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	5105793	A. BUILDING: _____ B. WING _____	09/10/2025

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A 000	Initial Comment Annual Licensure Survey The following violations were cited: 1. Section 295.2000a)c)1)2) 2. Section 295.3000a)h)1)2)3)7) 3. Section 295.4010a)b)d)e)g)A)C)2)3)5)h)	A 000		
A2000	Section 295.2000 Residency Requirements This Regulation is not met as evidenced by: General Violation Section 295.2000 Residency Requirements a) No individual shall be accepted for residency or remain in residence if the establishment cannot provide or secure appropriate services, if the individual requires a level of service or type of service for which the establishment is not licensed or which the establishment does not provide, or if the establishment does not have the staff appropriate in numbers and with appropriate skill to provide such services. (Section 75(a) of the Act. c) A person shall not be accepted for residency if: 12) The person requires treatment of stage 3 or stage 4 decubitus ulcers or exfoliative dermatitis. These requirements were not met as evidenced by: Based on interview and record review, the facility failed to comply with regulatory requirements by admitting a resident (R6) with an unstageable pressure injury.	A2000		

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A2000	Continued From page 1 These failures resulted in: R6 with Unstageable pressure injury (to the left foot) was admitted in the establishment after the wound was debrided (on July 17, 2025). Five days after admission (July 21, 2025), 90% of the wound surface area was covered with slough. The findings include: R6 moved into the establishment on July 25, 2025, with history of fracture of the tibia, transient ischemic attack, difficulty walking, and need for assistance with personal care. On September 4, 2025, at 10:20 AM, E1 (Executive Director) and E3 (ADON) explained, "R6 was admitted from a skilled rehab facility." R6 was described as alert and oriented, needing one physical assist from staff with bathing, toileting, and transferring, and requiring a wheelchair for mobility. E1 explained, prior to R6's admission to the establishment, R6 was sent for wound assessment and identified the wound as Stage 2. The following was documented: Podiatry progress notes dated July 17, 2025: - HPI (History of Present Illness)- with pressure injury of the left foot, "Unstageable". - Assessment and Plan: Excisional debridement to wound site done. - Procedure: Debridement: Partial removal of eschar from the ulcer to assess the depth of the wound. The revised NPUAP (National Pressure Ulcer Advisory Panel) staging system define Unstageable Full-Thickness Pressure Injury: Obscured Full thickness skin and tissue loss.	A2000		

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A2000	Continued From page 2 Definition: Full thickness skin and tissue loss in which the extend of tissue damage within the ulcer cannot be confirmed because it is obscured by SLOUGH or ESCHAR. If slough or eschar is removed, a Stage 3 or Stage 4 pressure injury will be revealed. Home health nurse assessment show the following: - July 28, 2025, left lateral foot (pressure injury), measured at 1.8 (cm in length) x 1.8 (cm in width)- with 100% slough. - August 15, 2025, measured at 1.2 (cm length) x 1.5 (cm width) x 0.2 (cm depth) with slough covering 90% of the wound. This finding was discussed and confirmed by E1 and E3 on September 4, 2025.	A2000		
A3000	Section 295.3000 Personnel Requirmts, Qualifns, and Trng This Regulation is not met as evidenced by: Type 1 Violation Section 295.3000 Personnel Requirements, Qualifications and Training a) The establishment shall have staff sufficient in number with qualifications, adequate skills, education and experience to meet the 24 hour scheduled and unscheduled needs of residents and who participate in ongoing training to serve the resident population. (Section 35(a)(3) of the Act) h) The establishment shall have sufficient	A3000		

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A3000	Continued From page 3 personnel to provide the following for its current resident population: 1) All mandatory services; 2) Services established in each resident's service plan. 3) Service to meet the needs of each resident, including 24 hour scheduled and unscheduled needs, general supervision, and the ability to intervene in a crisis; 7) Any optional services to be provided by the establishment as stated in the service plan. These requirements were not met, as evidenced by: Based on interview and record review, the facility failed to: 1. Provide supervision and monitoring to residents identified as at risk for fall. 2. Conduct a comprehensive assessment to identify the specific risk factor/root cause for the fall. 3. Ensure the identified needs for assistance and supervision are consistently implemented and carried out. These failures resulted in R2 sustaining a right hip fracture on January 11, 2025, that required surgical intervention.These failures caused severe harm to a resident and creates a substantial probability of severe harm to other residents. The findings include: R2 moved into the community on August 22nd, 2023, with diagnoses of encephalopathy, seizures, diabetes mellitus type 2, hypertension, transient global amnesia, unsteadiness on feet, and Parkinson's disease.	A3000		

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A3000	Continued From page 4 On August 21,2025, at 3:03 PM, E1 (Executive Director), E2 (Resident Services Director) and E3 (Assistant Resident Services Director) described R2 has having cognitive impairment, at high risk for fall, and requiring one physical assist from the staff with all activities of daily living. R2 utilizes wheelchair for ambulation. R2 was also identified as having, "no safety awareness, slides off the bed and almost onto the floor every day!" On August 21, 2025, at 1:18 PM, E1 and E3 presented R2's most recent service plan dated December 13, 2023. This identifed R2 requiring moderate assistance for toileting, hands on assistance with transferring and mobility/ambulation, and for the staff to "provide supervision to reduce risk for fall." Review the nurse's notes show the following fall incidents: - December 22, 2024, at 9:22 AM, R2 was found the floor. - December 19, 2024, at 9:01 AM, was found on the floor. - January 11, 2025, at 2:15 PM, was found on the floor, 'attempting to go to the bathroom." R2 complained of pain (7 out of 10 on pain scale), unable to feel the right leg and requested to go to the hospital. R2 was admitted to the hospital and was diagnosed with a right hip fracture requiring surgical intervention. - July 23, 2025, at 6:50 PM, missed the chair when attempting to sit and fell on the floor. The establishment was unable to present documentation(s) that a root cause analysis was done, nor was an individualized plan of care implemented to prevent or minimize R2's incident of falls.	A3000		

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A4010	Continued From page 5	A4010		
A4010	Section 295.4010 Service Plan	A4010		

This Regulation is not met as evidenced by:
Type 1 Violation

Section 295.4010 Service Plan

a) Based on the physician's assessment and establishment evaluation (see Section 295.4000), a written service plan shall be developed and mutually agreed upon by the establishment and the resident. (Section 15 of the Act) The establishment shall respect and accept the resident's choices regarding the service plan.
b) The service plan shall be developed by
1) The resident, resident's representative or any individual requested by the resident.
2) The manager or manager's designee; and
3) A registered nurse, if the resident is receiving nursing services or medication administration or is unable to direct self-care.
d) The service plan, which shall be reviewed annually, or more often as the resident's condition, preferences, or service needs change, shall serve as a basis for the service delivery contract between the provider and the resident (see Section 295.2030). (Section 15 of the Act).
e) The service plan shall be reviewed and revised, if necessary, immediately after a significant change in the resident's physical, cognitive, or functional condition (see Section 295.4000).
g) Service plans shall address:
1) The level of service the resident is receiving, including:
A) assistance with activities of daily living.

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A4010	Continued From page 6 B) dietary needs, if the establishment provides therapeutic diets; and C) special accommodations for the resident. 2) The amount, type, and frequency of health-related services needed by the resident. 3) Staff responsible for the provisions of the service plan. 4) Any risk being negotiated; and 5) Whether the resident requires medication reminders, supervision of self-administered medication, or medication administration. h) The service plan shall include all support services provided or arranged for by the establishment. i) Disclosure of the risks of refusing services or approaches must be documented in the service plan. These requirements were not met, as evidenced by: Based on interview and record review, the facility failed to: 1. Develop and implement a preventative measure to address residents identified as: a. At risk for fall - R1 and R2. b. At risk for development of skin alteration (R3). 2. Implement an individualized plan of care based on the assessed needs of the residents. 3. Identify the frequency of the services needed and the staff responsible for the provisions of the plan. 4. Coordinate the plan of service with the outside provider. 5. Conduct a significant change of status for R2 and R1. These failures resulted in: A. On April 11, 2025, R1 sustained a fall that	A4010		

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resulted in a (1) right hip fracture, (2) ruptured vertebrae and, (3) cracked pelvis.
B. R3 development of skin alterations:
(1) On January 12, 2025- redness to the right hip was identified. On January 20, 2025, this wound deteriorated, noted with infection requiring antibiotic therapy.
(2) On January 20, 2025, identified with additional wounds to: (a) right upper posterior leg- identified as redness, measured at 0.9 cm length x 0.7 cm width, (b) right lower posterior leg- described with 90 % slough, measured at 2.5 cm length x 2.7 cm width x 0.1 cm depth.

These failures caused severe harm to a resident and creates a substantial probability of severe harm to other residents.

The findings include:

1. R1 moved into the establishment on May 20, 2024, with diagnosis to include hypothyroidism, moderate dementia, and hyperlipidemia on August 21, 2025, at 2:36 PM, R1 was identified by E2 (Resident Services Director) as alert and oriented (x4). E3 (Assistant Resident Services Director) described R1 requiring bathing and dressing assistance and a standby assist in toileting. E1 stated, "R1 is impulsive and with unsteady gait."

R1's service plan dated March 5, 2025, identified as:
- R1 with moderate (cognitive) impairment, with history of occasional disorientation to person, place, time, or situation even in familiar surroundings and requires supervision and oversight for safety.
- With judgement issue, needing protection and supervision due to unsafe or inappropriate

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A4010	Continued From page 8	A4010		

decisions.
- Toileting- requires the standby assistance for toileting task and identified as a
- Fall potential (there was no intervention listed).
- There was no behavior concern/problem (impulsive behavior) identified in R1's Service plan.

R1's nurses notes show the following incidents:
- March 8, 2025, R1 was found face down on the floor. R1's Service plan was not revised; it remained without interventions.
- April 11, 2025, at 10:33 PM, R1 was found on the floor, complaint of pain to the right hip and unable to move the right leg. R1 was admitted to the hospital and was diagnosed with a right hip fracture, ruptured vertebrae, and a cracked pelvis.

On June 5, 2025, R1 was readmitted back from a rehabilitation center. The establishment had not developed a service plan revision based on R1's significant change of condition.

2. On August 21,2025, at 3:03 PM, E1 (Executive Director), E2 (Resident Services Director) and E3 (Assistant Resident Services Director) described R2 as having cognitive impairment, at high risk for fall, and requiring one physical assist from the staff with all activities of daily living. R2 requires a wheelchair for ambulation and was described as having, "no safety awareness, slides off the bed and almost onto the floor every day!"

On January 11, 2025, R2 sustained an unwitnessed fall incident. R2's nurses notes documented, "Attempting to go to the bathroom." R2 was admitted into the hospital and was diagnosed with a right hip fracture requiring

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A4010	Continued From page 9	A4010		

surgical intervention. R2 was readmitted to the establishment on January 21, 2025. The establishment failed to develop a significant change of status.

This finding was discussed and confirmed by E1 (Executive Director) and E2 (Resident Services Director) on August 21, 2025.

3. R3 moved in the community on August 24, 2023, with diagnoses to include Alzheimer's disease, depression, hypothyroidism, and hypertension.

R3's nurses notes show R3's development of a wound:
- On January 12, 2025, "redness on the right hip, with a break (opening) in the center; swollen and painful to touch."
- On January 20, 2025, a sign of infection was noted on the wound and was described as "purulent drainage", antibiotic therapy prescribed. There was no further assessment found or presented related to the right hip wound.

The home health nurse documentation dated January 20, 2025, identified two areas of wound located on R3's:
(a) right upper posterior leg- identified as redness, measured at 0.9 cm length x 0.7 cm width and,
(b) on the right lower posterior leg- described with slough covering 90% of wound surface area, measured at 2.5 cm length x 2.7 cm width x 0.1 cm depth.

None of R3's wounds were reflected in R3's service plan; this was discussed and confirmed by E1 and E2 on September 4, 2025.

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A4010	Continued From page 10 4. The following residents sustained a significant change of condition: - R3 - admitted to hospice care on January 31, 2025. - R2 - on January 21, 2025, readmitted to the community from a skilled/ rehab facility post fracture of the right hip. - R1 - sustained a right hip fracture, ruptured vertebrae, and cracked pelvis on April 11, 2025. R1 was re admitted on June 15, 2025. On September 4, 2025, at 11:40 AM, E1, (Executive Director), E3 (Assistant Resident Services Director) confirmed that the establishment had not updated the residents (R1, 2 and R3) service plan to reflect the residents condition changes. The establishment service plans failed to identify the frequency of the services that each resident requires; there's no integration of the services with the outside providers. These concerns were discussed with the Management Team during this survey.	A4010		