STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185466	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 01 - WESTPORT PLACE B. WING	04/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Westport Place Health Campus	4247 Westport Road , Louisville, Kentucky, 40207

(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
K0000 Bldg. 01	INITIAL COMMENTS Based on the acceptable Plan of Correction (POC) and the onsite revisit survey initiated and concluded on 04/02/2026, it was determined the facility had achieved substantial compliance with Life Safety Code on 03/21/2026.	K0000		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185466	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 01 - WESTPORT PLACE B. WING	02/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Westport Place Health Campus	4247 Westport Road , Louisville, Kentucky, 40207

(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
K0000	INITIAL COMMENTS 42 CFR 483.90(a) K3 BUILDING: 0101 K6 PLAN APPROVAL: 2010, 2012 K7 SURVEY UNDER: 2012 Existing K8 SNF/NF Type of Structure: One (1) Story, (2010, 2012), Type V (111), protected combustible construction with seven (7) smoke compartments and a complete automatic wet and dry sprinkler system. A Life Safety Code Recertification Survey was initiated on 02/10/2026 and concluded on 02/10/2026, in accordance with 42 Code of Federal Regulations (CFR), Subpart 483:90(a) Requirements for Long Term Care Facilities. During this Recertification Survey, Westport Place Health Campus was found not to be in compliance with the Requirements for Participation in Medicare and Medicaid. The requirement at 42 CFR, Subpart 483.90(a) is NOT MET as evidenced by:	K0000		03/21/2026
K0920 SS = D	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for	K0920	Address what corrective action will be accomplished for those residents found to have been affected by the deficient practice. On 2/10/2026, the Director of Plant Operations (DPO) and Facility Maintenance Support (FMS) removed extension cords and/or power strips from the Medical Records Office, Biohazard room, and resident room 202. Address how the facility will identify other residents having the potential to be affected by the same deficient practice.	03/21/2026

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		A. BUILDING 01 - WESTPORT PLACE B. WING	02/10/2026

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K0920 SS = D	Continued from page 1 non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This STANDARD is NOT MET as evidenced by: Based on observation and interview, the facility failed to maintain power strips and extension cords in accordance with National Fire Protection Association (NFPA) Standards. The deficient practice had the potential to affect three (3) rooms, staff, and two (2) residents. The facility had the capacity for 62 beds with a census of 58 on the day of the survey. The findings include: 1). Observation, during the building inspection tour on 02/10/2026 at 11:55 AM, revealed an extension cord was being used, as a substitute for fixed wiring of a structure, for personal electronics located in the Medical Records Office by Therapy. Interview, on 02/10/2026 at 11:56 AM with the Director of Plant Operations, revealed the facility was unaware of the extension cord being used. 2). Observation, during the building inspection tour on 02/10/2026 at 12:26 PM, revealed a refrigerator was plugged into a power strip, overloading the rating, located in the Biohazard Room by Room 202. Interview, on 02/10/2026 at 12:27 PM with the Director of Plant Operations, revealed the facility was unaware of the power strip being used to plug in the refrigerator. 3). Observation, during the building inspection tour on 02/10/2026 at 12:28 PM, revealed an ungrounded extension cord being used, as a substitute for fixed wiring of a structure, for personal electronics in Resident Room 202. Interview, on 02/10/2026 at 12:29 PM with the Director of Plant Operations, revealed the facility was unaware of the ungrounded extension cord being used. The findings were verified by the Director of Plant Operations at the time of observations and the	K0920	Continued from page 1 On 2/10/2026, the Director of Plant Operations (DPO) and Facility Maintenance Support (FMS) inspected all office spaces and resident rooms for improper use of power strips and extension cords, with no further issues identified. Address what measure will be put into place or systemic changes made to ensure that the deficient practice will not recur. Beginning on 2/11/2026, the Director of Plant Operations, Executive Director and Scheduling Coordinator, educated all staff on the appropriate use of power strips and that extension cords are strictly prohibited in all areas, including resident rooms. All staff will be educated by 3/20/2026. After 3/20/2026, any staff not educated with be educated prior to their next scheduled shift, and any newly hired staff will be educated through orientation by the employee experience manager (EXM). The campus does not use agency staff. Indicate how the facility plans to monitor its performance to ensure that solutions are sustained. Beginning on 2/11/2026, the Director of Plant Operations, Executive Director or Director of Environmental Services will conduct an audit of all resident rooms and all office spaces to ensure proper use of power strips, and no extension cords are in use, weekly for 4 weeks, every other week for 4 weeks and monthly for 3 months. An Ad Hoc Quality Assurance meeting was held on 3/10/2026 with the Medical Director and the facility QAPI Committee, consisting of Executive Director, Facility Maintenance Support, Director of Plant Operations, DHS, and MDS to review the incident, proposed Plan of Correction and ensure the implementation of the plan. The Director of Plant Operations or Director of Environmental Services will present the findings from the audits to the monthly QAPI Committee consisting of the Executive Director, Director of Health Services, Assistant Director of Health Services, Medical Director, Social Services Director, MDS Coordinator and Infection Preventionist. The QA Committee will	

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		A. BUILDING 01 - WESTPORT PLACE B. WING	02/10/2026

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K0920 SS = D	Continued from page 2 Executive Director at the exit conference on 02/10/2026. Actual NFPA Standard: NFPA 99 Health Care Facilities Code, (2012) 10.2.3.6 Multiple Outlet Connection. Two or more power receptacles supplied by a flexible cord shall be permitted to be used to supply power to plug-connected components of a movable equipment assembly that is rack-, table-, pedestal-, or cart mounted, provided that all of the following conditions are met: (1) The receptacles are permanently attached to the equipment assembly. (2)*The sum of the ampacity of all appliances connected to the outlets does not exceed 75 percent of the ampacity of the flexible cord supplying the outlets. (3) The ampacity of the flexible cord is in accordance with NFPA 70, National Electrical Code. (4)*The electrical and mechanical integrity of the assembly is regularly verified and documented. 10.2.4 Adapters and Extension Cords. 10.2.4.1 Three-prong to two-prong adapters shall not be permitted. 10.2.4.2 Adapters and extension cords meeting the requirements of 10.2.4.2.1 through 10.2.4.2.3 shall be permitted. 10.2.4.2.1 All adapters shall be listed for the purpose. 10.2.4.2.2 Attachment plugs and fittings shall be listed for the purpose. 10.2.4.2.3 The cabling shall comply with 10.2.3 10.2.3.2 Grounding Conductor. 10.2.3.2.1 Each electric appliance shall be provided with a grounding conductor in its power cord. Actual NFPA Standard: NFPA 70 National Electrical Code, (2011) 400.8 Uses Not Permitted. Unless specifically permitted in 400.7, flexible cords and cables shall not be used for the following:	K0920	Continued from page 2 determine the ongoing frequency as to the frequency of the monitoring plan based on the findings from the above-mentioned, ongoing audits. The Administrator has the oversight to ensure an effective plan is in place to meet the residents' wellbeing as well as an effective plan to identify facility concerns and implement a plan of correction. Facility alleges compliance 03/21/2026.	

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		A. BUILDING 01 - WESTPORT PLACE B. WING	02/10/2026

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K0920 SS = D	Continued from page 3 (1) As a substitute for the fixed wiring of a structure (2) Where run through holes in walls, structural ceilings, suspended ceilings, dropped ceilings, or floors (3) Where run through doorways, windows, or similar openings (4) Where attached to building surfaces Exception to (4): Flexible cord and cable shall be permitted to be attached to building surfaces in accordance with the provisions of 368.56(B) (5) Where concealed by walls, floors, or ceilings or located above suspended or dropped ceilings (6) Where installed in raceways, except as otherwise permitted in this Code (7) Where subject to physical damage	K0920		
K0927 SS = D Bldg. 01	Gas Equipment - Transfilling Cylinders CFR(s): NFPA 101 Gas Equipment - Transfilling Cylinders Transfilling of oxygen from one cylinder to another is in accordance with CGA P-2.5, Transfilling of High Pressure Gaseous Oxygen Used for Respiration. Transfilling of any gas from one cylinder to another is prohibited in patient care rooms. Transfilling to liquid oxygen containers or to portable containers over 50 psi comply with conditions under 11.5.2.3.1 (NFPA 99). Transfilling to liquid oxygen containers or to portable containers under 50 psi comply with conditions under 11.5.2.3.2 (NFPA 99). 11.5.2.2 (NFPA 99) This STANDARD is NOT MET as evidenced by: Based on observation and interview, the facility failed to maintain oxygen transfilling area in accordance with National Fire Protection Association (NFPA) Standards. The deficient practice had the potential to affect one (1) transfilling room, staff, and four (4) residents. The facility had the capacity for 62 beds with a census of 58 on the day of the survey. The findings include:	K0927	Address what corrective action will be accomplished for those residents found to have been affected by the deficient practice. On 2/11/2026, a temporary transfilling sign was placed on the oxygen storage room. On 2/12/2026, a permanent transfilling sign was ordered. On 3/4/2026, the permanent sign was received and placed on the oxygen storage and transfilling room. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. On 2/11/2026, a temporary transfilling sign was placed on the oxygen storage room. On 2/12/2026, a permanent transfilling sign was ordered. On 3/4/2026, the permanent sign was received and placed on the oxygen storage and transfilling room. There is only one oxygen storage room in the campus, therefore, no additional deficient practices were identified. Address what measure will be put into place or systemic changes made to ensure that the deficient practice will not recur.	03/21/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185466	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 01 - WESTPORT PLACE B. WING	.. 02/10/2026

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K0927 SS = D Bldg. 01	Continued from page 4 Observation, during the building inspection tour on 02/10/2026 at 12:05 PM, revealed the Oxygen Transfilling Room by the Salon did not have a sign to indicate "Transfilling was Occurring". Interview, on 02/10/2026 at 12:06 PM with the Director of Plant Operations, revealed the facility was unaware of the missing signage. The finding was verified by the Director of Plant Operations at the time of observation and the Executive Director at the exit conference on 02/10/2026. Actual NFPA Standard: NFPA 99 Health Care Facilities Code, (2012) 11.5.2.3 Transfilling Liquid Oxygen Transfilling of liquid oxygen shall comply with 11.5.2.3.1 or 11.5.2.3.2, as applicable. 11.5.2.3.1 Transfilling to liquid oxygen base reservoir containers or to liquid oxygen portable containers over 344.74 kPa (50 psi) shall include the following: 1) A designated area separated from any portion of a facility wherein patients are housed, examined, or treated by a fire barrier of 1 hour fire-resistive construction. (2) The area is mechanically ventilated, is sprinklered, and has ceramic or concrete flooring. (3) The area is posted with signs indicating that transfilling is occurring and that smoking in the immediate area is not permitted. (4) The individual transfilling the container(s) has been properly trained in the transfilling procedures. 11.5.2.3.2 Transfilling to liquid oxygen portable containers at 344.74 kPa (50 psi) and under shall include the following: (1) The area is well ventilated and has noncombustible flooring. (2) The area is posted with signs indicating that smoking in the area is not permitted. (3) The individual transfilling the liquid oxygen portable container has been properly trained in the	K0927	Continued from page 4 Beginning on 2/11/2026, the Director of Plant Operations and all licensed nursing staff were educated on oxygen storage and transfilling safety requirements, including mandatory signage during transfilling. On 2/11/2026, the oxygen transfilling process was updated to include a step requiring verification of "transfilling in progress" signage prior to initiating transfilling. Director of Plant Operations and all licensed nursing staff will be educated by 3/20/2026. After 3/20/2026, any staff not educated with be educated prior to their next scheduled shift, and any newly hired staff will be educated through orientation by the employee experience manager (EXM). The campus does not use agency staff. Indicate how the facility plans to monitor its performance to ensure that solutions are sustained. Beginning on 2/11/2026, the Director of Plant Operations or Executive Director will conduct an audit of the oxygen storage and transfilling area weekly for 4 weeks and monthly for 2 months. An Ad Hoc Quality Assurance meeting was held on 3/10/2026 with the Medical Director and the facility QAPI Committee, consisting of Executive Director, Facility Maintenance Support, Director of Plant Operations, DHS, and MDS to review the incident, proposed Plan of Correction and ensure the implementation of the plan. The Director of Plant Operations or Director of Environmental Services will present the findings from the audits to the monthly QAPI Committee consisting of the Executive Director, Director of Health Services, Assistant Director of Health Services, Medical Director, Social Services Director, MDS Coordinator and Infection Preventionist. The QA Committee will determine the ongoing frequency as to the frequency of the monitoring plan based on the findings from the above-mentioned, ongoing audits. The Administrator has the oversight to ensure an effective plan is in place to meet the residents' wellbeing as well as an effective plan to identify facility concerns and implement a plan of correction. Facility alleges compliance 03/21/2026.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185466	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 01 - WESTPORT PLACE .. B. WING	02/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K0927 SS = D Bldg. 01	Continued from page 5 transfilling procedure. (4) The guidelines of CGA P-2.6, Transfilling of Low-Pressure Liquid Oxygen to be Used for Respiration, are met.	K0927		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185466	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 02/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Westport Place Health Campus	**4247 Westport Road , Louisville, Kentucky, 40207**

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E0000	Initial Comments 42 CFR 483.73 Type of Structure: One (1) story, (2010, 2012) Type V (111), protected combustible construction with seven (7) smoke compartments and a complete automatic wet and dry sprinkler system. An Emergency Preparedness Recertification Survey was conducted on 02/10/2026, in accordance with 42 Code of Federal Regulations, Subpart 483.73 (a)(3): (Emergency Preparedness) Requirements for Long Term Care Facilities. During this Recertification Survey, Westport Place Health Campus was found to be in compliance with the Requirements for Participation in Medicare and Medicaid.	E0000		03/21/2026

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185466	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F0000	INITIAL COMMENTS A Desk Review Revisit Survey was initiated on 03/31/2026 and concluded on 04/01/2026. It was determined the facility had achieved substantial compliance on 03/21/2026 as alleged.	F0000		

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.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F0000	INITIAL COMMENTS A Re-Certification Survey, in conjunction with an Abbreviated Survey concluded 02/14/2026 and found the facility not to be in substantial compliance with 42 CFR 483 subpart B. Survey Dates 02/09/2026 - 02/14/2026 Survey Census: 56 Survey Sample: 17 Supplemental Sample: 15 No deficiencies were issued related to complaints 2568789, 2585290, 2633859, or 2713971.	F0000		03/21/2026
F0554 SS = D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is NOT MET as evidenced by: Number of residents sampled: Number of residents cited: Review of facility policy titled, "Medication Administration – General Guidelines," revised 11/2018, indicated, "Medications are administered as prescribed in accordance with good nursing principles and practices and only by persons legally authorized to do so." The policy revealed, "B. Administration" included, "13) Residents are allowed to self-administer medications when specifically authorized by the attending physician and in accordance with procedures for self-administration of medications."	F0554	Address what corrective action will be accomplished for those residents found to have been affected by the deficient practice. On 2/12/2026, Clinical Support Nurse completed a self-medication administration assessment for resident #10. Resident #10 was found to be appropriate to self-administer PO Tums, after initial set up by nurse. A physician's order was obtained for resident #10 to have Tums at bedside and self-administer Tums, after initial set up by nurse. No adverse reactions identified. On 2/6/2026, upon admission, a self-medication administration assessment was completed for resident #69. At the time of the assessment, the resident declined self-administration of medications and agreed that medications would be administered by facility staff, however the resident brought over the counter medications in from home without staff knowledge. On 2/12/2026, the resident was educated regarding facility policy related to medication storage and administration. The resident verbalized understanding and consented to staff removing the medication from the room. The medications were secured in the medication cart until they could be picked up by the resident's family.	03/21/2026

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F0554 SS = D	Continued from page 1 Review of facility policy titled, "Guidelines for Self-Administration of Medications," last reviewed 12/16/2025, indicated, "The purpose of this policy is: To ensure the safe administration of medication for residents who request to self-medicate or when self-medication is a part of their plan of care." The policy revealed the "Procedure" included, "Residents requesting to self-medicate or has self-medication as a part of their plan of care shall be assessed using the [the facility's parent company's name] Self-Administration of Medication within the electronic health record. Results of the assessment will be presented to the physician for evaluation and an order for self-medication." 1. Review of "Resident Face Sheet" indicated the facility admitted Resident #10 on 01/28/2022. According to the Resident Face Sheet, the resident had a medical history that included a diagnosis of gastro-esophageal reflux disease (GERD) without esophagitis. Review of the quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 01/08/2026, revealed the facility assessed Resident #10 with a Brief Interview for Mental Status (BIMS) score of 12, which indicated the resident had moderate cognitive impairment. Review of Resident #10's "Care Plan" included a problem area initiated 03/17/2023, that indicated the resident was malnourished or was at risk for malnutrition. Interventions directed staff to provide diet, supplements, medications, and adaptive equipment as ordered (initiated 03/17/2023). Continued review revealed the resident's Care Plan did not include information about the resident self-administering medications or leaving medications at the resident's bedside. An observation on 02/09/2026 at 2:04 PM revealed Resident #10 had three antacids at their bedside. During an interview at that time, the resident stated they wanted to self-administer their medications as needed and to keep them at the bedside and did not recall who the nurse was who gave them the medication. An observation on 02/10/2026 at 9:07 AM revealed a cup of antacids on Resident #10's bedside table.	F0554	Continued from page 1 On 2/12/2026, the attending physician of resident #69 was notified, and new physician orders were obtained for the over-the-counter medications the resident wished to continue taking. These medications were then processed and administered by facility staff per physician order. No adverse reactions identified. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. On 2/16/2026, during AM medication administration, the Clinical Support Nurse completed an audit on all campus residents. No medications were observed at bedside without a self-administration assessment and physician order in place. Address what measure will be put into place or systemic changes made to ensure that the deficient practice will not recur. Beginning on 2/16/2026, the Clinical Support Nurse, DHS, Infection Prevention Nurse and Admissions Nurse educated all staff on Trilogy's Self-Administration of Medication Policy and Medication Storage Policy. Education included: The requirement that residents may only self-administer or keep medications at bedside after a Self-Medication Administration Assessment has been completed and a physician order is obtained. The requirement that all medications, including over-the-counter and home medications, must be secured according to facility policy unless approved for self-administration. Instruction that any staff member who observes medications in a resident room must immediately notify licensed nursing staff. Education for licensed nurses on completing the Self-Medication Administration Assessment, obtaining physician orders, and ensuring proper storage and documentation of resident owned medications. After education was provided, and to ensure	

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F0554 SS = D	Continued from page 2 An observation on 02/12/2026 at 10:05 AM revealed Resident #10 sitting in their recliner with a medication cup with three antacids in it on the over-the-bed table in front of them. Review of Resident #10's physician "Order History," for the timeframe from 01/14/2026 to 02/14/2026, revealed an order, dated 02/27/2022, for calcium carbonate (an antacid) chewable tablets 500 milligrams (mg) orally four times a day as needed (PRN). The Order History revealed no order to self-administer the medication or leave the medication at the resident's bedside. During an interview on 02/12/2026 at 11:10 AM, Registered Nurse (RN) #7 stated medications should not be left at the bedside. Upon entering Resident #10's room, RN #7 confirmed that the resident had a medication cup with three antacids in it on the over-the-bed table. He stated the antacids were there when he gave the resident their medications that morning. He stated he did not think about removing them when he saw them, but he should have. RN #7 went to the nurses' station and confirmed that Resident #10 did not have an order to leave them at the bedside, and he was unable to locate a self-administration assessment for the resident. During an interview on 02/13/2026 at 1:21 PM, Licensed Practical Nurse (LPN) #2 stated that if a resident wanted to self-administer a medication, the resident would have to sign a consent. She stated she always stayed with the resident until they took all their medications and did not leave medications at the bedside. She stated she did know Resident #10 had antacids at the bedside before but did not know if they had been assessed and thought that it was okay. She stated that she thought Resident #10 was capable of self-administering the antacids. She stated she did not think they needed an order, just consent from the resident. She stated that if she found medications in a room, she would remove them and educate the resident. 2. Review of a "Resident Face Sheet" indicated the facility admitted Resident #69 on 02/05/2026. According to Resident Face Sheet, the resident had a medical history that included diagnoses of non-pressure chronic ulcers of the right and left calf with necrosis of the muscle, and age-related osteoporosis.	F0554	Continued from page 2 understanding, all staff completed a post-test regarding the self-administration of medications and medication storage. A minimum score of 100% was required to pass. All staff achieved a passing score of 100%. The post-test was administered at the time of training. All licensed nurses will be educated by 3/20/2026. After 3/20/2026, any staff not educated will be educated prior to their next scheduled shift and any newly hired staff will be educated through orientation by the employee experience manager (EXM), with a post-test completed to ensure staff knowledge was retained on the training material provided with a passing score of 100%. The campus does not use agency staff. Indicate how the facility plans to monitor its performance to ensure that solutions are sustained. An Ad Hoc Quality Assurance meeting was held on 3/10/2026 with the Medical Director and the facility QAPI Committee, consisting of Clinical Support, DHS, Infection Preventionist, Admissions Nurse and MDS to review the incident, proposed Plan of Correction and ensure the implementation of the plan, and the Medical Directors expectation related to self-medication administration and medication storage. Beginning 2/16/2026, the Clinical Support Nurse, Director of Health Services, Assistant Director of Health Services, Infection Preventionist or Medical Records Nurse will conduct audits to ensure compliance with the facility's Self-Administration of Medication Policy and proper medication storage procedures. Audits will include observation of resident rooms for medications stored at bedside and verification that a Self-Medication Administration Assessment, physician order, and appropriate documentation are in place when applicable. Audits will be conducted as follows: Daily (Monday-Friday) for 2 weeks: Review 5 random residents for medications stored at bedside and required documentation. Twice weekly (Monday-Friday) for 2 weeks: Review 3 random residents for medications stored at bedside and required documentation. Weekly for 4 weeks: Review 1 random resident for medication stored at bedside and required	

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F0554 SS = D	Continued from page 3 Review of Resident #69's "Care Plan" revealed problem statement initiated 02/12/2026, that indicated the resident demonstrated forgetfulness and benefitted from cueing. The Care Plan revealed that it did not include information about the resident self-administering medications or leaving medications at the bedside. Review of Resident #69's "[the facility's parent company name]-Self-Administration of Medications" assessment, dated 02/06/2026, indicated the resident did not want to self-administer medications. The assessment indicated that the resident would not be self-administering medications. An observation on 02/09/2026 at 10:33 AM revealed Resident #69 had multiple bottles of medications in their windowsill, including collagen peptides (a dietary supplement), Florastor (an antidiarrheal probiotic), zinc (a mineral), and bone support (dietary supplement for bone health). There was also a bottle of loratadine (an antihistamine) and fluticasone (a nasal steroid) on the dresser. An observation on 02/10/2026 at 8:30 AM, 12:32 PM, and 2:03 PM revealed the bottles of medications in the windowsill and dresser remained. During an interview at the time of the observation, Resident #69 stated they tried to remember to take the medications but did not always. Resident #69 stated they did not recall having any type of assessment, but the staff never told them that they could not have the medication. An observation on 02/11/2026 at 9:31 AM revealed all the bottles of medications were removed from the windowsill and dresser but there was a bottle of fluticasone on the nightstand. An observation on 02/12/2026 at 10:00 AM revealed a bottle of fluticasone on the nightstand. Resident #69's Physician "Order History," for the timeframe from 01/14/2026 through 02/14/2026, revealed an order, dated 02/05/2026, for fluticasone propionate 50 micrograms (mcg) per actuation, one spray in each nostril twice a day. The Order History revealed no orders for the other medications found in the resident's room. The Order History revealed no orders	F0554	Continued from page 3 documentation. Monthly for 2 months: Review 1 random resident for medication stored at bedside and required documentation. The Director of Health Services and/or Assistant Director of Health Services will present the findings from the audits to the monthly QAPI Committee consisting of the Executive Director, Director of Health Services, Assistant Director of Health Services, Medical Director, Social Services Director, MDS Coordinator and Infection Preventionist. The QA Committee will determine the ongoing frequency as to the frequency of the monitoring plan based on the findings from the above-mentioned, ongoing audits. The Administrator has the oversight to ensure an effective plan is in place to meet the residents' wellbeing as well as an effective plan to identify facility concerns and implement a plan of correction. Facility alleges compliance 3/21/2026.	

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F0554 SS = D	Continued from page 4 for the resident to keep medications at the bedside or to self-administer medications. During an interview on 02/12/2026 at 11:07 AM, Registered Nurse (RN) #12 stated medications should not be left at residents' bedside. He stated if a resident wanted to self-administer their own medications, they needed to be assessed, and it would have to be approved by the Interdisciplinary Team (IDT), and they would need a physician order. He stated they also needed a physician order to keep the medication at the bedside. RN #12 stated that Resident #69 did not have an order to keep medications at the bedside or to self-administer their medications. He also stated that Resident #69's self-administration assessment indicated the resident did not want to self-administer medications. During an interview on 02/13/2026 at 3:44 PM, the Infection Control Nurse (ICN) stated that if a resident was alert and oriented and wanted to self-administer their medications, they completed an assessment first, and if the resident was assessed to be able to administer their own medications, they called the physician to get an order to self-administer and leave at the bedside. She stated that the nurse would document the use of the medication. During an interview on 02/13/2026 at 4:36 PM, the Director of Nursing Services (DNS) stated a resident could self-administer their own medications if an assessment was completed to determine if they were able to, then they notified the physician and got an order. She stated that the medications could be left at the bedside with an order from the physician.	F0554		
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:	F0695	Address what corrective action will be accomplished for those residents found to have been affected by the deficient practice. On 2/16/2026, the Clinical Support Nurse completed an audit on residents #30, #48, and #69. Resident #30, CPAP mask was cleaned and placed in a new resident belonging bag, labeled with the resident's name and date. Resident #48, O2 tubing was replaced and placed in a new resident belonging bag, labeled with the resident's name and date. Resident #69, nebulizer mask and medication cannister was replaced and placed in a new resident belonging bag, labeled with the resident's name and date.	03/21/2026

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F0695 SS = D	Continued from page 5 Based on observation, interview, and record review, the facility failed to ensure staff provided respiratory care consistent with resident care policies related to cleaning and storage of equipment for 3 of 4 residents sampled for respiratory therapy out of a total sample of 17 residents (Residents (R) 30, 48, and 69). Observations revealed used respiratory equipment not cleaned and/or stored appropriately after use. The findings include: 1. Review of facility policy, "Respiratory Equipment," last reviewed 12/16/2026, revealed the "Overview" indicated, "To provide infection control guidelines to help prevent infections associated with respiratory therapy equipment and to prevent transmission of infections to residents and staff." The policy also indicated, "2. Oxygen Administration" included, "j. Keep oxygen cannula and tubing used PRN [pro re nata; as needed] in a plastic bag when not in use." The policy revealed, "Medication Nebulizers/Continuous Aerosol" included, "c. After completion of therapy," which included, "i. Remove nebulizer container," "ii. Rinse container with fresh tap water," "iii. Allow to dry on clean paper towel or gauze sponge," and "iv. Reconnect to administration 'set up.'" The policy continued, "e. Wipe mouthpiece with damp paper towel or gauze sponge. f. Store circuit in plastic bag, marked with date and resident's name, between uses." During an interview on 02/11/2026 at 2:20 PM, the Director of Nursing Services (DNS) stated that there was no specific policy for use of CPAP machines. Review of facility document "Resident Face Sheet" revealed the facility admitted Resident #69 on 02/05/2026. According to the Resident Face Sheet, the resident had a medical history that included a diagnosis of asthma. Review of Resident #69's "Care Plan" included a problem area initiated 02/11/2026, that indicated the resident had the potential for complications, functional and cognitive status decline related to respiratory disease. Interventions initiated 02/11/2026 directed staff to provide respiratory therapy per orders and provide medications as ordered. Review of Resident #69's physician's "Order History," for the timeframe from 01/14/2026 through 02/14/2026, revealed an active order, dated 02/05/2026, for ipratropium-albuterol (a bronchodilator combination)	F0695	Continued from page 5 On 2/16/2026, the Clinical Support Nurse completed a full assessment of residents #30, #48, and #69 for signs and symptoms of infection, with no findings. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. On 2/16/2026, the Clinical Support Nurse and Infection Control nurse observed all residents in the campus with oxygen, nebulizer and/or CPAP orders and verified the O2 tubing, CPAP mask and/or nebulizer tubing was appropriately stored in a bag, labeled with name and date, when not in use. Address what measure will be put into place or systemic changes made to ensure that the deficient practice will not recur. Beginning on 2/16/2026, the Clinical Support Nurse, Director of Health Services, Infection Prevention Nurse and Admissions Nurse educated all current staff on appropriate storage of oxygen tubing, CPAP masks and nebulizer equipment. After education was provided, and to ensure understanding, all staff completed a post-test regarding the appropriate storage of respiratory equipment. A minimum score of 100% was required to pass. All staff achieved a passing score of 100%. The post-test was administered at the time of training. All current staff will be educated by 3/20/2026. Beginning on 2/16/2026, the Clinical Support Nurse, Director of Health Services, Infection Prevention Nurse and Admissions Nurse educated all licensed nurses on the policy for cleaning and storing nebulizer masks, mouth pieces and medication cannisters, after completion of therapy. After education was provided, and to ensure understanding, all staff completed a post-test regarding the appropriate storage of respiratory equipment. A minimum score of 100% was required to pass. All staff achieved a passing score of 100%. The post-test was administered at the time of training. All licensed nurses will be educated by 3/20/2026. After 3/20/2026, any staff not educated will be educated prior to their next scheduled shift and any newly hired staff will be educated through orientation	

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F0695 SS = D	Continued from page 6 solution for nebulization 0.5 milligrams (mg)-3 mg/3 milliliters (mL) one vial inhaled every four hours PRN for wheezing and shortness of air. An observation on 02/09/2026 at 10:33 AM revealed a nebulizer machine on Resident #69's nightstand with dried debris in the mask and fluid in the medication cannister. There was no bag to store the equipment in. Observations on 02/10/2026 at 8:30 AM and 12:32 PM revealed the nebulizer machine on Resident #69's nightstand with the mask and medication cannister in the top drawer with dried debris in the mask. The equipment was not stored in a bag. During an observation and interview on 02/10/2026 at 2:03 PM, Resident #69 stated they used the nebulizer machine when they were short of breath. The resident stated the staff laid the mask on top of the machine or in the drawer, and they had not seen staff rinse it out. The medication cannister and mask were lying on top of the nightstand and were not stored in a bag. There was fluid in the medication cannister. Review of Resident #69's "Medication Administration History" revealed staff documented the resident received an ipratropium-albuterol nebulizer treatment on 02/10/2026 at 8:12 PM. An observation on 02/11/2026 at 9:31 AM revealed Resident #69's nebulizer machine was on the nightstand with the tubing attached, with the mask and medication cannister lying on top of the nightstand. There was dried debris in the mask and liquid in the medication cannister, and it was not stored in a bag. An observation on 02/12/2026 at 10:00 AM revealed Resident #69's nebulizer machine on Resident #69's nightstand with the tubing attached, with the mask and medication cannister lying on top of the nightstand, with dried debris in the mask and a scant amount of liquid in the medication cannister. The mask and medication cannister were not stored in a bag. During an interview on 02/12/2026 at 11:07 AM, Registered Nurse (RN)#12 entered Resident #69's room and confirmed that the nebulizer mask was dirty and not stored in a bag. He opened the top drawer of the nightstand and there was a bag to store the equipment in. He stated the mask should be wiped out after use and the medication cannister rinsed, dried, and stored in the bag. RN #12 put Resident #69's name, room number and date on the bag and then set it next to the machine. He then removed the mask and tubing and threw	F0695	Continued from page 6 by the employee experience manager (EXM), with a post-test completed to ensure staff knowledge was retained on the training material provided with a passing score of 100%. The campus does not use agency staff. Indicate how the facility plans to monitor its performance to ensure that solutions are sustained. Beginning 2/16/2026, the Clinical Support Nurse, Director of Health Services, Assistant Director of Health Services, Infection Preventionist or Medical Records nurse will audit for appropriate storage of oxygen cannula and tubing, CPAP mask and nebulizer equipment. Audits will be conducted as follows: Three times weekly for 2 weeks for five random residents. Twice weekly for 2 weeks for three random residents. Twice weekly for 2 weeks for two random residents. Monthly for 2 months for two random residents. An Ad Hoc Quality Assurance meeting was held on 3/10/2026 with the Medical Director and the facility QAPI Committee, consisting of Clinical Support, DHS, Infection Preventionist, Admissions Nurse and MDS to review the incident, proposed Plan of Correction and ensure the implementation of the plan, and the Medical Directors expectation related to storage and cleaning of respiratory equipment. The Director of Health Services and/or Assistant Director of Health Services will present the findings from the audits to the monthly QAPI Committee consisting of the Executive Director, Director of Health Services, Assistant Director of Health Services, Medical Director, Social Services Director, MDS Coordinator and Infection Preventionist. The QA Committee will determine the ongoing frequency as to the frequency of the monitoring plan based on the findings from the above-mentioned, ongoing audits. The Administrator has the oversight to ensure an effective plan is in place to meet the residents' wellbeing as well as an effective plan to identify facility concerns and implement a plan of correction. Facility alleges compliance 3/21/2026.	

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F0695 SS = D	Continued from page 7 them away and stated that he was going to get new equipment. During an interview on 02/13/2026 at 1:21 PM, Licensed Practical Nurse (LPN) #2 stated that after a nebulizer treatment, the mask should be wiped out and put in a plastic bag, and the medication cannister should be rinsed and allowed to air-dry then put in the bag. During a telephone interview on 02/13/2026 at 10:14 AM, RN #13 stated they were supposed to put the nebulizer mask in a bag after use. She stated that she had administered Resident #69 a nebulizer treatment on 02/10/2026, and once it was done, she placed the mask in the top drawer of the nightstand because the resident did not have a bag in their room at that time. She stated she meant to get one and put it in the room, but she got busy and forgot. 2. Review of "Resident Face Sheet" revealed the facility admitted Resident #48 on 03/31/2025. According to the Resident Face Sheet, the resident had a medical history that included diagnoses of acute on chronic combined systolic (congestive) and diastolic (congestive) heart failure (CHF) and chronic pulmonary embolism. Review of the quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 12/18/2025, revealed Resident #48 had a Brief Interview for Mental Status (BIMS) score of 14, which indicated the resident had intact cognition. The MDS indicated that the resident received oxygen therapy during the assessment timeframe. Review of Resident #48's "Care Plan" included a problem area initiated 04/07/2025, that indicated the resident had a potential for cardiovascular distress and complications related to CHF. Interventions directed staff to administer oxygen therapy per physician orders (initiated 04/07/2025). Review of Resident #48's physician's "Order History," for the timeframe from 01/14/2026 through 02/14/2026, revealed an active order, dated 03/31/2025, for supplemental oxygen at 2 liters continuous per nasal cannula. The Order History indicated that the order was changed to PRN on 02/11/2026. An observation on 02/09/2026 at 9:54 AM revealed an oxygen concentrator in Resident #48's room with the oxygen tubing lying on the floor. A portable oxygen tank was under and behind a chair in the room, with the tubing and nasal cannula touching the floor. At 11:49	F0695		

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F0695 SS = D	Continued from page 8 AM, the oxygen tubing was wadded up on top of the concentrator. An observation on 02/10/2026 at 8:29 AM revealed the oxygen concentrator in Resident #48's room was on, and the tubing was hanging over the open drawer of the nightstand, with the cannula touching the side of the nightstand. The portable oxygen tank remained on its side under and behind the chair, with the cannula and the tubing touching the floor. An observation on 02/11/2026 at 9:30 AM revealed the oxygen concentrator in Resident #48's room was on. The tubing was not plugged in but was wadded up on top of the machine. The portable oxygen tank remained on its side under and behind the chair, with the cannula and the tubing touching the floor. An observation on 02/11/2026 at 10:01 AM revealed the oxygen concentrator in Resident #48's room was off, and the tubing was lying across the resident's bed. The portable oxygen tank remained on its side under and behind the chair, with the cannula and the tubing touching the floor. During an interview on 02/12/2026 at 11:09 AM, Registered Nurse (RN) #12 stated that when oxygen tubing was not in use, it should be stored in a plastic bag. Upon entering Resident #48's room, RN #12 noticed the portable tank lying under and behind the chair. He set it up, removed the tubing, and threw it away. He stated the tubing on the bed should be stored in a plastic bag, and he was going to have to get a bag to store the equipment in. He removed the tubing from the concentrator and threw it away and stated he was going to replace it. During an interview on 02/13/2026 at 1:21 PM, Licensed Practical Nurse (LPN) #2 stated oxygen tubing should be stored in a bag when not in use, and if it fell on the floor, it should be thrown away and replaced. During an interview on 02/13/2026 at 3:44 PM, the Infection Control Nurse (ICN) stated that oxygen tubing should be stored in a bag when not in use. He stated the bag was dated and had the resident's name on it. He stated that if it touched the floor, then it should be replaced. He stated that the nebulizer mask and medication cannister should be rinsed out and stored in a plastic bag after use. During an interview on 02/13/2026 at 4:36 PM, the Director of Nursing Services (DNS) stated oxygen tubing should be stored in a bag when not in use, and if it	F0695		

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F0695 SS = D	Continued from page 9 fell on the floor, it should be thrown away and a new one obtained. She stated that per the facility policy, nebulizer equipment should be washed with soap and water, air-dried, and stored in a bag. During an interview on 02/13/2026 at 4:36 PM, the Executive Director stated staff should follow the facility policy related to respiratory equipment. 3. Review of facility document "Resident Face Sheet" indicated the facility admitted Resident #30 on 01/30/2026 with diagnoses including obstructive sleep apnea. Review of the admission Minimum Data Set (MDS), with an Assessment Reference Date of 02/02/2026, indicated the facility assessed Resident #30 with a Brief Interview for Mental Status (BIMS) score of 10, which indicated the resident had moderate cognitive impairment. The MDS indicated Resident #30 received non-invasive mechanical ventilator respiratory treatments while a resident. Review of Resident 30's "Care Plan," included a problem statement initiated 02/03/2026, that indicated the resident had the potential for shortness of breath (SOB) while lying flat related to obstructive sleep apnea (OSA). Interventions directed staff to administer oxygen per the physician's order and as needed (started 02/03/2026). Resident 30's "Care Plan," included a problem statement initiated 02/03/2026, that indicated the resident required the use of home continuous positive airway pressure (CPAP) due to OSA. Interventions directed staff to provide CPAP treatments per the physician's orders (started 02/03/2026). An observation on 02/09/2026 at 3:36 PM of Resident #30's room revealed a CPAP mask on the top of a side table, not stored in a receptacle bag. An observation on 02/10/2026 at 10:43 AM of Resident #30's room revealed the CPAP mask on the top of the side table, not stored in a receptacle bag. During an interview on 02/11/2026 at 12:58 PM, Licensed Practical Nurse (LPN) #10 stated that Resident 30's CPAP mask should be stored in a respiratory bag when	F0695		

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F0695 SS = D	Continued from page 10 not in use. During an interview on 02/11/2026 at 1:21 PM, the acting Director of Nursing Services (DNS) stated licensed nurses were responsible for CPAP device care, including storing masks in clean plastic bags. During a concurrent observation and interview on 02/11/2026 at 1:40 PM, the DNS confirmed that upon entering Resident #30's room, the CPAP mask was observed on the top of the resident's side table, not stored in a plastic bag.	F0695		
F0759 SS = D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is NOT MET as evidenced by: Based on observation, record review and interviews the facility failed to ensure medication error rates were less than five percent (5%). Observations during medication administration revealed three medication errors during administration of 27 medication events resulting in a medication error rate of 11.11%. The findings include: Review of facility policy, "Medication Administration – General Guidelines," revised 01/2018, indicated the "Procedures" included, "4) Five Rights – Right resident, right drug, right dose, right route and right time, are applied for each medication being administered. A triple check of these 5 Rights is recommended at three steps in the process of preparation of a medication for administration: (1) when the medication is selected, (2) when the dose is removed from the container, and finally (3) just after the dose is prepared and the medication put away." The policy continued, "a. Check #1: Select the Medication – label, container and contents are checked for integrity and compared against the medication administration record (MAR) by reviewing the 5 Rights. b. Check #2: Prepare the dose – the dose is removed from the	F0759	Address what corrective action will be accomplished for those residents found to have been affected by the deficient practice. On 2/11/2026, the Clinical Support Nurse verified with the CMT who did not administer the MiraLAX to resident #59 and with the supervising nurse that the medication was held due to the resident experiencing loose stools. The Clinical Support Nurse also confirmed that the physician was notified of the medication omission. No adverse reactions identified. On 2/13/2026 and 2/16/2026, the Clinical Support Nurse reviewed the bowel movement list with no findings. The failure to follow instructions on priming insulin pen needle did not reach any residents, so no residents are identified as being affected by the deficient practice. On 2/11/2026, the Clinical Support Nurse verified with the nurse and the surveyor that the MiraLAX for resident #39 which was omitted during the initial medication administration, was administered at a later time on 2/11/2026. The physician was notified, and no adverse reactions were identified. On 2/13/2026 and 2/16/2026, the Clinical Support Nurse reviewed the bowel movement list with no findings. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. On 2/16/2026, the Clinical Support Nurse completed an observation of the medication administration for four nurses. Residents chosen for audit were residents that had physician orders for MiraLAX and residents that	03/21/2026

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F0759 SS = D	Continued from page 11 container and verified against the label and the MAR by reviewing the 5 Rights. c. Check #3: Complete the preparation of the dose and re-verify the label against the MAR by reviewing the 5 Rights when putting the medication away." The policy also indicated, "D. Documentation" included, "6. If a dose of regularly scheduled medication is withheld, refused, not available, or given at a time other than the scheduled time, (e.g. [exempli gratia, for example], the resident is not in the facility at scheduled dose time, or a starter dose of antibiotic is needed), it is documented on MAR or in the EHR [electronic health record]. An explanatory note is also entered." 1. Review of facility document, "Resident Face Sheet," indicated the facility admitted Resident #59 on 12/02/2021. According to the Resident Face Sheet, the resident had diagnoses including irritable bowel syndrome and constipation. Review of the facility quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 12/12/2025, revealed the facility assessed Resident #59 with a Brief Interview for Mental Status (BIMS) score of 3, which indicated the resident had severe cognitive impairment. Review of Resident #59's physician "Order History" for the timeframe from 01/01/2026 to 02/14/2026, included an active order, dated 12/15/2025, for polyethylene glycol (a laxative) 17 grams mixed in 8 ounces of liquid orally once a day. During a medication administration observation on 02/11/2026 at 8:11 AM, Certified Resident Medication Assistant (CRMA) #3 prepared and administered medication to Resident #59. However, CRMA #3 omitted administering the polyethylene glycol to the resident. During an interview on 02/11/2026 at 2:34 PM, CRMA #3 stated that he did not give Resident #59 their polyethylene glycol because the resident had diarrhea. He stated that he should have documented why it was not given. 2. Review of "Basaglar [a type of insulin] KwikPen Instruction for Use" specified, "Prime before each injection. Priming means removing the air from the	F0759	Continued from page 11 utilize a KwikPen for insulin administration with education provided with any instance of deficient practice. On 3/9/2026, lead nurse consultant with Syncrony pharmacy observed medication administration with education provided with any instance of deficient practice. Address what measure will be put into place or systemic changes made to ensure that the deficient practice will not recur. Beginning on 2/16/2026, the Clinical Support Nurse, Director of Health Services, Infection Prevention Nurse and Admissions Nurse educated all licensed nurses and certified medication technicians on the 5 Rights of Medication Administration, priming insulin pen needles and the administration of medications per physician orders with notification to physician for any withheld medications. All licensed nurses and certified medication technicians will be educated by 3/20/2026. After education was provided, and to ensure understanding, all staff completed a post-test regarding the appropriate storage of respiratory equipment. A minimum score of 100% was required to pass. All staff achieved a passing score of 100%. The post-test was administered at the time of training. All licensed nurses will be educated by 3/20/2026. After 3/20/2026, any staff not educated will be educated prior to their next scheduled shift and any newly hired staff will be educated through orientation by the employee experience manager (EXM), with a post-test completed to ensure staff knowledge was retained on the training material provided with a passing score of 100%. The campus does not use agency staff. Indicate how the facility plans to monitor its performance to ensure that solutions are sustained. An Ad Hoc Quality Assurance meeting was held on 3/10/2026 with the Medical Director and the facility QAPI Committee, consisting of Clinical Support, DHS, Infection Preventionist, Admissions Nurse and MDS to review the incident, proposed Plan of Correction and ensure the implementation of the plan, and the Medical Directors expectation related to medication	

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F0759 SS = D	Continued from page 12 Needle and Cartridge that may collect during normal use. It is important to prime your Pen before each injection so that it will work correctly. If you do not prime before each injection, you may get too much or too little insulin." The instructions continued, "Step 6," "To prime your Pen, turn the Dose Knob to select 2 units." The instructions continued, "Step 7," "Hold your Pen with the Needle pointing up. Tap the Cartridge Holder gently to collect air bubbles at the top." The instructions revealed, "Step 8," "Continue holding your Pen with Needle pointing up. Push the Dose Knob in until it stops, and '0' is seen in the Dose Window. Hold the Dose Knob in and count to 5 slowly. You should see insulin at the tip of the Needle. If you do not see insulin, repeat the priming steps, but not more than 4 times. If you still do not see insulin, change the needle and repeat the priming steps." Review of a "Resident Face Sheet" indicated the facility admitted Resident #39 on 12/28/2018. According to the Resident Face Sheet, the resident had a medical history that included diagnoses of diabetes mellitus and constipation. Review of the quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 11/25/2025, revealed the facility assessed Resident #39 with a Brief Interview for Mental Status (BIMS) score of 10, which indicated the resident had moderate cognitive impairment. Review of Resident #39's physician "Order History," for the timeframe from 01/01/2026 through 02/14/2026, included an active order, dated 12/17/2025, for Basaglar KwikPen insulin 100 units/milliliter (ml) 40 units subcutaneous once a day. The Order History also included an active order, dated 11/24/2025, for polyethylene glycol (a laxative) 17 grams by mouth twice a day. During a medication administration observation on 02/11/2026 at 8:39 AM, Licensed Practical Nurse (LPN) #2 prepared and administered medication to Resident #39. LPN #39 omitted administering the polyethylene glycol to the resident and failed to prime the Basaglar KwikPen insulin pen needle prior to turning the dose knob to 40 units. During an interview on 02/11/2026 at 12:20 PM, LPN #2	F0759	Continued from page 12 administration. Beginning 2/16/2026, the Clinical Support Nurse, Director of Health Services, Assistant Director of Health Services, Infection Preventionist or Medical Records Nurse will conduct medication administration audits to ensure compliance with the 5 Rights of Medication Administration and ensure the campus maintains a medication error rate of less than 5%. Audits will be conducted as follows: Three times weekly for 2 weeks: Observe medication administration for 5 random residents. Twice weekly for 2 weeks: Observe medication administration for 3 random residents. Twice weekly for 2 weeks: Observe medication administration for 2 random residents. Monthly for 2 months: Observe medication administration for 2 random residents. The Director of Health Services and/or Assistant Director of Health Services will present the findings from the audits to the monthly QAPI Committee consisting of the Executive Director, Director of Health Services, Assistant Director of Health Services, Medical Director, Social Services Director, MDS Coordinator and Infection Preventionist. The QA Committee will determine the ongoing frequency as to the frequency of the monitoring plan based on the findings from the above-mentioned, ongoing audits. The Administrator has the oversight to ensure an effective plan is in place to meet the residents' wellbeing as well as an effective plan to identify facility concerns and implement a plan of correction. Facility alleges compliance 3/21/2026.	

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F0759 SS = D	Continued from page 13 stated that she forgot to give the polyethylene glycol to Resident #39. She stated she was nervous, but she should have double and triple checked the orders to ensure she administered everything that was ordered to be given at that time. LPN #2 stated she had never been educated to prime an insulin pen needle. During an interview on 02/13/2026 at 3:44 PM, the Infection Control Nurse (ICN) stated that when administering medications, staff should follow the five rights. She stated they should move the medication cart in front of the room to verify the room number and the resident with a picture, then they should double check the medication with the MAR to ensure the right medication, right dose, right time, and right route for the right resident. He stated they should check the orders against the pharmacy packet. He stated they had to have a reason if a medication was not given, and it must be documented. He stated that insulin pen needles should be primed with two units. During an interview on 02/13/2026 at 4:36 PM, the acting Director of Nursing Services (DNS) stated staff should follow the five rights of medication administration, the right resident, medication, dose, route, and time. The DNS stated that insulin pen needles should be primed with two units or until the insulin was seen coming out of the needle. During an interview on 02/13/2026 at 4:36 PM, the Executive Director (ED) stated the staff	F0759		