STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175563	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AZRIA HEALTH WICHITA	7057 WEST VILLAGE CIRCLE , WICHITA, Kansas, 67205

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F0000	INITIAL COMMENTS The following citations represent the findings of a Health Recertification Survey and complaint survey regarding allegations in 2726467, 2725767, 2726421, 2716705, 2693217, and 2749367.	F0000		
F0552 SS = D	Right to be Informed/Make Treatment Decisions CFR(s): 483.10(c)(1)(4)(5) §483.10(c) Planning and Implementing Care. The resident has the right to be informed of, and participate in, his or her treatment, including: §483.10(c)(1) The right to be fully informed in language that he or she can understand of his or her total health status, including but not limited to, his or her medical condition. §483.10(c)(4) The right to be informed, in advance, of the care to be furnished and the type of care giver or professional that will furnish care. §483.10(c)(5) The right to be informed in advance, by the physician or other practitioner or professional, of the risks and benefits of proposed care, of treatment and treatment alternatives or treatment options and to choose the alternative or option he or she prefers. This REQUIREMENT is NOT MET as evidenced by: The facility identified a census of 65 residents. The sample included 16 residents with five residents sampled for unnecessary medications. Based on observation, interview, and record review, the facility failed to inform Resident (R) 27 or her representative about the risk and benefits of taking an antianxiety (a class of medications that calm and relax people), antidepressant (a class of medications used to treat mood disorders), and antipsychotic (a class of medications used to treat major mental conditions that cause a break from reality).	F0552		

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

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

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F0552 SS = D	Continued from page 1 Findings included: - R27's Electronic Medical Record (EMR) revealed the following diagnoses: anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), depressive disorder (major mood disorder that causes persistent feelings of sadness), and drug induced dyskinesia (inability to execute voluntary movements) R27's 07/19/25 “Annual Minimum Data Set" (MDS), documented a Brief Interview for Mental Status (BIMS) of 15, indicating intact cognition. The MDS recorded R27 took an antipsychotic, antidepressant, and antianxiety medications. R27’s “Psychotropic Drug Use CAA" documented R27 received high risk medications; two antidepressants and anti-anxiety medications on one or more days of the lookback period. Risk factors included falls and injuries related to falls. R27’s "Care Plan" documented R27 took an antidepressant for depression, dated 10/13/23. The plan noted R27 took an antianxiety medication for anxiety, dated 12/05/23, and directed staff to educate her family and her on the risks and benefits and the side effects of the medication. R27’s "Care Plan" documented she took an antipsychotic medication, dated 07/18/24. R27’s “Physician’s Orders” documented an order for Lexapro (antidepressant) 10 milligrams (mg) one time a day for depression, start date 03/19/24. R27’s “Physician’s Orders” documented an order for haloperidol (antipsychotic) tablet 1 mg one time a day for dyskinesia. Take at 11:00 AM, start date 12/18/25. R27’s “Physician’s Orders” documented an order for trazodone 75 mg by mouth at bedtime for dyskinesias, start date 04/10/25. R27’s “Physician’s Orders” documented an order for Klonopin (antianxiety) 0.5 mg by mouth two times a day for anxiety, start date 05/30/24. R27's clinical record lacked evidence of informed consent regarding Lexapro, haloperidol Trazodone, or Klonopine. On 02/23/26 at 11:30 AM, R27 laid in bed with her oxygen on. She had just woken up, and she reported she usually slept until about 11:00 AM.	F0552		

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F0552 SS = D	Continued from page 2 On 10/07/25 at 11:37 AM, Licensed Nurse (LN) L stated she was unaware of what the policy was when a resident received psychotropic medication. On 10/07/25 at 11:38 AM, Administrative Nurse D stated that she or another nurse completed the Psychotropic Evaluation and notified the family when a new psychotropic medication was prescribed. She said the facility had a physician's assistant (PA) that completed psychiatric medication management and put in a note about the medications, but the PA did not see R27 because R27 saw an outside provider, so no notes were completed for her. Administrative Nurse D said the facility also did not do a psychotropic consent because the off-site provider would get the consent. The facility policy for "Azria Antipsychotic Medication Use", undated, documented antipsychotic medication will be prescribed at the lowest possible dose for the shortest period of time and are subject to gradual dose reduction and review.	F0552		
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;	F0628		

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F0628 SS = D	Continued from page 3 (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 (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	F0628		

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F0628 SS = D	Continued from page 4 (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 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.	F0628		

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F0628 SS = D	Continued from page 5 §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; (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,	F0628		

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F0628 SS = D	Continued from page 6 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: The facility had a census of 65 residents. The sample included 16 residents with three residents reviewed for hospitalization. Based on observation, interview, and record review, the facility failed to issue written notification as soon as practicable for transfers, for Resident (R) 5, R9, and R50. Findings included: 1. R9's Electronic Medical Record (EMR) "Nurses Note" on 02/20/26 recorded R9 was observed vomiting a reddish-brown-colored substance. R9 reported pain in his right shoulder. The nurse received orders from the provider to send this resident to the emergency room (ER) for evaluation. R9 transferred to the hospital via Emergency Medical Services (EMS) on 02/20/26. R9's EMR lacked evidence the facility provided written notification of the transfer to R9 and/or his representative. 2. R5's "Progress Notes," dated 12/25/25 at 15:58 PM, documented that a verbal order was received to send to R5 to the ER for evaluation and treatment, and R5 was sent to the hospital via emergency medical services (EMS). R5's Electronic Medical Record (EMR) lacked evidence the facility provided written notification of the transfer to R5 and/or her representative. 3. R50's "Nurses Note," dated 01/24/26 at 11:35 PM, documented the resident was hallucinating and talking to people that were not there. R50's daughter was notified and wanted the resident to be taken to the hospital. R50's Electronic Medical Record (EMR) lacked evidence the facility provided written notification of the transfer to R50 and/or her representative.	F0628		

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F0628 SS = D	Continued from page 7 During an interview on 02/24/26 at 03:12 PM, Social Services X stated that the bed hold was sent with the residents upon their transfer to the hospital and the family was notified by phone call of the transfer. Social Service X stated she was not aware that a written notification of transfer was needed for a transfer to the hospital. During an interview on 02/24/26 at 03:22 PM, Administrative Staff A stated upon a residents transfer to the hospital the transfer packet included the bed hold. Administrative Staff A then stated she had not heard of the written notification for transfers to the hospital and asked what regulation that fell under. Administrative Staff A stated that the facility would create a form that included all of the required information, and the form would be sent to the representative when a resident transferred to the hospital. The facility's policy "Azria Transfer or Discharge, Facility-Initiated," dated 2001 (October 2002), documented facility-initiated discharges require resident/representative notification, orientation, and documentation.	F0628		
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: The facility reported a census of 65 residents; the sample included five residents reviewed unnecessary medications. Based on observation, interview, and record review revealed the facility failed to monitor and respond to Resident (R) 27's lack of bowel movements. Findings included: - R27's Electronic Medical Record (EMR) revealed the following diagnoses: anxiety (mental or emotional	F0684		

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F0684 SS = D	Continued from page 8 reaction characterized by apprehension, uncertainty, and irrational fear), depressive disorder (major mood disorder that causes persistent feelings of sadness), and drug induced dyskinesia (inability to execute voluntary movements) R27's 07/19/25 “Annual Minimum Data Set" (MDS) documented a Brief Interview for Mental Status (BIMS) of 15, indicating intact cognition. R27 was always continent of bowel and did not have constipation. R27’s “Urinary Incontinence Care Area Assessment” (CAA) triggered due to R27 needing assistance with toileting and toileting hygiene and was frequently incontinent of urine. Contributing factors included a cognitive communication deficit. R27’s 01/19/26 “Quarterly MDS” documented a BIMS of 14, indicating intact cognition. R27 was always continent of bowel and did not have constipation. R27’s "Care Plan" documented R27 took an antidepressant for depression dated 07/20/23 and directed staff to monitor for side effects which included constipation. R27’s “Physician Orders” in the EMR documented an order to follow the bowel routine as per the facility protocol dated 07/12/23. R27’s “Physician Orders” in the EMR documented an order for Prune juice 4-8 ounces daily as needed for constipation, dated 07/12/23. R27’s “Physician Orders” in the EMR documented an order for Milk of Magnesia 400 milligrams (mg) per five milliliters (ml). Give 30 ml daily as needed, dated 07/12/23. R27’s “Physician Orders” in the EMR documented an order for Fleet Enema every 24 hours as needed for constipation, dated 07/12/23. Review of R27's bowel movement frequency under the “Tasks” in the EMR, dated 0/27/26 through 02/25/26, revealed the resident exceeded three days/72 hours without a bowel movement and/or treatment from 02/02/26 at 12:52 AM until 02/08/26 at 05:07 PM (six consecutive days) with no medication given for constipation and no assessment documented. Review of R27’s “Progress Notes” revealed no documentation of assessment or treatment for constipation during that time.	F0684		

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F0684 SS = D	Continued from page 9 On 02/25/26 at 10:06 AM, Licensed Nurse (LN) said the nurse monitored the residents for bowel movements. The nurse received an alert if a resident goes 3 days without a bowel movement. The nurse follows the standing orders for the bowel movement protocol. On 02/25/26 at 10:48 AM, Administrative Nurse D stated the nurse monitored the residents for bowel movements. If there was no bowel movement the nurse assessed the resident and should document the assessment. Then the nurse followed the standing orders for the bowel movement protocol. The facility's "Constipation Management Policy" documented if no bowel movement has occurred in three days, give Milk of Magnesia. If there are no results in 24 hours, give Lactulose 20ml every two hours up to three doses. If there are no results, give Dulcolax 10mg suppository. If there are no results, give a Fleet Enema. Notify provider if there are no results.	F0684		
F0685 SS = D	Treatment/Devices to Maintain Hearing/Vision CFR(s): 483.25(a)(1)(2) §483.25(a) Vision and hearing To ensure that residents receive proper treatment and assistive devices to maintain vision and hearing abilities, the facility must, if necessary, assist the resident- §483.25(a)(1) In making appointments, and §483.25(a)(2) By arranging for transportation to and from the office of a practitioner specializing in the treatment of vision or hearing impairment or the office of a professional specializing in the provision of vision or hearing assistive devices. This REQUIREMENT is NOT MET as evidenced by: The facility reported a census of 65 residents; the sample included 16 residents which included one resident reviewed for communication-sensory. Based on observation, interview, and record review the facility failed to provide necessary hearing treatments and failed to maintain the hearing devices for Resident (R) 21. Findings included:	F0685		

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F0685 SS = D	Continued from page 10 -R21's Electronic Health Record (EHR) revealed a diagnosis of cognitive communication deficit (an impairment in organization, sequencing, attention, memory, planning, problem-solving, and safety awareness), and a need for assistance with personal care. R21's "Quarterly Minimum Data Set (MDS)," dated 11/25/25, documented a Brief Interview for Mental Status (BIMS) score of 15, which indicated intact cognition. The assessment documented R21 was independent for putting on his footwear. He needed supervision or touching assistance for bathing and required set-up or clean-up assistance for all other activities of daily living (ADL). The assessment also documented that R21 had highly impaired hearing. R21's "Care Plan (CP)," had a revised intervention, dated 04/06/22, which instructed staff to anticipate and meet R21's needs, as needed. R21's CP, dated 12/03/25, lacked documentation related to his impaired hearing. R21 had an audiology (hearing) report, dated 12/22/25, which documented R21 had impacted cerumen (earwax). The facility's "Team Health: Standing Orders for Skilled Nursing & Long-Term Care Units," dated 04/24/24, documented a standing order for Cerumen Impaction-Debrox (a medication used to remove excessive ear wax) 5-6 drops twice daily for three days and then flush the ears with warm water and a bulb syringe. R21's EHR revealed a standing order, dated 12/23/25, for Debrox Solution 6.5 %, instill five drops in both ears one time a day for wax build up for three days. May use up to 10 drops per instillation. Flush the affected ear with water at end of third day. R21's December 2025 "Medication Administration Record (MAR)" revealed that Debrox solution had been administered on 12/03/25, 12/04/25, 12/05/25, 12/23/25, 12/24/25, 12/25/25 and 12/26/25. Review of R21's progress notes lacked documentation that the facility assessed effectiveness of the Debrox treatments performed in December 2025. R21's MAR for January 2026 and February 2025 lacked evidence that he received Debrox treatments. Observed on 02/23/26 10:58 AM, R21 would move closer, and he kept tilting and turning his head from side to	F0685		

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F0685 SS = D	Continued from page 11 side when he was asked questions. R21 reported he had trouble hearing and it was due to wax build up in his ears. On 02/24/26 at 08:43 AM, R21 reported he had hearing aids, but they did not work. He also reported that staff would clean his hearing aids occasionally, but not recently. On 02/24/26 at 11:54 AM, Certified Nurse Aide (CNA) M stated she would make sure hearing aids were functional when she assisted the resident with cares, and if they did not work, she would then notify the nurse. CNA M also said that if the hearing aids worked and the resident still could not hear, she would then notify the nurse, and the nurse would then clean the resident's ears. On 02/24/26 at 12:03 PM, Licensed Nurse (LN) H, stated that she would verify that hearing aids worked and if there was an issue with them, she would notify the director of nursing (DON). LN H also said that R21's ears were cleaned regularly. On 02/24/26 at 12:13 PM, administrative Nurse D stated that she expected staff to have provided daily verification that the hearing aids were fully operational. Administrative Nurse D also said that if there was a problem with the hearing aids, staff were expected to notify the assistant director of nursing (ADON) or DON for coordination to repair or replace the hearing aids. She also said that it was expected that nursing would monitor and report any hearing concerns to the provider. The facility policy "Hearing Impaired Resident, Care of," dated February 2018, documented staff would assist the resident (or representative) with locating available resources, scheduling appointments and arranging transportation to obtain needed services. The policy also documented that staff would assist residents with care and maintenance of hearing devices.	F0685		
F0694 SS = D	Parenteral/IV Fluids CFR(s): 483.25(h) § 483.25(h) Parenteral Fluids. Parenteral fluids must be administered consistent with professional standards of practice and in accordance with physician orders, the comprehensive person-centered care plan, and the resident's goals and preferences.	F0694		

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F0694 SS = D	Continued from page 12 This REQUIREMENT is NOT MET as evidenced by: The facility identified a census of 91 residents. The sample included 19 residents with one resident received for an intravenous catheter (IV-catheter placed in a vein to administer medications or fluids directly into the bloodstream). Based on observation, record review, and interviews, the facility failed to provide IV care and services consistent with standards of practice when staff did not assess, identify and take actions for Resident (R) 69's soiled IV dressing and failed to use adequate infection control practices during IV medication administration. Findings included: - R69's Electronic Medical Record (EMR) included diagnoses of urinary tract infection (UTI) and hypertension (high blood pressure). R69 "Annual Minimum Data Set" (MDS) was still in progress. R69's "Care Plan," dated 02/20/26, instructed the Licensed Nurse (LN) to change the midline dressing every Thursday. The plan instructed staff to observe and report concerns of infection to the physician and administer prescribed medication per physician order. Staff were to monitor for signs and symptoms of infection, pain, redness, infiltration (the leaking of IV fluids or medications into surrounding tissue instead of the vein), bruising, embolism (an obstruction in a blood vessel due to a blood clot or other foreign matter that gets stuck while traveling through the bloodstream), phlebitis (a vein near an IV insertion becomes inflamed, red, or swollen), fluid overload (where the body retains excessive fluid, affecting organ function) electrolyte imbalance (the levels of minerals in your body are too high or too low disrupting essential bodily functions) and monitor for signs and symptoms of adverse reactions; report any adverse reactions to the medical doctor (MD). R69's "Physician Orders," dated 02/20/26, ordered to change the midline dressing every Thursday. The orders did not indicate an as needed (PRN) dressing change was ordered. R69's "Physician Orders," dated 02/20/26, ordered to monitor for signs and symptoms of infection, pain, redness, infiltration, bruising, embolism, phlebitis, fluid overload, and electrolyte imbalance two times a day.	F0694		

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F0694 SS = D	Continued from page 13 R69's "Physician Orders," dated 02/19/26, ordered ertapenem sodium solution (antibiotic) one gram IV one time a day for UTI for thirteen days. R69's "Physician Orders," dated 2/20/26, ordered Heparin (an injectable blood thinner used to prevent and treat blood clots), flush solution with 10 unit/milliliter (ml) use 5 ml IV one time a day for antibiotic use flush with normal saline prior to administration and after administration. Add Heparin to line after second normal saline. R69's February 2026 "Medical Administration Record" (MAR) and "Treatment Administration Record" (TAR) showed staff documented for signs and symptoms of infection, pain, redness, infiltration, bruising, embolism, phlebitis, fluid overload, and electrolyte imbalance two times a day. R69's February 2026 MAR/TAR lacked evidence staff monitored the dressing status for cleanliness and if the dressing was intact. Review of R69's "Progress Notes" and "N ADV Skilled Evaluation," reviewed from 02/20/26 through 02/25/26, lacked documentation or evidence staff assessed R69's midline dressing. On 02/23/26 at 09:45 AM, R69 laid in bed wearing a nebulizer mask. The nebulizer treatment chamber was empty. He appeared to be sleeping. Further observation revealed a single lumen midline IV to his right upper arm. The undated dressing had a large amount of blood collected under the dressing and the blood had seeped through the soft cloth border on the dressing. The blood was dried. On 02/24/26 at 02:20 PM, Licensed Nurse (LN) Q prepared to administer R69's IV antibiotic. She washed her hands and done gloves and a gown. After applying the gloves, she placed her hand in her pocket to retrieve supplies. Wearing the same gloves, she wiped the IV hub site with an alcohol wipe then allowed the hub to rest back on R69's arm. LN Q then began untangling the IV line, touched her hair, and removed items from her pocket multiple times. Wearing the same gloves, LN Q connected the IV tubing to the hub. Upon questioning the dressing, LN Q stated that she felt it needed changed as it had dried blood soaked through the bottom portion of the dressing and it was loose. She stated that the Registered Nurse (RN) manager changed the dressing on its scheduled day. She stated that if the dressing was soiled, she could change it if there was a PRN order to	F0694		

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F0694 SS = D	Continued from page 14 do so. She stated if there was not a PRN order, and the dressing needed to be changed, she would call the physician and get an order to change it. LN Q verified there was no date on the IV dressing. LN Q then removed her gloves and gown, performed hand hygiene and exited the room. On 02/25/26 at 08:42 AM, R69's dressing was unchanged from the previous day. The dried blood remained on the cloth portion of the bottom part of the dressing. The bottom seal of dressing was loose. The top of the dressing was still reinforced. On 02/25/26 at 11:00 AM, LN J stated R69's dressing was scheduled to be changed on Thursdays. She confirmed there was dried blood on the soft cloth portion of the dressing and verified the dressing needed to be changed. After reviewing R69's orders, LN J confirmed there was not a PRN order to change the dressing if soiled and stated she would call the provider because the dressing did need to be changed. On 02/25/26 at 10:00 AM, Licensed Nurse (LN) I stated hand hygiene and glove changes should be performed when touching something dirty prior to touching something clean. On 02/25/26 at 10:48 AM, Administrative Nurse D stated she expected to always do good hand hygiene and change gloves when they touch anything dirty. On 02/25/26 at 11:50 AM, Administrative Nurse D stated IV sites should be assessed daily and the assessment should always include the dressing. She stated she expected midline dressings to be changed to Monday, Wednesday and Fridays and as needed. She stated if the dressing needed to be changed and there was no order, the nurses should contact the physician to obtain the order. She confirmed that if they assess it while administering medication, they should be documenting the site and dressing condition. She expected them to change it if it was soiled. The facility policy "…Peripheral IV Catheter and Site Selection" documented the purpose of the policy was to select the most appropriate intravenous access device for the resident's condition. The policy did not address the care and monitoring of the site and the dressing.	F0694		
F0732 SS = C	Posted Nurse Staffing Information CFR(s): §483.35(g)(1)-(4)	F0732		

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F0732 SS = C	Continued from page 15 §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents, staff, and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.	F0732		

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F0732 SS = C	Continued from page 16 §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is NOT MET as evidenced by: The facility reported a census of 65 residents. Based on observation, interview, and record review, the facility failed to ensure the posted daily nurse staffing sheets included accurate and identifiable information to include the actual hours worked, as required. Findings included: - Observed on 02/23/26 at 08:00 AM, the posted staffing sheet lacked the actual hours worked Observed on 02/24/26 at 07:30 AM, the posted staffing sheet lacked the actual hours worked. Review of the daily staffing sheets from 12/21/24 and 07/21/25 revealed that the staffing sheets lacked the actual hours worked. On 02/24/26 at 09:47 AM, Administrative Staff A stated that the staffing coordinator, Certified Medication Aide (CMA) R, had been responsible for the posting and accuracy of the daily staffing sheets. On 02/24/26 at 09:57 AM, CMA R stated that she had provided the staffing numbers to the receptionist and the receptionist then printed the daily staffing sheet and posted it in the lobby. CMA R verified that the actual hours worked had not been listed on the posted daily staffing sheets. On 02/24/26 at 11:46 AM, Administrative Staff A confirmed that the posted daily staffing sheets did not include the actual hours worked for the resident care medical staff. The facility policy “Posting Direct Care Daily Staffing Number,” dated July 2016, documented that the shift staffing information would be recorded the Nursing Staff Directly Responsible for Resident Care for each shift. The policy also documented that the information recorded on the form would include the name of the facility, the date for which the information was posted, the resident census at the beginning of the shift, the 24-hour shift schedule operated by the facility, the shift for which the information was	F0732		

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F0732 SS = C	Continued from page 17 posted, the type and category of nursing staff who was working that shift, the actual time worked during that shift for each category and type of nursing staff, and the total number of licensed and non-licensed nursing staff working for the posted shift.	F0732		
F0756 SS = D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident.	F0756		

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F0756 SS = D	Continued from page 18 This REQUIREMENT is NOT MET as evidenced by: The facility identified a census of 65 residents. The sample included 16 residents with five sampled residents reviewed for unnecessary medications. Based on observation, record review, and interview, the facility failed to ensure the Consultant Pharmacist (CP) identified and reported when Resident (R) 3's antihypertensive medications were given outside of the physician ordered hold parameters. Findings included: - R3's Electronic Medical Record (EMR) documented diagnoses of hypertension (HTN- elevated blood pressure) and congestive heart failure (CHF-a condition with low heart output and the body becomes congested with fluid). R3's "Admission Minimum Data Set" (MDS), dated 10/09/25, documented a Brief Interview for Mental Status (BIMS) score of 12, which indicated a moderately impaired cognition. R3 was dependent on staff for her activities of daily living (ADLs). R3 received an anticoagulant (a class of medications sued to prevent the blood from clotting) and a diuretic (a class of medications sued to prevent the blood from clotting). R3's "Functional Abilities Care Area Assessment" (CAA), dated 10/16/25, documented her care plan would be developed to improve the highest practical level the ADL functional abilities, optimize comfort, and plan to have caregivers assist with ADLs as needed. R3's "Care Plan," revised on 11/03/25, directed staff to administer medications as ordered. The plan directed staff to obtain vital signs at least daily per physician's orders and as needed and notify the physician of any abnormal readings. R3's "Orders" tab of the EMR documented a physicians order, dated 10/16/25, for isosorbide mononitrate (medication used to treat high blood pressure) 30 milligram (mg) tablet give one tablet by mouth one time a day for HTN; hold medications if pulse less than 50 beats per minute (BPM) or greater than 120 BPM; hold if blood pressure (BP) was less than 120/40 or greater than 200/90 millimeters of mercury (mm/Hg). R3's "Orders" tab of the EMR documented a physicians order, dated 10/16/25, for amlodipine besylate (medication used to treat high blood pressure) 10 mg to give one tablet by mouth one time a day for HTN; hold medications if pulse was less than 50 BPM or greater	F0756		

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F0756 SS = D	Continued from page 19 than 120 BPM; hold if BP was less than 120/40 or greater than 200/90 mm/Hg. Review of R3's November 2025 "Medication Administration Record" (MAR) revealed the amlodipine was given outside of the physician ordered parameters on six of 30 opportunities. Review of R3's November 2025 MAR revealed her physician ordered antihypertensive isosorbide mononitrate was given outside of the ordered parameters on six of 30 opportunities. Review of R3's December 2025 MAR revealed her physician ordered amlodipine was given outside of the physician ordered parameters on 12 of 30 opportunities. Review of R3's December 2025 MAR revealed her physician ordered isosorbide mononitrate was given outside of the physician ordered parameters on 12 of 30 opportunities. Review of R3's January 2026 MAR revealed her physician order antihypertensive medication amlodipine was given outside of the physician ordered parameters on 15 of 30 opportunities. Review of R3's January 2026 MAR revealed her physician ordered antihypertensive isosorbide mononitrate was given outside of the physician ordered parameters on 15 of 30 opportunities. Review of R3's February 2026 MAR revealed R3's amlodipine was given outside of the physician ordered parameters on five of 24 opportunities Review of R3's February 2026 MAR revealed her physician ordered antihypertensive isosorbide mononitrate was given outside of the physician ordered parameters on five of 24 opportunities. The CP "Medication Regimen Review" (MRR) for R3 from January 2025 to present lacked identifying or reporting that antihypertensive medications amlodipine and isosorbide were given outside of the physician order parameters. On 02/24/26 at 08:13 AM, R3 sat in her wheelchair upon her return to the facility after an appointment. Staff propelled her to the dining table for breakfast. On 02/24/26 at 08:24 AM, Consultant GG stated that although the physician parameters for R3's BP medications were not hers, she interpreted them as the medications that should be held if any reading or the	F0756		

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F0756 SS = D	Continued from page 20 pulse were below or above the ordered numbers. Consultant GG stated she would expect the CP to identify and report when the medication was not held when the BP or pulse was outside of the ordered parameters. On 02/25/26 at 08:01 AM, Certified Medication Aide (CMA) R stated she would get the BP and pulse, and if the reading was low, she would wait for a bit and retake it. CMA R stated if the BP and or pulse continued to still be low, she would notify the nurse and would hold the medication. On 02/25/26 at 08:10 AM, Licensed Nurse (LN) I stated that the physicians provided the parameters for the BP medications. LN I stated if she was the one passing medications, she would hold the medication if the BP reading or pulse was below the parameters. LN I stated she would expect CMAs to notify her when a residents BP or pulse was low and have them retake the reading before the medication was held. On 02/25/26 at 12:20 PM, Administrative Nurse D stated she expected anyone that was administering medication to hold the medication when the BP or pulse reading was outside of the ordered parameters. Administrative Nurse D stated she expected the CP to report when medications were given outside of the ordered parameters. The facility's "Pharmacy Services Overview," dated April 2019. documented the consultant pharmacist, in collaboration with the dispensing pharmacy and the facility, oversees the development of procedures related to pharmacy services, including (but not limited to): acquisition and availability of medications: receipt, labeling and storage of medications; reconciliation of medications from the pharmacy; control of medications from point of receipt to secured storage areas; and facility staff roles and responsibilities during the receipt and storage of medication; medication packaging and dispensing systems; administration of medications; disposition of medications; authorization, training and competency of personnel; and documentation of processes, as applicable.	F0756		
F0757 SS = D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when	F0757		

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F0757 SS = D	Continued from page 21 used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is NOT MET as evidenced by: The facility identified a census of 65 residents. The sample included 16 residents with five sampled residents reviewed for unnecessary medications. Based on observation, record review, and interview, the facility failed to ensure staff held Resident (R) 3's antihypertensive medications per physician's orders when R3's blood pressure (BP) and pulse measurements were outside of the physician ordered parameters. Findings included: - R3's Electronic Medical Record (EMR) documented diagnoses of hypertension (HTN- elevated blood pressure) and congestive heart failure (CHF-a condition with low heart output and the body becomes congested with fluid). R3's "Admission Minimum Data Set" (MDS), dated 10/09/25, documented a Brief Interview for Mental Status (BIMS) score of 12, which indicated a moderately impaired cognition. R3 was dependent on staff for her activities of daily living (ADLs). R3 received an anticoagulant (a class of medications sued to prevent the blood from clotting) and a diuretic (a class of medications sued to prevent the blood from clotting). R3's "Functional Abilities Care Area Assessment" (CAA),	F0757		

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F0757 SS = D	Continued from page 22 dated 10/16/25, documented her care plan would be developed to improve the highest practical level the ADL functional abilities, optimize comfort and plan to have caregivers assist with ADLs as needed. R3's "Care Plan," revised on 11/03/25, directed staff to administer medications as ordered. The plan directed staff to obtain vital signs at least daily per physician's orders and as needed and notify the physician of any abnormal readings. R3's "Orders" tab of the EMR documented a physicians order, dated 10/16/25, for isosorbide mononitrate (a medication used to treat high blood pressure) 30 milligram (mg) tablet give one tablet by mouth one time a day for HTN; hold medications if pulse less than 50 beats per minute (BPM) or greater than 120 BPM; hold if blood pressure (BP) was less than 120/40 or greater than 200/90 millimeters of mercury (mm/Hg). R3's "Orders" tab of the EMR documented a physicians order, dated 10/16/25, for amlodipine besylate (a medication used to treat high blood pressure) 10 mg to give one tablet by mouth one time a day for HTN; hold medications if pulse was less than 50 BPM or greater than 120 BPM; hold if BP was less than 120/40 or greater than 200/90 mm/Hg. Review of R3's November 2025 "Medication Administration Record" (MAR) revealed the amlodipine was given outside of the physician ordered parameters on six of 30 opportunities. Review of R3's November 2025 Medication Administration Record (MAR) revealed her physician ordered antihypertensive isosorbide mononitrate was given outside of the ordered parameters on six of 30 opportunities. Review of R3's December 2025 MAR revealed her physician ordered amlodipine was given outside of the physician ordered parameters on 12 of 30 opportunities. Review of R3's December 2025 MAR revealed her physician ordered isosorbide mononitrate was given outside of the physician ordered parameters on 12 of 30 opportunities. Review of R3's January 2026 MAR revealed her physician order antihypertensive medication amlodipine was given outside of the physician ordered parameters on 15 of 30 opportunities. Review of R3's January 2026 MAR revealed her physician ordered antihypertensive isosorbide mononitrate was	F0757		

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F0757 SS = D	Continued from page 23 given outside of the physician ordered parameters on 15 of 30 opportunities. Review of R3's February 2026 MAR revealed R3's amlodipine was given outside of the physician ordered parameters on five of 24 opportunities Review of R3's February 2026 MAR revealed her physician ordered antihypertensive isosorbide mononitrate was given outside of the physician ordered parameters on five of 24 opportunities. On 02/24/26 at 08:13 AM, R3 sat in her wheelchair upon her return to the facility after an appointment. Staff propelled her to the dining table for breakfast. On 02/24/26 at 08:24 AM, Consultant GG stated that although the physician parameters for R3's BP medications were not hers, she interpreted them as the medications which should be held if any reading or the pulse were below or above the ordered numbers. On 02/25/26 at 08:01 AM, Certified Medication Aide (CMA) R stated she would get the BP and pulse and if the reading was low, she would wait for a bit and retake it. CMA R stated if the BP and or pulse continued to still be low, she would notify the nurse and would hold the medication. On 02/25/26 at 08:10 AM, Licensed Nurse (LN) I stated that the physicians provided the parameters for the BP medications. LN I stated if she was the one passing medications, she would hold the medication if the BP reading or pulse was below the parameters. LN I stated she would expect CMAs to notify her when a residents BP or pulse was low and have them retake the reading before the medication was held. On 02/25/26 at 12:20 PM, Administrative Nurse D stated she expected anyone that was administering medication to hold the medication when the BP or pulse reading was outside of the ordered parameters. The facility's "Azria Medication and Treatment Orders" policy revised July 2016 documented physician orders shall be followed, if unable to follow physician orders, notify the Director of Nursing Services/Designee and physician as appropriate.	F0757		
F0812 SS = F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements.	F0812		

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F0812 SS = F	Continued from page 24 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: The facility had one main kitchen and two kitchenette/serving areas. Based on observation, record review, and interview, the facility failed to ensure foods in the kitchen were properly labeled and stored. The facility failed to ensure food service areas, refrigerators, counters and cabinets in the kitchenettes were clean. Findings included: - Observation during the initial tour of the main kitchen on 02/23/26 at 08:04 AM revealed the following: The dry storage area had a box of cream of wheat that was opened, not dated and not in a sealed container/bag. An opened 10-pound bag of macaroni noodles that was not dated and not in a sealed bag. A half-gallon sized opened carton of rainbow sprinkles that was not dated or in a sealed container. An open bag with five hamburger buns not dated or sealed.	F0812		

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F0812 SS = F	Continued from page 25 The walk-in refrigerator had a five-pound bag of shredded cheese that was opened, not dated and not in a sealed bag, and a container with fish in it was not sealed. The kitchen serving area refrigerator had about 12 slices of cheese in plastic wrap not sealed or dated, an onion wrapped in plastic wrap contained no date, lettuce in a Ziploc bag was not dated, and a pint-sized plastic container with chicken base was opened without an open date on it. The kitchen freezer had an opened and undated bag of chicken strips which were not in a sealed bag, two opened bags of potato wedges were not dated or in sealed bag, an open box with beef patties with an open bag had no open date, an opened bag with chicken nuggets were not sealed, dated, or labeled, an opened box of corn dogs was unsealed and a few of the corn dogs had frost buildup on them. The ice machine was not working and had visible rust at the hinges of the machine. On 02/23/26 at 08:31 AM, there was trash in the dining kitchenette area on the West side. The bottom cabinet had clean folded towels stored directly on floor. The juice machine area had open single water bottle, unlabeled and undated. A juice concentrate box had a black sticky substance on bottom of it, with the expiration date illegible. A small refrigerator had a Rubbermaid food container that was undated and the inside of the refrigerator was dirty. There was an open, one third full unlabeled bottle of Coke. Further observation revealed calcium buildup on ice dispenser; black particles floating amongst ice in cooler at nurses' station, and the scoop laid on a towel where the cooler sat. On 02/23/26 at 09:40 AM, an observation of the East dining room revealed calcium buildup on the juice machine, and juice splatter behind the dispenser and on the wall next to juice machine. In the small refrigerator, there was an undated and unlabeled container with a spoon inside, partially full of some type of green dessert, and a Motts single serve applesauce, opened with no name or open date. The inside of the refrigerator was dirty. There was a container of rice casserole in a Rubbermaid container with no name or date. The lower cabinet near the drink serving area had food crumbs and particles, the second drawer had loose coffee grounds and the trash cabinet, and under the sink had discoloration from leakage, grounds, spills, and peeling laminate present with exposed wood.	F0812		

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F0812 SS = F	Continued from page 26 On 02/24/26 at 07:53 AM, the dietary aide in the West kitchenette plated food. Wearing the same pair of gloves, the aide touched the scoop of the eggs, picked up two meal tickets and set them back down on the counter, then picked up bread, touching the bread, and placed it on the plate. The aide then removed her gloves but did not perform hand hygiene. She put on new gloves and took a container of food from another staff, rearranged more meal tickets, touched the egg scoop and the hashbrown scoop, and while wearing the same gloves, picked up toast with her hands and buttered it. She set the toast down, grabbed two clean plates, then picked up the toast with the same soiled gloves and placed the toast on the plate. On 02/24/26 at10:04 AM, the West kitchen dining area ice cooler had the scoop laying directly in the ice, and dirty cups and pitcher on the cart. The cart had a sign that stated no dirty dishes on this rack. On 02/24/26 at 10:15 AM, in the East kitchenette, the condiments cabinet area had dried liquid spills and crumbs. There were baskets and food debris on floor as well as a thermometer. Under the sink was dried brown stains from liquids or leaks, and dried black chunks of an unknow substance. The trash compartment had food debris, crumbs, and laminate missing exposing raw wood. The refrigerator had a food container with a green dessert. The container had a plastic spoon in it laying on the food, and was unlabeled and undated. There was also a plastic container with rice casserole in it without a date or name who it belonged to. On 02/24/26 at 10:35 AM, the East kitchenette serving area was visibly soiled under the sink with brown and spots with black debris of unknown substance around the buckets of liquid cleaner in the cabinet below the sink. The counter had an opened bag hot dog buns with no date or label on them. The East dining area ice and water machine appeared to have rust on the drain/drip rack, and there was water deposits or calcium build up on the metal dispenser area on the outside of the machine. On 02/24/26 at 10:00 AM, observation revealed a tray of food for Resident (R) 50 sat on top of the serving table. It had a bowl of oatmeal with a plastic cover, and a plate with a plastic cover that contained eggs, bacon, and toast. On 02/24/26 at 10:50 AM, R50's tray remained on top of the service table. Dietary CC measured the temperature of the food items upon request. The temperatures were	F0812		

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F0812 SS = F	Continued from page 27 as follows: oatmeal was 95 degrees Fahrenheit (F.), the eggs were 76 degrees F., and the bacon was 77 degrees F. Dietary CC confirmed the temperatures were not appropriate holding temperatures for the food items and stated the tray would be discarded at 11:00 AM if the resident did not eat it before then. On 02/24/26 at 11:55 AM, upon request, Dietary DD discarded R50's food tray. On 02/24/26 at 11:59 AM, Dietary CC brought the food to the kitchenette area on a cart. Dietary CC put gloves on but did not perform hand washing prior to putting on the gloves. With gloved hands, Dietary CC removed the covered food containers and set them up on the steam table. Dietary CC left the steam table area and removed her gloves but did not perform hand hygiene after removal. She made a phone call, and without washing her hands or donning gloves, she resumed removing covers on food containers and placed them in servicing area. Dietary CC then placed tongs and spoons in the food containers. Without performing hand hygiene, Dietary CC then put on clean gloves and began to serve the food. On 02/25/26 at 07:48 AM, observation of the East end dining area revealed the area was still dirty; The condiments cabinet, trash cabinet, and under the sink area was unchanged from the previous day. The trash cabinet had additional trash noted. On 02/25/26 at 09:03 AM, the West side dining area was unchanged from the previous day's observations. On 02/23/26 at 08:31 AM, Dietary CC stated the dietary aides were responsible for cleaning the kitchenettes and the dining area service station. She said there was no one in the facility to clean on the weekends though so it would get messy. Dietary CC said she would clean the area. On 02/25/26 at 10:34 AM, Dietary BB stated in the kitchenettes dietary aides are to wipe down the beverage area, around the steam table, and the dining tables, before and after each meal, and as needed throughout the day. Dietary BB stated the floor-cleaning duties are shared with housekeeping, due to them getting off their shift by 6pm each night. Dietary BB stated that it was standard practice to remove the trash can while scraping plates and emptying items into trash can so that food was not spilled. The facility's "Food Receiving and Storage" policy, dated October 2017, documented food services, or other designated staff, will maintain clean food storage	F0812		

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F0812 SS = F	Continued from page 28 areas at all times. Dry foods that are stored in bins will be removed from original packaging, labeled and dated ("use by" date). Such foods will be rotated using a "first in - first out" system. All foods stored in the refrigerator or freezer will be covered, labeled and dated ("use by" date).	F0812		
F0849 SS = D	Hospice Services CFR(s): 483.70(n)(1)-(4) §483.70(n) Hospice services. §483.70(n)(1) A long-term care (LTC) facility may do either of the following: (i) Arrange for the provision of hospice services through an agreement with one or more Medicare-certified hospices. (ii) Not arrange for the provision of hospice services at the facility through an agreement with a Medicare-certified hospice and assist the resident in transferring to a facility that will arrange for the provision of hospice services when a resident requests a transfer. §483.70(n)(2) If hospice care is furnished in an LTC facility through an agreement as specified in paragraph (o)(1)(i) of this section with a hospice, the LTC facility must meet the following requirements: (i) Ensure that the hospice services meet professional standards and principles that apply to individuals providing services in the facility, and to the timeliness of the services. (ii) Have a written agreement with the hospice that is signed by an authorized representative of the hospice and an authorized representative of the LTC facility before hospice care is furnished to any resident. The written agreement must set out at least the following: (A) The services the hospice will provide. (B) The hospice's responsibilities for determining the appropriate hospice plan of care as specified in §418.112 (d) of this chapter. (C) The services the LTC facility will continue to provide based on each resident's plan of care. (D) A communication process, including how the	F0849		

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F0849 SS = D	Continued from page 29 communication will be documented between the LTC facility and the hospice provider, to ensure that the needs of the resident are addressed and met 24 hours per day. (E) A provision that the LTC facility immediately notifies the hospice about the following: (1) A significant change in the resident's physical, mental, social, or emotional status. (2) Clinical complications that suggest a need to alter the plan of care. (3) A need to transfer the resident from the facility for any condition. (4) The resident's death. (F) A provision stating that the hospice assumes responsibility for determining the appropriate course of hospice care, including the determination to change the level of services provided. (G) An agreement that it is the LTC facility's responsibility to furnish 24-hour room and board care, meet the resident's personal care and nursing needs in coordination with the hospice representative, and ensure that the level of care provided is appropriately based on the individual resident's needs. (H) A delineation of the hospice's responsibilities, including but not limited to, providing medical direction and management of the patient; nursing; counseling (including spiritual, dietary, and bereavement); social work; providing medical supplies, durable medical equipment, and drugs necessary for the palliation of pain and symptoms associated with the terminal illness and related conditions; and all other hospice services that are necessary for the care of the resident's terminal illness and related conditions. (I) A provision that when the LTC facility personnel are responsible for the administration of prescribed therapies, including those therapies determined appropriate by the hospice and delineated in the hospice plan of care, the LTC facility personnel may administer the therapies where permitted by State law and as specified by the LTC facility. (J) A provision stating that the LTC facility must report all alleged violations involving mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and	F0849		

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F0849 SS = D	Continued from page 30 misappropriation of patient property by hospice personnel, to the hospice administrator immediately when the LTC facility becomes aware of the alleged violation. (K) A delineation of the responsibilities of the hospice and the LTC facility to provide bereavement services to LTC facility staff. §483.70(n)(3) Each LTC facility arranging for the provision of hospice care under a written agreement must designate a member of the facility's interdisciplinary team who is responsible for working with hospice representatives to coordinate care to the resident provided by the LTC facility staff and hospice staff. The interdisciplinary team member must have a clinical background, function within their State scope of practice act, and have the ability to assess the resident or have access to someone that has the skills and capabilities to assess the resident. The designated interdisciplinary team member is responsible for the following: (i) Collaborating with hospice representatives and coordinating LTC facility staff participation in the hospice care planning process for those residents receiving these services. (ii) Communicating with hospice representatives and other healthcare providers participating in the provision of care for the terminal illness, related conditions, and other conditions, to ensure quality of care for the patient and family. (iii) Ensuring that the LTC facility communicates with the hospice medical director, the patient's attending physician, and other practitioners participating in the provision of care to the patient as needed to coordinate the hospice care with the medical care provided by other physicians. (iv) Obtaining the following information from the hospice: (A) The most recent hospice plan of care specific to each patient. (B) Hospice election form. (C) Physician certification and recertification of the terminal illness specific to each patient.	F0849		

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F0849 SS = D	Continued from page 31 (D) Names and contact information for hospice personnel involved in hospice care of each patient. (E) Instructions on how to access the hospice's 24-hour on-call system. (F) Hospice medication information specific to each patient. (G) Hospice physician and attending physician (if any) orders specific to each patient. (v) Ensuring that the LTC facility staff provides orientation in the policies and procedures of the facility, including patient rights, appropriate forms, and record keeping requirements, to hospice staff furnishing care to LTC residents. §483.70(n)(4) Each LTC facility providing hospice care under a written agreement must ensure that each resident's written plan of care includes both the most recent hospice plan of care and a description of the services furnished by the LTC facility to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, as required at §483.24. This REQUIREMENT is NOT MET as evidenced by: The facility identified a census of 65 residents. The sample included 16 residents with three sample residents reviewed for Hospice services. Based on record review and interview. The facility failed to ensure the collaboration of care between Resident (R) 7 and R50's hospice provider and the facility which included the hospice provider contact information, the services the hospice provider would provide to the residents, the supplies, equipment and medications the hospice provider would provide, as well as how often hospice staff members would visit the facility. Findings included: 1. R7's "Orders" tab of the Electronic Medical Record (EMR) documented a physician's order, dated 01/06/26, for a referral for hospice services. The EMR lacked an order to admit to Hospice services. R7's "Care Plan," dated 01/07/26, directed staff to adjust provision of activities of daily living (ADLs) to compensate for resident's changing abilities. The plan directed staff to encourage resident participation to the extent the resident wishes to participate. The	F0849		

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F0849 SS = D	Continued from page 32 plan directed staff to consult with physicians and Social Services to have Hospice care for residents in the facility. The plan directed staff to encourage support systems of family and friends. The plan directed staff to work cooperatively with hospice team to ensure the resident's spiritual, emotional, intellectual, physical and social needs are met. The plan directed staff to work with nursing staff/hospice staff to provide maximum comfort for the residents. R7's plan lacked staff direction on the services the hospice provider would provide to the residents, the supplies, equipment and medications the hospice provider would provide, as well as how often hospice staff members would visit the facility. On 02/23/26 at 11:20 AM, R7 sat in a high-back wheelchair in his room. He had a soft touch call light near him, on the dresser. There was a fall mat folded up and leaning against the wall. 2. R50's "Orders" tab of the EMR documented a physician's order, dated 10/15/25. R50's "Care Plan," which was revised on 02/02/26, directed staff she was on end-of-life support. The plan directed staff to have residents participate in activities as tolerated, the plan directed staff to assist with supporting ADL function of ambulation and mobility to the extent needed. The plan directed staff to keep her comfortable to the extent possible. R50's plan lacked staff direction on the services the hospice provider would provide to the residents, the supplies, equipment, and medications the hospice provider would provide, as well as how often hospice staff members would visit the facility. On 02/25/26 at 11:03 AM, Certified Nurse Aide (CNA) N stated typically the nurse would notify the aide who was on hospice. CNA N stated the nurse would tell them which days the hospice aide would be here to give the hospice resident their shower. CNA N stated she could not say what hospice provided as far as supplies and equipment, but the nurse did know. On 02/25/26 at 11:10 AM, Licensed Nurse (LN) I stated that each resident on hospice had a book that had the hospice provider's plan of care that included the medications, supplies, equipment, and when and how often hospice staff would make visits. LN I stated the hospice book had all the hospice information in it and did not feel it needed to be included in the resident's person-centered plan. On 02/25/26 at 12:10 PM, Administrative Nurse D stated	F0849		

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F0849 SS = D	Continued from page 33 she expected the nurse to inform staff when a resident was on hospice as well as telling staff what equipment, supplies and how often hospice staff would visit. Administrative Nurse D stated that the residents plan of care should include all the information such as the medications, supplies, equipment, and what hospice staff would visit and how often they would visit. Administrative Nurse D verified there was not an order for hospice in R7's EMR and stated the order was likely in the hospice binder. She stated the information in hospice's binder was not entered into the residents' EMR until after the resident passed or when the hospice event ended. The facility policy "Palliative/End-of Life Care – Clinical Protocol," dated March 2018, documented the physician and staff will identify individuals who desire or are likely candidates for palliative care; for example, those with a known terminal illness or end-stage condition (that is, a condition that has resulted in substantial functional dependency, impairment and/or medical instability and continued decline anticipated, regardless of whether medical treatments are rendered). The physician will review the resident's decision-making capacity and support the resident's participation in the plan to the extent possible. The interdisciplinary assessment of the resident and the family is the basis of the individualized plan. The assessment will include at least: documentation of disease status, including diagnosis and prognosis; documentation of co-morbid medical and/or psychiatric conditions; functional status; strengths; concerns, goals, and values of the resident and family; preferences and documentation for end-of-life decisions and care; and appropriateness of hospice referral. Comprehensive assessment will recur on a regular basis and in response to significant changes of condition, or a change in resident and family goals and wishes.	F0849		
F0880 SS = E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program.	F0880		

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F0880 SS = E	Continued from page 34 The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.	F0880		

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F0880 SS = E	Continued from page 35 §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is NOT MET as evidenced by: The facility reported a census of 65 residents. The sample included 16 residents. Based on observation, interview and record review, the facility failed to use appropriate infection control practices related to hand hygiene, respiratory equipment, Enhanced Barrier Precautions (EBP-infection control interventions designed to reduce transmission of resistant organisms which employ targeted gown and glove use during high contact care), and indwelling catheter (tube placed in the bladder to drain urine into a collection bag) care. Findings included: 1. On 02/23/26 at 10:37 AM, Resident (R)30 was in her room in bed, with the catheter bag attached to her bed. A sign for EBP was on the door. There was a bin for personal protective equipment (PPE- gowns, face shields and/or eyeglasses/goggles, and gloves), but there were no gowns in the bin. On 02/24/26 at 09:10 AM, R30 sat at the dining room table drinking her chocolate milk, the catheter bag was hanging outside of the dignity bag and catheter bag was touching the floor. On 02/24/26 at 09:20 AM, Certified Medication Aide (CMA) S assisted R30 back to her room. R30's catheter bag remained dragging on the ground as CMA S wheeled her wheelchair. On 02/25/26 at 07:42 AM, Certified Nurse Aide (CNA) N unhooked the catheter bag and placed the bag on the floor and drained the urine from the catheter tubing into the bag. CNA N then hooked the bag on the foot board above the level of the bladder. CNA P entered the room, applied gloves, and attached the bag to the bed at a lower position to be below the level of the bladder. CNA N and CNA P continued taking off R30's brief. CNA N wiped R30 several times and placed the	F0880		

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F0880 SS = E	Continued from page 36 wipes in the trash that CNA P was holding up for her. CNA N removed the soiled brief placed a fresh brief under R30 while CNA P held her to her side. They adjusted the brief and fastened it. CNA N and CNA P each took a pant leg and put her legs in the pant leg. CNA P put the catheter bag through the pant leg. Both CNAs rolled R30 as they pulled her pants up and placed the sling under her. The CNA's attached the sling and lifted her with the mechanical lift. CNA N removed R30's gown, then applied the deodorant and applied the shirt. Throughout all this there was no hand hygiene or glove changes. No gown was worn throughout the procedure. On 02/25/26 at 10:00 AM, CNA P stated she was aware that the catheter had to be below the level of the bladder. CNA P also stated that the catheter bag should never touch the floor. She said she was not aware that her gloves had to be changed and hand hygiene performed while doing cares. CNA P stated she would normally wait until she was finished with resident's care then do hand hygiene when she left. CNA P did not know if she should wear a gown when providing cares for a resident with a catheter. On 02/25/26 at 10:00 AM, Licensed Nurse (LN) I stated she expected staff to perform excellent infection control when dealing with a catheter. She stated the bag should never be above the level of the bladder and should never touch the floor; hand hygiene and glove changes should be performed when touching something dirty prior to touching something clean. 2. On 02/23/26 at 11:26 AM, R27's oxygen tubing was wrapped around the handle of her wheelchair. R27 laid in bed at that time with her oxygen on. On 02/24/26 at 08:08 AM, R27's oxygen tubing remained wrapped around the handle of her wheelchair. On 02/25/26 at 10:00 AM, CNA P stated when she assisted a resident with oxygen out of bed or transferred them to a chair or back to bed, she wound the tubing up and laid it on something. She was not aware of a bag or sanitary container to place the tubing. On 02/25/26 at 10:00 AM, LN I stated she expected staff to place oxygen tubing in a bag when not in use. On 02/25/26 at 10:48 AM, Administrative Nurse D stated she expected staff to provide good peri care and catheter care and wear the proper PPE for EBP. She said the catheter should never be above the bladder or touch the ground and staff should always do good hand hygiene	F0880		

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F0880 SS = E	Continued from page 37 and change gloves when they touch anything dirty. Administrative Nurse D said oxygen tubing should be kept in a bag when not in use to avoid contamination. The policy “Azria Catheter Care, Urinary” documented the catheter drainage bag is to be kept off of the floor. Position the catheter drainage bag lower that the bladder at all times to prevent urine from flowing back into the urinary bladder. The policy “Azria Handwashing/Hand Hygiene” documented to preform hand hygiene after removing gloves, and after touching a contaminated area of the body or coming into contact with body fluids.	F0880		