STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 205095	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/16/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KENNEBUNK CENTER FOR HEALTH & REHABILITATION, LLC	**158 ROSS RD , KENNEBUNK, Maine, 04043**

(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 From 4/12/26 through 4/15/26 on-site visits were completed at Kennebunk Center for Health and Rehabilitation for the purpose of conducting the annual Long Term Care Survey Process for Federal Recertification, and investigation of facility reported incidents and complaints # 217215, #2572796, #2651068, and #2786740. It was determined that Kennebunk Center for Health and Rehabilitation is not in compliance with 42 CFR Part 483, Subpart B-Requirements for Long Term Care Facilities.	F0000	The plan of correction is prepared and submitted as required by law. By submitting this plan of correction, Kennebunk Center for Health and Rehabilitation does not admit that the deficiencies on this form exist, not does the center admit to any statements, findings, facts, or conclusions that may form basis for the alleged deficiency. The Center reserves the right to challenge in legal or regulatory or administrative proceedings the deficiency statements, facts, and conclusions that form the basis for the deficiency.	
F0584 SS = E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition;	F0584		

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
Joleen Nelson	Administrator	5/13/2026

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F0584 SS = E	Continued from page 1 §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is NOT MET as evidenced by: Based on observations and interviews, the facility failed to adequately provide housekeeping and maintenance services necessary to maintain the building in a sanitary, orderly, and comfortable environment for the medication storage room and the laundry room for 2 of 4 days of survey. Findings: 1.On 4/13/26 from 11:15 a.m. to 11:30 a.m., a tour of the laundry room too place with the Director of Operations and Director of housekeeping where the following was observed and confirmed: - Chipped wood on the door of the folding table, making it an uncleanable surface. -2 broken floor tiles by the door that goes from the clean side to the dirty side along with a rusted door frame and missing sheet rock. -Chipped paint on the windowsill of the dirty side making it an uncleanable surface. -Dirt and debris noted behind all 3 washers, along with broken floor tiles exposing untreated cement. -Wall by the sink on the dirty laundry side stained with an unknown substance, wall is noted to be lifting up, and the rubber floor trim is lifting up. 2.On 4/13/26 at 1:45 p.m. while observing the medication storage room a surveyor noticed the floor on the ride side of the back of room, under the	F0584	F0584 Safe Environment The table was repaired. The two broken floor tiles by the door that goes from the clean side to the dirty side were repaired. The rusted door was repaired and the sheetrock was repaired. The chipped paint on the windowsill was repaired. The dirt and debris noted behind all 3 washers was cleaned. The broken floor tiles and exposed cement is scheduled to be replaced. The wall by the sink on the dirty laundry side was cleaned and the wall was repaired. The floor is scheduled to be replaced. The pink substance on the floor of the medication storage room was immediately cleaned. The dust / debris on the floor of the medication storage room has been cleaned.	

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F0584 SS = E	Continued from page 2 counter had dust/debris and a dried, pink substance on the floor. On 4/13/26 at 1:49 p.m. in an interview with a surveyor the Director of Nursing confirmed the unclean floor and stated she would have housekeeping clean the floor. On 4/14/26 at 7:50 a.m. a surveyor observed the medication room floor again and the pink substance had been cleaned, but the floor still appeared to have dust/debris in the corner as well as other areas of the floor, and the wall between the frig and cabinet had chipped/missing paint, and stains creating an uncleanable surface. On 4/14/26 at 7:55 a.m. during an interview with a surveyor Register Nurse #1 confirmed this finding.	F0584	The wall between the refrigerator and cabinet has been cleaned and repaired. Staff Development Coordinator / designee educated facility staff on identifying areas of environmental safety and sanitary practices. Any area requiring repair will be reported to maintenance using maintenance work orders. The Maintenance Director / designee will conduct random audits of the laundry room and medication storage room Monday through Friday x4 weeks and then weekly x2 months. The results of these audits will be reviewed with the QAPI committee monthly x3 months to ensure compliance is maintained. The Administrator is responsible for compliance.	05/27/26
F0656 SS = E	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)-	F0656	F0656 Comprehensive Care Plan Resident #55 comprehensive care plan includes a plan of care for Dementia. Resident #9 comprehensive care plan includes a plan for fall risk. The Director of Nurses / designee has completed a house audit of residents with diagnoses of Dementia / Alzheimer's and fall risks to ensure no other resident was affected by this practice. The Staff Development Coordinator / designee will complete education with license nurses on developing care plans for residents with diagnoses of Dementia / Alzheimer's and at risk for falls. The Unit Managers / designee will complete random audits 3x / week x 60 days of residents with diagnoses of Dementia / Alzheimer's and at risk for falls. The results of these audits will be reviewed with the QAPI committee monthly x2 months to ensure compliance is maintained. The DNS is responsible for compliance.	05/27/2026

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F0656 SS = E	Continued from page 3 (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is NOT MET as evidenced by: Based on record reviews and interviews, the facility failed to ensure that a care plan was developed in the area of dementia care for 1 of 2 residents reviewed for dementia (Resident #55), and in the area of accidents for 1 of 4 residents reviewed for falls (Resident #9). Findings: 1.Review of Resident #55's medical record stated he/she was admitted to the facility in July of 2025 with a diagnosis of dementia. The most recent care plan dated 2/9/26 lacked evidence that a comprehensive care plan was developed in the area of dementia care. On 4/15/26 at 1:29 p.m. in an interview with a surveyor, the Regional Director of Clinical Operations confirmed this finding. 2. On 10/22/25 the Division of Licensing and Certification (DLC) received a facility-reported incident that indicated that Resident #9 had sustained an unwitnessed fall on 10/21/25 and was subsequently transferred to an acute care hospital and diagnosed with multiple fractures. The facility's 5-day follow-up report, submitted to the DLC on 10/28/25 stated, "...A toileting schedule has been added to care plan to attempt to decrease risk of falls while trying to get to the bathroom." A review of Resident #9's clinical record indicated that Resident #9 has diagnoses to include, but not limited to repeated falls and abnormalities of gait	F0656		

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F0656 SS = E	Continued from page 4 and mobility. Resident #9's most recent quarterly Minimum Data Set (MDS) Assessment completed 2/9/26 under Section GG indicates Resident #9 requires setup assistance for toilet transfers and toileting. A review of Resident #9's care plan revealed, "Resident has a Deficit in Self Care Function...TOILETING: Independent (No help or staff oversight at any time)" and lacked evidence of an intervention for a toileting schedule. Additionally, the care plan lacked evidence that goals and interventions were developed and implemented for falls. On 4/14/26 at 2:49 p.m., the surveyor discussed the above concern during an interview with the Director of Nursing (DNS). At this time, the DNS reviewed Resident #9's entire care plan and confirmed that it does not contain goals and interventions for falls. The DNS then stated that for some reason, Resident #9's fall care plan was resolved on 2/26/26.	F0656		
F0657 SS = E	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident.	F0657		

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F0657 SS = E	Continued from page 5 (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is NOT MET as evidenced by: Based on record reviews and interviews, the facility failed to review and revise the care plan by an interdisciplinary team (IDT) meeting, which included the participation of the resident and resident's representative, after each Minimum Data Set (MDS) 3.0 assessment, for 7 of 21 residents whose care plans were reviewed (Resident #2, #7, #8, #23, #35, #40, & #79). Findings: 1. On 4/15/26 a review of Resident #2's medical record contained a quarterly Minimum Data Set (MDS) version 3.0 dated 1/16/26 and 10/16/25. The clinical record lacked evidence of his/her IDT meeting being held within 7 days of the Quarterly MDS assessment. 2. On 4/15/26 a review of Resident #35's medical record contained a quarterly Minimum Data Set (MDS) version 3.0 dated 3/4/26, 1/13/26, 10/2/25, and 7/3/25. The clinical record lacked evidence of his/her IDT meeting being held within 7 days of the Quarterly MDS assessment. 3. On 4/15/26 a review of Resident #79's medical record contained an annual Minimum Data Set (MDS) version 3.0 dated 2/25/26. The clinical record lacked evidence of his/her IDT meeting being held within 7 days of the Quarterly MDS assessment. On 4/15/26 at 12:20 p.m. in an interview with a surveyor, the Director of Social Services confirmed the above findings stating they are working on this. She stated they are having the care plans first then the MDS assessment and need to swap so the MDS assessment comes first. She also stated that they always ask the residents if they want anything added to the care plan and the nurses can add items anytime as they come up. 4. On 4/15/26 a review of Resident #8's medical record contained a Significant Change Minimum Data Set (MDS) version 3.0 completed 1/21/26. The clinical record lacked evidence of his/her IDT meeting being held within 7 days of the Significant Change MDS assessment.	F0657	F0657 Care Plan Timing and Revision Resident #2 - Quarterly MDS ARD 3/14/26, completion date 03/25/26. Care conference held on 04/07/26. Resident #35 - Quarterly MDS ARD 02/18/26, completion date 03/04/26. Care conference held on 01/19/26 and 04/15/26. Resident #79 - Quarterly MDS ARD 02/12/26, completion date 02/25/26. Care conference held on 03/11/26. Resident #8 - Quarterly MDS ARD 04/23/26, completion date 04/29/26. Care conference held on 05/06/26. Resident #7 - Quarterly MDS ARD 03/20/26, completion date 03/27/26. Care conference held on 04/15/26. Resident #23 - Quarterly MDS ARD 04/22/26, completion date 04/28/26. Care conference held on 05/06/26. Resident #40 - Quarterly MDS ARD 03/26/26, completion date 03/27/26. Care conference held on 04/13/26.	05/27/26

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F0657 SS = E	Continued from page 6 On 4/15/26 at 1:40 p.m., in an interview with the Director of Social Services, the above information was discussed and confirmed. 5. A review of Resident #7's clinical record revealed an MDS Quarterly Assessment was completed on 3/27/26. Further review of Resident #7's clinical record revealed that an IDT meeting was scheduled for 4/15/26 (19 days after assessment) and lacked evidence that an IDT meeting was held within 7 days following the assessment. 6. A review of Resident #23's clinical record revealed an MDS Quarterly Assessment was completed on 2/5/26. Further review of Resident #23's clinical record revealed that an IDT meeting was held 2/16/26 (11 days after assessment) and lacked evidence that an IDT meeting was held within 7 days following the assessment. 7. A review of Resident #40's clinical record revealed an MDS Quarterly Assessment was completed on 3/26/26. Further review of Resident #40's clinical record revealed that an IDT meeting was held 4/13/26 (17 days after assessment) and lacked evidence that an IDT meeting was held within 7 days following the assessment. On 4/15/26 at 9:44 a.m., during an interview with the Social Services Director, 2 surveyors discussed the above findings. At this time, the Social Services Director confirmed that Resident #7's IDT meeting is scheduled to be held today, and that the facility schedules IDT meetings within 2 weeks following the care plan review date and not within 7 days following the MDS assessments.	F0657	The Regional Director of Clinical Reimbursement completed a house wide audit to reconcile care plan meetings within the last 3 months. Residents identified as out of compliance were offered a care plan meetings with the IDT. Staff Development Coordinator / designee will educate the IDT on the Resident Assessment Process (RAI) including each triggered Care Area, indicate whether a new care plan, care plan revision, or continuation of current care plan is necessary to assess the problem(s) identified in your assessment of the care area. The Care Planning Decision must be completed within 7 days of completing the RAI (MDS). The IDT will review, at a minimum weekly, the Care Plan Due list to guide the team on which residents are scheduled in PCC; the IDT will review the Comprehensive Care Plan with the deadline of the Target Completion Date; the Social Worker ' or designee will schedule the Care Plan Meeting thereafter, or as practicable with the resident / representative. The Administrator or designee will complete random weekly audits to ensure the care plan is reviewed and revised by the IDT that includes, to the extent possible, participation of the resident and/or representative after each MDS assessment. Audits will be completed until 100% compliance is met for a period of 3 consecutive months. Patterns and trends will be reported to QAPI.	
F0684 SS = E	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 policy reviews, record reviews, and	F0684	F0684 Quality of Care Resident #43 is receiving blood sugar finger sticks as ordered. Resident #69 no longer resides at the facility. Resident #15 no longer has an order for insulin. The Director of Nurses / designee has completed a house audit of residents with orders for blood sugar finger sticks and residents receiving long-acting insulin to ensure no other residents were affected by this practice. The Staff Development Coordinator / designee will educate license nurses on blood sugar finger sticks administration time ordered and timing of administration of insulin per provider order.	05/27/26

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F0684 SS = E	Continued from page 7 interviews, the facility failed to adequately follow physician orders for blood sugar checks before meals for 2 of 3 residents reviewed and failed to adequately follow the facility's policy for administering long-acting insulin for 1 of 2 residents reviewed (Resident #15, #43 & #69). Findings: The facility's "Medication Pass Policy", last revised 9/24 states, "it is the policy of the facility that medications are administered safely and timely per the physician's orders", and "for facilities that support a 'liberalized' med pass, the following times may also be added": - Liberalized Med Pass Morning 7 AM – 11 AM - Liberalized Med Pass Lunch/Midday 11 AM – 2 PM - Liberalized Med Pass Evening 3 PM – 7 PM - Liberalized Med Pass Bedtime/HS 7 PM – 10 PM - Liberalized Med Pass Sunrise 4 AM – 6 AM The facility's "Diabetes Management Protocol", last revised 2/25 states, "Insulin: Basal Insulin (Long acting): Glargine (Lantus), Detemir (Levemir), or Degludec (Tresiba) provides 24-hour glucose control." 1. On 4/14/26 at 9:11 a.m. a surveyor observed several late blood sugar orders during the medication administration observation that were highlighted in red in the electronic medical record. On 4/14/26 at 12:00 p.m., surveyor reviewed the "Medication Admin Audit Report" for R#43 that states they have an order for "Fingerstick Blood Sugar (FSBS) before meals and at bedtime for diabetic management, notify HCP (Health Care Provider) for FSBS 70 or greater than 350 unless otherwise indicated." The record showed that on 4/14/26 R#43's blood sugar was checked at 9:29 a.m. after breakfast. 2. On 4/14/26 at 12:00 p.m. surveyor reviewed the "Medication Admin Audit Report" for R#69 that states they have an order for "Fingerstick Blood Sugar before meals and at bedtime for diabetic management, notify HCP for FSBS 70 or greater than 350 unless otherwise indicated." The record showed that on 4/14/26 R#69's blood sugar was checked at 9:47 a.m. after breakfast.	F0684	The Director of Nurses / designee will complete random daily (Mon - Fri) audits x3 months of blood sugar finger sticks administration time and administration time of long-acting insulin. The results of these audits will be reviewed with the QAPI committee monthly x3 months to ensure compliance in maintained. The DNS is responsible for compliance.	

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F0684 SS = E	Continued from page 8 3. On 4/14/26 at 11:54 a.m. during observation of R#5's medication administration, a surveyor observed the Medication Administration Record (MAR) which showed that the resident had not been given their Insulin. The order states, "Glargine subcutaneous solution 100 unit/ml (units per milliliter), inject 15 units subcutaneously one time a day in the morning with a start date of 4/6/26." MedTech #1 stated that they do not do injections, the nurse does them. On 4/14/26 at 12:28 p.m. during an interview with a surveyor the Director of Nursing (DON) pulled the MAR up for R#15, and confirmed it had been given at 11:47 p.m. The surveyor questioned the timing of the administration of the medication and the DON stated that R15 is under the liberalized medication administration times. When the surveyor stated that it was past the liberalized time frame the DON stated, "well an hour before and an hour after" and "all we can do is follow provider orders". On 4/14/26 at 12:30 p.m. in an interview with a surveyor, the DON confirmed the above findings.	F0684		
F0725 SS = E	Sufficient Nursing Staff CFR(s): §483.35(a)(1)(2) §483.35 Nursing Services. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity, and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.71. §483.35(a) Sufficient Staff. §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and	F0725	F0725 Sufficient Staffing The facility is staffing sufficiently to minimum staffing ratios / occupied beds. All residents have the potential to be affected by this practice. The Administrator / designee will educate the staffing coordinator, and clinical leadership on the minimum staffing ratios. The staffing coordinator / designee will complete random daily audits of staffing levels x90 days. The results of the audits will be reviewed monthly with the QAPI committee monthly x3 months to ensure compliance is maintained. The Director of Nurses is responsible for compliance.	05/27/26

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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
F0725 SS = E	Continued from page 9 (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is NOT MET as evidenced by: Based on record review, interview and Payroll Based Journal Report (PBJ), the facility failed to ensure it was sufficiently staffed on weekends for 1 of 1 quarters reviewed (10/1/25 through 12/31/25). Findings: Review of Center for Medicare & Medicaid (CMS) PBJ Report revealed the facility triggered for low weekend staffing during the first quarter (10/1/24 through 12/31/24). On 4/15/25 at 12:00 p.m., during a review of first quarter weekend staffing with a surveyor, the Administrator confirmed the facility was not adequately staffed for 5 of 39 days reviewed (day shifts).	F0725		
F0761 SS = E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.	F0761	F0761 Label / Store Drugs and Biologicals The expired lab supplies were discarded immediately on 04/14/2026 during survey. The treatment cart was locked immediately on 04/15/2026. The Assistant Director of Nurses / designee completed a house audit of lab supplies and the treatment cart to ensure no other residents had the potential to be affected by this practice. The Staff Development Coordinator / designee has educated the license nurses on expired lab collection tubes and locking the treatment cart. The Unit Managers / designee will complete random weekly audits of lab collection tubes x 60 days and random daily (Mon-Fri) of treatment carts locked. The results of these audits will be reviewed with the QAPI committee monthly x3 months to ensure compliance is maintained. The Director of Nurses is responsible for compliance.	05/27/26

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 205095	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/16/2026

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F0761 SS = E	Continued from page 10 §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is NOT MET as evidenced by: Based on observations and interviews, the facility failed to ensure expired lab supplies were removed from supply, available for use for 4 of 4 units, and the facility failed to ensure treatment carts were locked when unattended for1 of 1 carts, for 1 of 4 days of survey. Findings: 1.On 4/14/26 at 7:50 a.m. two surveyors identified lab supplies (blood collection tubes) that had expired: * 95 blue top blood collection tubes with expiration date 3/20/26 * 3 yellow top blood collection tubes with expiration date 2/28/26 * 29 red blood collection tubes with expiration of 3/20/26 On 4/14/26 at 7:59 a.m. the Assistant Director of Nursing confirmed the expired blood collection tubes with two surveyors and removed them from use. On 4/14/26 at 10:23 a.m. in an interview the Regional Director of Operations confirmed that the facility does sometimes do their own blood draws. 2. On 4/15/26 at 9:37 a.m. 2 surveyors observed an unlocked and unattended treatment cart located on the Windmere Unit. The third and fourth drawers on the left side of the cart contained various resident medications/treatments, including but not limited to Compound W, Nystatin, Diclofenac, Asperflex, hydrocortisone cream, ammonium lactate, as well as individually packaged SaniCloth disinfecting wipes. Throughout the observation, several staff members walked past the surveyors going through the cart. Throughout the survey, the survey team observed multiple residents foot propelling in their wheelchairs in the halls.	F0761		

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	205095	A. BUILDING B. WING	04/16/2026

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F0761 SS = E	Continued from page 11 On 4/15/26 at 9:40 a.m., the Administrator walked past the surveyors going through the cart. At this time, the surveyors stopped the Administrator and discussed the observation. During an interview at this time, the Administrator stated that the nurse assigned to the treatment cart is doing wound rounds on the unit and proceeded to lock the cart.	F0761		
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 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 observations, interviews, and facility policy, the facility failed to ensure the kitchen was maintained in a clean and sanitary manner related to floors, walls, food preparation surfaces, the walk-in freezer, and the dish room for 1 of 1 initial kitchen tour. Additionally, the facility failed to ensure foods were sealed, labeled, and dated in a food preparation area, a dry storage room, a reach-in refrigerator, a walk-in refrigerator, and a walk-in freezer for 2 of 2 kitchen tours. Furthermore, the facility failed to maintain an emergency food supply for 2 of 4 days of survey (4/12/26, 4/13/26). Findings:	F0812		

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F0812 SS = E	Continued from page 12 Review of facility policy, "Storage of Food & Supplies," revised 2/2022 states, "...Labeling and rotating food supply...Food products that are opened and not completely used; transferred from its original package to another storage container; or prepared at the facility and stored should be labeled as to its contents and used by dates...Food removed from its original container must be labeled with the common name of the food..." Review of facility policy, "Dishwashing- Dish machine," revised 1/2022 states, "...Check that the machine is clean. Check wash arms, scrap trays, and final rinse jets... Clean dish machine throughout the day and during use as necessary to prevent recontamination of equipment and utensils...After Dishwashing is Complete...Clean dish room tables and dish machine. Use a de-limer whenever necessary to remove mineral deposits caused by hard water..." 1. On 4/12/26 from 9:05 a.m.-9:45 a.m., a surveyor conducted an initial kitchen tour with Cook #1, during which the following was observed: In the main Kitchen/Food Preparation (prep) area: The wash sink's sanitizer solution hose was immersed below the water in the sink. There were cracks on the wall behind the sink, creating an uncleanable surface. A dedicated handwashing sink, with signage posted above the sink indicating the same, was located on a wall between the Dish Room and the food prep area. During an interview, Cook #1 stated that he sometimes uses the handwashing sink to rinse vegetables "as a last resort." The surveyor observed that there was no air gap separation under the handwashing sink. Kitchen staff's personal water bottles, a can of RedBull energy drink, an ID badge, and a personal charger were stored on a food prep surface. There were crumbs and food debris on the stainless-steel countertop (food prep area) where the mixer is stored. A heavily soiled yellow radio was stored on the food prep countertop behind the mixer. A 48 ounce (oz) undated box of coarse flake kosher salt was observed on the bottom shelf of the food prep station next to the sink. The flip top was open,	F0812	F0812 Food Procurement, Store / Prepare / Serve - Sanitary The wash sink sanitizer solution hose was adjusted to the appropriate length. The cracks on the wall behind the sink were repaired. Dietary staff were provided education that the handwashing sink is to be utilized for handwashing only. The personal items were removed from the food prep surface. The crumbs and food debris on the stainless-steel countertop was cleaned. The yellow radio was discarded.	05/27/26

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F0812 SS = E	Continued from page 13 exposing the contents to air. When the surveyor discussed the finding, Cook #1 stated the salt was opened 3/17/26 but with repeated use, the marker used to date food items rubs off. A gallon container of Lea & Perrins Worcestershire sauce was undated. A label on the side of container is dated 11/26/25. Cook #1 stated the label indicates the "delivered date" and that he opened the item the day it was delivered. An unlabeled, undated white bin with a clear lid was in the food prep area, containing what appeared to be oats. Food debris and crumbs were noted on the floor in multiple areas throughout the kitchen. Buildup was noted on floors, especially in corners and on baseboard trim throughout kitchen. The pink tray on top of the microwave was covered with crumbs and food debris and dried liquid. Additionally, a bottle of Smart Water was being stored on the pink tray. Cook #1 confirmed it is a staff member's water bottle. In the Dry Storage Area: 1 pound (lb) box of baking soda, unlabeled, undated, and available for use. The flip top was open and exposing the contents to air. The reach-in (cook's) refrigerator contained the following available for use: - a square stainless steel container covered with foil, labeled "[Cook #1's] Fat" undated. Cook #1 stated this is bacon grease saved for him to use for food prep. - an undated 16 oz bag of whipped topping. The package indicated, "Perishable...Best if used by... 14 days refrigerated." The Walk-In refrigerator contained the following available for use: - an unlabeled and undated open bag of spinach, located on the top right shelf. - 6 heads of green cabbage and1 head of purple cabbage, located on a silver tray on the right lower shelf. The tray was uncovered, unlabeled, and undated. - An unlabeled, open bag of shaved cheese, marked	F0812	The salt has been discarded. The Worcestershire sauce has been discarded. The oats have been discarded. Food debris and crumbs on the floor were cleaned. Buildup noted on floors, in corners and on baseboard was cleaned. The pink tray on top of the microwave was cleaned and the water bottle was removed. The baking soda was discarded. The bacon grease was discarded. The whipped topping was discarded. The bag of spinach was discarded. The 6 heads of cabbage and 1 head of purple cabbage was discarded. The open bag of shaved cheese was discarded.	

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F0812 SS = E	Continued from page 14 with an open date of 3/9/26 but no discard date, located on the top left shelf. The Walk-In freezer contained the following available for use: - an undated, open box of ground beef patties with the inner bag open and sticking out of the box, exposing the patties to air, located on the top left shelf. The surveyor noted freezer burn/discoloration on the edges of the exposed patties. - 2 unlabeled, a pork tenderloin, and a roll of ground beef (package imprint indicated 4/17/26 expiration date), located on the second left shelf. All were unlabeled and undated. - Additionally, the floor at back center of the freezer was covered in debris, trash, and residue buildup. The Dish Room contained the following: - The grate under the dish machine contained significant food debris. - The walls had multiple spackled areas that were unpainted, creating an uncleanable surface. -there were two wall- mounted oscillating fans, and the fan blades were covered in dust. One of the fans was blowing in the direction of the clean dishes. On 4/12/26 at 1:55 p.m., the surveyor conducted a repeat tour of the kitchen with the Administrator and discussed the above findings. At this time, the Administrator removed the visibly freezer-burnt beef patties from the walk-in freezer. On 4/13/26 at 12:48 p.m., the surveyor discussed the above findings with the Food Services Director (FSD). During an interview at this time, the FSD stated that foods should be labeled with the date received, the date opened, and a discard date. 2. On 4/13/26 at 12:48 p.m., during a repeat kitchen tour with the FSD, the surveyor requested to see the facility's emergency food supply. During an interview at this time, the FSD stated that the emergency water supply is stored in the shed, but that when he started working for the facility four months ago, the emergency food supply was expired. The FSD then stated that he knows a delivery is coming tomorrow. On 4/14/26 at 9:37 a.m. during an interview, the interim Food Service Director stated that the	F0812	The ground beef patties were immediately discarded. The two pork tenderloin and roll of ground beef were discarded. The back center of the freezer was cleaned of debris, trash and residue. The grate under the dish machine was cleaned. The walls have been repaired. The two wall-mounted oscillating fans and fan blades were cleaned. The Food Service Director / designee will educate dietary staff on identifying areas of environmental safety, labeling and dating and kitchen sanitation. Any area requiring repair will be reported to maintenance using maintenance work orders. The Food Service Director / designee will complete daily audits Mon-Fri x2 months and weekly 1x month of labeling and dating, kitchen sanitation and environmental. The Food Service Director / designee will complete monthly audits x3 to ensure compliance is maintained with emergency food supply. The results of these audits will be reviewed with the QAPI committee monthly x2 months to ensure compliance is maintained. The Administrator is responsible for compliance.	

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F0812 SS = E	Continued from page 15 facility's replacement emergency food supply is going to be delivered this afternoon and stated as far as she knows, the facility has always had an emergency food supply, but that she can't speak to what happened. At this time, the interim FSD stated that the facility does not have an emergency food supply list, but that she will create one today. On 4/14/26 at 9:38 a.m., during an interview in the presence of 2 surveyors, the Administrator stated the facility was utilizing its emergency food supply for routine meal prep because the supply was nearing expiration, but that there was a miscommunication, and the FSD was not replenishing the emergency supply as he used it. The Administrator then stated that the facility's emergency food supply will be delivered this afternoon. On 4/14/26 at 11:13 a.m., the surveyor observed that the emergency food supply had been delivered and was being stored in the back room of the kitchen's dry storage area.	F0812		
F0909 SS = E	Resident Bed CFR(s): 483.90(d)(3) §483.90(d)(3) Conduct Regular inspection of all bed frames, mattresses, and bed rails, if any, as part of a regular maintenance program to identify areas of possible entrapment. When bed rails and mattresses are used and purchased separately from the bed frame, the facility must ensure that the bed rails, mattress, and bed frame are compatible. This REQUIREMENT is NOT MET as evidenced by: Based on observations, interviews, record review, and facility policy, the facility failed to conduct regular inspection of all bed frames and mattresses as part of a regular maintenance program to ensure that the mattresses and bed frames are compatible and identify areas of possible entrapment for 4 of 4 units observed (Eagle, Regina, Sagamore, and Windmere). Finding: Facility Policy "Patient Bed Side Rails," revised 5/2/25 states, "...The following areas of entrapment will be checked when the bed is in the flat position...Zone #7 between the head and foot board and the mattress end will not exceed more than 4 ¾ inches... Zones 5, 6 and 7 will be measured in accordance with the measurements for zones 1-4	F0909	F0909 Resident Bed A mattress extender was implemented at the end of each bed needed to correct the gap. Maintenance Director / designee completed a house audit to measure zone #7 on every bed within the center.	

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F0909 SS = E	Continued from page 16 until such time as new recommendations are made by the FDA [Food and Drug Administration]...All the beds in the facility will be checked annually using the Bed Assessment Tool to Prevent Entrapment, and when there is a change in side rail status. .." On 04/12/26 at 10:59 a.m., a surveyor observed Resident #7 asleep in his/her bed with his/her head at the foot end of the bed. During a repeat observation on 4/12/26 at 2:56 p.m., the surveyor observed a large gap between Resident #7's mattress and the footboard of the bed, creating an area of possible entrapment On 4/12/26 from 3:23 p.m. to 3:34 p.m., 3 surveyors observed large gaps between the mattress and the footboard on the following beds: - Windmere Unit: Rooms 100 Door (D), 106 D, 107 Window (w), 108 W, 109 W - Eagle Unit: Room 36 W - Sagamore Unit: Room 8W - Regina Unit: Rooms 18 D, 20 D On 4/12/26 at 3:38 p.m., during an interview with the Administrator, 3 surveyors discussed the above observations. At this time, the Administrator stated that the improperly fitting mattresses are something the facility has identified and has been auditing and actively working on replacing. The surveyors then requested evidence of the facility's audits and bed gap measurements. On 4/13/26 at 10:24 a.m. during an interview with the Regional Engineering Director and the Administrator in the presence of 4 surveyors, the Regional Engineering Director stated that the facility inspects zone 1-4 annually and provided a binder containing the facility's measurements. The Administrator was unable to provide evidence of the facility's original audit to the survey team and stated that a facility-wide audit was completed this morning. A review of the provided "Bed System Measurement Device Test Results Worksheet" revealed that only 10 beds were measured in 2024, only 6 beds were measured 9/25/25, and lacked evidence of annual measurements.	F0909	Staff Development Coordinator / designee will educate maintenance staff and clinical staff to ensure that a mattress extender is in place at all times for beds that have a gap at the foot of the mattress. Administrator will educate maintenance staff to measure all beds within the center annually. The Maintenance Director / designee will complete random audits daily Monday through Friday of the bed gap x3 months. The results of these audits will be reviewed with the QAPI committee monthly x3 months to ensure compliance is maintained. The Administrator is responsible for compliance.	05/27/26
F0550 SS = D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights.	F0550		

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F0550 SS = D	Continued from page 17 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. §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 and interviews, the facility failed to provide care to residents in a manner that maintains each resident's dignity by failing to serve all residents seated at the same table at the same time for 1 of 2 dining observations on 1 of 4 days of survey (4/12/26). Finding: On 4/12/26 between 12:07 p.m. and 12:18 p.m., a	F0550	F0550 Resident Rights The residents are being served at the same time when seated at the same table. The Unit Managers / designee has completed a house audit of dining service tray sequence delivery to ensure no other residents are affected by this practice. The Staff Development Coordinator / designee will educate facility staff on serving all residents at the same table together. The Unit Managers / designee will complete random meal service table delivery 3x / week x 60 days. The results of these audits will be reviewed with the QAPI committee monthly x2 months to ensure compliance is maintained. Director of Nurses is responsible for compliance.	05/27/26

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F0550 SS = D	Continued from page 18 surveyor observed the lunch meal service in the facility's dining room. Upon surveyor entrance to the dining room at 12:07 p.m., Residents #7 and #48 were seated at a table with Resident #29. Resident #29 had received his/her meal, and Residents #7 and #48 had not yet received their meals. Staff proceeded to deliver meals to residents at other tables in the dining room. At 12:10 p.m., Resident #7 asked Certified Nursing Assistant (CNA) #1 where their meals were and told the CNA that Resident #29 was waiting to begin eating until he/she and Resident #48 received their meal. CNA #1 replied that she was waiting for the rest of the meal trays to be delivered to the dining room, and then continued delivering meals to residents at the other tables. At 12:16 p.m. Residents #7 and #48 still had not received their meal, and Resident #48 asked a staff member when they were going to receive their meals. At this time, the staff member replied, "It's going to come out. They're really busy today." At 12:17 p.m., Resident #48 received his/her meal, followed by Resident #7. On 4/12/26 at 12:21 p.m. during an interview, CNA #2 stated that the facility recently started a new way of passing meals on the weekend and that there is supposed to be one meal cart specifically for residents seated in the dining room, but that some residents' meals ended up on the carts designated for delivery to the units. On 4/13/26 at 3:40 p.m. the surveyor discussed the above observation with the Administrator. During an interview at this time, the Administrator stated that until recently, all residents were eating in their rooms, except residents who require special assistance with meals, and that this is only the second day of implementing meal delivery in the dining room on the weekends.	F0550		
F0580 SS = D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical,	F0580		

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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
F0580 SS = D	Continued from page 19 mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is NOT MET as evidenced by: Based on record review, interview and facility policy, the facility failed to ensure the physician was notified of a significant change and/or incident for 1 of 3 residents reviewed for hospitalizations. (Resident #91)	F0580	F0580 Notification of Changes Resident #91 was discharged home. The Assistant Director of Nurses / designee completed a house audit of residents sent to the hospital with a change in condition in the last 2 weeks to ensure no other residents were affected by this practice. The Staff Development Coordinator / designee will complete education with license nurse on policy / procedure for change in condition. The Assistant Director of Nurses / designee will complete a random daily audit Mon-Fri x2 month then weekly x1 months of residents sent to the hospital with a change in condition / provide notification. The results of these audits will be reviewed with QAPI committee monthly x3 months to ensure compliance is maintained. The Director of Nurses is responsible for compliance.	05/27/26

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 205095	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/16/2026

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F0580 SS = D	Continued from page 20 Findings: Facility policy titled "Change of Condition Notification" states "The facility will inform the resident, consult with the resident's healthcare provider, and if known, notify the resident's legal representative or family member when there is... A significant change in the resident's physical, mental, or psychosocial status... A decision to transfer the resident from the facility". Under the section titled Procedure it states " Physician/family notification must be documented in the electronic health record". A review of Resident #91's clinical record shows a progress note dated 2/16/25 at 1:59 p.m., which stated "Patient lethargic this afternoon. Patients unable to answer simple questions. Vitals signs reflect an infectious process. BP (blood pressure) 159/88, p (pulse) 108, temp 99.1, oxygen saturation 88% on RA (room air) .... Is appearing to be off [his/her] baseline. Writer will contact on-call. Writer applied supplemental oxygen at 2 L/m (liters per minute) ... Patient has a history of Urosepsis." Progress note dated 2/16/25 at 2:19 p.m., stated, "Writer spoke with on-call [provider] orders from provider are as follows. CBC (complete blood count), CMP (comprehensive metabolic panel), procalcitonin, and UA (urine analysis) STAT (urgent). Start Augmentin 875 mg for 5 days. Start NS (normal Saline) at 75 ml/hr (milliliter/per hour) for 1 bag. Start neuro checks. Notify on call for any changes in condition". Further review of the clinical record showed a progress note dated 1/16/25 at 3:13 p.m. which stated, ... resident unable to swallow antibiotic... writer unable to start IV (intravenous) due to lack of supplies... Writer entered labs into PCC (point click care) for lab draw on Monday morning due to lab drop off center being closed on Sunday... Another progress note on 2/16/25 at 4:34 p.m., stated "Temp is up to 101.2, POA (power of attorney) wants patient send to hospital. Patient sent out to the ED (Emergency Department) for further evaluation via EMS (Emergency Medical Services) for AMS (Altered Mental Status), abnormal vitals, and increased weakness." A review of the resident's entire clinical record lacked evidence that the provider was notified regarding the residents further change in condition after he/she was initially seen by the provider along with the inability to obtain stat labs, lack of supplies needed to start an IV, and the resident's inability to swallow the antibiotics. On 4/14/26 at 9:05 a.m., in an interview with the	F0580		

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F0580 SS = D	Continued from page 21 Facility Administrator, it was confirmed that the physician was not notified of the residents further change in condition.	F0580		
F0628 SS = D	Discharge Process CFR(s): 483.15(c)(2)(iii)(3)-(6)(8)(d)(1)(2); 483.21(c)(2) §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and	F0628	F0628 Discharge Process The Director of Social Services / designee has completed a house audit of residents who have been transferred or discharged in the last 2 weeks to ensure no other residents were affected by this practice. The Staff Development Coordinator / designee will educate licensed nurses, social services and administration on the facility transfer discharge process. The Director of Social Services / designee will complete random audits daily Monday through Friday of transfer discharge notices and bed hold x1 month and then weekly x2 months. The results of these audits will be reviewed with the QAPI committee monthly x3 months to ensure compliance is maintained. The Administrator is responsible for compliance.	05/27/26

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F0628 SS = D	Continued from page 22 (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and	F0628		

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F0628 SS = D	Continued from page 23 telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility;	F0628		

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F0628 SS = D	Continued from page 24 (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). This REQUIREMENT is NOT MET as evidenced by: Based on record review and interview, the facility failed to issue a written transfer/discharge notice and a bed hold notice to include cost of care and a statement of the resident's appeal rights to the legal representative for 1 of 5 sampled residents reviewed for transfer to an acute care hospital (Resident #77). Finding: 1. Documentation in Resident #77's clinical record indicated that he/she was transferred to an acute care hospital on 1/15/26 and on 4/12/26. Further review of Resident #77's clinical record lacked	F0628		

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F0628 SS = D	Continued from page 25 evidence that the facility issued a written transfer and discharge notice and bed hold notice to the resident's representative for the above dates. On 4/15/26 at 2:19 p.m. during an interview in the presence of 4 surveyors, the Business Office Manager confirmed that she does not issue a written transfer/discharge notice and bed hold notice to resident representatives.	F0628		
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 observations, record review, and interviews, the facility failed to ensure physician orders were followed for 1 of 1 resident receiving oxygen therapy (Resident #11). Finding: On 4/12/26 at 9:09 a.m. and 11:48 a.m., a surveyor observed Resident #11 asleep in bed, wearing oxygen (O2) via a nasal cannula with the oxygen concentrator flow rate set between 3.5 and 4 liters per minute. A review of Resident #11's clinical record revealed an active physician order for "Oxygen at 2 liters per minute continuous via nasal cannula...every shift for shortness of breath." On 4/13/26 at 3:59 p.m., during an interview, Resident #11 stated that staff hand him/her the oxygen tubing and that he/she puts it on and takes it off, but that staff make all adjustments to the oxygen concentrator settings. On 4/14/26 at 8:45 a.m., the surveyor observed Resident #1 asleep in bed wearing oxygen with the oxygen concentrator flow rate set to 2.5 liters per minute.	F0695	F0695 Respiratory Care Resident #11 is receiving oxygen liter flow per Provider orders. The Unit Managers / designee has completed a house audit of residents with oxygen orders to ensure no other residents were affected by this practice, also auditing if residents are removing or changing flow rate to ensure care plan interventions are in place. The Staff Development Nurse / designee will educate facility nursing staff on oxygen administration per provider orders. If the resident is removing oxygen or adjusting flow rate document in medical record care plan interventions regarding education on risk of not following oxygen order. The Unit Managers / designee will complete random daily audits Mon-Fri x3 months of residents with oxygen orders and care plan interventions on resident who choose to remove or adjust flow rate. The results of these audits will be reviewed with the QAPI committee monthly x3 months to ensure compliance is maintained. The Director of Nurses is responsible for compliance.	05/27/26

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F0695 SS = D	Continued from page 26 On 4/15/26 at 11:45 a.m., during a repeat observation, Resident #11 was lying in bed and was not wearing oxygen, and his/her oxygen concentrator was powered off. During an interview at this time, Resident #11 stated that he/she does not need to wear his/her oxygen today. On 4/15/26 at 1:55 p.m.. the surveyor discussed the order for continuous oxygen at 2 liters per minute and the above observations during an interview with the Director of Nursing (DNS). At this time, the DNS stated that the providers definitely do not want Resident #11's oxygen to be worn "as needed," but that it is within Resident #11's rights to remove his/her oxygen and that he/she often does. The surveyor then discussed that Resident #11's clinical record, such as nursing progress notes and/or care plan, does not reflect Resident #11's frequent removal of the oxygen. On 4/15/26 at 3:49 p.m., the surveyor discussed the finding with the Administrator and the Regional Director of Operations.	F0695		
F0868 SS = D	QAA Committee CFR(s): 483.75(g)(1)(i)-(iii)(2)(i); 483.80(c) §483.75(g) Quality assessment and assurance. §483.75(g) Quality assessment and assurance. §483.75(g)(1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of: (i) The director of nursing services; (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; and (iv) The infection preventionist. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must:	F0868	F0868 QAA The Infection Preventionist is attending Quality Assurance committee meeting quarterly. House audited completed of QAPI meeting attendance for the last month by the Administrator. The Administrator / designee has educated QAPI committee members on the attendance requirements The Administrator / designee will complete monthly QAPI meeting attendance audits x12 months. The results will be reviewed monthly with QAPI committee members to ensure compliance is maintained. Administrator is responsible for compliance.	05/27/26

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F0868 SS = D	Continued from page 27 (i) Meet at least quarterly and as needed to coordinate and evaluate activities under the QAPI program, such as identifying issues with respect to which quality assessment and assurance activities, including performance improvement projects required under the QAPI program, are necessary. §483.80(c) Infection preventionist participation on quality assessment and assurance committee. The individual designated as the IP, or at least one of the individuals if there is more than one IP, must be a member of the facility's quality assessment and assurance committee and report to the committee on the IPCP on a regular basis. This REQUIREMENT is NOT MET as evidenced by: Based on review of the quarterly Quality Assurance Committee meeting attendance sheets and interview, the facility failed to provide evidence that all required members attended for 2 of the 4 quarterly meetings held. Finding: A review of the Quarterly Quality Assurance Committee meeting attendance sheets indicated that the facility's Infection Preventionist did not attend the required quarterly meetings on 4/21/25 and 1/3/26. On 4/15/26 at 12:30 p.m., in an interview with a surveyor, the Administrator confirmed the Infection Preventionist did not attend the two quarterly meetings.	F0868		