STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165437	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Maple Crest Manor	**100 Bolger Drive , Fayette, Iowa, 52142**

(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
F0000	INITIAL COMMENTS Correction date: _____ The following deficiencies resulted from the facility's annual recertification survey and investigation of complaint #3034221-C and facility reported incident #3040176-I conducted July 6, 2026 to July 9, 2026. Facility reported incident #3040176-I resulted in a deficiency. Complaint #3034221-C resulted in a deficiency. See Code of Federal Regulations (42CFR) Part 483, Subpart B-C.	F0000		
F0805 SS = E	Food in Form to Meet Individual Needs CFR(s): 483.60(d)(3) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(3) Food prepared in a form designed to meet individual needs. This REQUIREMENT is NOT MET as evidenced by: Based on observation, document review, policy review, and staff interview, the facility failed to prepare the correct puree servings and serve the dietician approved pureed menu to 4 of 4 residents reviewed (Resident #13, #19, #32 and #36). The facility identified a census of 38 residents. Findings include: The Week Five 5/5/26 Dietician Approved Pureed Menu for lunch on 7/7/26 listed the following: a. 3 ounce (oz) lemon garlic pork loin b. 4 oz Pasta Alfredo c. 4 oz broccoli	F0805		

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

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

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F0805 SS = E	Continued from page 1 d. 1 slice garlic toast e. 1 square pumpkin earthquake cake. Observation on 7/7/26 at 11:25 AM, Staff D, Dietary stated she planned to prepare five servings of pork loin. Staff D measured out 16 oz of pork loin, placed in the blender and added two ladles of gravy to the blender and blended. Staff D checked the mixture and added additional ladles of gravy to the blender and blended again. At 11:32 AM the Dietary Supervisor informed Staff D to “measure.” Staff D proceeded to take the same 4 oz scoop that she measured the pork loin with and scooped four, 4 oz serving from the blender into a steam pan. The blender had over ½ cup of the mixture left in the blender. Observation on 7/7/26 at 11:39 AM Staff D placed four, 4 oz servings of broccoli into the blender. Staff F added milk and blended the mixture. Staff D checked the mixture and added more milk and blended again. Staff D using the same 4 oz scoop placed four, 4 oz scoops of the broccoli puree into a steam pan and placed the pan in the oven. The blender still had approximately ½ cup of broccoli puree left in the blender. Observation on 7/7/26 at 11:46 AM Staff D stated she would prepare five puree servings of the pumpkin earthquake cake. Staff D placed five cake squares into the blender and added milk, then blended. Staff D added milk to the blender three more times as she prepared the puree. Staff D took a 4 oz spoodle and scooped out four spoodles of the cake puree and placed each 4 oz scoop into individual dessert bowls. The blend had approximately one cup of cake puree mixture left in the blender. Staff D failed to measure the total volume of food and utilize the Pureed Diet Portion Sizes/Dishers Chart to obtain correct serving sizes after more volume was added during the food preparation. Staff D failed to puree the pasta alfredo and the garlic bread. Resident #13, 19, #32, and #36 were not served the approved menu. Observation on 7/7/26 at 1:10 PM revealed Resident #13, #32 and #36 had eaten almost all of the pureed food and staff continued to assist Resident #19 with her meal. Interview completed on 7/7/26 at 2:35 PM, Staff F, Dietary explained when she prepared pureed food,	F0805		

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F0805 SS = E	Continued from page 2 she looked at the menu for each item to get the correct serving size. She used the appropriate scoop size to place the number of servings she needed into the blender, then added whatever liquid she needed to puree. Then she used the scoop size from the menu to serve out the pureed food. Staff F failed to identify she would measure the total volume of the pureed mixture and use the Pureed Diet Portion Sizes/Dishers chart to ensure a corrected serving size for each resident. During an interview on 7/7/26 at 3:00 PM the Dietary Supervisor reported she expected the staff to measure the total volume of the puree mixture during food preparation, then use the Pureed Diet Portion Sizes/Dishers Chart that was on the refrigerator in the kitchen to get the correct serving size. She reported the cook had not prepared and served out the pasta alfredo and a substitution had not been provided. She failed to identify that the garlic bread had not been provided. The How to Measure Correct Puree Foods Policy dated 2026 directed to measure the appropriate number of servings into the blender (i.e. 3 oz of meat x 4 servings = 12 oz meat). Add liquid, such as milk or meat broth. Blend to a pudding consistency. Use thickener if necessary. Pour all the blended product into a measuring pitcher to measure the amount of product and refer to the Pureed Diet Portion Sizes/Dishers Chart for serving sizes. The Puree Food Preparation Policy, 2026, directed residents receiving puree diets should always receive portions equivalent to those served on the regular or therapeutic diet.	F0805		
F0812 SS = E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility	F0812		

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F0812 SS = E	Continued from page 3 gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is NOT MET as evidenced by: Based on observation, 2017 United States (US) Food and Drug Administration (FDA) Food Code, document review, policy review, and staff interview the facility failed to ensure food was dated when stored, maintain clean equipment per the cleaning schedule, prevent soiled gloves from contacting food, failed to wash hands between glove changes and before starting new tasks, maintain appropriate cold beverage temperatures, and ensure staff entering the kitchen wore hairnets. The facility identified a census of 38 residents. Findings include: During an initial visit to the kitchen on 7/6/26 at 9:32 AM the following observations were made: a. Staff C, Dietary Aide had two bottles mild thickened consistency Cranberry juice (one ½ full and one ¼ full); one bottle thickened Peach Mango juice (1/4 full); and one bottle of mild thickened consistency orange juice ½ full as she placed pieces of tape dated 7/4/26 onto each bottle. When queried if she was just now dating the bottles, Staff D responded, “yes.” The bottles contained a statement to discard the product if not used within 10 days. b. The microwave had an orange, greasy, tacky substance splattered throughout the top, back and sides of the microwave. c. The refrigerator contained a bottle of mild thickened water, ¼ full, undated. The Label directed if the product was not used within 14 days to discard the product. A gallon of chocolate milk, ½ full was undated. d. Observation of the griddle revealed a black stuck down tacky substance coming out from the back part of the griddle down the entire length of the right side of the griddle from the back to the front. And approximately 10 inches from the back toward the front of the griddle on the left side. A large blacked area extended from the right middle part of the	F0812		

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F0812 SS = E	Continued from page 4 griddle out approximately 10 inches toward the middle of the griddle. e. The oven directly below the griddle observed with a thick black, gritty, stuck down substance a from the right side of the oven extended from the back to the front of the oven and out to the middle of the oven with a piece of tin foil rumpled up in the middle of the black, gritty, tacky substance. During a follow-up visit to the kitchen on 7/7/26 at 10:51 AM all the observations from 7/6/26 were still present. Further observation at this time revealed: a. The electric toaster contained a build-up of a brown/black gritty tacky, substance along all the horizontal bread holders. The bottom of the toaster had a brown, red, rust type surface approximately 5 inches deep and 12 inches across filled with bread crumbs. b. A large bowl with two 3-inch by 4-inch blocks of butter sat next to the electric toaster covered with plastic wrap, undated. c. The freezer contained an open, untied, undated bag of breaded shrimp. A bag of French fries with a 1.5-inch rip in the bag with fries exposed, a bag of four, 8 to 10 inch pie crusts, undated with an approximate 2 inch tear in the bag with crusts exposed, a plastic bag ½ full of snickerdoodle cookies, undated, ½ bag frozen bread rolls unsecured, and undated, ½ plastic bag of frozen bread cubes, undated. d. The refrigerator contained a ½ gallon of white milk, undated, a 5-pound container of sour cream, ½ full, undated, a 16 ounce container of chicken base, ½ full, undated. e. A brownish black gritty substance noted along the top of the ice machine. A finger swipe along the top of the top of the ice machine brought up a black, moist substance. The Dietary Supervisor reported she had seen that. f. Observation of the griddle revealed a black stuck down tacky substance coming out from the back part of the griddle down the entire length of the right side of the griddle from the back to the front. And approximately 10 inches from the back toward the front of the griddle on the left side. A large blacked area extended from the right middle part of the griddle out approximately 10 inches toward the middle of the griddle. The oven under the griddle continued to have a black tacky substance from the	F0812		

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F0812 SS = E	Continued from page 5 right side of the oven extended from the back to the front of the oven and extended out into the middle of the oven with a piece of tin foil rumpled up in the middle of the black gritty, tacky substance. Further observation at 10:58 AM Staff D, Dietary placed a sheet pan of garlic bread in the oven that would be served for lunch. g. The first steam table well from the left-hand side contained a black sticky, gritty, stuck down substance approximately 24 inches in length and 12 – 14 inches across. The second well had a black stuck down substance along the front half of the well. At 11:01 AM the Dietary Supervisor asked if there was a special way to clean it. The third well had a black orange stuck down substance along the left side of the well approximately 12 inches in length and 8 inches in width. The area below the steam table shelf had food spills extending approximately 8 inches in length down the steam table above the burner dials extending from each well. At 11:07 AM the Dietary Supervisor reported she had spilled something in the first steam table well a while back and it was hot so by the time she got done it was stuck down. h. At 11:10 AM the Dietary Supervisor stated she had to find some testing strips to test the quat sanitizing bucket. She was told if the buckets were premixed, they no longer had to test the buckets. At 11:12 AM the Dietary Supervisor returned to the kitchen and tested the Quat bucket. Review of the [Brand Name] Testing Strips showed they were expired 6/1/23. i. At 11:20 AM Staff D failed to wash her hands, applied a glove to her right hand, and grabbed a bag of breaded shrimp with her right gloved hand, used scissors placed in her right gloved hand to cut open the bag of shrimp, dumped the bag of shrimp out onto a baking sheet, the proceeded to take her right gloved hand in a sweeping motion across the breaded shrimp pieces to smooth them into a single layer on the baking sheet. j. At 12:12 PM Staff D placed her left hand on the left upper part of her uniform and wiped it along her face, then proceeded to place foil over a pan of breaded shrimp and placed it on the steam table without washing her hands. k. At 12:17 PM Staff D place a dirty spoodle into the dishwasher, then proceeded to set up clean tongs and scoops on the steam table preparing for the noon meal without washing her hands.	F0812		

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F0812 SS = E	Continued from page 6 l. At 12:24 PM Staff D opened a drawer and removed a white handled, 3-ounce scoop by touching the inside of the scoop directly with her left hand which had touched multiple surfaces. She placed the scoop into the pureed pork loin to serve Resident #32. m. At 12:41 PM Staff D placed dirty dishes into the dishwasher, then returned to the steam table without washing her hands and plated up Resident #6 lunch meal and served it out. At 12:42 PM Staff D obtained the food processor blade and canister from the dishwasher, touched the food processor blade to place directly into the food processor with her bare hand, placed Resident #1's serving of pork loin into the food processor and proceeded to grind the meat which was served out to Resident #1. n. At 12:45 PM the Dietary Supervisor washed her hands, proceeded to remove several packages of meat from the refrigerator and dispose of it into the garbage. She then took a package of meat and a bag of white bread and placed it on the front preparation table. She donned gloves and opened the bread bag with her left hand and reached into the bread bag with her right gloved hand to remove two slices of bread placing the bread on a plate. She then picked the bread up with the left glove to hold the bread in place as she buttered the bread with a knife in her right hand. Then she opened the meat package with her gloves, removed three slices of meat with the same gloves and placed the meat on the bread. She steadied the sandwich in her left gloved hand as she cut the sandwich in half with a knife in her right hand, then picked up the two sandwich halves with her soiled gloves and placed the sandwich on a plate. The sandwich was served out to Resident #28. o. Continuous observation of the meal service provided on 7/8/26 from 12:21 PM to 1:17 PM revealed various juices, a gallon of white milk and a gallon of chocolate milk in a square cold container positioned in front of the steam table. The cold container did not contain any ice. At 1:17 PM Staff D placed a thermometer in a glass of white milk at the end of the meal service which revealed a temperature of 44.5 degrees Fahrenheit. During an observation and interview on 7/7/26 at 1:18 PM Staff D took a sip of the glass of milk and made a wrinkled face, slightly shaking her head side to side, stating she would like the milk to be colder. She explained 44 degrees was not an appropriate temperature for the milk. Staff C informed Staff D the temperature guide was hanging on the [redacted] refrigerator. Staff D walked over to the [redacted] refrigerator. A sign outlined cold beverages were to	F0812		

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F0812 SS = E	Continued from page 7 be maintained between 38-40 degrees. On 7/7/26 at 2:35 PM Staff F, Dietary reported she was the afternoon cook. She explained during the supper meal they placed the juice and milk bottles in a cold container on a cart to serve out during meals. They did not put ice in the cold container. They had the hot/cold temperatures posted on the refrigerator. She stated milk should be held at 35 degrees. She further explained gloves were used for a single task only, then staff needed to wash their hands after they removed the gloves. The griddle and the ovens were to be cleaned every week. The steam table could not be cleaned with abrasive chemicals, so she just tried to wipe it down with soap and water the best she could. They tried to do a deep cleaning on the steam table once a week. The microwave was supposed to be wiped out twice a day. She had a cleaning chart every weekend that she had to complete. The Dietary Supervisor placed a list of duties in the communication book for them to follow-up on. Staff F didn't think they tested the quat buckets on a regular basis as part of their regular duties. She had not tested the bucket since she was hired. They didn't have any place to document any type of check. Observation on 7/7/26 at 2:40 PM revealed therapy personnel entered the back door of the kitchen without wearing a hairnet and obtained ice from the ice machine. Observation on 7/7/26 at 2:55 PM revealed Staff G, Registered Nurse (RN) in the kitchen without a hairnet on and poured two cups of coffee to take out to residents. The Point of Care Audit Report for Dietary Cleaning documented the following cleaning: 1. Microwave a.7/6/26 at 1:47 PM by Staff H. b.7/6/26 at 5:30 PM by Staff I. c.7/7/26 at 2:07 PM by Staff D. d.7/7/26 at 7:14 PM by Staff F. 2. Refrigerator Outdated Food: a.7/6/26 at 1:46 PM by Staff H. b.7/7/26 at 2:07 PM by Staff F.	F0812		

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F0812 SS = E	Continued from page 8 3. Steamtable: a.7/6/26 at 1:47 PM by Staff H. b.7/6/26 at 6:52 PM by Staff I. c.7/7/26 at 2:07 PM by Staff D. 4. Stovetop/Griddle: a.7/6/26 1:46 PM by Staff H. b.7/6/26 at 5:29 PM by Staff I. c.7/7/26 at 2:06 PM by Staff D. d.7/7/26 at 7:10 PM by Staff F. 5. Toaster a.7/6/26 at 1:46 PM by Staff H. b.7/6/26 at 5:30 PM by Staff I. c.7/7/26 at 2:06 PM by Staff D. d.7/7/26 at 7:15 PM by Staff F. During an interview on 7/7/26 at 3:00 PM the Dietary Supervisor reported the steam table was to be wiped out every shift with soapy water. According to the manual, they could not use any abrasive cleaners. The microwave was to be cleaned out after each shift with soapy water. She stated the ovens are to be cleaned weekly and they really don't use the griddle anymore. The staff were to place ice in the cold containers with the drink containers during the meal to keep items cold. Ideally, she would like to have the cold temperatures held at 37 degrees. She expected the staff to use hairnets before coming into the kitchen. They hung racks outside of the kitchen to remind staff to wear the hairnets. Staff should wash their hands before and after glove use. Once they finished a task, they should remove the gloves and wash their hands. Ready to eat foods should be handled with gloved hands. The Dietary Supervisor explained she had a daily cleaning list that moved to the computer and they were documenting on the computer. On 7/7/26 at 3:35 PM the Consulting Dietician, present during the Dietary Supervisor interview, stated it was obvious they needed to work on some things. The Cleaning Duties and Schedules Policy, undated,	F0812		

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F0812 SS = E	Continued from page 9 directed the dietary area would be kept clean and in an orderly, sanitary way. The Policy Procedure directed the kitchen would be cleaned each day as the regular work schedule states, and every week, the kitchen would receive an extra thorough cleaning by a dietary staff person. The policy further stated extra cleanings were listed with names of those responsible for completing them. These were to be initialed as completed. The Dietary Manager would file. The Deep Cleaning List directed on week 2 for the AM cook to clean the ovens, the oven drip trays, and wipe the stove down. The (Brand Specific) Electric Sealed Well Food Warmer Service Manual for the steam table under Maintenance, Stainless Steel Care and Cleaning directed to use non-alkaline-based or non-chloride cleaning solutions. Anything containing chloride will damage the protective film on stainless steel. Chlorides are found in household and industrial cleaners and also in hard water and salts. If a chloride or alkaline cleaner has been used, rinse repeatedly and dry thoroughly. Always use only soft cloths or plastic scouring pads. For routine cleaning, use warm soapy water. For stubborn stains, use a non-abrasive cleanser. For heavy grease, use a degreaser. For best results, rub with the grain of the steel. The Glove Use in Food Service Policy, undated, directed the staff to wash hands thoroughly before and after wearing or changing gloves. When feasible, no direct contact with food should occur. Sanitized utensils should be used for handling ready-to-eat foods. Change gloves whenever changing activity. Wear gloves only when needed. The Hand Washing Technique Policy, undated, directed to wash hands before and after contact with a source of microorganisms (body fluids, mucous membranes, nonintact skin). The Ready to Eat (RTE) Foods Policy, undated, directed tongs would be used for RTE foods. RTE foods could not be handled with bare hands. The Food Temperature Check Policy, undated, directed cold beverages should be held less than or equal to 38-40 degrees Fahrenheit. The Food Storage Policy, undated, directed all opened food would be dated and sealed before returning to storage.	F0812		

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F0812 SS = E	Continued from page 10 The Cleaning Oven Policy, undated, directed ovens would be cleaned weekly and as spills occurred. The United States Food and Drug Administration 2017 Food Code outlined: a. Chapter 2, Section 2-402.11 Food employees shall wear hair restraints such as hats, hair coverings or nets that are designed and worn to effectively keep hair from contacting exposed food. b. Chapter 2-301.14 When to Wash (hands) directs food employees to clean their hands and exposed portions of their arms immediately before engaging in food preparation, after handling soiled equipment or utensils, during food preparation, as often as necessary to remove soil and contamination and to prevent cross contamination when changing tasks, before donning gloves to initiate a task that involves working with food, and after engaging in other activities that contaminate the hands. c. Chapter 3-301.11 Preventing Contamination from Hands directs food employees may not contact exposed, ready to eat food with their bare hands and shall use suitable utensils such as deli tissue, spatulas, tongs, single-use gloves or dispensing equipment. d. Chapter 4, part 4-6 Cleaning of Equipment and Utensils directs at 4-601.11 (B) food contact surfaces of cooking equipment shall be kept free of encrusted grease deposits and other soil accumulations; non-food contact surfaces of equipment must be kept free of accumulations of dust, dirt, residue and other debris.	F0812		
F0550 SS = D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident.	F0550		

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F0550 SS = D	Continued from page 11 §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, record review, and policy review the facility failed to ensure a staff member treated a resident with dignity and respect regarding an interaction between the resident and Staff O, Certified Nursing Assistant (CNA) for 1 of 3 sampled residents reviewed for dignity (Resident #27). The facility reported a census of 38 residents. Findings include: Review of Resident #27's Minimum Data Set (MDS) dated 6/4/26 documented the resident had short-term and long-term memory problems and had severely impaired cognitive skills for daily decision-making. The assessment indicated the resident experienced physical and verbal behavioral symptoms directed toward others on 4 to 6 days during the 7-day look-back period. Per the assessment, the resident used a wheelchair and had impairment on both sides of her lower extremities. Resident #27 was dependent on staff for hygiene, bathing, dressing, and transfers. The resident frequently experienced urinary and bowel incontinence. Resident #27's diagnoses included	F0550		

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F0550 SS = D	Continued from page 12 non-Alzheimer's dementia and depression, and she received hospice care. Review of Resident #27's Care Plan, initiated on 12/24/24, revealed a focus on Activity of Daily Living (ADL) self-care deficit related to aggressive behavior and dementia. The care plan goal directed staff to help the resident maintain her current level of function. Interventions initiated on 3/27/25 directed staff to accommodate the family's preference to let the resident sleep in, and to offer breakfast snacks, cereal, toast, or supplemental drinks when she woke to prevent weight loss. Toileting interventions initiated on 2/3/25 required the assistance of two staff members for toilet use. Transfer interventions initiated on 1/14/25 required a two-person pivot transfer with a gait belt, handheld assistance, or a grab bar. A second Care Plan focus initiated on 12/13/24 identified that the resident was physically aggressive toward staff who tried to intervene and redirect related to dementia, The intervention initiated on 12/29/25 directed staff to clear clutter, reduce noise, and create a calm and supportive environment, considering factors like temperature and lighting. An intervention for agitation, initiated on 12/29/25, instructed staff to intervene before agitation escalated, guide the resident away from distress, and engage calmly in conversation. If the resident responded aggressively, staff received instructions to walk calmly away and approach her later. Review of the Director of Nursing (DON) Recap, titled Events from 5/29/26 investigation, revealed the DON wasn't present in the facility on 5/29/26. The Assistant Director of Nursing (ADON) served as the on-call supervisor that day. The DON checked the phone around 11:00 AM and returned a phone call to the Administrator at 11:03 AM. When asked about the situation, the Administrator replied he called to keep the DON in the loop because Staff L, Licensed Practical Nurse (LPN) heard Staff O, CNA yelling at a resident and intervened. The DON requested specific details regarding the identity of the resident, the words spoken by Staff O, and whether the interaction constituted abuse or an approach issue. The Administrator repeated the initial statement. The DON requested a complete description including the who, why, what, where, and when to understand the situation. The Administrator stated he read what happened, reported the incident to the Department of Inspections, Appeals, and Licensing (DIAL), and sent Staff O home for the day. The DON noted the lack of details made it difficult to provide direction or assistance without being onsite and stated she	F0550		

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F0550 SS = D	Continued from page 13 would speak with Staff L. The DON asked the Administrator what Staff O said during their office meeting, and the Administrator replied he hadn't met with Staff O yet. The DON messaged Staff L to schedule a follow-up call, and Staff L responded that the ADON and the Administrator handled the matter. The ADON later called the DON, read staff statements, reported that the Administrator called DIAL, and noted that resident and staff interviews indicated a coachable moment rather than suspected abuse. On 6/1/26, the DON returned to the facility and asked the ADON about the status of the investigation. The ADON stated she gave the information to the Administrator, who planned to complete the investigation. The Administrator remained out for the day on 6/1/26. The DON called Staff O to obtain her statement. Staff O stated she raised her voice because the resident hit her and it hurt. Staff O told the resident it hurt and asked her to stop. On 7/8/26 at 11:52 AM, Staff O, CNA stated on the morning of 5/29/26, she worked the 6:00 AM to 2:00 PM shift, communicated well with the day staff, and coordinated care duties with her partner, Staff M, CNA, while Staff L served as the hall nurse. Staff O and Staff M entered Resident #27's room and approached her quietly to avoid agitation. Staff O noted Resident #27 required a two-person transfer. Resident #27 selected her clothing, and when the staff attempted to stand her up from the toilet, Resident #27 began hitting and pinching Staff O. Staff O explained that sitting the resident back down to reapproach would create a safety hazard. While Resident #27 struck her, Staff O used a stern voice and told the resident it hurt and asked her to stop hitting. Resident #27 later ate breakfast, and management subsequently instructed Staff O to go home. Staff O further stated Resident #27 exhibited aggressive behaviors daily, typically sat by the nurse's station, and experienced frequent mood shifts despite being generally sweet and kind. Staff O noted the resident hit, pinched, and grabbed staff on multiple occasions. The facility instructed staff to remain calm, talk through procedures, and suggested customer service. Management later suggested Staff O review online CNA customer service education modules and recommended staff maintain eye level during reapproaching techniques. On 7/8/26 at 12:17 PM, Staff N, CNA, stated she worked on the [redacted] hallway around 8:30 AM on 5/29/26. She observed Staff O used an inappropriate tone of voice with Resident #27. Staff N noted she	F0550		

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F0550 SS = D	Continued from page 14 witnessed Staff M going to assist Staff O, and the tone of voice caused her concern. On 7/9/26 at 9:41 AM, Staff M, CNA, stated Resident #27 could be hard to get up. Staff O and Staff M assisted Resident #27 into the bathroom, where the resident began displaying her typical behavioral symptoms. Staff O began yelling at Resident #27, which Staff M disliked, prompting Staff M to call the Licensed Practical Nurse (LPN), Staff L, into the room. Staff O continued yelling while Resident #27 pinched, scratched, bit, kicked, and hit Staff O. Staff O yelled at Resident #27 to stop it and knock it off. Staff M noted sometimes had to get stern, but not in a mean way. On 7/9/26 at 9:36 AM, Staff L, LPN, stated she didn't witness the physical interactions between Resident #27 and Staff O. She heard Staff O yell at Resident #27 to stop, quit, and avoid those actions. Staff L explained felt the interaction went too far, though she didn't suspect abuse. Resident #27 appeared slightly worked up but remained safe after the incident. Staff L noted Resident #27 pinched, scratched, spit, bit, kicked, and hit staff, and Staff L had experienced these behaviors firsthand. Staff L described Staff O as a naturally loud person who should've used a quieter voice to instruct Resident #27 to stop. On 7/9/26 at 10:28 AM, Staff K, CNA and Restorative Aide, stated Resident #27 participated in activities and transfers depending on her daily mood. She exhibited positive behaviors when staff allowed her to wake up on her own, but she hit and kicked staff on difficult days. On the morning of 5/29/26, Staff K stood at the nurse's station while Staff O and Resident #27 remained in the resident's room. Staff K heard Staff O yelling at Resident #27 to stop being rude and telling her she acted rudely. Staff L entered the room to check on the situation. Staff K characterized the voice as more than just a loud voice. On 7/9/26 at 10:21 AM, Staff J, CNA, stated Resident #27's behaviors depended heavily on the day. She experienced good moods, but she also spit, grabbed, pinched, and cursed at staff on difficult days, particularly during morning care when staff woke her up. On 7/9/26 at 10:43 AM, the DON stated the facility assigned customer service education to the staff and initiated visual audits on Resident #27. The facility's undated Residents' Bill of Rights	F0550		

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F0550 SS = D	Continued from page 15 policy instructed the facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality, The facility must protect and promote the rights of the resident.	F0550		
F0641 SS = D	Accuracy of Assessments CFR(s): 483.20(g)(h)(i)(j) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. §483.20(h) Coordination. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. §483.20(i) Certification. §483.20(i)(1) A registered nurse must sign and certify that the assessment is completed. §483.20(i)(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. §483.20(j) Penalty for Falsification. §483.20(j)(1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. §483.20(j)(2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is NOT MET as evidenced by: Based on clinical record review, Centers for Medicare and Medicaid (CMS) Long-Term Care (LTC) Resident Assessment Instrument (RAI) 3.0 User	F0641		

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F0641 SS = D	Continued from page 16 Manual, facility policy review, and staff interview, the facility failed to ensure nursing staff accurately completed Minimum Data Set (MDS) assessments for 2 of 15 residents reviewed (Resident #23 and Resident #7). The facility reported a census of 38 residents. Findings include: 1.Resident #23's Quarterly Minimum Data Set (MDS) Assessment dated 5/22/26 documented Resident #23 had a diagnoses of Alzheimer's Disease and received an antipsychotic medication. The May 2026 Electronic Medication Administration Record (EMAR) lacked documentation Resident #23 received an antipsychotic medication in the 7 day lookback period. Review of Resident #23's Clinical Physician Order list included Aricept (Donepezil) (a medication classified as a cholinesterase inhibitor and used to treat dementia) Oral Tablet 5 milligram (mg), give 1 tablet by mouth in the morning with start date 2/13/26. On 7/8/26 at 10:16 AM, during an interview, the Assistant Director of Nursing (ADON)/MDS Coordinator confirmed she was responsible for completing the MDS Assessments for residents, and had completed the MDS assessments for Resident #23 and #7. The ADON/MDS Coordinator explained she thought that the Centers for Medicare and Medicaid (CMS) had classified drugs used to treat dementia, like Donepezil and Memantine, as antipsychotics. The ADON/MDS Coordinator reported both residents took Donepezil, so she had coded them as receiving an antipsychotic medication. Review of the facility policy, titled Conducting an Accurate Resident Assessment, dated 2025, revealed, in part, “Accuracy of assessment” means that the appropriate, qualified health professionals correctly document the resident’s medical, functional, and psychosocial problems and identify resident strengths to maintain or improve medical status, functional abilities, and psychosocial status using the appropriate Resident Assessment Instrument (RAI) (i.e. comprehensive, quarterly, significant change in status). 2a. Resident #7's Significant Change in Status MDS Assessment dated 5/28/26 documented diagnoses	F0641		

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F0641 SS = D	Continued from page 17 of Non-Alzheimer's Dementia, and the resident received antipsychotic medication during the seven day look-back period. The May 2026 EMAR lacked documentation Resident #7 received antipsychotic medication. The EMAR documented Resident #7 received Donepezil Hydrochloride Tablet 10 mg, give 1 tablet by mouth at bedtime related to vascular dementia with unspecified severity, psychotic disturbance, mood disturbance and anxiety. Start date 5/24/24. The EMAR showed all doses signed out as administered from 5/1/26 – 5/27/26. During an interview on 7/8/26 at 2:46 PM, the Director of Nursing (DON) reported she didn't know what the MDS Coordinator used as a drug resource guide to code antipsychotic medications. Originally when she discussed it with the ADON, she referenced when she put a physician order in the electronic healthcare record (EHR), it would come up as a psychotropic medication or neuropsychotropic medication and that is where she was getting it from. Then the ADON reached out to the pharmacist and the pharmacist stated no as well. On 7/8/26 at 2:55 PM, the ADON reported she swore she received an email communication regarding information to code those medications as antipsychotic medications. When queried if she was aware that the RAI Section N required medications to be coded based on the drug classification, she responded not off the top of her head. She explained she used the RAI to code the MDS, but some of it could be the interpretation of how you read it. The LTC RAI User's Manual October 2025 revealed per Chapter 3, Page N-6 under Coding Instructions to code all high-risk drug class medications according to their pharmacological classification, not how the medications are used. Page N-9 further directed: a. Facilities may wish to identify a resource that their staff consistently use to identify pharmacological classification as assessors should be able to identify the source(s) used to support coding the MDS 3.0. b. Assessors should consult the manufacturer's package insert, which may contain the medication's pharmacological classification. They can also work with the resident's pharmacist to confirm the medication classification(s) for a resident's medication(s). c. Medications that have more than one therapeutic	F0641		

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F0641 SS = D	Continued from page 18 category and/or pharmacological classification should be coded in all categories/classifications assigned to the medication, regardless of how it is being used. 2b. Resident #7's Quarterly MDS dated 6/15/26 documented diagnoses of respiratory failure and exhibited shortness of breath/trouble breathing when lying flat. The MDS lacked documentation Resident #7 utilized oxygen. The June 2026 Electronic Treatment Administration Record (ETAR) showed a physician order for oxygen 2-5 liters per nasal cannula for comfort, every shift, start date 5/29/26. The ETAR showed nursing staff signed off the oxygen daily as provided during the 7 day lookback assessment period. During an interview on 7/8/2026 at 9:33 AM the ADON/MDS Coordinator explained she reviewed progress notes, talked with the staff, and she filled out an MDS Assessment Worksheet with the resident information when she completed the MDS. The ADON provided the last quarterly MDS Assessment Worksheet which showed Section O "oxygen" with "continuous" circled. She reported the MDS was a miscode and needed to be modified. The CMS RAI User Manual, October 2025, Chapter 3, Section O, Page O-4 directed to code continuous or intermittent oxygen administered via cannula.	F0641		
F0695 SS = D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is NOT MET as evidenced by: Based on observation, clinical record review, manufacturer user manual, policy review, and staff interview, the facility failed to change and date oxygen tubing and maintain a clean exterior filter for 1 of 1 resident receiving oxygen therapy (Resident #7). The facility identified a census of 38 residents.	F0695		

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F0695 SS = D	Continued from page 19 Findings include: The Minimum Data Set (MDS) Assessment for Resident #7 dated 6/15/26 showed a Brief Interview for Mental Status (BIMS) score of 14 out of 15 indicating intact cognition. The MDS documented Resident #7 exhibited shortness of breath when laying flat and a diagnosis of respiratory failure. The MDS lacked documentation Resident #7 utilized oxygen therapy. An 5/29/26 Order Audit Report showed a physician order for oxygen via nasal cannula, 2-5 liters for comfort. Observation on 7/6/26 at 12:20 PM revealed Resident #7 sat in the wheelchair at the dining room table with portable oxygen running at 2 liters per nasal cannula. Further observation revealed the oxygen tubing was not dated. During an observation on 7/6/26 at 2:09 PM, Resident #7 lay in bed resting with oxygen running at 2 liters per nasal cannula continuously per concentrator. The oxygen concentrator external filter noted with a white, gritty white film and the oxygen tubing was not dated to indicate when the tubing had been changed. Observation on 7/7/26 at 6:35 AM revealed Resident #7 lay in bed with oxygen running continuously at 2 liters per nasal cannula per oxygen concentrator. The oxygen tubing was not dated and the condition of the external concentrator filter was unchanged. Observation on 7/8/26 at 7:30 AM revealed Resident #7 lay in bed with oxygen running per nasal cannula at 2 liters per oxygen concentrator. The oxygen tubing lacked a date and the external concentrator filter condition was unchanged. A 7/8/26 review of Resident #7's Care Plan revealed the Assistant Director of Nursing (ADON) updated the Congestive Heart Failure Care Plan to include the use of oxygen on 7/8/26. A 7/8/26 review of the June and July 2026 Electronic Medication Administration Record (EMAR) and Electronic Treatment Administration Record (ETAR) lacked documentation nursing staff changed the oxygen tubing or cleaned the concentrator external filter. Interview on 7/8/26 at 9:07 AM revealed Staff A, Certified Medication Aide (CMA) reported they checked oxygen saturation levels several times a	F0695		

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F0695 SS = D	Continued from page 20 day on Resident #7. His oxygen was ordered for his comfort and he tolerated it well. Night shift changed the oxygen tubing, but she didn't know when, how often, or where they documented the change. On 7/8/26 at 9:10 AM, Staff B, Licensed Practical Nurse (LPN) reported the oxygen tubing was changed by the night shift, but she didn't know where the nurses documented the change. She thought it would be documented on the ETAR. Staff B reviewed Resident #7's ETAR and reported she did not find any documentation. Observation on 7/8/26 at 9:11 AM revealed Resident #7 sat in the wheelchair in his room and got a haircut. Resident #7 received oxygen at 2 liters per nasal cannula from the oxygen concentrator. The oxygen tubing was undated and the concentrator external filter condition was unchanged. On 7/8/2026 at 9:12 AM, the Director of Nursing (DON) explained the oxygen tubing was changed every 14 days. When queried how often the external filter was rinsed out and cleaned, the DON checked the monthly cleaning list and stated the changing of the oxygen tubing was not on the cleaning list and the ADON would have more information as she took care of the oxygen. On 7/8/26 at 9:18 AM, the ADON explained the oxygen supplier addressed the cleaning of the filter. At this time, the DON informed the ADON Resident #7 did not have an order to have his oxygen tubing changed. Observation on 7/8/2026 at 9:27 AM revealed the ADON walked down to Resident #7's room and stated the oxygen concentrator was one of the facility's concentrators. The oxygen concentrator external filter was removed and revealed a white, gritty film visible 1/4 inch into the half-inch filter. The ADON confirmed the external filter was dirty and needed to be cleaned. She reported she had completed batch orders for the oxygen care for residents, but Resident #7 was not in the orders. She further explained the nurses were responsible to get the oxygen orders, so the nurses missed setting up an order to change the oxygen tubing and cleaning the filter. On 7/09/26 at 11:25 AM, the DON reported she had talked with the night nurse last night and the night nurse stated they do wash out the external oxygen filters on the oxygen concentrators, but they don't document it. She further reported, the facility did not do any maintenance on the oxygen concentrators,	F0695		

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F0695 SS = D	Continued from page 21 they called a vendor that maintained the machines. The DON referenced if not documented, it was not done. The Oxygen Policy, 2025, documented a purpose was to establish responsibilities for the care and use of oxygen concentrators. The Policy under Care of the Concentrator directed to follow the manufacturer's recommendations for the frequency of cleaning filters and servicing of the device. The Nurse Responsibilities included to change the oxygen cannula/tubing every 14 days. The Oxygen Concentrator (Brand Specific) Patient Manual under "Filters" revealed, Air enters the unit through an air intake gross particle filter located on the back of the oxygen concentrator. The filter removes dust particles and other impurities from the air. Make sure the filter is clean and positioned correctly before the unit is in operation. On a weekly basis, wash the air intake gross filter (external concentrator filter). Remove and wash in a warm solution of soap and water. Rinse the filter thoroughly and remove excess water with a soft absorbent towel, then replace the filter.	F0695		
F0810 SS = D	Assistive Devices - Eating Equipment/Utensils CFR(s): 483.60(g) §483.60(g) Assistive devices The facility must provide special eating equipment and utensils for residents who need them and appropriate assistance to ensure that the resident can use the assistive devices when consuming meals and snacks. This REQUIREMENT is NOT MET as evidenced by: Based on observation, clinical record review, document review, resident interview, and staff interview, the facility failed to provide adaptive equipment of divided plates necessary to meet resident needs for 2 of 7 residents sampled (Resident #12 and #30). The facility identified a census of 38 residents. Findings include: On 7/7/26 the facility provided a Diet Order Excel Spread sheet, updated July seventh. The List identified seven resident that required the use of divided plates, including Resident's #12 and #30. A 7/7/26 review of Resident #12's Nutritional	F0810		

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F0810 SS = D	Continued from page 22 Problem Care Plan, dated 2/24/26, related to a diagnosis of Parkinson's Disease lacked direction to provide a divided plate for meals. A 7/7/26 review of Resident #30's Potential for Nutritional Problem Care Plan noted a diagnosis of Parkinson's Disease and included a 4/14/26 intervention per Occupational Therapy (OT) recommendations to provide a divided plate for meals. Observation on 7/7/26 at 12:35 PM revealed Staff D, Dietary plated a serving of broccoli, breaded shrimp, and cocktail sauce on a regular plate which was served out to Resident #12. Staff E, Dietary looked at Resident #12's meal ticket as she took the plate from Staff D and continued to serve the plate out to Resident #12. Resident #12's Meal Ticket at the bottom under Adaptive Equipment listed to use a divided plate. Observation on 7/7/26 at 12:54 PM revealed Staff D plated breaded shrimp, French fries, garlic bread on a regular plate which was served out to Resident #30. Resident #30's Meal Ticket at the bottom under Adaptive Equipment listed to use a divided plate. On 7/7/26 at 2:15 PM, Resident #12 reported she usually received her meals in a divided plate and she had received her lunch meal on a regular plate. Resident #12 reported it would have been nice if her lunch would have come on her divided plate as she lost a lot of food off her plate and on the floor when she tried to eat lunch. Resident #12 stated she needed her divided plate. On 7/7/26 at 2:25 PM, Resident #30 reported she usually received her meals on a divided plate but had a regular plate today. Resident #30 reported it did not cause her any issues at lunch. Resident #30's family member stated she had received finger food, so she was able to eat her lunch off of the regular plate, but she was supposed to get her meals on a divided plate. On 7/7/26 at 2:36 PM Staff F, Dietary stated the adaptive equipment was listed on the resident's meal ticket and on a list above the steam table. They checked the list as they served out the meals. During an interview on 7/7/26 at 3:00 PM, the Dietary Supervisor reported she was not aware Resident #12 had not received her meal on a divided plate, but the Director of Nursing (DON) reported Resident #12 had not received her divided plate. They communicated the adaptive equipment on the	F0810		

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F0810 SS = D	Continued from page 23 meal tickets and also on a “cheat sheet” on the steam table that communicated who got the divided plates. Staff should check the ticket and the list as they served out the meals.	F0810		
F0849 SS = D	Hospice Services CFR(s): 483.70(n)(1)-(4) §483.70(n) Hospice services. §483.70(n)(1) A long-term care (LTC) facility may do either of the following: (i) Arrange for the provision of hospice services through an agreement with one or more Medicare-certified hospices. (ii) Not arrange for the provision of hospice services at the facility through an agreement with a Medicare-certified hospice and assist the resident in transferring to a facility that will arrange for the provision of hospice services when a resident requests a transfer. §483.70(n)(2) If hospice care is furnished in an LTC facility through an agreement as specified in paragraph (o)(1)(i) of this section with a hospice, the LTC facility must meet the following requirements: (i) Ensure that the hospice services meet professional standards and principles that apply to individuals providing services in the facility, and to the timeliness of the services. (ii) Have a written agreement with the hospice that is signed by an authorized representative of the hospice and an authorized representative of the LTC facility before hospice care is furnished to any resident. The written agreement must set out at least the following: (A) The services the hospice will provide. (B) The hospice's responsibilities for determining the appropriate hospice plan of care as specified in §418.112 (d) of this chapter. (C) The services the LTC facility will continue to provide based on each resident's plan of care. (D) A communication process, including how the communication will be documented between the LTC facility and the hospice provider, to ensure that the needs of the resident are addressed and met 24	F0849		

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F0849 SS = D	Continued from page 24 hours per day. (E) A provision that the LTC facility immediately notifies the hospice about the following: (1) A significant change in the resident's physical, mental, social, or emotional status. (2) Clinical complications that suggest a need to alter the plan of care. (3) A need to transfer the resident from the facility for any condition. (4) The resident's death. (F) A provision stating that the hospice assumes responsibility for determining the appropriate course of hospice care, including the determination to change the level of services provided. (G) An agreement that it is the LTC facility's responsibility to furnish 24-hour room and board care, meet the resident's personal care and nursing needs in coordination with the hospice representative, and ensure that the level of care provided is appropriately based on the individual resident's needs. (H) A delineation of the hospice's responsibilities, including but not limited to, providing medical direction and management of the patient; nursing; counseling (including spiritual, dietary, and bereavement); social work; providing medical supplies, durable medical equipment, and drugs necessary for the palliation of pain and symptoms associated with the terminal illness and related conditions; and all other hospice services that are necessary for the care of the resident's terminal illness and related conditions. (I) A provision that when the LTC facility personnel are responsible for the administration of prescribed therapies, including those therapies determined appropriate by the hospice and delineated in the hospice plan of care, the LTC facility personnel may administer the therapies where permitted by State law and as specified by the LTC facility. (J) A provision stating that the LTC facility must report all alleged violations involving mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of patient property by hospice personnel, to the hospice administrator immediately when the LTC facility becomes aware of the alleged	F0849		

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F0849 SS = D	Continued from page 25 violation. (K) A delineation of the responsibilities of the hospice and the LTC facility to provide bereavement services to LTC facility staff. §483.70(n)(3) Each LTC facility arranging for the provision of hospice care under a written agreement must designate a member of the facility's interdisciplinary team who is responsible for working with hospice representatives to coordinate care to the resident provided by the LTC facility staff and hospice staff. The interdisciplinary team member must have a clinical background, function within their State scope of practice act, and have the ability to assess the resident or have access to someone that has the skills and capabilities to assess the resident. The designated interdisciplinary team member is responsible for the following: (i) Collaborating with hospice representatives and coordinating LTC facility staff participation in the hospice care planning process for those residents receiving these services. (ii) Communicating with hospice representatives and other healthcare providers participating in the provision of care for the terminal illness, related conditions, and other conditions, to ensure quality of care for the patient and family. (iii) Ensuring that the LTC facility communicates with the hospice medical director, the patient's attending physician, and other practitioners participating in the provision of care to the patient as needed to coordinate the hospice care with the medical care provided by other physicians. (iv) Obtaining the following information from the hospice: (A) The most recent hospice plan of care specific to each patient. (B) Hospice election form. (C) Physician certification and recertification of the terminal illness specific to each patient. (D) Names and contact information for hospice personnel involved in hospice care of each patient. (E) Instructions on how to access the hospice's	F0849		

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F0849 SS = D	Continued from page 26 24-hour on-call system. (F) Hospice medication information specific to each patient. (G) Hospice physician and attending physician (if any) orders specific to each patient. (v) Ensuring that the LTC facility staff provides orientation in the policies and procedures of the facility, including patient rights, appropriate forms, and record keeping requirements, to hospice staff furnishing care to LTC residents. §483.70(n)(4) Each LTC facility providing hospice care under a written agreement must ensure that each resident's written plan of care includes both the most recent hospice plan of care and a description of the services furnished by the LTC facility to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, as required at §483.24. This REQUIREMENT is NOT MET as evidenced by: Based on clinical record review, review of the facility's hospice contract, and staff interview, the facility failed to ensure the written agreement with a contracted hospice included required language to address immediate hospice administration notification in the event of alleged abuse by hospice staff for 1 of 1 resident reviewed with hospice services (Resident #16). The facility reported a census of 38 residents. Findings include: Review of the Care Plan for Resident #16, dated 7/5/2026, revealed a focus area of hospice level of care related to terminal prognosis of CVA (stroke) and heart failure and identified a Hospice A as the provider. On 7/8/2026, review of the facility's contract with Hospice A, dated 9/23/2015, revealed, in part, the contract included the following language: "...Incident reporting. Any of the following alleged incidents involving a Hospice Patient residing at a Facility: mistreatment or neglect; verbal, mental, sexual or physical abuse; injuries of an unknown source; or misappropriation of patient property." The contract language failed to specify facility staff must report alleged incidents of abuse, mistreatment, neglect or misappropriation of resident property by hospice staff to the hospice administrator immediately when the facility becomes aware. On 7/08/2026 1:28 PM, during an interview, the Administrator reported that they did not have an updated contract with the hospice that included the	F0849		

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F0849 SS = D	Continued from page 27 required language that was missing from contract, dated 9/23/2015.	F0849		