STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165614	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rose Haven Nursing Home	1500 N FRANKLIN AVENUE , MARENGO, Iowa, 52301

(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 ✓ OK/CP	INITIAL COMMENTS Correction date: 12/29/2025 The following deficiencies resulted from the facility's annual recertification survey and investigation of complaints #2666162-C and 2689956-A, conducted 12/8/25 to 12/11/25. Complaint #2666162-C resulted in deficiencies. Findings for #2689956-A will be sent to the facility at a later date under separate cover. See Code of Federal Regulations (42CFR) Part 483, Subpart B-C.	F0000		
F0554 SS = D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is NOT MET as evidenced by: Based on observation, clinical record review, policy review, and staff interviews, the facility failed to determine that it was clinically appropriate and safe for a resident to self-administer medications for 1 of 1 residents reviewed for the self-administration of medications(Resident #13). The facility reported a census of 45 residents. Findings included: The Quarterly Minimum Data Set(MDS) assessment tool, dated 9/30/25, listed diagnoses for Resident #13 which included chronic obstructive pulmonary disease(COPD), a disease which caused symptoms such as shortness of breath), heart failure, and diabetes. The MDS listed the resident's Brief Interview for Mental Status(BIMS) score as 15 out of 15, indicating intact cognition. The 2022 facility policy "Self-Administration of	F0554	On 12/11/25, upon identification of the deficient practice involving Resident #13, the facility immediately ensured the resident no longer retained nebulizer medication in his possession. All Ipratropium-Albuterol vials were removed from the resident's room and secured in the medication cart. Nursing staff resumed full administration of the resident's nebulizer treatments per physician orders. The resident was educated that nebulizer medications are to be administered by licensed nursing staff unless a formal self-administration assessment is completed and approved.	12/12/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	Administrator	12/29/2025

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F0554 SS = D	Continued from page 1 Medications" stated residents had the right to self-administer medications if the interdisciplinary team determined that it was clinically appropriate and safe for the resident to do so. The December 2025 Medication Administration Record(MAR) listed a 7/21/25 order for Ipratropium-Albuterol Solution(a medication used to treat COPD) 0.5-2.5 milligrams(mg)/milliliters(ml) 3 ml inhale orally four times a day related to COPD. 2/20/24 Care Plan entries stated the resident was at risk for altered respiratory status and difficulty breathing related to COPD, a history of respiratory failure, and a history of pneumonia. The entries directed staff to administer medications as ordered and monitor for effectiveness. On 12/11/25 at 1:00 p.m. Staff A Licensed Practical Nurse(LPN) stated that she would administer the resident's nebulizer(a medical device that turns liquid medicine into a fine, inhalable mist) treatment. She retrieved a 3 ml vial of Ipratropium-Albuterol Solution 0.5-2.5 mg/ml from the medication cart and went to the resident's room. When she arrived, the resident was putting the cap on his nebulizer's medicine cup and stated he already added the medication from a vial he had in his pocket. The facility lacked documentation of an assessment carried out to show the resident was safe to self-administer his medication. On 12/10/25 at 1:05 p.m. Staff A stated Resident #13 was not supposed to carry out his nebulizer treatments on his own. On 12/11/25 at 11:19 a.m., the Assistant Director of Nursing(ADON) stated residents who did not have an assessment completed for the self-administration of medications should not keep medications in their rooms. She stated the nurses should administer the resident's nebulizer treatment. On 12/11/25 at 11:51 a.m., the Director of Nursing(DON) stated residents should not keep albuterol vials in their rooms for self-administration.	F0554	The resident was assessed for respiratory status, medication compliance, and potential adverse outcomes. No adverse respiratory events were identified. All other similarly situated residents were assessed for self-administration of medication and completed by 12/11/2025. Nursing staff were re-educated regarding the self-administration of medications for residents on 12/12/2025. DON/Designee will audit to ensure residents are being assessed for medication self-administration periodically to ensure compliance. Audit findings will be brought to QAPI for review.	
F0600 SS = D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation	F0600	Resident #35 was assessed for injuries, changes in condition, psychosocial distress, and fear of staff involvement. No physical injuries were identified.	12/23/2025

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F0600 SS = D	Continued from page 2 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is NOT MET as evidenced by: Based on observation, clinical record review, policy review, and staff interviews, the facility failed to ensure residents were free from physical abuse for 1 of 1 residents reviewed for abuse(Resident #35). The facility reported a census of 45 residents. Findings: The Minimum Data Set(MDS) assessment tool, dated 9/2/25, listed diagnoses for Resident #35 which included unspecified intellectual disabilities, hearing loss, and coronary artery disease. The MDS listed the resident's Brief Interview for Mental Status(BIMS) score as 6 out of 15, indicating severely impaired cognition. The facility "Abuse Policy", dated 7/1/25, stated all residents had the right to be free from abuse and neglect. The policy stated "assault of a dependent adult" was the commission of any act which was generally intended to cause pain or injury or which was generally intended to result in physical contact considered by a reasonable person to be insulting or offensive or any act intended to place another in fear of immediate physical contact which would be painful, injurious, insulting, or offensive, coupled with the apparent ability to execute the act. Care Plan entries, dated 4/4/25, stated the resident had impaired cognitive function, intellectual disability, and hearing loss impeding communications. The entries directed staff to orient the resident as needed, keep his routine consistent, and engage him in simple structured activities that avoided overly demanding tasks.	F0600	The resident was monitored for behavioral or emotional changes, and no signs of fear, distress, or trauma were observed or reported. The facility conducted a review of Guardian Angel visits, incident reports, grievance logs, and staff disciplinary records for the prior 90 days to identify any additional allegations or concerns related to staff behavior, verbal abuse, or inappropriate physical interactions. No additional substantiated allegations of abuse were identified during this review. Abuse will be reported/investigated per policy. Policy Reviewed 12/10/2025. An audit was completed to ensure all employees have completed their Dependent Adult Abuse required training, completed 12/11/2025. Relias Inservice Education About Caregiver Conduct assigned to all staff and completed by 12/15/2025. Policy reviewed/re-educated with staff and signed for understanding Completed 12/23/2025. Guardian Angels rounding will be continued bi-weekly. Audits will be completed by the Administrator or Designee periodically to ensure compliance. Ongoing Audit findings will be brought to the monthly QAPI meetings. Ongoing	

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F0600 SS = D	Continued from page 3 An Unwitnessed Fall report, dated 10/28/25 at 1:46 p.m., stated the resident sat on the floor after he slid out of bed. The resident did not have any observable injuries. A 10/28/25 2:59 p.m. Nurses Note stated the resident sat on the floor in front of the bed. He denied injuries and stated he slipped out of bed. The facility applied slide strips in front of his bed for safety. An untitled facility investigation, dated 12/8/25, stated that the staff notified the Administrator on 10/28/25 that Staff A Licensed Practical Nurse(LPN) yelled and "poked" the resident in the chest. The resident reported that no one poked him in the chest or yelled at him. The resident denied being fearful or afraid of the nursing staff. A 10/28/25 statement, written by Staff B Certified Nursing Assistant(CNA), stated she went into the resident's room to help him up and Staff A came in and asked what happened. Staff A started poking him in the chest and stated that she was sicker than him and this was not funny, she didn't feel good, and was stuck here until 4:00 p.m. because "you"(the resident) couldn't stay off the floor. A 10/28/25 statement, written by Staff F CNA, stated she was in the room after Resident #35 fell. Staff A came in and started to get stern with him and told him this wasn't funny and he should stay off the floor. She then cried and got "in his face" and told him that she was sicker than "you"(the resident) and she could not deal with this. A 10/28/25 statement, written by Staff C CNA, stated the resident fell out of bed around 1:30 p.m. and Staff A came in and was upset because this was the second fall of the day. Staff A yelled and said that she felt worse than the resident did and now she had to stay until 4:00 pm. to keep an eye on him. While she said this, she poked the resident's chest "kind of roughly". A 10/28/25 statement, written by Staff D CNA stated Resident #35 was on the floor and Staff A came in and almost cried and said he was the second person on the floor and she wouldn't be able to finish work until 4:00 p.m. and she didn't feel good. Staff D stated she did not see Staff A poke the resident and stated this was blown up for nothing. A 10/28/25 statement, written by Staff A, stated staff called her to the room and the resident sat on the	F0600		

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F0600 SS = D	Continued from page 4 floor and leaned against his bed. Staff A stated she felt overwhelmed by the number of aides in the room and tried to finish her assessment. She spoke very loudly to the resident due to his hearing loss. She stated she did not feel well today and was upset about not being able to leave on time due to another fall. She wrote that she did become visually frustrated in the room and teared up during her assessment. She stated she did not yell at the resident or poke at him in any way. She stated she did feel frustrated with the CNAs at the time. On 12/8/25 at 2:13 p.m., Resident #35 sat in his recliner in his room. The resident did not answer when spoken to by the State Agency. On 12/8/25 at 12:21 p.m., via phone, Staff B stated she received a page that the resident was on the floor. The resident sat on the floor and Staff A asked why he was still on the floor. Staff A stated she wasn't worried about the resident's vitals. She walked up to him and poked him in the chest because she had to work late. The resident was standing at the time she "jabbed" him. Staff B stated after this occurred, she and Staff F told the Administrator and wrote out statements. She stated she did not see Staff A be physical before this but it was normal for her to be rude. On 12/10/25 at 10:57 a.m., Staff F stated on the day Resident #35 fell, Staff A had a rough day. She had had surgery and was feeling under the weather. She stated when the resident fell, she, Staff B CNA, Staff C CNA and another CNA entered the room and then Staff A came in. She stated another resident had just fallen prior to this and Staff A was overwhelmed and crying and this was toward the end of the shift. Staff F stated Staff A entered the room and said "why did you fall on the floor, what are you doing?". Staff F stated the resident was on the floor but leaned against the bed. Staff F stated Staff A completed an assessment including obtaining vitals and looking over his legs. Staff F stated they stood him up and he was walking and Staff A "tapped" his left shoulder one time and stated "why did you do that?". Staff F demonstrated on the table how hard she thought Staff A tapped the resident. Staff F tapped the table in a manner that did not appear to be with any force. She stated after the incident, she went to the Administrator to report this and filled out a statement. On 12/10/25 at 1:50 p.m., Staff F stated after the resident fell, he was startled and overwhelmed but was not crying and did not appear scared.	F0600		

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F0600 SS = D	Continued from page 5 On 12/11/25 at 8:08 a.m., Staff F stated Staff A already had her vital equipment with her when she walked in the resident's room. On 12/10/25 at 11:08 a.m., via phone Staff C stated the day Resident #35 fell was chaotic and another resident had also fallen. She stated she and other staff entered the room after he fell and Staff A followed. Staff C stated Staff A was pretty angry and wanted them to get him up but she hadn't taken his vitals. They got him off the floor and Staff A didn't check him at all. Staff A told them to get him off the floor. After they assisted him to stand, Staff A obtained his vitals and started yelling that she felt worse than "you" referring to the resident and now she had to stay later because "you" had to fall. Staff C stated she poked him in his chest and sternum. She stated she poked him 3-4 times in a "rough" manner. Staff C stated that Staff A was mean to the residents but could not give an example of which residents or further details. She stated she wrote out a statement for the Administrator related to this incident. On 12/10/25 at 1:54 p.m., via phone, Staff C stated after the fall, the resident seemed confused like he didn't understand what was happening or why Staff A was upset with him but he was not crying. On 12/10/25 at 1:05 p.m. Staff A stated on the day the resident fell, she was sick and had just returned from the facility after surgery. She stated 20 minutes before the end of her shift, she had another resident fall. She had just gotten the other resident to the nursing station to continue neurological checks when staff notified her that Resident #35 was on the floor. Staff A stated she was tearful and disappointed with her staff. She stated when she walked into the resident's room, she was tearful and disappointed that the staff were not watching the residents but instead stood at the nursing station waiting for their shift to end. Staff A stated she said to Staff B that she was sick and didn't feel good and now had to stay longer. Staff A stated she told staff to back away from the resident and admitted she was "terse" at this time. She assessed the resident on the floor. She stated she is sure she raised her voice but did not change her tone. She stated she had to talk to the resident into his left ear. She stated she did not ask the resident why he fell and did not poke him. She stated none of her comments were directed to the resident but were directed to Staff B. She stated the resident did not cry during this event. Staff A stated she immediately implemented the intervention of placing strips in his room and sat with the resident after the fall. She	F0600		

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F0600 SS = D	Continued from page 6 stated she would not ask the resident why he fell because this would hurt his pride. She stated after the incident, the office called her in and she told them the same thing. Staff A stated she should have never said anything to Staff B(regarding being sick or having to work later). On 12/10/25 at 2:16 p.m. via phone, Staff D stated when the resident fell, Staff A assessed him before they got him up. On 12/10/25 at 2:53 p.m., the Administrator stated that 2 CNAs approached her and said that Resident #35 fell and Staff A was in his face and yelled at him. They stated Staff A and the resident were both crying so she said she would look at that. She interviewed the resident and Staff A. On 12/11/25 at 9:53 a.m., Staff A stated staff called her down to Resident #35's room and she was tearful. She stated to Staff B that she didn't feel good and just wanted to go home. She stated she already had her vitals equipment with her as well as a neurological sheet. She completed an assessment on the resident including obtaining vital signs and checking range of motion. She asked the aides if this was the third time the resident had a fall to verify this. She stated after the fall they placed strips on his floor. After she assessed him, she asked them to assist him into a wheelchair and bring him to the nursing station so she could carry out 15 minute neurological checks. She stated she did not poke the resident's shoulder or his chest. She stated she had asked staff to back away while she assessed the resident and they were behind her so she didn't know how they would have seen her poke his chest. She stated the resident's assessment was normal and he did not have any injuries or bruises. She stated she did not ask the resident why he fell and did not say that she was sicker than the resident. She stated she did say that now she had to stay late but did not say it to the resident but to the staff in the room. She stated she did not say that she didn't care about the vital signs and to just get him up. She stated she regretted that she said she was sick and wanted to go home. She stated after the fall, she stayed at the facility to complete assessments. She stated the resident was fine and had a soft drink and she sat with him. She stated the resident did not cry during or after this incident. On 12/11/25 at 11:19 a.m., the Assistant Director of Nursing(ADON) stated staff should treat residents with respect and dignity.	F0600		

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F0600 SS = D	Continued from page 7 On 12/11/25 at 11:51 a.m., the Director of Nursing(DON) stated staff should report allegations of abuse to the administrator and they would remove the staff member(from resident care) and notify the State Agency. On 12/11/25 at 12:45 p.m., the Administrator stated the facility should report all allegations of abuse to the State Agency. She stated she trusted the previous DON's judgement regarding this and she shouldn't have. She stated the facility would suspend the staff member pending an investigation.	F0600		
F0605 SS = D	Right to be Free from Chemical Restraints CFR(s): 483.10(e)(1),483.12(a)(2),483.45(c)(3)(d)(e) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any . . . chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must-. . . §483.12(a)(2) Ensure that the resident is free from . . . chemical restraints imposed for purposes of discipline or convenience and	F0605	The facility completed a medication review for Resident #35 and identified that the GDR requirements had not been met. Ordering provider contacted, verbally declined to address a GDR until the resident's next face-to-face appointment. The interdisciplinary team (IDT) reviewed the resident's diagnoses, cognitive status (BIMS score of 6), behavioral symptoms, and current medication regimen to ensure psychotropic medications were clinically appropriate and necessary for the resident's condition. No immediate adverse effects were identified. The facility conducted an audit of all residents receiving medications subject to GDR requirements, including those prescribed by external providers. Records were reviewed to ensure appropriate GDR attempts of documented clinical contraindications were present. The Medical Director will assist the facility in reviewing and ensuring compliance with GDR requirements for medications ordered by providers who practice outside of the facility.	12/18/2025

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F0605 SS = D	Continued from page 8 that are not required to treat the resident's medical symptoms. . . . . §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic. §483.45(d) Unnecessary drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. §483.45(e) Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that-- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs;	F0605	Facility implemented a process requiring the Medical Director review of GDR compliance for all applicable medications, including those ordered by external providers. Policy updated to reflect this. The DON or designee will conduct monthly audits of residents receiving medications subject to GDR requirements to ensure appropriate attempts or clinical justifications are documented. Findings will be reviewed during QAPI meetings and corrective actions will be implemented as needed.	

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F0605 SS = D	Continued from page 9 §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is NOT MET as evidenced by: Based on clinical record review, policy review, and staff interviews, the facility failed to carry out a gradual dose reduction(GDR) or ensure the provider documented why the reduction would be clinically contraindicated for 1 of 5 residents reviewed for psychotropic medications(Resident #35). The facility reported a census of 45 residents. Findings included: The Minimum Data Set(MDS) assessment tool, dated 9/2/25, listed diagnoses for Resident #35 which included unspecified intellectual disabilities, hearing loss, and coronary artery disease. The MDS listed the resident's Brief Interview for Mental Status(BIMS) score as 6 out of 15, indicating severely impaired cognition. The December 2025 Medication Administration Record(MAR) listed the following: A 3/27/25 order for Trazodone(an antidepressant) 100 milligrams(mg) daily. A 3/28/25 order for Duloxetine(an antidepressant) 120 mg daily.	F0605		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0605 SS = D	Continued from page 10 As of 12/8/25, the facility lacked documentation of an attempted GDR for the above medications or provider documentation as to why the reduction would be clinically contraindicated. On 12/11/25, the Administrator provided a 9/26/25 Pharmacist's Recommendation to Prescriber form. On 12/10/25, the provider checked the form's boxes which stated a reduction of the medications was contraindicated but did not provide documentation as to why the reductions were contraindicated. The facility lacked provider documentation related to the GDRs prior to 12/10/25, after the State Agency requested information. On 12/11/25 at 11:19 a.m., the Assistant Director of Nursing(ADON) stated within the first year of a resident starting a psychotropic medication, they needed to make two attempts at a GDR in 2 separate quarters or have supporting documentation from the provider as to why the GDR would be contraindicated. She stated they faxed the provider multiple times and they did not get a response. The undated facility policy "Psychotropic Drug Monitoring" stated all psychotropic medication use would be appropriate and given in the lowest effective dose to help minimize the risk of side effects. The policy stated that the facility should carry out a GDR twice in 2 separate quarters during the first year of the medication's usage.	F0605		
F0609 SS = D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services	F0609	On 12/11/25, the facility reviewed the care, safety, and psychosocial status of Resident #35. Resident #35 was assessed for physical injury, emotional distress, fear, or behavioral changes related to the alleged incident. No injuries or ongoing distress were identified. The resident was monitored for signs of fear, anxiety, or changes in behavior related to staff interactions. The resident's care plan was reviewed and reinforced to ensure staff approaches were consistent with his cognitive impairment, intellectual disability, and hearing loss, emphasizing calm communication, reassurance, and respectful interactions.	12/23/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165614	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/11/2025

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F0609 SS = D	Continued from page 11 where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is NOT MET as evidenced by: Based on clinical record review, policy review, and staff interviews, the facility failed to report an allegation of abuse to the State Agency for 1 of 1 residents reviewed for abuse(Resident #35). The facility reported a census of 45 residents. Findings: The Minimum Data Set(MDS) assessment tool, dated 9/2/25, listed diagnoses for Resident #35 which included unspecified intellectual disabilities, hearing loss, and coronary artery disease. The MDS listed the resident's Brief Interview for Mental Status(BIMS) score as 6 out of 15, indicating severely impaired cognition. The facility "Abuse Policy", dated 7/1/25, stated the facility would report all allegations of abuse to the State Agency within 2 hours. Care Plan entries, dated 4/4/25, stated the resident had impaired cognitive function, intellectual disability, and hearing loss impeding communications. The entries directed staff to orient the resident as needed, keep his routine consistent, and engage him in simple structured activities that avoided overly demanding tasks. An Unwitnessed Fall report, dated 10/28/25 at 1:46 p.m., stated the resident sat on the floor after he slid out of bed. The resident did not have any observable injuries. A 10/28/25 2:59 p.m. Nurses Note stated the resident sat on the floor in front of the bed. He denied injuries and stated he slipped out of bed. The facility applied slide strips in front of his bed for safety.	F0609	Environmental safety interventions (including floor safety strips) remained in place and were monitored for effectiveness. A facility-wide review was conducted for all residents under the care of Staff A to identify any additional allegations, grievances, unusual incidents, or concerns related to abuse, neglect, or disrespectful treatment. Staff interviews and review of incident reports, grievances, and nurse's notes for the prior 90 days revealed no additional unreported allegations. No other residents were identified as having been affected by similar reporting failures. Re-education to management staff regarding the abuse policy, reporting abuse through incident reports, and reporting to Administrator/DON was completed on 12/10/2025. Abuse will be reported/investigated per policy. Policy Reviewed 12/10/2025. An audit was completed to ensure all employees have completed their Dependent Adult Abuse required training, completed 12/11/2025. Audits will be completed by the Administrator or Designee periodically to ensure compliance of properly identified, timely, and reportable allegations. Ongoing Audit findings will be brought to the monthly QAPI meetings. Ongoing	

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F0609 SS = D	Continued from page 12 An untitled facility investigation, dated 12/8/25, stated that the staff notified the Administrator on 10/28/25 that Staff A Licensed Practical Nurse(LPN) yelled and "poked" the resident in the chest. The resident reported that no one poked him in the chest or yelled at him. The resident denied being fearful or afraid of the nursing staff. A 10/28/25 statement, written by Staff B Certified Nursing Assistant(CNA), stated she went into the resident's room to help him up and Staff A came in and asked what happened. Staff A started poking him in the chest and stated that she was sicker than him and this was not funny, she didn't feel good, and was stuck here until 4:00 p.m. because "you"(the resident) couldn't stay off the floor. A 10/28/25 statement, written by Staff F CNA, stated she was in the room after Resident #35 fell. Staff A came in and started to get stern with him and told him this wasn't funny and he should stay off the floor. She then cried and got "in his face" and told him that she was sicker than "you"(the resident) and she could not deal with this. A 10/28/25 statement, written by Staff C CNA, stated the resident fell out of bed around 1:30 p.m. and Staff A came in and was upset because this was the second fall of the day. Staff A yelled and said that she felt worse than the resident did and now she had to stay until 4:00 pm. to keep an eye on him. While she said this, she poked the resident's chest "kind of roughly". A 10/28/25 statement, written by Staff D CNA stated Resident #35 was on the floor and Staff A came in and almost cried and said he was the second person on the floor and she wouldn't be able to finish work until 4:00 p.m. and she didn't feel good. Staff D stated she did not see Staff A poke the resident and stated this was blown up for nothing. A 10/28/25 statement, written by Staff A, stated staff called her to the room and the resident sat on the floor and leaned against his bed. Staff A stated she felt overwhelmed by the number of aides in the room and tried to finish her assessment. She spoke very loudly to the resident due to his hearing loss. She stated she did not feel well today and was upset about not being able to leave on time due to another fall. She wrote that she did become visually frustrated in the room and teared up during her assessment. She stated she did not yell at the resident or poke at him in any way. She stated she did feel frustrated with the CNAs at the time.	F0609		

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F0609 SS = D	Continued from page 13 The facility lacked documentation they reported the allegation of abuse to the State Agency. On 12/8/25 at 2:13 p.m., Resident #35 sat in his recliner in his room. The resident did not answer when spoken to by the State Agency. On 12/8/25 at 12:21 p.m., via phone, Staff B stated she received a page that the resident was on the floor. The resident sat on the floor and Staff A asked why he was still on the floor. Staff A stated she wasn't worried about the resident's vitals. She walked up to him and poked him in the chest because she had to work late. The resident was standing at the time she "jabbed" him. Staff B stated after this occurred, she and Staff F told the Administrator and wrote out statements. She stated she did not see Staff A be physical before this but it was normal for her to be rude. On 12/10/25 at 10:57 a.m., Staff F stated on the day Resident #35 fell, Staff A had a rough day. She had had surgery and was feeling under the weather. She stated when the resident fell, she, Staff B CNA, Staff C CNA and another CNA entered the room and then Staff A came in. She stated another resident had just fallen prior to this and Staff A was overwhelmed and crying and this was toward the end of the shift. Staff F stated Staff A entered the room and said "why did you fall on the floor, what are you doing?". Staff F stated the resident was on the floor but leaned against the bed. Staff F stated Staff A completed an assessment including obtaining vitals and looking over his legs. Staff F stated they stood him up and he was walking and Staff A "tapped" his left shoulder one time and stated "why did you do that?". Staff F demonstrated on the table how hard she thought Staff A tapped the resident. Staff F tapped the table in a manner that did not appear to be with any force. She stated after the incident, she went to the Administrator to report this and filled out a statement. On 12/10/25 at 1:50 p.m., Staff F stated after the resident fell, he was startled and overwhelmed but was not crying and did not appear scared. On 12/11/25 at 8:08 a.m., Staff F stated Staff A already had her vital equipment with her when she walked in the resident's room. On 12/10/25 at 11:08 a.m., via phone Staff C stated the day Resident #35 fell was chaotic and another resident had also fallen. She stated she and other staff entered the room after he fell and Staff A followed. Staff C	F0609		

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F0609 SS = D	Continued from page 14 stated Staff A was pretty angry and wanted them to get him up but she hadn't taken his vitals. They got him off the floor and Staff A didn't check him at all. Staff A told them to get him off the floor. After they assisted him to stand, Staff A obtained his vitals and started yelling that she felt worse than "you" referring to the resident and now she had to stay later because "you" had to fall. Staff C stated she poked him in his chest and sternum. She stated she poked him 3-4 times in a "rough" manner. Staff C stated that Staff A was mean to the residents but could not give an example of which residents or further details. She stated she wrote out a statement for the Administrator related to this incident. On 12/10/25 at 1:54 p.m., via phone, Staff C stated after the fall, the resident seemed confused like he didn't understand what was happening or why Staff A was upset with him but he was not crying. On 12/10/25 at 1:05 p.m. Staff A stated on the day the resident fell, she was sick and had just returned from the facility after surgery. She stated 20 minutes before the end of her shift, she had another resident fall. She had just gotten the other resident to the nursing station to continue neurological checks when staff notified her that Resident #35 was on the floor. Staff A stated she was tearful and disappointed with her staff. She stated when she walked into the resident's room, she was tearful and disappointed that the staff were not watching the residents but instead stood at the nursing station waiting for their shift to end. Staff A stated she said to Staff B that she was sick and didn't feel good and now had to stay longer. Staff A stated she told staff to back away from the resident and admitted she was "terse" at this time. She assessed the resident on the floor. She stated she is sure she raised her voice but did not change her tone. She stated she had to talk to the resident into his left ear. She stated she did not ask the resident why he fell and did not poke him. She stated none of her comments were directed to the resident but were directed to Staff B. She stated the resident did not cry during this event. Staff A stated she immediately implemented the intervention of placing strips in his room and sat with the resident after the fall. She stated she would not ask the resident why he fell because this would hurt his pride. She stated after the incident, the office called her in and she told them the same thing. Staff A stated she should have never said anything to Staff B(regarding being sick or having to work later). On 12/10/25 at 2:16 p.m. via phone, Staff D stated when	F0609		

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F0609 SS = D	Continued from page 15 the resident fell, Staff A assessed him before they got him up. On 12/10/25 at 2:53 p.m., the Administrator stated that 2 CNAs approached her and said that Resident #35 fell and Staff A was in his face and yelled at him. They stated Staff A and the resident were both crying so she said she would look at that. She interviewed the resident and Staff A. On 12/11/25 at 9:53 a.m., Staff A stated staff called her down to Resident #35's room and she was tearful. She stated to Staff B that she didn't feel good and just wanted to go home. She stated she already had her vitals equipment with her as well as a neurological sheet. She completed an assessment on the resident including obtaining vital signs and checking range of motion. She asked the aides if this was the third time the resident had a fall to verify this. She stated after the fall they placed strips on his floor. After she assessed him, she asked them to assist him into a wheelchair and bring him to the nursing station so she could carry out 15 minute neurological checks. She stated she did not poke the resident's shoulder or his chest. She stated she had asked staff to back away while she assessed the resident and they were behind her so she didn't know how they would have seen her poke his chest. She stated the resident's assessment was normal and he did not have any injuries or bruises. She stated she did not ask the resident why he fell and did not say that she was sicker than the resident. She stated she did say that now she had to stay late but did not say it to the resident but to the staff in the room. She stated she did not say that she didn't care about the vital signs and to just get him up. She stated she regretted that she said she was sick and wanted to go home. She stated after the fall, she stayed at the facility to complete assessments. She stated the resident was fine and had a soft drink and she sat with him. She stated the resident did not cry during or after this incident. On 12/11/25 at 11:19 a.m., the Assistant Director of Nursing(ADON) stated staff should treat residents with respect and dignity. On 12/11/25 at 11:51 a.m., the Director of Nursing(DON) stated staff should report allegations of abuse to the administrator and they would remove the staff member(from resident care) and notify the State Agency. On 12/11/25 at 12:45 p.m., the Administrator stated the facility should report all allegations of abuse to the State Agency. She stated she trusted the previous DON's	F0609		

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F0609 SS = D	Continued from page 16 judgement regarding this and she shouldn't have. She stated the facility would suspend the staff member pending an investigation.	F0609		
F0610 SS = D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is NOT MET as evidenced by: Based on clinical record review, policy review, and staff interviews, the facility failed to separate an alleged perpetrator of abuse from residents for 1 of 1 residents reviewed for abuse(Resident #35). The facility reported a census of 45 residents. Findings: The Minimum Data Set(MDS) assessment tool, dated 9/2/25, listed diagnoses for Resident #35 which included unspecified intellectual disabilities, hearing loss, and coronary artery disease. The MDS listed the resident's Brief Interview for Mental Status(BIMS) score as 6 out of 15, indicating severely impaired cognition. The facility "Abuse Policy", dated 7/1/25, stated the facility would separate the employee accused of abuse from all residents. Care Plan entries, dated 4/4/25, stated the resident had impaired cognitive function, intellectual	F0610	On 12/11/25, the facility reviewed the care, safety, and psychosocial status of Resident #35. Resident #35 was assessed for physical injury, emotional distress, fear, or behavioral changes related to the alleged incident. No injuries or ongoing distress were identified. The resident was monitored for signs of fear, anxiety, or changes in behavior related to staff interactions. The resident's care plan was reviewed and reinforced to ensure staff approaches were consistent with his cognitive impairment, intellectual disability, and hearing loss, emphasizing calm communication, reassurance, and respectful interactions. Environmental safety interventions (including floor safety strips) remained in place and were monitored for effectiveness. A review was conducted for all residents to identify any additional allegations, grievances, unusual incidents, or concerns related to abuse, neglect, or disrespectful treatment. Staff interviews and review of incident reports, grievances, and nurse's notes for the prior 90 days revealed no additional unreported allegations. No other residents were identified as having been affected by similar reporting failures.	12/23/2025

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F0610 SS = D	Continued from page 17 disability, and hearing loss impeding communications. The entries directed staff to orient the resident as needed, keep his routine consistent, and engage him in simple structured activities that avoided overly demanding tasks. An Unwitnessed Fall report, dated 10/28/25 at 1:46 p.m., stated the resident sat on the floor after he slid out of bed. The resident did not have any observable injuries. A 10/28/25 2:59 p.m. Nurses Note stated the resident sat on the floor in front of the bed. He denied injuries and stated he slipped out of bed. The facility applied slide strips in front of his bed for safety. An untitled facility investigation, dated 12/8/25, stated that the staff notified the Administrator on 10/28/25 that Staff A Licensed Practical Nurse(LPN) yelled and "poked" the resident in the chest. The resident reported that no one poked him in the chest or yelled at him. The resident denied being fearful or afraid of the nursing staff. A 10/28/25 statement, written by Staff B Certified Nursing Assistant(CNA), stated she went into the resident's room to help him up and Staff A came in and asked what happened. Staff A started poking him in the chest and stated that she was sicker than him and this was not funny, she didn't feel good, and was stuck here until 4:00 p.m. because "you"(the resident) couldn't stay off the floor. A 10/28/25 statement, written by Staff F CNA, stated she was in the room after Resident #35 fell. Staff A came in and started to get stern with him and told him this wasn't funny and he should stay off the floor. She then cried and got "in his face" and told him that she was sicker than "you"(the resident) and she could not deal with this. A 10/28/25 statement, written by Staff C CNA, stated the resident fell out of bed around 1:30 p.m. and Staff A came in and was upset because this was the second fall of the day. Staff A yelled and said that she felt worse than the resident did and now she had to stay until 4:00 pm. to keep an eye on him. While she said this, she poked the resident's chest "kind of roughly". A 10/28/25 statement, written by Staff D CNA stated Resident #35 was on the floor and Staff A came in and almost cried and said he was the second person on the floor and she wouldn't be able to finish work until	F0610	Re-education to management staff regarding the abuse policy, reporting abuse through incident reports, and reporting to Administrator/DON was completed on 12/10/2025. Abuse will be reported/investigated per policy. Policy Reviewed 12/10/2025. An audit was completed to ensure all employees have completed their Dependent Adult Abuse required training, completed 12/11/2025. Audits will be completed by the Administrator or Designee periodically to ensure compliance of properly identified, timely, and reportable allegations. Any identified failures will result in immediate corrective action. Ongoing Audit findings will be brought to the monthly QAPI meetings. Ongoing	

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F0610 SS = D	Continued from page 18 4:00 p.m. and she didn't feel good. Staff D stated she did not see Staff A poke the resident and stated this was blown up for nothing. A 10/28/25 statement, written by Staff A, stated staff called her to the room and the resident sat on the floor and leaned against his bed. Staff A stated she felt overwhelmed by the number of aides in the room and tried to finish her assessment. She spoke very loudly to the resident due to his hearing loss. She stated she did not feel well today and was upset about not being able to leave on time due to another fall. She wrote that she did become visually frustrated in the room and teared up during her assessment. She stated she did not yell at the resident or poke at him in any way. She stated she did feel frustrated with the CNAs at the time. Staff A's Archived Time Card Report documented she continued to work at the facility from the date of the allegation of abuse on 10/28/25 until 12/10/25. On 12/8/25 at 2:13 p.m., Resident #35 sat in his recliner in his room. The resident did not answer when spoken to by the State Agency. On 12/8/25 at 12:21 p.m., via phone, Staff B stated she received a page that the resident was on the floor. The resident sat on the floor and Staff A asked why he was still on the floor. Staff A stated she wasn't worried about the resident's vitals. She walked up to him and poked him in the chest because she had to work late. The resident was standing at the time she "jabbed" him. Staff B stated after this occurred, she and Staff F told the Administrator and wrote out statements. She stated she did not see Staff A be physical before this but it was normal for her to be rude. On 12/10/25 at 10:57 a.m., Staff F stated on the day Resident #35 fell, Staff A had a rough day. She had had surgery and was feeling under the weather. She stated when the resident fell, she, Staff B CNA, Staff C CNA and another CNA entered the room and then Staff A came in. She stated another resident had just fallen prior to this and Staff A was overwhelmed and crying and this was toward the end of the shift. Staff F stated Staff A entered the room and said "why did you fall on the floor, what are you doing?". Staff F stated the resident was on the floor but leaned against the bed. Staff F stated Staff A completed an assessment including obtaining vitals and looking over his legs. Staff F stated they stood him up and he was walking and Staff A "tapped" his left shoulder one time and stated "why did you do that?". Staff F demonstrated on the	F0610		

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F0610 SS = D	Continued from page 19 table how hard she thought Staff A tapped the resident. Staff F tapped the table in a manner that did not appear to be with any force. She stated after the incident, she went to the Administrator to report this and filled out a statement. On 12/10/25 at 1:50 p.m., Staff F stated after the resident fell, he was startled and overwhelmed but was not crying and did not appear scared. On 12/11/25 at 8:08 a.m., Staff F stated Staff A already had her vital equipment with her when she walked in the resident's room. On 12/10/25 at 11:08 a.m., via phone Staff C stated the day Resident #35 fell was chaotic and another resident had also fallen. She stated she and other staff entered the room after he fell and Staff A followed. Staff C stated Staff A was pretty angry and wanted them to get him up but she hadn't taken his vitals. They got him off the floor and Staff A didn't check him at all. Staff A told them to get him off the floor. After they assisted him to stand, Staff A obtained his vitals and started yelling that she felt worse than "you" referring to the resident and now she had to stay later because "you" had to fall. Staff C stated she poked him in his chest and sternum. She stated she poked him 3-4 times in a "rough" manner. Staff C stated that Staff A was mean to the residents but could not give an example of which residents or further details. She stated she wrote out a statement for the Administrator related to this incident. On 12/10/25 at 1:54 p.m., via phone, Staff C stated after the fall, the resident seemed confused like he didn't understand what was happening or why Staff A was upset with him but he was not crying. On 12/10/25 at 1:05 p.m. Staff A stated on the day the resident fell, she was sick and had just returned from the facility after surgery. She stated 20 minutes before the end of her shift, she had another resident fall. She had just gotten the other resident to the nursing station to continue neurological checks when staff notified her that Resident #35 was on the floor. Staff A stated she was tearful and disappointed with her staff. She stated when she walked into the resident's room, she was tearful and disappointed that the staff were not watching the residents but instead stood at the nursing station waiting for their shift to end. Staff A stated she said to Staff B that she was sick and didn't feel good and now had to stay longer. Staff A stated she told staff to back away from the resident and admitted she was "terse" at this time. She	F0610		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F0610 SS = D	Continued from page 20 assessed the resident on the floor. She stated she is sure she raised her voice but did not change her tone. She stated she had to talk to the resident into his left ear. She stated she did not ask the resident why he fell and did not poke him. She stated none of her comments were directed to the resident but were directed to Staff B. She stated the resident did not cry during this event. Staff A stated she immediately implemented the intervention of placing strips in his room and sat with the resident after the fall. She stated she would not ask the resident why he fell because this would hurt his pride. She stated after the incident, the office called her in and she told them the same thing. Staff A stated she should have never said anything to Staff B(regarding being sick or having to work later). On 12/10/25 at 2:16 p.m. via phone, Staff D stated when the resident fell, Staff A assessed him before they got him up. On 12/10/25 at 2:53 p.m., the Administrator stated that 2 CNAs approached her and said that Resident #35 fell and Staff A was in his face and yelled at him. They stated Staff A and the resident were both crying so she said she would look at that. She interviewed the resident and Staff A. On 12/11/25 at 9:53 a.m., Staff A stated staff called her down to Resident #35's room and she was tearful. She stated to Staff B that she didn't feel good and just wanted to go home. She stated she already had her vitals equipment with her as well as a neurological sheet. She completed an assessment on the resident including obtaining vital signs and checking range of motion. She asked the aides if this was the third time the resident had a fall to verify this. She stated after the fall they placed strips on his floor. After she assessed him, she asked them to assist him into a wheelchair and bring him to the nursing station so she could carry out 15 minute neurological checks. She stated she did not poke the resident's shoulder or his chest. She stated she had asked staff to back away while she assessed the resident and they were behind her so she didn't know how they would have seen her poke his chest. She stated the resident's assessment was normal and he did not have any injuries or bruises. She stated she did not ask the resident why he fell and did not say that she was sicker than the resident. She stated she did say that now she had to stay late but did not say it to the resident but to the staff in the room. She stated she did not say that she didn't care about the vital signs and to just get him up. She stated she regretted that she said she was sick and	F0610		

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F0610 SS = D	Continued from page 21 wanted to go home. She stated after the fall, she stayed at the facility to complete assessments. She stated the resident was fine and had a soft drink and she sat with him. She stated the resident did not cry during or after this incident. On 12/11/25 at 11:19 a.m., the Assistant Director of Nursing(ADON) stated staff should treat residents with respect and dignity. On 12/11/25 at 11:51 a.m., the Director of Nursing(DON) stated staff should report allegations of abuse to the administrator and they would remove the staff member(from resident care) and notify the State Agency. On 12/11/25 at 12:45 p.m., the Administrator stated the facility should report all allegations of abuse to the State Agency. She stated she trusted the previous DON's judgement regarding this and she shouldn't have. She stated the facility would suspend the staff member pending an investigation.	F0610		
F0658 SS = D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is NOT MET as evidenced by: Based on clinical record review, policy review, and staff interview, the facility failed to administer insulin in a timely manner with respect to the obtainment of the resident's blood sugar(BS) for 1 of 2 residents(Resident #2) reviewed for insulin(an injectable medication used to lower blood sugars). The facility reported a census of 45 residents. Findings included: The Minimum Data Set(MDS) assessment tool, dated 11/2/25, listed diagnoses for Resident #2 which included diabetes(a disease which causes irregularities in blood sugars), arthritis, and anxiety, and listed his Brief Interview for Mental Status(BIMS) score as 15 out of 15, indicating intact cognition. The resident's Blood Sugar Summary included the	F0658	Resident blood sugar checks and insulin orders reviewed by DON/ADON. All other residents that have orders for blood sugar checks and insulin were reviewed by DON/ADON reviewed to ensure accuracy and timing. Physician orders for blood sugar and insulin resident's medication administration records, and medication labels and dosages were reviewed to ensure that all residents are receiving prescribed medication according to physician's orders, and coordinated appropriately with breakfast, lunch and dinner timing. Policies for Medication Administration and Insulin Pen Administration reviewed, specifically for insulin administration and timing and administration of insulin and blood sugar checks updated.	12/16/2025

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F0658 SS = D	Continued from page 22 following blood sugar readings: 11/23/25 5:20 a.m. 110 mg/dl(milligrams(mg)/deciliter(dl) and 8:11 a.m. 110 mg/dl 11/24/25 5:25 a.m. 150 mg/dl and 9:18 a.m. 150 mg/dl 11/25/25 5:30 a.m. 225 mg/dl and 6:50 a.m. 225 mg/dl 11/26/25 6:23 a.m. 222 mg/dl and 8:58 a.m. 222 mg/dl 11/29/25 5:37 a.m. 188 mg/dl and 8:28 a.m. 188 mg/dl 11/30/25 5:19 a.m. 253 mg/dl and 826 a.m. 253 mg/dl The November 2025 Medication Administration Record(MAR) listed an 11/21/25 order for humalog(a type of insulin) per sliding scale as follows: 20 units for BS between 60 and 150 mg/dl and 40 units for BS between 151 and 400 mg/dl. The order directed staff to call the provider for BS under 60 or over 400 mg/dl. The MAR documented nurses utilized the above blood sugars obtained on the night shift to determine the resident's breakfast sliding scale insulin amount. On 12/10/25 at 10:50 a.m., Staff E Registered Nurse(RN) stated the third shift nurses obtained blood sugars and the day shift nurses utilized that reading to determine the amount of sliding scale insulin to administer. On 12/10/25 at 1:05 p.m. Staff A Licensed Practical Nurse(LPN) stated that third shift staff obtained most blood sugars and the day shift nurses utilized those to determine the amount of sliding scale insulin to give. She stated the day shift nurses entered the third shift blood sugars into the electronic record when they administered the sliding scale insulin. Staff A stated breakfast used to be at 7:00 a.m. but was now later so this needed discussed. On 12/11/25 at 11:19 a.m., the Assistant Director of Nursing(ADON) stated the night nurse carried out blood sugars but stated best practice would be to check it within 30 minutes of the administration of sliding scale insulin. On 12/11/25 at 11:51 a.m., the Director of Nursing(DON) stated staff should carry out blood sugars around 30 minutes prior to the administration of sliding scale insulin, or as close as they could get. The undated facility policy "Insulin Pen Administration" did not provide guidelines for staff	F0658	Nurses and CMA staff were educated to policy for blood sugar checks and insulin administration, completed on 12/16/2025. QAPI action plan instituted 12/16/2025. Audits will be completed by the DON/or Designee periodically to ensure compliance. Ongoing Audit findings will be brought to the quarterly QAPI meetings. Ongoing	

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F0658 SS = D	Continued from page 23 with regard to the obtainment of blood sugars in relation to the administration time of sliding scale insulin.	F0658		
F0684 SS = D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is NOT MET as evidenced by: Based on clinical record review, policy review, and staff interview, the facility failed to assess and intervene in a timely manner after a resident complained of signs and symptoms of an infection for 1 of 2 residents reviewed for a change in condition(Resident #26). The facility reported a census of 45 residents. Findings included: The Minimum Data Set(MDS) assessment tool, dated 9/23/25, listed diagnoses for Resident #26 which included diabetes(a disease which caused irregularities in blood sugars), non-Alzheimer's dementia, and depression. The MDS listed the resident's Brief Interview for Mental Status(BIMS) score as 15 out of 15, indicating intact cognition. On 12/8/25 at 1:42 p.m., Resident #26 stated it took the facility a week before they obtained medication for her yeast infection. She stated she had burning and itching and it was "very, very uncomfortable". A 11/25/25 5:11 AM Nurses Note documented that the facility sent a fax to the resident's provider related to a possible yeast infection. The resident's vaginal area was red and she had discomfort when using the bathroom and sitting. The resident requested an order for Diflucan(an antifungal medication). A 12/2/25 Nurses Note stated the facility received an order for Diflucan 150 milligrams(mg) x 1 dose.	F0684	Resident #26's medical record and clinical review by DON to confirm that the ordered antifungal medication had been administered as ordered and that the resident's symptoms had resolved. The resident was educated to notify nursing staff promptly of any recurrence of symptoms. DON or designee conducted an audit of all current residents for the previous 30 days who had documented signs or symptoms of infection requiring provider notification to include a review of assessments, provider notification, timeliness of provider response, and follow-up if no response received within facility policy guidelines. Any identified concerns were addressed immediately, including reassessment of residents, provider notification, and documentation of follow-up actions. Policy reviewed and updated on Documentation Assessment Guidelines. Nursing staff educated on assessment guidelines and follow-up per facility policy completed on 12/24/2025. DON or designee will conduct weekly audit for four weeks, then monthly for two months to ensure compliance. Audit findings will be reviewed during QAPI, and any identified issues will be immediately addressed.	12/29/2025

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F0684 SS = D	Continued from page 24 The facility lacked documentation of a follow-up to the fax sent between 11/25/25 and 12/2/25 and lacked documentation of assessments carried out related to the resident's concern between 11/25/25 and 12/7/25. On 12/10/25 at 1:05 p.m. Staff A Licensed Practical Nurse(LPN) stated if a resident had signs and symptoms of an infection, she would assess them and notify the doctor. She stated if they didn't get a response to a provider's fax in 24 hours, they would call them. She stated the nurses had a clipboard and should check it every shift. She stated this may be where the communication breakdown occurred. She stated if nurses didn't go through the clipboard, they wouldn't know what needed followed up on. She stated if a resident started a medication, the nurses would complete follow-up assessments. On 12/11/25 at 11:19 a.m., the Assistant Director of Nursing(ADON) stated if a resident complained of signs and symptoms of infection, they would obtain vitals and complete an assessment. She stated they would call or fax the provider. She stated nurses had a clipboard to follow up on the faxes. She stated she was gone on vacation and had inquired as to what happened with regard to Resident #26's complaints. On 12/11/25 at 11:51 a.m., the Director of Nursing(DON) stated staff should follow up on a fax to a provider within 24 hours. The undated facility policy "Documentation Assessment Guidelines" stated the facility should facilitate accurate assessments of residents when the resident had physical changes.	F0684		