STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 535042	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Shepherd of the Valley Rehabilitation and Wellness	**60 Magnolia St , Casper, Wyoming, 82604**

(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 A recertification survey was conducted by Healthcare Licensing and Surveys from 7/27/26 through 7/30/36. Also reviewed in the course of the survey were complaint intakes 2977191, 2986702, 3038447, 3056885, 3066799, 3068460, 3093340, 3093346, 3108865, 3121764, 3121813, 3121855, 3121894, 3121912, 3121937, 3121956, 3121969, 3121994, and 3122005. The following common abbreviations are used throughout this document: ADL: Activity of Daily Living BIMS: Brief Interview for Mental Status CNA: Certified Nursing Assistant DON: Director of Nursing ED: Emergency Department LPN: Licensed Practical Nurse MA-C: Medication Aide - Certified MDS: Minimum Data Set mg: milligram RN: Registered Nurse Less commonly used abbreviations will be annotated in each deficiency.	F0000		
F0600 SS = G	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse,	F0600	"Past Noncompliance - no plan of correction required"	07/17/2026

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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F0600 SS = G	Continued from page 1 neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is NOT MET as evidenced by: Based on resident representative and staff interview, medical record review, facility incident review, and policy review, the facility failed to ensure residents were free from abuse from other residents for 1 of 8 sample residents (#37) reviewed for abuse. This failure resulted in actual harm to resident #37. The findings were: The facility had implemented corrective action prior to the survey and was determined to be in substantial compliance as of 7/17/26. 1. Review of the annual MDS assessment dated 7/24/26 showed resident #37 had a BIMS score of 3 out of 15, which indicated severe cognitive impairment, and had diagnoses which included non-Alzheimer's dementia, depression, and psychotic disorder. Further review showed the resident had behaviors of wandering daily. Review of the admission MDS assessment dated 6/11/26 showed resident #13 had a BIMS score of 10 out of 15, which indicated moderate cognitive impairment, and a patient health questionnaire-9 (PHQ-9) score of 24, which indicated severe depression. Further review showed the resident had diagnoses which included schizophrenia and a personal history of traumatic brain injury. The following concerns were identified: a. Review of an incident report dated 7/15/26 and timed 2 PM showed a CNA observed resident #13 hit resident #37 on the left side of his/her face. Both residents were assessed and sent to the emergency department (ED). Resident #27 returned from the ED on 7/15/26, and resident #13 returned from the ED on 7/24/26. Upon return from the ED, resident #13 received one-to-one supervision from staff.	F0600		07/17/2026

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F0600 SS = G	Continued from page 2 b. Review of a progress note dated 7/15/26 and timed 6:05 PM showed "...[name] had a reddened area 1 x 1 inches in diameter on the left side of [his/her] face, next to [his/her] left eye, that was abraded. [S/he] also has reddened areas on [his/her] left cheekbone. Ice pack applied to left side of face..." c. Interview with the resident's representative on 7/28/26 at 9:39 AM revealed she visited the resident on 7/19/26 and the resident told her s/he did not feel safe and felt "afraid." d. Interview with CNA #3 on 7/30/26 at 9:05 AM revealed she had been assisting another resident in the bathroom when she heard an "aggressive voice" through the wall. She reported she found the shower aide to assist the resident in the bathroom, and when she went to the room next door, she saw resident #13 hit resident #37 “2 to 3” times with a "closed fist." She separated the residents, and took resident #37 to the nurses' station where the resident was assessed by the nurse. Further interview revealed resident #37 had a "small abrasion" on the left side of his/her face, and was "scared" and "skittish" following the incident. e. Interview with LPN #1 on 7/30/26 at 12:26 PM revealed she had been called to the secure unit after the incident. She stated resident #37's cheek was "a little red" and she was not sure if it was from the ice pack or being hit. She stated resident #37's demeanor was typically "apprehensive" and the resident was "shaken" after the incident. f. Interview with the DON on 7/30/26 at 12:45 PM revealed resident #37 had an ice pack applied to his/her cheek but there was no open skin. g. Interview with RN #2 on 7/30/26 at 1:06 PM revealed she had been told resident #13 punched resident #37. When she assessed the resident it was "reddened." Further interview revealed the resident was quiet and "stoic" and "afraid for [his/her] safety." 3. Review of the facility policy titled "Freedom from Abuse, Neglect, Corporal Punishment, Involuntary Seclusion, Mistreatment, Misappropriation of Resident Property, and Exploitation" last updated March 2025 showed "...Each resident has the right to be free from abuse, including verbal, mental, sexual, or physical abuse...The Center implements policies and processes so that residents are not subjected to abuse by staff, other residents, volunteers,	F0600		07/17/2026

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F0600 SS = G	Continued from page 3 consultants, family members, and others who may have unsupervised access to residents..." 4. The facility implemented the following corrective action by 7/17/26: a. Resident #37 was assessed and provided with an ice pack and sent to the ED on 7/15/26. The resident returned to the facility on 7/15/26. b. Resident #13 was assessed and sent to the ED on 7/15/26. The resident returned to the facility on 7/24/26, and received one-to-one supervision upon his/her return from the hospital. c. The facility reported the incident to the State Survey Agency and the Police Department on 7/15/26. d. All facility staff involved were interviewed. e. The DON completed an audit in the secure unit, to validate there were no skin concerns, and interviewed staff and residents to validate anyone that may not have reported previous abuse. f. The DON/designee educated staff immediately. g. The Executive Director/designee began a daily audit in the morning meeting and reviewed progress notes to ensure no abuse occurred. Audits to be done daily and reported monthly in the Quality Assurance (QAPI) Meeting for 90 days or until substantial compliance was achieved.	F0600		07/17/2026
F0679 SS = E	Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1) §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is NOT MET as evidenced by: Based on observation, resident representative, and	F0679	Personalized and desired activity services are being provided to Residents 34, 123, and 178 per resident preferences. Audit of activities programs was conducted by the ED/designee to validate residents are receiving activities of interest and activities that meet their needs. ED/designee educated staff to provide activities based on the residents' needs and interests. ED/Designee will audit residents randomly to validate accuracy. Audits will be weekly for 12 weeks. Results of audits will be discussed at the monthly QAPI meeting for 90 days to determine correction compliance and discussion	08/14/2026

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F0679 SS = E	Continued from page 4 staff interviews, medical record review, and policy and procedure review, the facility failed to ensure individual activities designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident were provided for 3 of 4 sample residents (#34, #123, #178) reviewed for activity participation. The findings were: 1. Review of the annual MDS assessment dated 11/20/25 showed resident #34's cognition was not assessed and they had diagnoses which included non-Alzheimer's dementia and depression. Further review showed the resident felt it was "very important" to go outside to get fresh air when the weather was good and "somewhat important" to have books, newspapers, and magazines to read, be around animals such as pets, keep up with the news, and perform his/her favorite activities. Review of the "Activities" care plan last revised on 3/31/26 showed interventions which included "I would like staff to continue to invite me to activities of that [sic] may be of interest to me" and "Some of my activity interests include animals and pets, board games, volunteering, dining out, movies, spending time outdoors, listening to the radio, watching sports, and TV." The following concerns were identified: a. Interview with the resident's representative on 7/27/26 at 5:52 PM revealed she wished the facility would encourage the resident to participate in activities. She revealed the staff offered, but if the resident refused then staff did not attempt to reapproach him/her. b. Continuous observation on 7/29/26 beginning at 9:27 AM through 11:02 AM showed the resident was in his/her room seated in the recliner with his/her legs elevated, and no activities were offered during that time. Continuous observation on 7/29/26 from 2:26 PM through 4:15 PM showed the resident was in his/her room seated in the recliner with his/her legs elevated, and no activities were offered during that time. Review of the activity calendar for July 2026 showed the scheduled activities on 7/29/26 included daily chronicle, fun with fitness, reading time, treats, music, and reading/trivia. c. Review of the activity participation record from 4/28/26 through 7/29/26 showed the resident was documented as being offered activities 115 times which included 107 independent activities, 7 one to one activities, and 1 group activity. Further review showed the resident "refused" activities 52 out 107 activities offered which included refusing one to one activities once and independent activities 51 times.	F0679	Continued from page 4 of continuation or discontinuation of audit based on results.	08/14/2026

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F0679 SS = E	Continued from page 5 2. Review of the admission MDS assessment dated 9/24/26 showed resident #123 had a BIMS score of 8 out 15, which indicated moderate cognitive impairment, and diagnoses which included progressive neurological conditions, non-Alzheimer's dementia, and seizure disorder or epilepsy. Further review showed the resident felt it was "Very important" to have books, newspapers, and magazines to read, to keep up with the news, and to go outside to get fresh air when the weather was good. Review of the "Activities" care plan last revised on 6/8/26 showed interventions which included "The resident's preferred activities are: arts and crafts, ceramics, visiting with others, shuffleboard, watching sports, tv and movies, listening to 'oldies,' being outdoors, etc." Review of the "I refuse to eat often r/t [related to] dementia and chemo treatments" care plan last revised on 12/23/25 showed interventions which included "Invite the resident to food-related activities and offer food, beverages of choice to encourage intake." The following concerns were identified: a. Review of the activity participation record from 5/27/26 through 7/29/26 showed the resident was documented as being offered activities 75 times which included 69 independent activities, 5 one to one activities, and 1 group activity. Further review showed the resident "refused" activities 10 times out of 75 activities offered, which included refusing group activities once and independent activities 9 times. 3. Review of the admission MDS assessment dated 7/27/26 showed resident #178 had a BIMS score of 3 out of 15, which indicated severe cognitive impairment, and diagnoses which included nontraumatic intracerebral hemorrhage, and macular degeneration. Further review of the MDS assessment showed it was very important to the resident to be around animals such as pets and somewhat important to listen to music he/she liked, do his/her favorite activities, and get outside for fresh air when the weather was good. Review of resident #178's initial activity evaluation dated 7/27/26 at 9:33 AM showed listed activity preferences of games, bingo, board games, cards, television, movies, animals, and pets. Review of resident #178's care plan dated 7/27/26 showed the resident had the ability to attend activities. Documented preferences included "directed/independent activities in room including: watching TV, reading, iPad games, etc. and has supplies needed for independent activities... preferred activities are: games, movies, animals, and	F0679		08/14/2026

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F0679 SS = E	Continued from page 6 going outdoors." The following concerns were identified: a. Observation of resident #178 throughout the survey showed the resident visited with his/her daughter, sat alone in his/her wheelchair in his/her room, and slept in bed. The resident did not participate in any group or individual activities. Further observation on 7/30/26 at 9:20 AM showed there were four copies of the “Daily Chronicle” in the resident’s room, but no activity calendar. b. Interview with the resident’s representative on 7/28/26 at 10:09 AM revealed staff had not invited the resident to any activities and the resident had not attended any activities since admission. Further interview revealed she had not seen an activity calendar in the resident’s room. c. Review of the medical record showed no evidence of activity participation. 3. Interview with COTA #1 on 7/30/26 at 8:41 AM revealed she was consulting for the activity program because the facility did not have an activity director. She revealed she did not perform activities daily, she only "checked in" with the team. She revealed one to one activities should be attempted 2 to 3 times per week and all residents should be invited to every group activity. She confirmed the facility did not facilitate independent activities for resident #34 or resident #123. She revealed newly admitted residents received an initial activity evaluation within 3 to 14 days of admission and activities staff were expected to invite every resident to every activity, distribute the "Daily Chronicle" daily, and invite residents to activities during distribution. Further interview confirmed staff had not offered resident #178 the opportunity to participate in any activities. 4. Review of the policy titled "Activity Program" last revised 2015 showed "...5. Activities include individual, small or large group, one-to-one, and independent activities to meet the resident's needs, abilities, and interests. For residents confined to, or who choose to, remain in their room, the Activity Department provides and assists with in-room activities/projects/leisure pursuits in keeping with needs, abilities, and interests..."	F0679		08/14/2026
F0761 SS = E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2)	F0761	The opened, undated, and expired medications were discarded at the time of discovery by unit managers and DNS.	08/14/2026

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F0761 SS = E	Continued from page 7 §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. §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 observation, staff interview, professional standard review, and policy review, the facility failed to ensure insulin medications were dated with an open date in 1 of 7 medication storage units (rehabilitation unit cart A). The findings were: 1. Observation on 7/29/26 at 11:04 AM of the rehabilitation cart A, with RN #1 showed the following concerns: a. Insulin Glargin-yfgn 100 unit per (ml) milliliter pen with an open date of 6/29/26, 30 days prior to the observation. b. Insulin Glargin-yfgn 100 units per ml pen with no open date. c. Insulin Lispro KwikPen 100 units per ml with an open date of 6/11/26, 48 days prior to the observation. d. Insulin Lispro KwikPen 100 units per ml with no open date.	F0761	Continued from page 7 Initial audit completed by DNS/designee of medication storage areas with any identified concerns corrected. Nurse management will validate insulin pens are dated when they are removed from the refrigerator and disposed of when expired. DNS/designee educated staff on expectations with medication labeling, handling, storage, and disposal. DNS/Designee will audit randomly to validate compliance. Audits will be weekly for 12 weeks. Results of audits will be discussed at the monthly QAPI meeting for 90 days to determine correction compliance and discussion of continuation or discontinuation of audit based on results.	08/14/2026

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F0761 SS = E	Continued from page 8 2. Interview with RN #1 on 7/29/26 at 11:04 AM revealed the insulin pens were good for 28 days, and confirmed the medications were available for resident use. 3. Interview with the DON on 7/29/26 at 2:13 PM revealed she expected staff to date the insulin when it was removed from the fridge and made available for use, and to discard the insulin when they expired. 4. Review of policy "Medication Storage" provided by the DON on 7/29/26 at 3 PM showed "...12. Insulin products should be stored in the refrigerator until opened. Note the date on the label for insulin vials and pens when first used...14. Outdated, contaminated, discontinued or deteriorated medications...are immediately removed from stock, disposed of according to procedures for medication disposal..." 5. Review of web page "drxservices.com/did-you-know-insulin-glp-1-expiration-guide/" showed insulin lispro days good at room temperature was 28 days, and insulin glargine was good at room temperature for 28 days.	F0761		08/14/2026
F0550 SS = D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §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	F0550	Staff were made aware of surveyor observations at time of discovery and immediately verbally educated staff. Resident 57's rights including dignity and privacy during ADL care are being followed. Audit performed by ADNS and DNS on 7/28/26, to validate compliance with resident rights including dignity and privacy during ADL care. Any corrections needed were done at that time. DNS/designee educated staff on expectations regarding resident rights, ensuring resident dignity and privacy are maintained during ADL cares. DNS/Designee will audit to validate compliance. Audits will be weekly for 12 weeks. Results of audits will be discussed at the monthly QAPI meeting to determine correction compliance and discussion of continuation or discontinuation of audit based on results.	08/14/2026

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F0550 SS = D	Continued from page 9 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, medical record review, and staff interviews, the facility failed to 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 for 1 of 4 sample residents (#57). The findings were: 1.Review of the significant change MDS assessment dated 5/15/26 showed resident #57 had a BIMS score of 5 out of 15, which indicated severe cognitive impairment, and had diagnoses which included cerebrovascular accident, depression, and benign prostatic hyperplasia. The MDS review showed the resident had bilateral impairment of the upper and lower extremities, required total assistance for toileting, upper and lower body dress, putting on footwear, and substantial/maximal assistance for personal hygiene. Further review showed the resident was always incontinent of bowel and bladder. Review of the ADL self-care performance deficit care plan showed “Impaired balance. BED MOBILITY: I am Substantial/Maximum assistance on staff to routinely turn and reposition in bed and as necessary. DRESSING: I am Dependent assistance on staff of 1-2 to dress my upper body and lower body dressing. PERSONAL HYGIENE: I am Substantial/Maximum on staff of one with personal hygiene.” The following concerns were identified:	F0550		08/14/2026

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F0550 SS = D	Continued from page 10 a. Observation on 7/27/26 at 3 PM showed the resident was lying on his/her bed with the resident's pants pulled down around his/her ankles and the bed sheet at the foot of the bed. The resident had a used brief rolled up under his/her upper legs, brown substance his/her left upper thigh, and his/her perineal area was exposed. The lift sling was positioned under the resident, the mechanical lift was positioned beside the bed, the bed was elevated up in the air, and the privacy curtain was open. The residents roommate was in the room. Continuous observation of the resident's room showed at 4:11 PM RN #3 entered the resident's room, and stated she was going to check on the roommate. Upon entering the room, the RN stated it looked like someone was changing resident #57, got called away, and did not finish the job. The RN covered the resident with the sheet and left the room to find help. At 4:20 PM the RN returned returned to the room, with CNA #4, donned gloves, provided perineal care, changed the brief, changed the resident's pants, and removed the dirty sling. At that time, CNA #4 stated CNA #1 had told her he had put the resident to bed at 1 PM, and she had planned to check the resident before the RN came and got her. b. Interview with CNA #1 on 7/27/26 at 4:28 PM revealed he got the resident in his/her bed around 12:45 PM and had his/her brief tucked under him/her. He revealed the resident was incontinent of bowel and bladder, and he had left the resident exposed for the nurse to do a skin check, because his/her peri area was bleeding and hurting. He revealed the nurse was going to give a medication and then go check resident #57's skin. c. Interview with the DON on 7/27/26 at 5:22 PM revealed she expected the staff to check residents every 2-3 hours, and to finish providing care. Interview with the DON on 7/28/26 at 10 AM revealed the facility did not have a policy related to providing turning, repositioning, or checking the residents. Further interview revealed staff should follow professional standards. 2. Review of the policy titled "Resident Rights" hand delivered by the DON during the survey showed "...Policy Statement: Residents are informed about their rights at admission and at least annually during their stay..."	F0550		08/14/2026

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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 (iii) Include in the notice the items described in paragraph (c)(5) of this section.	F0628	Bed Hold was created and sent to RP for Resident 34. Audit of residents requiring a bed hold/transfer form was complete by DNS/designee to validate bed hold/transfer forms were in compliance with regulation. DNS/designee educated staff on the need to provide written copy of the bed hold/transfer form anytime someone goes to the hospital. DNS/Designee will audit transfers to validate compliance with bed hold/transfer forms. Audits will be weekly for 12 weeks. Results of audits will be discussed at the monthly QAPI meeting for 90 days to determine correction compliance and discussion of continuation or discontinuation of audit based on results.	08/14/2026

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F0628 SS = D	Continued from page 12 §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 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	F0628		08/14/2026

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F0628 SS = D	Continued from page 13 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; (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	F0628		08/14/2026

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F0628 SS = D	Continued from page 14 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 medical record review, resident representative and staff interview, and policy and procedure review, the facility failed to provide a written notice of transfer and bed-hold for 1 of 5 sample residents (#34) reviewed for transfer and discharge. The findings were: 1. Review of a progress note dated 11/20/25 and timed 12:48 PM showed resident #34 was transferred non-emergent to the hospital for evaluation. Review of a transfer notice dated 11/20/25 showed the resident's representative was verbally notified of the transfer; however, there was no evidence the transfer notice was provided in writing to the resident's representative. Review of a "Bed Hold Agreement" dated 11/20/25 showed the resident was notified verbally of the bed hold; however, there was no evidence the resident's representative was	F0628		08/14/2026

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F0628 SS = D	Continued from page 15 notified of the bed hold in writing. 2. Interview with the resident representative for resident #34 on 7/27/26 at 5:52 PM revealed the facility did not notify her of changes to the resident such as transfers to the hospital, new medication orders, or health status changes. Further she revealed when a resident was sick, the facility should notify the representative. 3. Interview with the DON on 7/30/26 at 12:54 PM confirmed the facility did not have evidence resident #34's representative was provided a written notice for transfer or bed-hold. 4. Review of the policy titled "Transfer and Discharge" last revised May 2025 showed "...5. When a transfer or discharge is initiated, the resident receives written notice using the Resident Notice of Transfer or Discharge... 10. In case of emergency transfer, written notice including bed-hold policy is sent to the resident/responsible party..."	F0628		08/14/2026
F0637 SS = D	Comprehensive Assessment After Signifcant Chg CFR(s): 483.20(b)(2)(ii) §483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is NOT MET as evidenced by: Based on observation, medical record review, staff interview, and CMS RAI manual review, the facility failed to complete a significant change MDS assessment for 1 of 5 sample residents (#123) reviewed for a significant change. The findings were: 1. Review of the admission MDS assessment dated 9/18/25 showed resident #123 had a BIMS score of 8 out of 15, which indicated moderate cognitive	F0637	MDS Significant Change assessment was completed on 08/03/26, for resident 123. A significant change MDS was not completed in a timely manner but was entered after deficiency was found. All other MDS assessments for resident 123 are current. Audit of residents was completed by the DNS/designee to validate significant change MDS was completed upon change of condition. DNS/designee educated staff on the need to open a significant change MDS assessment when significant change occurs. DNS/Designee will audit random MDS assessments to validate compliance with significant change MDS assessments. Audits will be weekly for 12 weeks. Results of audits will be discussed at the monthly QAPI meeting for 90 days to determine correction compliance and discussion of continuation.	08/14/2026

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F0637 SS = D	Continued from page 16 impairment, and diagnoses which included progressive neurological conditions, non-Alzheimer's dementia, and seizure disorder or epilepsy. Further review showed the resident had no upper or lower range of motion impairment, did not use mobility devices, and was independent or set-up/clean up help only for all activities of daily living (ADL). The following concerns were identified: a. Observation on 7/29/26 at 2:30 PM showed the resident and a staff member exited the resident's room with the resident using a walker for ambulation and a gait belt in place around the resident's torso. b. Review of the quarterly MDS assessment dated 3/27/26 showed the resident did not use a walker. Further review showed the resident required partial/moderate assistance with oral hygiene, personal hygiene and shower/bathe self. The resident was independent or required set-up/clean up help for all other ADLs. c. Review of the quarterly MDS assessment dated 6/27/26 showed the resident did not use a walker. Further review showed the resident required partial/moderate assistance with oral hygiene, toileting hygiene, and personal hygiene and required supervision or touching assistance with shower/bathe self and putting on/taking off footwear. d. Review of the resident's completed MDS assessments showed no evidence a comprehensive MDS assessment, including a significant change assessment, had been completed since the admission assessment. 2. Interview with MDS coordinator #1, MDS coordinator #2, and MDS coordinator #3 on 7/30/26 at 9:55 AM revealed they were not aware the resident was using a walker and the resident "probably" should not have been coded as independent for ADLs at the time of the admission MDS assessment. They revealed at times, the CNAs do not document accurately regarding resident needs. They confirmed a significant change MDS should have been completed and had not been. 3. Review of the "CMS Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual version 1.30.1" dated October 2025 showed "...Significant Change in Status Assessment (SCSA) (A0310A = 04) The SCSA is a comprehensive assessment for a resident that must be completed	F0637		08/14/2026

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F0637 SS = D	Continued from page 17 when the IDT has determined that a resident meets the significant change guidelines for either major improvement or decline. It can be performed at any time after the completion of an Admission assessment, and its completion dates (MDS/CAA(s)/care plan) depend on the date that the IDT's determination was made that the resident had a significant change. A 'significant change' is a major decline or improvement in a resident's status that: 1. Will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions, the decline is not considered 'selflimiting'; 2. Impacts more than one area of the resident's health status; and 3. Requires interdisciplinary review and/or revision of the care plan..."	F0637		08/14/2026
F0656 SS = D	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)- (A) The resident's goals for admission and desired outcomes.	F0656	IDT was made aware of surveyor observations at time of discovery and immediately verbally educated. Resident 7 care plan has been updated. Audit performed by ADNS and DNS, of resident care plans to validate accuracy with anticoagulant care plans. Any corrections needed were done at that time. DNS/designee educated staff on expectations with anticoagulant care plans. DNS/Designee will audit to validate compliance. Audits will be weekly for 12 weeks. Results of audits will be discussed at the monthly QAPI meeting for 90 days to determine correction compliance and discussion of continuation or discontinuation of audit based on results.	08/14/2026

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F0656 SS = D	Continued from page 18 (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 observation, medical record review, resident and staff interview, and policy review the facility failed to ensure they had developed and implemented a comprehensive person-centered care plan for for 1 of 31 sample residents (#7). The findings were: 1. Review of the 5/19/25 significant change MDS assessment showed resident #7 had a BIMS score of 14 out of 15, which indicated intact cognition, and diagnoses which included hemiplegia, stroke, history of venous thrombosis and embolism. The resident received medications which included the anticoagulant apixaban. Review of the physician orders showed the resident received apixaban oral tablet (anticoagulant) 5 mg (milligrams) by mouth two times a day and "ANTICOAGULANT MEDICATION SIDE EFFECT MONITORING: New Onset - Bleeding, bruising, black tarry stools, red urine, sudden severe headache, N/V. every shift Nurse Initials = Side effects monitored. If noted, document in Progress Notes and notify the Medical Provider." The following concerns were identified: a. Observation on 7/28/26 at 11:13 AM showed resident #7 had bruises on both lower arms. Interview with the resident at that time revealed the bruising happened at the hospital, and s/he was on an anticoagulant. b. Review of a progress note dated on 7/24/26 and timed 3:51 PM showed the resident had been readmitted from a hospital. His/her skin condition included scattered bruising to bilateral arms from IV starts and blood draws.	F0656		08/14/2026

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F0656 SS = D	Continued from page 19 c. Review of the care plan failed to show anticoagulant use or interventions as part of the plan of care. 2 Interview with the DON on 7/30/26 at 10 AM confirmed the facility did not have an anticoagulant care plan for the resident, and the facility had formatted an anticoagulant care plan that day.	F0656		08/14/2026
F0677 SS = D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is NOT MET as evidenced by: Based on observation, staff interview, medical record review, and professional standard review, the facility failed to ensure necessary services were provided timely for 1 of 4 sample residents (#57) reviewed for activities of daily living. The findings were: 1. Review of the significant change MDS assessment dated 5/15/26 showed resident #57 had a BIMS score of 5 out of 15, which indicated severe cognitive impairment, and had diagnoses which included cerebrovascular accident, depression, and benign prostatic hyperplasia. The MDS review showed the resident had bilateral impairment of the upper and lower extremities, required total assistance for toileting, upper and lower body dress, putting on footwear, and substantial/maximal assistance for personal hygiene. Further review showed the resident was always incontinent of bowel and bladder. Review of the ADL self-care performance deficit care plan showed “Impaired balance. BED MOBILITY: I am Substantial/Maximum assistance on staff to routinely turn and reposition in bed and as necessary. DRESSING: I am Dependent assistance on staff of 1-2 to dress my upper body and lower body dressing. PERSONAL HYGIENE: I am Substantial/Maximum on staff of one with personal hygiene.” The following concerns were identified: a. Observation on 7/27/26 at 3 PM showed the resident was lying on his/her bed with the resident’s pants pulled down around his/her ankles and the bed sheet at the foot of the bed. The	F0677	Staff were made aware of surveyor observations at time of discovery and immediately verbally educated staff. Resident 57 is receiving appropriate care per care plan. Audit performed by ADNS and DNS, to validate compliance with direct care. Any corrections needed were done at that time. DNS/designee educated staff on expectations with peri-care and following care plan. DNS/Designee will audit to validate compliance. Audits will be weekly for 12 weeks. Results of audits will be discussed at the monthly QAPI meeting for 90 days to determine correction compliance and discussion of continuation or discontinuation of audit based on results.	08/14/2026

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F0677 SS = D	Continued from page 20 resident had a used brief rolled up under his/her upper legs, brown substance on his/her left upper thigh, and his/her perineal area was exposed. The mechanical lift sling was positioned under the resident, the mechanical lift was positioned beside the bed, the bed was elevated, and the privacy curtain was open. Continuous observation of the resident's room showed at 4:11 PM RN #3 entered the resident's room, and stated she was going to check on the roommate. Upon entering the room, the RN stated it looked looks like someone was changing resident #57, got called away, and did not finish the job. The RN covered the resident with the sheet and left the room to find help. At 4:20 PM the RN returned to the room, with CNA #4, donned gloves, provided perineal care, changed the brief, changed the resident's pants, and removed the dirty sling. At that time, CNA #4 stated CNA #1 told her he had put the resident to bed at 1 PM, and she had planned to check the resident before the RN came and got her. b. Interview with CNA #1 on 7/27/26 at 4:28 PM revealed he got the resident in his/her bed around 12:45 PM and had his/her brief tucked under him/her. He revealed the resident was incontinent of bowel and bladder, and he had left the resident exposed for the nurse to do a skin check, because his/her peri area was bleeding and hurting. He revealed the nurse was going to give a medication and then go check resident #57's skin. c. Interview with the DON on 7/27/26 at 5:22 PM revealed she expected the staff to check residents every 2-3 hours, and to finish providing care. Interview with the DON on 7/28/26 at 10 AM revealed the facility did not have a policy related to providing turning, repositioning, or checking the residents. Further interview revealed staff should follow professional standards. 2. Review of the professional standard titled "Tertiary Prevention" provided by the DON on 7/29/26 at 3 PM showed "Tertiary prevention addresses the treatment of established disease to avoid complications and death. The major areas of focus for the older adult and the adult with a disability are preventing the complications of immobility and rehabilitation...Positions… 2. The recommendation is to change body position every 2 hours and, preferably, more frequently for patients who have no spontaneous movement…"	F0677		08/14/2026

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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 resident and staff interview, medical record review, and policy and procedure review, the facility failed to ensure that 1 of 3 sample residents (#14) was provided with respiratory care, including tracheostomy care. The findings were: 1. Review of the comprehensive MDS assessment dated 7/6/26 showed resident #14 had a BIMS score of 15 out of 15, which indicated the resident was cognitively intact, and had diagnoses which included pneumonia, anxiety disorder, chronic lung disease, and respiratory failure. Further review showed the resident received tracheostomy care. Review of the medical record and hospital discharge instructions dated 7/14/26 showed the resident had a hospital admission from 7/3/26 to 7/14/26 for sepsis due to pneumonia. Review of the physician orders showed an order with a start date of 6/23/26 to "change disposable inner cannula (6 internal diameter) every day and PRN [as needed] every day shift for Trach Care." The following concerns were identified: a. Interview with the resident on 7/27/26 at 1:57 PM revealed staff had not changed his/her inner tracheostomy cannula daily, and stated, “They are supposed to change the inner cannula everyday, but they aren’t doing it daily. They have been out of inner cannulas.” Interview with the resident on 7/29/26 at 3:41 PM revealed the last inner cannula change s/he remembered occurred the previous Tuesday or Wednesday. S/he stated when no inner cannula was available, “sometimes they pull it out and inspect it to make sure it's not dirty and reinstall it. They have talked about cleaning the inner cannula, but I haven’t seen them clean it.” b. Review of the treatment administration record (TAR) for June 2026 showed no evidence the inner cannula change was performed on 6/23/26, 6/25/26, 6/27/26, 6/28/26, and 6/29/26. Review of the TAR	F0695	Staff were made aware of surveyor observations at time of discovery and immediately verbally educated. Resident 14 is receiving appropriate respiratory care including trach cares being administered as ordered. Audit performed by ADNS and DNS, to validate compliance with trach care following orders. Any corrections needed were done at that time. DNS/designee educated staff on expectations with trach cleaning and care and following physician orders. DNS/Designee will audit to validate compliance. Audits will be weekly for 12 weeks. Results of audits will be discussed at the monthly QAPI meeting for 90 days to determine correction compliance and discussion of continuation or discontinuation of audit based on results.	08/14/2026

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F0695 SS = D	Continued from page 22 for July 2026 showed no evidence the inner cannula change was performed on 7/1/26, 7/2/26, 7/20/26, 7/21/26, 7/22/26, 7/23/26, 7/27/26, 7/28/26 and 7/29/26. c. Review of progress notes showed the disposable inner cannula was not changed and was documented “not available” on 6/23/26, 6/25/26, 6/27/26, 6/28/26, 6/29/26, 7/1/26, 7/2/26, 7/20/26, and 7/28/26. d. Interview with RN #1 on 7/29/26 at 3:04 PM revealed staff had not changed the inner cannula that day because the facility had only one inner cannula available, which was reserved for emergencies. He revealed the facility had difficulty obtaining inner cannulas from their supplier. Further interview revealed his expectation for tracheostomy care when no inner cannulas were available was to remove the inner cannula and “assess for patency, cleanliness, and excessive secretions, or clean or sanitize the inner cannula and reuse it.” e. Interview with the DON on 7/29/26 at 3:17 PM revealed her expectation was for the disposable tracheostomy inner cannula to be changed daily per physician orders. She stated when inner cannulas were unavailable, staff "contacted the doctor and were given permission to clean the inner cannula with a tracheostomy cleaning kit." Further interview confirmed no physician order existed to clean the tracheostomy inner cannula if none were available. She stated the facility had ordered 45 inner cannulas two weeks prior and had not received the shipment. 2. Review of the facility's policy and procedure titled "Tracheostomy Care," dated December 2017, showed: "...Unlock inner cannula by turning counterclockwise. Remove inner cannula. Place inner cannula in basin with hydrogen peroxide…Clean lumen and sides of inner cannula using pipe cleaners or sterile brush. Rinse inner cannula thoroughly by agitating in normal saline for several seconds…replace inner cannula into outer cannula…”	F0695		08/14/2026
F0740 SS = D	Behavioral Health Services CFR(s): 483.40 §483.40 Behavioral health services. Each resident must receive and the facility must provide the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and	F0740	Staff were made aware of surveyor observations at time of discovery and immediately verbally educated. Resident 13 is scheduled for a neurocognitive evaluation on 9/28/26. Residents will continue with psychological support from social service staff weekly and as needed. Audit performed by social services to validate compliance with PASRR II recommendation and an audit to validate any	08/14/2026

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F0740 SS = D	Continued from page 23 plan of care. Behavioral health encompasses a resident's whole emotional and mental well-being, which includes, but is not limited to, the prevention and treatment of mental and substance use disorders. This REQUIREMENT is NOT MET as evidenced by: Based on medical record review, and staff interview, the facility failed to ensure behavioral health services were provided to 1 of 3 sample residents (#13) with a psychiatric diagnosis. The following concerns were identified: 1. Review of the admission MDS assessment dated 6/11/26 showed resident #13 had been admitted to the facility on 4/24/26, had a diagnosis of schizophrenia, and a BIMS score of 10 out of 15, which indicated moderate cognitive impairment. Review of the medication administration record (MAR) showed the resident received the antipsychotic medications haloperidol 2.5 mg, clozapine 12.5 mg, aripiprazole 15 mg. Review of the care plan initiated on 7/24/26 showed the resident had impaired psychosocial well-being as evidenced by behaviors requiring intervention and psychotropic drug utilization, and behaviors that included agitation, anger, cursing, grabbing, hitting and kicking. Interventions included redirection, remove from the situation, meaningful activity, reapproach, and one-to-one supervision. The following concerns were identified: a. Review of a facility incident report showed on 7/15/26 at 2 PM a CNA observed resident #13 hit resident #37 on the left side of his/her face. Both residents were assessed and sent to the emergency department (ED). b. Review of the medical record showed a preadmission screening and resident review (PASRR) Level II review had been completed on 4/23/26 and showed mental health rehabilitation services recommended were case management and a neurocognitive evaluation. c. Review of the medical record showed no evidence the resident received a neurocognitive evaluation or mental health services. d. Interview with the social services assistant #1 on 7/30/26 at 2:30 PM revealed she and the social	F0740	Continued from page 23 resident who may benefit from behavioral health support. No other residents are affected by this deficiency. ED/designee educated staff on expectations with PASRR II follow-up recommendation and the importance on meeting the resident behavioral health needs to ensure resident emotional and mental well-being. Residents who benefit from behavioral health services, social service/designee will communicate to the primary care provider for referral to a psychiatric service, counseling services for a comprehensive assessment and plan of care to meet resident needs. Social services will provide emotional and psychological support as indicated. Social Services/Designee will audit to validate compliance. Audits will be weekly for 12 weeks. Results of audits will be discussed at the monthly QAPI meeting to determine correction compliance and discussion of continuation or discontinuation of audit based on results.	08/14/2026

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F0740 SS = D	Continued from page 24 services assistant #2 checked on the resident "a couple of times a day, especially if [s/he] has behaviors." Further interview confirmed the resident had not received a neurocognitive evaluation upon admission and the resident did not receive case management services.	F0740		08/14/2026
F0755 SS = D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(f). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is NOT MET as evidenced by: Based on medical record review, and staff interview, the facility failed to ensure a pharmaceutical services procedure related to accurate acquiring, receiving, dispensing and administration of medications for 1 of 6 sample residents (#65) reviewed for medication availability. The findings were:	F0755	Resident 65 was assessed and unharmed by missing two doses of medication. Medication is no longer needed at this time with order being discontinued per provider. Initial audit completed by DNS/designee of medication orders to validate medications are being given upon receipt of order from physician. DNS/designee educated staff on expectations with giving medications upon receipt of order and validating medications are available in house when order by physician. DNS/Designee will audit randomly to validate compliance. Audits will be weekly for 12 weeks. Results of audits will be discussed at the monthly QAPI meeting for 90 days to determine correction compliance and discussion of continuation or discontinuation of audit based on results.	08/14/2026

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F0755 SS = D	Continued from page 25 1. Review of a quarterly MDS assessment dated 7/10/26 showed resident #65 had a BIMS score of 5 out of 15 which indicated severe cognitive impairment, and diagnoses which included Alzheimer's disease, non-Alzheimer's dementia, and seasonal allergic rhinitis. Review of the physician orders showed the resident was to receive Sudafed Sinus Congestion Oral Tablet 1 time a day for sinus congestion. The following concerns were identified: a. Review of the medication administration record (MAR) showed the resident did not receive the medication on 6/28/26 and 6/29/26, and the medication was on order from the pharmacy. b. Review of a progress note dated 6/28/26 and timed 11:46 PM showed "...Cough present. Productive cough..." c. Review of a progress note dated 6/29/26 and timed 7:12 AM showed "Sudafed Sinus Congestion Oral Tablet Give 1 tablet by mouth one time a day for sinus congestion. May dc [discharge] when sx [symptoms] resolve." d. Interview with the DON on 7/30/26 at 1:50 PM revealed her expectation was for nursing staff to check and verify medication was not in backup. Further interview confirmed the medication had been in the medication cart, the MA-Cs did not see it, and the resident did not receive the sudafed on the days identified.	F0755		08/14/2026
F0880 SS = D	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. 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	F0880	Nurse was made aware of surveyor observations at time of discovery and immediately verbally educated. EBP is provided per policy for those resident requiring such cares. Audit performed by ADNS and DNS, of entire building, randomly observing staff and units, to validate compliance with EDP. Any corrections needed were done at that time. DNS/designee educated staff on expectations with EBP and Infection Control. DNS/Designee will audit EBP to validate compliance. Audits will be weekly for 12 weeks. Results of audits will be discussed at the monthly QAPI meeting for 90 days to determine correction compliance and discussion of continuation or discontinuation of audit based on	08/14/2026

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F0880 SS = D	Continued from page 26 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. §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.	F0880	Continued from page 26 results.	08/14/2026

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F0880 SS = D	Continued from page 27 The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is NOT MET as evidenced by: Based on observation, staff interview, medical record review, and policy and procedure review, the facility failed to ensure an infection prevention and control program was designed to help prevent the development and transmission of communicable diseases and infections for 1 of 9 sample residents (#178). The findings were: 1. Review of the admission MDS assessment dated 7/27/26 showed resident #178 had a BIMS score of 3 out of 15, which indicated severe cognitive impairment, and diagnoses which included non-traumatic brain dysfunction, cerebrovascular accident, and non-traumatic intracerebral hemorrhage. Further review showed the resident had an indwelling catheter and required supervision for personal hygiene. Review of the care plan “EBP r/t a foley catheter” last revised on 7/27/26 showed the resident had a foley catheter and interventions which included "CDC guidelines for enhanced barrier precautions will be followed by personnel. Enhanced barrier precautions involve gown and glove use during high-contact care activities." The following concerns were identified: a. Observation on 7/29/26 at 11:21 AM showed CNA #2 applied hand sanitizer, donned gloves, drained the urine from the catheter bag, and wiped the end of the drainage tubing with an alcohol wipe. Further observation showed an Enhanced Barrier Precautions sign and a Personal Protective Equipment (PPE) cart was stationed outside the resident's room; however, no additional PPE was used during the catheter care. b. Interview with MA-C #1 on 7/30/26 at 12:50 PM revealed she did not wear a gown when she provided urinary catheter care; however, she was aware gowns and other PPE were available for use outside the resident’s room. c. Interview with the infection preventionist on 7/30/26 at 2:02 PM revealed all residents with a urinary catheter were on enhanced barrier precautions and a gown, gloves, faceshield/goggles should be worn when providing catheter care. 2. Review of the policy and procedure titled “Transmission Based Precautions” dated May 2015 and updated March 2026, showed “Enhanced Barrier	F0880		08/14/2026

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F0880 SS = D	Continued from page 28 Precautions (EBP), involve the use of gowns and gloves by care providers, during high contact resident care activities…EBP are used when caring for residents with colonization or infection with a targeted and epidemiologically important MDRO, chronic wounds, or indwelling medical device/s. Indwelling devices include…indwelling urinary catheter…High-contact care activities (gown and gloves required) Examples:...emptying drainage bags…"	F0880		08/14/2026