STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	015433	A. Building B. Wing	07/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Martin's IN the Pines	4941 Montevallo Road Irondale, AL 35210

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on observation, interview, record review, and facility policy review, the facility failed to ensure residents were provided baths/showers for 2 (Resident #70 and Resident #77) of 11 residents reviewed for activities of daily living (ADLs).Findings included:During an interview on 06/29/2025 at 5:53 PM, Director of Clinical Services (DCS) #12 stated they did not have a policy for ADL care; they only had a procedure. An undated form titled, CNA [Certified Nurse Aide] Bath & Shower Report, revealed, The following assessment is to be completed on all residents receiving a bath. The Charge Nurse will sign and verify each assessment for accuracy and completion. All wound and findings are to be addressed immediately by the Charge Nurse and forwarded to the Unit Manager and Treatment Nurse with follow up of a physician or Nurse Practitioner if needed. The bottom of the form included a place for the resident's name, the date, the name of the CNA who provided the bath or shower, and the name of licensed nurse who received the form.1. The admission Record revealed the facility admitted Resident #70 on 02/28/2025. According to the admission Record, the resident had a medical history that included diagnoses of unspecified dementia, limitation of activities due to disability, muscle weakness, cognitive communication deficit, the need for assistance with personal care, and hemiplegia and hemiparesis (weakness or partial paralysis on one side of the body) following a cerebral infarction (stroke).A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 03/24/2025, revealed Resident #70 had a Brief Interview for Mental Status (BIMS) score of 7, which indicated the resident had moderate cognitive impairment. The MDS revealed the resident exhibited verbal behaviors that occurred four to six days during the assessment's lookback period. The MDS revealed the resident did not reject care during the assessment's lookback period. The MDS revealed the resident was dependent on staff for showering and/or bathing.Resident #70's Care Plan Report, revealed a focus area initiated on 03/04/2024 and revised on 04/14/2025, that indicated the resident had a self-care deficit related to decreased abilities due to right hemiplegia and dementia. The focus area revealed the goal was that the resident's ADL needs would be met in a comfortable and caring manner. Interventions directed staff to assist with bathing as needed; provide cueing, supervision, and assistance with ADLs as needed; and provide partial/moderate assistance with showering/bathing.An undated Cottage A Shower Schedule revealed that Resident #70 was scheduled to have showers provided on the 3:00 PM to 11:00 PM shift on Tuesdays, Thursdays, and Saturdays. The schedule indicated that all bath sheets must be turned in to charge nurse for review by 12noon on 7-3 [shift] and 7PM on 3-11 [shift].During an interview on 06/28/2025 at 3:07 PM, DCS #12 stated she was not able to locate any of the shower sheets for Resident #70. She stated that she would not necessarily assume that the resident had not had showers by not having the actual bath sheets.An observation on 06/23/2025 at 11:00 AM revealed Resident #70 was sitting up in bed. The resident's hair appeared oily to the point of looking wet, and there was an odor in the room. During a concurrent interview, Resident #70 stated that staff did not provide showers, and it had been a month since their last shower.An observation on (continued on next page)

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

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

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	06/24/2025 at 3:25 PM revealed Resident #70 was in bed. The resident's hair still appeared greasy. There was an odor in the room. During a concurrent interview, Resident #70 stated that staff had not provided a bath or shower. An observation on 06/25/2025 at 12:35 PM revealed Resident #70's hair still appeared to be extremely greasy, to the point of looking wet. There was an odor in the room. During a concurrent interview, the resident reported that staff had still not provided a shower.An observation on 06/26/2025 at 12:21 PM revealed Resident #70 was sitting in bed. The resident's hair still appeared to be greasy, to the point where it almost looked wet. There was an odor in the room. During a concurrent interview, Resident #70 stated staff had not provided any bathing or a shower. During an interview on 06/26/2025 at 12:52 PM, CNA #47 stated staff were supposed to be providing showers three times a week. CNA #47 stated Resident #70 did not refuse showers.During an interview on 06/27/2025 at 8:18 AM, Licensed Practical Nurse (LPN) #51 stated she worked strictly in Cottage A. She stated that she did not track the showers staff provided. She stated staff were not turning in the shower sheets to her. LPN #51 stated she noticed Resident #70 was fairly malodorous, but the resident's showers were not on her shift, so she did not track them.During an interview on 06/27/2025 at 12:15 PM, DCS #12 stated that staff were supposed to be completing shower sheets when they provided showers or bathing as well as documenting in the electronic medical record (EMR).During an interview on 06/27/2025 at 1:33 PM, LPN #48 stated she normally worked in Cottage A where Resident #70 resided. She noted she was familiar with Resident #70, but did not know the resident's scheduled shower days. She stated the resident did not refuse care. LPN #48 stated staff were not putting any type of haircare products in the resident's hair. She noted that Resident #70 looked a little greasy at times. She stated staff should be offering showers/baths three times a week.An observation on 06/28/2025 at 9:50 AM revealed Resident #70 lying in bed asleep. The resident's hair appeared greasy, and there was an odor in the room that did not smell like urine or fecal material.During an interview on 06/28/2025 at 9:53 AM, Certified Medication Technician (CMT) #49 stated Resident #70 was not one who refused care, noting sometimes they had to coax the resident to do things.During an interview on 06/28/2025 at 9:59 AM, CNA #50 stated she was not sure when Resident #70's shower days were. She stated the staff did not put anything in the resident's hair, but she thought the resident's hair looked kind of oily.During an interview on 06/29/2025 at 11:12 AM, the Director of Nursing Services (DNS) stated she expected staff to make rounds when they first came in to observe the residents and as they were providing care. The DNS stated they had shower sheets available, and they were not being used. She stated they had processes that were broken that she was trying to fix. She stated she was familiar with Resident #70 and was not aware that the resident had not had a shower in a while until someone mentioned it to her the previous day. The DNS stated the task record showed her that the staff were not describing the care that was actually provided.During an interview on 06/29/2025 at 1:29 PM, the Administrator stated he expected residents' ADL needs to be met. He stated he was not aware that residents were not getting the care they needed.2. An admission Record revealed the facility admitted Resident #77 on 11/21/2024. According to the admission Record, Resident #77 had a medical history that included diagnoses of Alzheimer's disease, abnormal posture, generalized muscle weakness, and unspecified lack of coordination. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 05/14/2025, revealed Resident #77 had a Brief Interview for Mental Status (BIMS) score of 3, which indicated the resident had severe cognitive impairment. The MDS indicated the resident rejected care one to three days during the assessment's lookback period. The MDS revealed the resident was dependent on staff for showers/baths.Resident #77 Care Plan Report, included a focused area initiated 04/11/2025, that indicated the resident had a self-care deficit related to impaired (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	cognition/dementia. Interventions directed staff to provide all the effort with showering/bathing as the resident was dependent on staff. The Care Plan Report included a focused area initiated 12/02/2024, that indicated the resident was resistive to care and refused care. Interventions directed staff that if the resident was resistive to ADLs, reassure the resident and leave and return five to ten minutes later and try again. Resident #77's 01/2025 Documentation Survey Report revealed the section titled ADL - Bathing contained no documentation to denote Resident #77 received a bath/shower from 01/01/2025 through 01/21/2025. Resident #77's 02/2025 Documentation Survey Report revealed the section titled ADL - Bathing contained no documentation to denote Resident #77 received a bath/shower from 02/07/2025 through 02/24/2025 and had no documentation of any refusals. A Customer Concern/Grievance Communication Form, dated 02/20/2025, revealed that Resident #77's family member complained that they came to visit and found the resident sitting on the side of their bed without any pants and urine on the floor. The form revealed that the family member alleged that every time they came to visit the resident was wet. The form revealed the grievance issues were addressed and added to the Kardex and care plan. Resident #77's 06/2025 Documentation Survey Report revealed the section titled ADL - Bathing contained no documentation to denote that Resident #77 received a bath/shower from 06/01/2025 through 06/18/2025 and had no documentation of any refusals. During an observation on 06/23/2025 at 11:59 AM, Resident #77 had a foul odor. On 06/27/2025 at 3:22 PM, Certified Nurse Aide (CNA) #18 said she was not aware of Resident #77 not getting a bath or shower for two weeks, noting the resident allowed CNA #18 to provide bed baths. On 06/27/2025 at 3:36 PM, CNA #19 said Resident #77 refused care at times due to being combative. On 06/28/2025 at 10:11 AM, the Director of Nursing Services (DNS) said that she expected residents to receive showers as scheduled and if the resident asked for a shower on a non-scheduled day, staff should provide the resident with a shower. She indicated that if there were blanks on the shower/bath task, it meant a shower/bath was not provided, noting if the resident refused, staff should document the refusal and notify a nurse. On 06/28/2025 at 12:15 PM, the Administrator said that he expected residents to receive their baths/showers per their scheduled times.

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and facility document and policy review, the facility failed to prevent a fire in a kitchen near residents. Specifically, kitchen staff placed plastic and foam containers in an oven on the second and third floor kitchens of Cottage B, causing the containers to melt and excessive smoke to [NAME] out of the oven into an area near residents.It was determined the facility's non-compliance with one or more requirements of participation caused, or was likely to cause, serious injury, harm, impairment, or death to residents. The Immediate Jeopardy (IJ) was related to 483.25(d)(1) (Accidents).The IJ began on 06/23/2025 at 11:46 AM when Food Service Worker (FSW) #24 placed five plastic containers and one foam to-go container holding food for a lunch meal into an oven set to the warm setting on the second floor of Cottage B. FSW #24 then proceeded to deliver the lunch meal to the third floor of Cottage B. There was then a strong smell of burnt plastic in the living area on the second floor of Cottage B. Certified Nurse Aide (CNA) #33 opened the oven, and smoke billowed out into the kitchen and common area where residents were sitting. CNA #33 then turned the oven off and opened the door to the outdoor balcony to air out the living area of the second floor. An observation on 06/23/2025 at 12:05 PM revealed two burnt and melted foam to-go containers sitting on a countertop in the kitchen on the third floor of Cottage B.The Administrator (ADM) and Community Executive Director (ED) were notified of the IJ and provided the IJ template on 06/23/2025 at 5:49 PM. A Removal Plan was requested. The Removal Plan was accepted by the state survey agency on 06/27/2025 at 11:01 PM. The IJ was determined to be removed on 06/29/2025 at 7:00 PM after the survey team performed onsite verification that the Removal Plan had been implemented. Noncompliance remained at the lower scope and severity of E that was not immediate jeopardy for F689.Additional findings were identified related to Residents #36, #92, #77, and #53. Specifically, Resident #36 suffered a right femur fracture when staff provided care and a thorough investigation was not conducted, Resident #92 suffered a fall and the facility did not investigate for the root cause of the fall, Resident #77 was assessed to need a sit-to-stand lift for transfers when one was not available for staff to use, and Resident #53 was found outside of the facility, gone for an unknown period of time.Findings included:1. A facility policy titled, Fire Safety, dated 08/01/2012, indicated, It is the policy of this facility to insure [sic] that equipment is in compliance with applicable state and local regulations regarding fire safety.An owner's manual provided by the facility staff titled, Direct Air Convection Built-In Electric Wall Oven, revised in May 2024, indicated Do not store or use flammable materials in or near an oven, including paper, plastic, pot holders, linens, wall coverings, curtains, drapes and gasoline or other flammable vapors and liquids.Product specifications provided by facility staff, dated 06/23/2025, indicated the foam to-go containers should be stored at temperatures from 55 to 90 degrees Fahrenheit (F) and the plastic deli containers maximum storage temperature was 212 degrees F.An observation on 06/23/2025 at 11:46 AM revealed double ovens in the kitchen on the second floor of Cottage B. The observation revealed both ovens were dirty with crusty black lumps on the bottom of the ovens and inside the doors. Further observation revealed FSW #24 placed five small plastic containers and one foam to-go container holding food for the lunch meal directly on metal racks in an oven. During an interview at that time, FSW #24 stated that foam and plastic containers could go in the oven to keep the food warm.An observation on 06/23/2025 at 11:55 AM, revealed a strong smell of burnt plastic in the kitchen second floor. The observation revealed CNA #33 opened the oven, and smoke billowed out into the kitchen and common area where residents were sitting. The observation revealed CNA #33 pulled the food out of the oven and opened the door to the outdoor (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	balcony to air out the living area of the second floor.An observation on 06/23/2025 at 12:05 PM revealed two burnt and melted foam to-go containers sitting on a countertop in the kitchen on the third floor of Cottage B.During an interview on 06/29/2025 at 11:04 AM, CNA #27, who was on the third floor on 06/23/2025, stated she witnessed FSW #24 place the plastic and foam to-go containers into the oven, she knew they should not have been in the oven, but by the time she removed them from the oven they had already started melting.During an interview on 06/23/2025 at 4:05 PM, the Executive Chef stated the kitchen staff prepared food in the main kitchen located in the main building and then sent it to Cottage A and Cottage B in metal steam table pans, plastic deli containers, and individual meals in foam to-go containers. The Executive Chef further stated if the plastic containers holding the food for the residents in the cottages melted, then the ovens must have been on the wrong setting because they could withstand being reheated to 200 to 250 degrees F. Per the Executive Chef, the foam to-go containers were not designed to be put in an oven and should not have been in the oven at all. The Executive Chef further stated the plastic deli containers' maximum storage temperature was 212 degrees F and the foam to-go containers' storage temperature should be 55 to 90 degrees F per the product's specifications.During an interview on 06/28/2025 at 2:34 PM, the Director of Nursing Services (DNS) stated she expected staff to know how to operate the oven and to know what temperature to set the oven to when using it. The DNS further stated she expected staff to monitor the oven when in use for fire safety, and plastic and foam were not appropriate materials to use in the oven.During an interview on 06/28/2025 at 3:15 PM, the ADM stated he expected staff to keep the residents safe by having practices that met the safety requirements for fire prevention.On 06/28/2025 at 2:30 PM a Removal Plan was submitted by the facility and accepted by the State Agency. It read as follows: F689: Free from Accident Hazards/Supervision/Devices: Food placed in ovens in Cottages in plastic and Styrofoam [sic] containers which were not considered appropriate for the oven. Plastic overheated and created smoke on 2nd floor of Cottage B.1. Administrator and Maintenance Director were notified on 06/23/2025 at 12:15 p.m. by Nurse of containers placed in the oven which caused smoke.2. The ovens on the second and third floors of Cottage B were disabled by the Maintenance Director on 06/23/2025 at 8:05 p.m. The ovens were locked out/tagged out until assessed/repaired by Maintenance or an outside technician.3. Fire Safety re-education was initiated with [the facility's name] skilled nursing facility team members, nurses, aides, therapy, housekeepers and dietary, on 06/23/2025 by the Administrator/DNS or designee. An inservice [sic] was completed for all team members on not placing non cookware items on the stove top or in oven, no plastic or Styrofoam in the oven when heating/warming food and policy on fire safety. New hires will be educated by the Director of Clinical Orientation during orientation, and center does not utilize agency in the center.4. The Administrator or designee will monitor to ensure there are no inappropriate containers placed in the ovens for each meal for one week, five meals per week on each floor for four weeks then monthly for three months. Results will be reported at the monthly QAPI [Quality Assurance and Performance Improvement] for follow-up as needed.The immediacy of the IJ was removed on 6/23/25.On 06/28/2025 at 2:30 PM, the facility provided a Removal plan and was accepted by the State Survey Agency. Noncompliance remained at the lower scope and severity of E.Onsite Verification of Removal Plan:The IJ was removed on 06/29/2025 at 7:00 PM after the survey team performed onsite verification that the Removal Plan had been implemented. The survey team verified that the ADM and Maintenance Director were notified of the containers placed in the oven, which caused smoke. The survey team verified the ovens on the second and third floor of Cottage B were disabled by the Maintenance Supervisor. The ovens were locked out and tagged out until they were assessed and repaired by an outside technician. The completion of staff education (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	related to fire safety was reviewed and verified by the survey team through interviews. The survey team reviewed and verified audit plans through interview with the ADM.2. A facility policy titled, [Facility Name] Event Communication Pathway, dated January 2021, revealed the section titled, Key Components of Investigation, included, Once the immediate threat has been removed and all patients/residents are safe initiate a thorough investigation. Key components of an investigation - Detailed description of the event/allegation (objective and factual) - Assessment of patient/resident and description of any injury - Interview summaries of all pertinent parties (the interviewer completes the summary, the interviewee signs confirmation of facts) - Immediate protection initiated - Relevant causal/contributing factors and observations - Specific interventions to prevent reoccurrence - Summary of the outcome/investigative findings - Any pertinent monitoring/follow up.An admission Record indicated the facility admitted Resident #36 on 10/03/2022. According to the admission Record, the resident had a medical history that included diagnoses of senile degeneration of the brain, osteoarthritis, a periprosthetic fracture around the internal prosthetic right hip joint (a break in the bone around the internal right hip prosthetic) (onset date 12/12/2024), and encounter for orthopedic aftercare (onset date 12/12/2024).An annual Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 04/16/2025, revealed Resident #36 had severe impairment in cognitive skills for daily decision-making and had a short-term and long-term memory problem per a Staff Assessment of Mental Status (SAMS). The MDS indicated Resident #36 was dependent on staff with rolling left and right when in bed. The MDS indicated Resident #36 received hospice care while a resident.Resident #36's Care Plan Report, included a focus area initiated on 12/04/2023, that indicated the resident had a self-care deficit related to decreased functional abilities, fluctuating self-performance, and impaired cognition, with a history of a periprosthetic fracture around the internal prosthetic right hip joint. Interventions directed staff to allow adequate time with tasks (initiated 12/04/2023) and to provide all the effort with tasks including rolling to the left and right (initiated 01/30/2025). Resident #36's Care Plan Report, included a focus area initiated on 02/29/2024, and revised on 04/24/2025, that indicated the resident needed pain management and monitoring related to osteoarthritis, polyneuropathy, a history of transient ischemic attacks, and a history of periprosthetic fracture around the internal prosthetic right hip joint. Interventions directed staff to administer pain medication as ordered; provide dim lighting/quiet environment; evaluate and establish level of pain on numeric scale/evaluation tool; evaluate characteristics and frequency/pattern of pain; evaluate what made the pain worse; reposition as needed; and ensure rest.Resident #36's Order Recap [Recapitulation] Report, for the timeframe from 11/01/2024 through 06/30/2025, included an order dated 09/04/2024 for tramadol HCL (tramadol hydrochloride, an opioid agonist to treat moderate to severe pain) 100 milligrams (mg) every four hours as needed for pain related to osteoarthritis; the order had an end date of 12/12/2024. The Order Recap Report included an order dated 12/01/2023 for acetaminophen (a pain reliever) 1000 mg three times a day for pain; the order had an end date of 12/12/2024.Resident #36's 12/2024 Medication Administration Record [MAR], revealed staff documented that the resident received tramadol HCL100 mg on 12/06/2024 at 6:20 AM for a pain level of 5 (on a pain scale of 0-10, with 10 being the worst possible pain), and it was effective. The MAR revealed staff documented that the resident received tramadol HCL100 mg on 12/06/2024 at 2:38 PM for a pain level of 8, and it was effective. The MAR revealed staff documented that the resident received acetaminophen 1000 mg on 12/06/2024 at 9:00 AM for a pain level of 6 and at 2:00 PM for a pain level of 8.Resident 36's Weights and Vitals Summary, indicated that on 12/05/2024 the resident's pain level was rated 0 at 10:58 AM, 3:05 PM, 10:47 PM, and 10:49 PM, and the resident's pain level was rated 5 on 12/06/2024 at 6:20 AM. Resident #36's (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	hospice Visit Note Report, dated 12/06/2024, indicated a family member and Licensed Practical Nurse (LPN) #6 notified the hospice services that Resident #36 had severe pain in their right leg and requested a visit. The note revealed LPN #6 stated staff had left Resident #36 in bed due to hip pain, with no reports of a fall prior to the onset of pain. The note indicated the hospice nurse assessed Resident #36's right leg and noted the leg to be shortened and rotated with swelling to the thigh and no discoloration. The note indicated the hospice physician was notified, and the facility staff received an order to obtain an x-ray of Resident #36's right pelvis, hip, and femur. The note indicated Resident #36 received tramadol at 6:30 AM and 10:30 AM, and Tylenol (an analgesic, pain reliever) at 9:00 AM. The note indicated the hospice nurse visit began at 12:48 PM on 12/06/2024.A nursing Progress Notes, dated 12/06/2024 at 4:27 PM, indicated Resident #36 appeared to be in severe pain and was medicated with tramadol 100 mg per their PRN (pro re nata, as-needed) order. The Progress Notes indicated that upon assessment, Resident #36's right hip was swollen, very painful to touch, and the top part of the hip was larger than the bottom half. The Progress Notes indicated the nurse reached out to hospice staff, the hospice nurse came to the facility to assess the resident, and the hospice physician ordered an x-ray immediately. The Progress Notes indicated the x-ray results revealed a right femur fracture. The Progress Notes indicated the hospice physician was notified and then ordered Resident #36 to be sent to the emergency room for an evaluation. The Progress Notes indicated Resident #36's family was at bedside during that time. Resident #36's Radiology Interpretation, dated 12/06/2024 at 12:59 PM, indicated the resident had a right hip arthroplasty with displaced periprosthetic fracture at the subtrochanteric (upper area of the femur) femur with decreased osseous mineralization. The record revealed, This could reflect osteopenia or osteoporosis, in the correct clinical context.A facility incident report dated 12/06/2024 at 4:17 PM, indicated Resident #36 appeared to be in severe pain and was medicated with tramadol 100 mg per a PRN order. The report indicated that upon assessment, Resident #36's right hip appeared to be swollen, very painful to touch, and the top part of the hip was larger than the bottom half. The report indicated Resident #36 was unable to describe what occurred, and the resident's pain level was 8. The report indicated the physician was notified on 12/06/2024 at 1:23 PM. Resident #36's hospital Discharge Summaries, dated 12/12/2024, indicated the resident presented to the emergency room with right hip periprosthetic hip fracture. The summaries indicated that per the facility's records, Resident #36's sitter arrived at the facility on 12/06/2024 and was told by facility staff that the resident should not be transferred from the bed to the wheelchair due to hip pain. The summaries indicated that upon assessment, Resident #36's hip was found to be painful and swollen. The summaries indicated that due to the proximity of the fracture to the hardware, Resident #36 was transferred to another hospital for surgical repair. On 06/24/2025 at 1:58 PM, Family Member (FM #76), Resident #36's family member, stated they arrived at the facility on the day of the incident at about 8:00 to 8:30 AM after the sitter called them. FM #76 stated there was no urgency from staff that the staff thought anything was wrong, and the ambulance was not provided until 2:30 PM to 3:00 PM. FM #76 stated they met with the facility, and the facility said they were sorry and that the incident was not handled properly. FM #76 stated they thought the facility had notes, but there was no outcome from the investigation. FM #76 stated they did not know if Resident #36's bones were so brittle the bones could not stay attached to the prothesis, or if something happened.During an interview on 06/24/2025 at 3:03 PM, Hospice Nurse #42 stated a hospice nurse visited the resident on 12/06/2024 due to Resident #36's pain in the right leg. Hospice Nurse #42 stated Family Member #76 notified the hospice case manager, and LPN #6 called as well. Hospice Nurse #42 stated hospice services ordered an x-ray which revealed a right femur fracture. During an (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	interview on 06/25/2025 at 8:12 AM, Resident #36's sitter, Sitter #72, stated they came in on the morning of 12/06/2024 around 7:15 AM, and the facility staff told the sitter not to get Resident #36 up because the resident's side hurt and was swollen. Sitter #72 stated they notified the family of Resident #36's condition because the resident's hip looked broken. Sitter #72 stated they asked a CNA to have a nurse look at Resident #36 and for some pain medication for the resident. Sitter #72 stated staff revealed they had administered pain medication to Resident #36 at 6:30 AM that morning. Sitter #72 stated at 8:30 AM they asked for pain medication again for Resident #36, and the resident was given Tylenol. Sitter #72 stated a family member notified the hospice nurse who then came and obtained an x-ray of Resident #36's right hip. During an interview on 06/25/2025 at 9:02 AM, LPN #6 stated Registered Nurse (RN) #7 gave her report (information sharing between shifts) on the morning of 12/06/2024, informing her that Resident #36's hip was red and painful to touch, but RN #7 had not notified anyone including hospice staff. LPN #6 stated she then assessed Resident #36, found the resident's hip bruised and painful to touch, and contacted the hospice nurse requesting a stat (statim, immediately) x-ray. LPN #6 stated the hospice nurse then came to the facility and obtained an x-ray that revealed a femur fracture. LPN #6 stated they then contacted the management team notifying them of the fracture. LPN #6 stated the Community ED had interviewed her about the incident. During an interview on 06/26/2025 at 7:24 AM, the Community ED stated Resident #36's fracture was not reported to the state because when staff turned the resident the morning of 12/06/2024, they heard a pop, so the fracture was of known origin. The Community ED stated she did not see her file about the incident and did not know who the staff member was that repositioned Resident #36 at the time. The Community ED stated she did not know why the night shift did not notify hospice or get an x-ray, did not know who was on the night shift, but would have talked with everyone who worked that shift to see what happened. The Community ED stated the incident occurred during the overnight shift and was reported to the oncoming shift, who notified hospice and the physician to get an x-ray. The Community ED stated Resident #36 had osteoporosis. By the time of the survey exit, no investigation of the incident had been presented to the surveyors. On 06/26/2025 at 7:41 AM, the Ombudsman stated the facility had a care plan meeting with the family after the event, and the care plan meeting did not go well as the Community ED was unable to be there and the interim Director of Nursing Services (DNS) at that time did not really know any specifics. The Ombudsman stated the Community ED did an investigation, but the family was frustrated as findings were not communicated well and were ambiguous. The Ombudsman stated the interim DNS was supposed to do an investigation that day but did not, and there were unresolved issues about a nurse being unable to get to Resident #36 due to being on another floor and uncertainty about Resident #36's foot being caught in a bed rail.During an interview on 06/26/2025 at 9:35 AM, RN #7 stated CNA #46 notified her that when she changed Resident #36's brief, the resident was in pain, and RN #7 told the next shift's nurse that Resident #36 was in pain and to notify the physician that morning. RN #7 stated no incidents occurred on her shift that could have led to the fracture, and she gave Resident #36 pain medication. RN #7 stated that she did not remember if she completed an incident report or entered a nurse note. RN #7 stated the incident occurred later in her shift and the next shift was about to start, so she gave the responsibility to the following shift. RN #7 stated she had three floors of residents to handle, to give medications to, and she told the next shift of the incident.During an interview on 06/26/2025 at 10:50 AM, CNA #46 stated that when she provided care to Resident #36 the morning of 12/06/2024, she turned the resident onto their right side and the resident moaned, made sounds like they were in pain, and grimaced. CNA #46 stated she did not know what was going on with Resident #36 because no incident occurred on her shift, and she (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	into Resident #92's room to take care of the resident's needs. FM #73 stated the Director of Nursing Services (DNS) told her the resident fell out of bed during the night shift while a sitter sat outside the resident's room with the door closed due to the resident having a Clostridium difficile (C. diff, a bacteria,) infection. FM #73 stated Resident #92 fell on [DATE], went to the hospital, and stayed a week with diagnoses of pneumonia, urinary tract infection, and atrial fibrillation. FM #73 stated Resident #92 went to a different skilled nursing facility after discharge from the hospital. During an interview on 06/27/2025 at 10:39 AM, Director of Clinical Operations (DCO) #26 stated the Post Fall Review was the only documentation the facility was able to find related to Resident #92's fall on 06/02/2025. During an interview on 06/27/2025 at 2:57 PM, DNS stated her expectation was that staff document, report, and investigate all falls. The DNS stated her expectation was that a Post Fall Review was completed in the electronic medical record documenting new interventions for each fall. The DNS stated there was no documentation in Resident #92's progress notes about the fall on 06/02/2025. The DNS stated that a nurse called her to report Resident #92's fall, but the nurse did not complete the Post Fall Review, so she completed it herself. The DNS stated Resident #92 had a sitter, who was sitting outside the resident's room with the door closed when the resident fell out of bed. The DNS confirmed she did not do an investigation into the cause of the Resident #92's fall, because the resident did not return to the facility. 4. A facility policy titled, Lift 4 Care-Safe 4 All, dated 02/2023, revealed the section titled, Purpose, included, To provide team members guidance with assisting residents to safely reposition or transfer. The policy revealed the section titled, Guideline, included, 2. A licensed healthcare provider must complete a lift evaluation for every resident upon admission, readmission or with any change of condition. The lift evaluation will assist in establishing the resident's independence or the need for assistance during repositioning or transfers. The evaluation will also assist in determining sling size if appropriate and/or the number of team members required to assist during transfer or repositioning. Documentation of the lift evaluation must be completed in the resident's [electronic] chart, and communication of the lift evaluation findings must be documented in the care plan, caregiver guide or Kardex. The policy also indicated, 4. The sit-to-stand lift should be used for residents who can bear at least 25% weight on one or both legs, have the ability to follow simple commands, have upper torso and body strength and able to grip with one or both hands. Further review revealed, 7. In order to maintain residents' safety, residents should be lifted or transferred by the lift and sling which is deemed appropriate after the lift evaluation is completed. There should be no interchanging of lifts and slings.An admission Record indicated the facility admitted Resident #77 on 11/21/2024. According to the admission Record, the resident had a medical history that included late onset Alzheimer's disease, abnormal posture, generalized muscle weakness, and lack of coordination.A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 05/14/2025, revealed Resident #77 had a Brief Interview for Mental Status (BIMS) score of 3, which indicated the resident had severe cognitive impairment. The MDS indicated the resident was dependent on staff for chair/bed-to-chair transfers, going from the sitting to standing position, and tub/shower transfers.Resident #77's Care Plan Report, included a focus area initiated 11/22/2024, that indicated the resident had a physical functioning deficit with transfers. The care plan instructed staff to use the total mechanical lift with a large green sling and the EZ Way (type of sit-to-stand lift) Burgandy Large Sling. Both of these interventions were resolved on 01/09/2025. New interventions were implemented on 07/02/2025 that instructed the staff to use the sit-to-stand lift with the medium yellow sling, and physical therapy was to work with the resident to ensure safety with the sit-to-stand lift.Resident #77's Care Plan Report included a focus area initiated (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	04/11/2025, that indicated the resident had a self-care deficit related to impaired cognition/dementia. Interventions directed staff to provide all effort with transfers from the chair to the bed and tub and shower transfers since the resident was dependent on staff.Resident #77's Lift Transfer Evaluation (EZ Way), dated 11/22/2024, indicated the resident had a physical functioning deficit with transfers and required assistance of the EZ Way (sit-to-stand) lift with a large burgundy sling for weights of 190-320 pounds.Resident #77's Lift Transfer Evaluation (ARJO Maxi Sky Lift), dated 11/22/2024, indicated the resident had a physical functioning deficit with transfers and required assistance of the total mechanical lift with the large green sling for weights of 154-264 pounds.Resident #77's Progress Notes revealed a Clinical Health Status Evaluation note dated 11/21/2024 that indicated the resident transferred with the use of a sit-to-stand lift.Resident #77's Lift Transfer Evaluation (Hillrom/LIKO Ceiling Lift), dated 01/09/2025, indicated the resident transferred with a transfer/walking belt and one team member.Resident #77's Care Plan Report was updated to resolve the use of the lifts but did not reflect the use of the transfer/walking belt and one team member for transfers.Resident #77's Progress Notes revealed a Weekly Nurses Note dated 03/01/2025 that indicated the resident used a sit-to-stand lift for transfers.During an interview on 07/17/2025 at 3:10 PM, Registered Nurse (RN) #1 stated if a resident had been assessed and determined to need a lift for transfers, then it would not be safe to transfer a resident manually. She stated she thought Resident #77 was a 2-to-3-person transfer, but she was not sure and would have to check with the certified nursing assistants (CNAs).During a telephone interview on 07/18/2025 at 9:59 AM, RN #36 stated she thought Resident #77 could transfer with maximum assistance but thought the facility was requiring them to use lifts to get residents out of bed.During an interview on 07/1

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. Based on record review, interview, and facility policy review, the facility failed to have an effective pain management program for 1 (Resident #98) of 1 resident reviewed for pain management.Findings included:On 07/18/2025 at 6:03 PM, Corporate Director of Clinical Services (DCS) #12 stated the facility did not have a policy for pain management, but it was the resident's right to be free of pain.An admission Record indicated the facility admitted Resident #98 on 09/05/2024. According to the admission Record, the resident had a medical history that included orthopedic aftercare following surgical amputation of the right leg below the knee, peripheral vascular disease, chronic pain, and anxiety disorder. The admission record indicated the resident was discharged home with home health services on 09/25/2024.An admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 09/09/2024, revealed Resident #98 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition. The MDS indicated the resident frequently experienced pain that occasionally made it hard to sleep but rarely limited participation in therapy or day-to-day activities. The MDS indicated the resident rated their worst pain at an 8 (on a scale of 0 to 10, with 10 being the worst pain possible) in the last five days during the assessment period.Resident #98's Care Plan Report, included a focus area initiated 09/17/2024, that indicated the resident needed pain management and monitoring related to a surgical procedure, wound disruption, neuropathy, and peripheral vascular disease. Interventions directed staff to administer pain medication as ordered; evaluate and establish a level of pain on a numeric scale or using a pain evaluation tool; evaluate characteristics, frequency, and pattern of pain; evaluate need for routinely scheduled medications rather than as-needed pain medication administration; evaluate the need to provide medications prior to treatment or therapy; evaluate what made the resident's pain worse; provide dim lighting and quiet environment; reposition as needed; provide rest; and consults with the pharmacy as needed.Resident #98's hospital Discharge Summaries, dated 09/05/2024, indicated the resident's hospital course was complicated by difficulty controlling the resident's pain, and in-patient pain services were consulted. The summaries indicated that the resident was stable to transfer to a skilled nursing facility on a medication regimen.Resident #98's facility Order Recap [Recapitulation] Report, for the timeframe from 09/01/2024 through 06/24/2025, included an order dated 09/05/2024 for oxycodone 10 milligrams (mg) with instructions to give 10 mg orally every four hours as need for pain. Further review revealed there were no orders to monitor the resident's pain level on a routine basis or orders for non-pharmacological interventions.Resident #98's September 2024 Medication Administration Record [MAR], revealed Registered Nurse (RN) #79 documented that oxycodone 10 mg was administered on 09/19/2024 at 5:24 AM, for pain level that was rated 6 and documented as being ineffective with no follow-up. Further review revealed no non-pharmacological interventions were documented prior to the administration of the oxycodone.Resident #98's Progress Notes, revealed no evidence of non-pharmacological interventions implemented on 09/19/2024 prior to the administration of the oxycodone.Resident #98's Progress Notes revealed Daily Skilled Nurses Notes dated 09/15/2024, 09/16/2024, 09/18/2024, and 09/19/2024 that indicated the resident required frequent pain medication.During a phone interview on 07/18/2025 at 9:21 AM, RN #79 stated they should ask the resident what their pain level was every shift and when administering an as-needed pain medication. He stated if the medication was not effective, then he would give something else if it were available and if not, he would contact the physician to get something. He stated non-pharmacological interventions were not used often because the residents just wanted medication. RN #79 stated they did not remember Resident #98.During an interview on 07/18/2025 at 11:00 AM, former Director of Nursing Services (DNS) #53 stated that when a resident was in pain, it was (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	up to the nurse to treat that resident's pain with something and get ahold of the physician for orders. During an interview on 07/18/2025 at 1:05 PM, Licensed Practical Nurse (LPN) #22, a Unit Manager, stated residents' pain should be monitored every shift and documented on the MAR. She stated they should try non-pharmacological interventions first and document them, but she was not sure where. She stated they should always reassess a resident's pain after as-needed pain medication was given, and if it was not effective, they should try something else if available or contact the physician. During an interview on 07/18/2025 at 3:10 PM, the DNS stated pain should be monitored every shift and documented on the MAR. She stated non-pharmacological interventions should be tried and documented on the MAR. She stated if an as needed pain medication was given, the nurse should follow up, and if it was not effective, the nurse should give something else or contact the physician. During an interview on 07/18/2025 at 5:59 PM, RN #1 stated they should be documenting the resident's pain level every shift and whenever giving an as-needed pain medication. She stated she would attempt deep breathing or repositioning, but if the resident had a pain medication, they usually wanted the medication. She stated there was not a place to document non-pharmacological intervention except in a progress note. She stated if the pain medication that was given was not effective, it should be reported to the physician to see if an adjustment needed to be made or if they wanted to prescribe a one-time dose for a pain medication.