on the floor next to the PTAC unit covered in dead ants and roaches in numbers too numerous to count. Resident #66 indicated he had seen lots of small bugs near his bed. An interview with the Pest Control Technician on 9/11/25 at 11:16 AM revealed the company he worked for was contracted to provide services at the facility twice a month and when there were call-backs for pest sightings in between those visits. He indicated on each of the two monthly visits he would spray the common areas, kitchen, and office areas and check the rodent bait traps around the exterior of the facility. He stated he sprayed the resident rooms on the East hallway rooms one visit, and the resident rooms on the West hallway the next visit. He indicated spraying a room included spraying the bathroom, under beds, dressers, nightstands, and under the PTAC unit. The Pest Control Technician stated there were gaps in the seals around the PTAC units in almost all the resident rooms that would allow pests to enter the building, so he placed glue traps under the PTAC units. He indicated the seal around the front door was compromised and a door sweep strip affixed to this door would help fix to keep bugs out. He revealed the main pest problems at the facility were palmetto bugs (cockroaches) and water bugs. An interview on 9/11/2025 at 1:58 PM with the Regional Director of Maintenance revealed he had only been assigned to the facility for about two months. He	F0925		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345134	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pelican Health Randolph LLC	**4801 Randolph Road , Charlotte, North Carolina, 28211**

(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
F0925 SS = E	Continued from page 56 indicated the pest control company came bi-weekly and sprayed half the resident rooms visit and the other resident rooms on the next visit, the common areas, and kitchen were always sprayed every visit. He believed the roach problem was based on bugs coming indoors more as the weather was getting cooler and stated the facility did not have any issues with flies. The Regional Director of Maintenance revealed there were no fly traps at the front doors because there were a double set of doors that kept flies out. On 9/11/2025 at 2:12 PM an interview with the Maintenance Director revealed he had not seen roaches or flies in the facility. He indicated each visit the pest control company would spray the common areas, offices, kitchen, and one of the two resident hallways alternating on each visit. The Maintenance Director revealed he had been talking with management about having an air curtain (fan-powered device that creates an invisible air barrier over a doorway) installed on the front door, but no decision had been made yet. He indicated he was not familiar with the gaps around the PTAC units. An interview on 9/12/2025 at 5:46 PM with the Administrator revealed she had been monitoring pest activity in the facility and was concerned about the effectiveness of their current pest control efforts. She indicated she planned to assess the services of their current pest control provider and ask what else needed to be done to better control the pests in and around the facility and do something different.	F0925		