VERMONT

Department of Disabilities, Aging and Independent Living
Division of Licensing and Protection
280 State Drive/HC 2 South
Waterbury, VT 05671-2060
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AGENCY OF HUMAN SERVICES

October 28, 2025

Mr. Richard Kelly Barber, Administrator
Woodridge Nursing Home
142 Woodridge Drive
PO Box 550
Barre, VT 05641

Provider ID #: 475045

Dear Mr. Kelly Barber:

Enclosed is a copy of your acceptable plans of correction for the recertification survey conducted on **September 12, 2025.** Please post this document in a prominent place in your facility.

We may follow up to verify that substantial compliance has been achieved and maintained. If we find that your facility has failed to achieve or maintain substantial compliance, remedies may be imposed.

Sincerely,

Pamela M Cota RN
Pamela M. Cota, RN, BS
Assistant Division Director
State Survey Agency Director

Enclosure

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475045	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Woodridge Nursing Home	**142 Woodridge Drive PO Box 550, Barre, Vermont, 05641**

(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
E0000	Initial Comments The Division of Licensing and Protection conducted an emergency preparedness review during the annual recertification survey on 09/10/2025. There were regulatory violations identified.	E0000		
E0004	Develop EP Plan, Review and Update Annually CFR(s): 483.73(a) §403.748(a), §416.54(a), §418.113(a), §441.184(a), §460.84(a), §482.15(a), §483.73(a), §483.475(a), §484.102(a), §485.68(a), §485.542(a), §485.625(a), §485.727(a), §485.920(a), §486.360(a), §491.12(a), §494.62(a). The [facility] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must develop establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section. The emergency preparedness program must include, but not be limited to, the following elements: (a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be [reviewed], and updated at least every 2 years. The plan must do all of the following: * [For hospitals at §482.15 and CAHs at §485.625(a):] Emergency Plan. The [hospital or CAH] must comply with all applicable Federal, State, and local emergency preparedness requirements. The [hospital or CAH] must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. * [For LTC Facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually.	E0004	1. Emergency Preparedness Plan was reviewed on 9-22-2025 by the Nursing Home Administrator and the Leadership team. 2. Woodridge Emergency Preparedness Plan was reviewed and updated on 10-01- 2025 by the Nursing Home Administrator and Emergency Preparedness Manager on 10-01-2025 recommendations were completed. 3. Education provided to Leadership team of the requirement for the emergency preparedness plan to be reviewed annually and updated every two years on 10-10-2025. 4. Woodridge Emergency Preparedness Plan will be reviewed at the Monthly QAPI. 5. Compliance date: 10-14-2025. **Tag E0004 POC accepted on 10/27/25 by J. Schneckenburger/S. Stem**	

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
Wendy LaBate	Admin.	10/9/2025

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E0004	Continued from page 1 * [For ESRD Facilities at §494.62(a):] Emergency Plan. The ESRD facility must develop and maintain an emergency preparedness plan that must be [evaluated], and updated at least every 2 years. This STANDARD is NOT MET as evidenced by: Based on interview and record review, the facility failed to review and update the facility Emergency Preparedness Plan annually. This has the potential to impact all residents. Findings include: Per review of the Current Emergency Preparedness documents, they were last updated January 2024. Per interview on 9/10/25 at approximately 3:30PM with Licensed Practical Nurse in the Nurses station, s/he confirmed that they have a small guide to follow/use with phone numbers and guidance related to various emergent situations. This guide was marked with a publication/print date of 2019. Per interview on 9/10/2025 at approximately 2:30PM, the Director of Facility Support Services and the Emergency Preparedness Manager confirmed the last time the Emergency Preparedness Plan was updated was January 2024.	E0004		
F0000	INITIAL COMMENTS The Division of Licensing and Protection conducted an unannounced, onsite recertification survey and investigation of two complaints and one facility reported incident, including report(s) # 2602605, #2613507, and # 2602809, from 09/08/2025 through 09/10/2025, with offsite record review continuing through 9/12/25, to determine compliance with 42 CFR Part 483 requirements for Long Term Care Facilities. Deficiencies were cited as a result of this survey.	F0000		
F0550 SS = E	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	F0550		

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F0550 SS = E	Continued from page 2 to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is NOT MET as evidenced by: Based on observation and interview the facility failed to ensure that all residents were treated with dignity in regard to dining on 2 of 3 units. Findings include: 1. Per observation of lunch service on the Evergreen unit on 9/8/25 at 12:15 PM, 7 residents were in the side room for lunch sitting at one large table, and one small side table. Lunch was being served on trays, with warming dishes, to one resident at a time. As the trays were placed on the table, the warming lids were stacked in the middle of the table. Trash was also put in the middle of the table. At 12:19 PM, while other residents	F0550	1. Resident # 39 mealtimes were reviewed and updated by the Unit Manager and Food Services Director on 10-2-25 to ensure that meals are provided to meet the Resident's needs. Resident # 86 mealtimes were reviewed and updated by the Nursing Unit Manager and Food Services Director on 10-2- 2025 to ensure that meals are provided to meet the Resident's needs. Resident # 132 mealtimes were reviewed on 10-2-2025 and updated by the Unit Manager and the Food Services Director to ensure that meals are provided to meet the Resident's needs. 2. A review of Residents mealtimes was conducted on 10-2-2025 by the Unit managers and the Food Services Director to identify inconsistencies with meal delivery and adjustments were made as indicated. Including the removal of trays, trash and warming devices from the meal area. Nursing staff and Dietary staff will work collaboratively to ensure meal carts arrive at the designated times. 3. Re- education provided to Nursing and Dietary staff of tray delivery, mealtimes and resident dignity were provided by the Nurse Educators will be completed on 10-10-2025. 4. Meal Observation audits will be conducted weekly for 4 weeks, then monthly for 3 months and reviewed in the monthly QAPI meeting for substantial compliance. 5. Compliance date: 10-14-2025. **Tag F0550 POC accepted on 10/27/25 by J. Schneckenburger/S. Stem**	

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F0550 SS = E	Continued from page 3 were eating, Resident #39 said that s/he is really hungry. S/he was not served lunch until 12:43 PM. Resident #86, who was sitting in the common area outside of the side room since the start of lunch service was not served lunch until 12:54 PM. Per interview with the Dietary Manager on 9/10/25 at 1:35 PM, he explained that they cannot get all meals to each unit at the same time because there isn't enough staff to bring each food cart up to the unit. Per interview with the DON on 9/10/25 at approximately 3:00 PM, she confirmed that all residents should be served at the same time if they are sitting at the same table. 2. Per observation of lunch on 9/10/25 at 12:05 PM, Resident #132 was sitting while another resident was eating at same table. Per observation on 9/10/2025 at 12:13 PM, all residents had been served lunch except Resident #132. S/he was told by LNA#1 "Your tray is coming up, it's just a little late." On 9/10/2025 at 12:31 PM LNA #1 stated, "[The]trays got mixed up, they put [his/her] food on the jitney and accidentally sent it to the unit since [s/he] usually eats in [his/her] room." LNA #1 confirmed Resident #132 had not eaten lunch. Per observation on 9/10/2025 at 12:32 PM Resident #132 was given a tray of food on the unit, 27 minutes after the rest of his/her table.	F0550		
F0552 SS = E	Right to be Informed/Make Treatment Decisions CFR(s): 483.10(c)(1)(4)(5) §483.10(c) Planning and Implementing Care. The resident has the right to be informed of, and participate in, his or her treatment, including: §483.10(c)(1) The right to be fully informed in language that he or she can understand of his or her total health status, including but not limited to, his or her medical condition. §483.10(c)(4) The right to be informed, in advance, of the care to be furnished and the type of care giver or	F0552		

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F0552 SS = E	Continued from page 4 professional that will furnish care. §483.10(c)(5) The right to be informed in advance, by the physician or other practitioner or professional, of the risks and benefits of proposed care, of treatment and treatment alternatives or treatment options and to choose the alternative or option he or she prefers. This REQUIREMENT is NOT MET as evidenced by: Based on interview and record review, the facility failed to ensure a resident's right to be informed in advanced by the physician or other practitioner or professional of the risk and benefits by proposed care, of treatment alternatives or treatment options, and to choose the alternative or option he or she prefers for two of five residents in the sample. (Residents #4 and #12). Findings include: 1.) Per record review, Resident #4 has active orders for "Lorazepam 1 mg [milligram] tab: Give 1 tablet by mouth two times a day for Chronic Anxiety," and "Lorazepam Oral Tablet 0.5 mg [milligram]: Give 1 tablet by mouth every 12 hours as needed for increased anxiety/restlessness/agitation for 30 Days inability to redirect," both ordered on 8/28/25. Resident #4 also had an order for "Lorazepam Oral Tablet 0.5 MG (milligram): Give 0.5 mg by mouth one time a day for anxiety/agitation." This medication was originally ordered on 3/25/25 and discontinued on 5/22/25. Per record review, there is no evidence that residents were educated on the use and/or risk and benefits of the medications. Per record review of the facility's "High Risk Medications" policy [last revised February 2023] states, "8. Residents and/or representatives will be educated on the use and risks/benefits of high-risk medications, including adverse effects." Per interview with the Unit Manager on 9/10/2025 10:14 AM she stated the facility does not use consent forms for Lorazepam stating, "We only do them for antipsychotics like Seroquel and Olanzapine." She confirmed there is no consent form signed by resident or resident representative for Lorazepam in the resident's EMR [Electronic Medical Record]. On 9/10/2025 at 10:30 AM the DON [Director of Nursing] stated that they [the facility] do not use consent forms for psychotropic medications including Lorazepam.	F0552	1. Resident #4 Lorazepam was discontinued on 5-22-2025. Resident expired on 09-25-2025. Resident # 12 currently receiving Olanzapine, consent obtained on 09-30-2025 education for risk and benefits provide. 2. Residents currently prescribed psychotropic medications and consent documentation was reviewed by the Unit Managers and Assistant Nurse Managers on 09-30-2025. Resident and/or their legal representatives were contacted to provide informed consent including risks and benefits, and alternatives. 3. Education provided to Nursing Staff, Providers and Social Services regarding proper documentation of informed consent and the facility policy to obtain informed consent prior to initiating, continuing, or adjusting any psychotropic medications. By the Nurse Educators on 10-03-2025. 4. Audits will be conducted weekly for 4 weeks, then monthly for 3 months and reviewed in the monthly QAPI meeting for substantial compliance. 5. Compliance Date: 10-14-2025. **Tag F0552 POC accepted on 10/27/25 by J. Schneckenburger/S. Stem**	

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F0552 SS = E	Continued from page 5 2. Per record review of Resident #12's medical record, an Antipsychotic Informed consent form states that verbal consent was obtained on 1/7/2024 by Resident #12's responsible party for Olanzipine (Antipsychotic)10 mg once a day. Further review revealed a physician's order dated 9/2/2025 for Olanzapine 10 mg by mouth twice a day for dementia with behaviors. A progress note dated 9/2/2025 states "Message left to [responsible party] via phone regarding order updates for increase in Olanzapine AM dose..." There is no further documentation indicating that Resident #12's responsible party was ever notified of the increase in Olanzipine. Further record review reveals a physician's order for Citalopram (Antidepressant) 20 mg one time a day for dementia with behaviors. There is also no documented evidence that Resident #12's responsible party was provided the right to be informed in advanced by the physician or other practitioner or professional of the risk and benefits of the use of Citalopram or of treatment alternatives or treatment options. Per review of the facility policy titled Antipsychotics states "All residents with a new order for antipsychotic medications will have a signed consent form in the medical record." The facility policy titled High Risk Medications lists psychotropic medications as high-risk medications and states " Residents and/or representatives will be educated on the use and risks/benefits of high-risk medications, including adverse effects." Per interview on 9/10/2025 at 11:00 AM the Assistant Unit Manager at 11:00 AM confirmed that there is no documented evidence in the record that the facility obtained informed consent from Resident #12 or her/his responsible party prior to the increase of Olanzapine to 10 mg twice a day from once a day and that there is no evidence of consent or discussion of risks versus benefits of the Citalopram.	F0552		
F0577 SS = B	Right to Survey Results/Advocate Agency Info CFR(s): 483.10(g)(10)(11) §483.10(g)(10) The resident has the right to- (i) Examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to	F0577		

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F0577 SS = B	Continued from page 6 the facility; and (ii) Receive information from agencies acting as client advocates, and be afforded the opportunity to contact these agencies. §483.10(g)(11) The facility must-- (i) Post in a place readily accessible to residents, and family members and legal representatives of residents, the results of the most recent survey of the facility. (ii) Have reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding years, and any plan of correction in effect with respect to the facility, available for any individual to review upon request; and (iii) Post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public. (iv) The facility shall not make available identifying information about complainants or residents. This REQUIREMENT is NOT MET as evidenced by: Based on observation and interview, the facility failed to provide state survey results for residents and resident representatives to readily view. Findings include: Per observation on 9/9/25 at 1:25 PM there were no state survey results available on the second floor where all residents reside. Per interview with Resident #114 during resident council on 9/9/25 at approximately 1:30 PM, s/he stated, "It would be nice if we could have access to it [state survey results], I can't get to the first floor because I can't walk." Per record review Resident #114 has a BIMS [Brief Interview of Mental Status] score of 14, indicating that Resident #114 has no cognitive deficit. Resident #114 is dependent on staff for ADLs [Activities of Daily Living] and hygiene. Per interview with the Activities Director on 9/9/25 at 2:28 PM, she confirmed state survey results are not posted on the second floor and are only on the first floor of the building.	F0577	1. An additional location for the Survey Results was added to a clearly accessible area on the second floor. Residents and their representatives were notified verbally and writing about the location and contents. 2. The survey Binder containing the last three years of survey results, complaint investigations, and plans of corrections will be maintained in the front lobby and on the second floor. 3. Education was provided by the Nurse Educators to staff on 10-7-2025. Social Services on staff and Resident council of the locations of the Survey Binders on 10-2-2025. 4. The Survey results binders will be audited weekly for 4 weeks, then monthly for 3 months and reviewed in the monthly QAPI meeting for substantial compliance. 5. Compliance date: 10-14-2025. **Tag F0577 POC accepted on 10/27/25 by J. Schneckenburger/S. Stem**	
F0578	Request/Refuse/Discntnue Trmnt;Formlte Adv Dir	F0578		

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F0578 SS = D	Continued from page 7 CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is NOT MET as evidenced by: Based on record review and interview, the facility failed to ensure that a Resident's choice regarding his/her Advance Directives (wishes regarding life-sustaining treatment) was documented correctly, ordered, and care planned for 1 of 30 residents sampled	F0578	1. Resident #123 Advance directive was confirmed and updated in physicians' orders and the care plan. 2. Current Residents Advance Directives and Colst were audited by Social Services, nursing, and the providers on 10-07-2025 to ensure the residents wishes are accurately reflected in the physician orders and care plan. 3. Licensed staff were educated by the Nurse Educators on the implementation of the Residents advanced directives completed 10-10-2025. 4. Social Services will conduct a random audit of 10 medical records per month for the accurate alignment of the advanced directives, Colst, and care plan. Audits will be conducted weekly for 4 weeks, then monthly for 3 months and reviewed in the monthly QAPI meeting for substantial compliance. 5. Compliance date: 10-14-2025. **Tag F0578 POC accepted on 10/27/25 by J. Schneckenburger/S. Stem**	

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F0578 SS = D	Continued from page 8 (Resident #123). Findings include: Per record review, Resident #123's Electronic Health Record (EHR) has an Advanced Directive stating s/he wishes are do not resuscitate (DNR) and trial course of intubation (a tube to assist with breathing) and ventilation treatment for 5 days, signed 12/30/24 by the Resident. The Code Status in the EHR states DNR/DNI (Do Not Intubate), and the Care Plan (initiated on 2/28/25 and revised on 6/30/25) Focus states "Advanced directive, [Resident #123] has established advanced directives-DNR/DNI, Date Initiated: 02/28/2025, Revision on: 03/25/2025), and there is an Order for DNR/DNI with a start date of 2/28/25. The Care Plan, Order, and Resident dashboard don't reflect the Resident's wishes of DNR/Trial of intubation for 5 days per her/his documented Advanced Directives. Per interview on 9/9/25 at 1:50 PM, the Assistant Unit Nurse Manager confirmed Resident #123's Advanced Directive reveal their wishes are DNR and trial of five days of intubation. They confirmed the Code Status, Order, and Care Plan don't reflect the Resident's wishes.	F0578		
F0584 SS = E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services	F0584	1. Hallway clutter was removed and equipment properly stored. Boards in the hallways have been updated to focus on resident information. This was discussed with the Resident Council Presidents on 10-7- 2025 for their input. 2. A facility environmental and safety audit was conducted by the Support Services Director to identify areas where equipment storage could pose a risk for resident safety, and appropriate storage locations were identified. 3. Staff were re-educated on the importance of a home-like environment, maintaining clear hallways and promptly storing equipment after using it by the Nurse Educators on 10-10-2025. 4. Unit Managers and Charge Nurses will monitor the hallways to remain safe and clutter-free. Random audits will be the Director of Nursing to ensure equipment is safely stored. Audits will be conducted weekly for 4 weeks, then monthly for 3 months and reviewed in the monthly QAPI meeting for substantial compliance. 5. Compliance date:10-14-2025. **Tag F0584 POC accepted on 10/27/25 by J. Schneckenburger/S. Stem**	

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F0584 SS = E	Continued from page 9 necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is NOT MET as evidenced by: Based on observation and interview, the facility failed to ensure that all residents had a homelike environment for multiple areas of the facility, having the potential to impact many residents. Findings include: Per observation during a walkthrough of the facility on 9/8/25 at approximately 10:30 AM, two hallways of the Evergreen Unit had multiple wheelchairs, carts, lifts, medical machines, and bags lining one side of each hall. This was observed multiple times throughout the recertification survey on 9/8/25 through 9/10/25. Per interview on 9/10/25 at approximately 3:00 PM during a facility tour with the Director of Nursing, multiple hallways of the facility had multiple items in the hallway. She confirmed that the hallway should not be a place to store lifts and wheelchairs as there are spots tucked away in the halls for the equipment to be placed. During the tour, three large approximately 15 feet by 5 feet boards were observed across from the nursing stations by the resident common sitting areas. These boards contained multiple data points related to resident care and staffing concerns, including resident falls and other quality measures. While there was no resident specific data on these boards, they did appear to be business related. The DON stated that the board are used to share positive information with the	F0584		

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F0584 SS = E	Continued from page 10 residents, but does understand how they are not homelike.	F0584		
F0585 SS = F	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system;	F0585	1. On 10-2-2025, Social Services gave Resident #114 information about the procedure for filing an anonymous grievance. A. On 10-2-2025, Social Services gave Resident #57 information about the procedure for filing an anonymous grievance. B. On 10-2-2025, Social Services gave Resident #110 information about the procedure for filing an anonymous grievance. C. On 10-2-2025 Social Services gave Resident # 107information about the procedure for filing an anonymous grievance. D. On 10-2-2025 Social Services gave Resident # 133 information about the procedure for filing an anonymous grievance. 2. Other Residents have the potential of being affected by the deficient practice. 3. The grievance policy was reviewed and updated to include the residents' right to file an anonymous grievance. Social Services provided residents and their representatives with information about anonymous grievances and the location of grievance forms and newly placed locked boxes for submitting grievance forms. During resident council meeting and using emails Residents and families were informed. On 10-10-2025. Staff were educated on 10-10-2025 on the residents' right to file an anonymous grievance and the location of grievance forms and locked boxes. 4. The Quality Manager will complete and monitor the grievance log to identify receipt of any anonymous concerns and concerning trends, audits will be conducted weekly for 4 weeks, then monthly for 3 months and reviewed in the monthly QAPI meeting for substantial compliance. 5. Compliance date: 10-14-2025. **Tag F0585 POC accepted on 10/27/25 by J. Schneckenburger/S. Stem**	

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F0585 SS = F	Continued from page 11 (ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations; (iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated; (iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law; (v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued; (vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is NOT MET as evidenced by: Based on observation and interview, the facility failed to ensure residents could freely file anonymous grievances. This has the potential to impact all residents. Findings include:	F0585		

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F0585 SS = F	Continued from page 12 Per interview with five residents (Residents #114, #57,1#110, #107, and #133) at Resident Council on 9/9/25 at 1:30 PM, they stated they did not know how to file an anonymous grievance. Resident #110 stated, "I often wonder who I could go to if there was a problem with staff. I don't want it getting back to me." Per record review Resident #110 has a BIMS [Brief Interview of Mental Status] score of 15, indicating s/he has no cognitive impairment. Per observation of the second floor there were no blank grievance forms able to be located. The blank grievance forms were found behind the nurses station as shown by the Unit Manager. Per review of the facility's "Grievances/Complaints-Filing, Investigating and Resolving" policy [last reviewed 5/30/25], there is no mention to filing grievances anonymously. Per interview with the Unit Manager on 9/9/25 at 2:15 PM she stated, "There's really no way for them [residents or resident representatives] to file an anonymous grievance." Per interview with the Activities Director on 9/9/25 at 2:28 PM, she confirmed that residents and resident representatives have no way of filing an anonymous grievance. 1.	F0585		
F0605 SS = D	Right to be Free from Chemical Restraints CFR(s): 483.10(e)(1),483.12(a)(2),483.45(c)(3)(d)(e) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any . . . chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from abuse,	F0605		

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F0605 SS = D	Continued from page 13 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)(2) Ensure that the resident is free from . . . chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. . . . . §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic. §483.45(d) Unnecessary drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or	F0605	1. Resident #4 has expired. 2. Unit Managers conducted an audit of psychotropic medications orders, and any prn orders that exceed 14 days were reassessed by the provider for appropriate documentation of rationale for use or duration. 3. Nursing Staff and Providers were re-educated by the Nurse Educators on 10-10-2025 regarding the requirements of PRN psychotropic drug use including the 14-day limit and additional requirements for extending its use. 4. Psychotropic medications orders and documentation will be reviewed by the Unit Manager and discussed in the weekly behavioral management meeting. Weekly audits for PRN psychotropic drug orders will be conducted by the Director Nursing Services, audits will be conducted weekly for 4 weeks, then monthly for 3 months and reviewed in the monthly QAPI meeting for substantial compliance. 5. Compliance date: 10-14-2025. **Tag F0605 POC accepted on 10/27/25 by J. Schneckenburger/S. Stem**	

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F0605 SS = D	Continued from page 14 (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. §483.45(e) Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that-- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is NOT MET as evidenced by: Based on interview and record review the facility failed to ensure one of two sampled residents (Resident #4) were free from chemical restraints. Findings include: Per review of Resident #4's medical record, Resident #4 has a BIMS [Brief Interview of Mental Status] score of 4, indicating the resident has cognitive impairment. Resident #4 has diagnoses of Type II Diabetes, CHF	F0605		

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F0605 SS = D	Continued from page 15 [Congestive Heart Failure], anxiety disorder, and chronic pain syndrome. Resident #4 needs substantial/maximal assistance with ADLs [Activities of Daily Living] and hygiene. Per record review, Resident #4 has an order for "Lorazepam 0.5 mg [milligram]: Give 1 tablet by mouth every 12 hours as needed for increased anxiety/restlessness/agitation for 30 Days inability to redirect." The order was placed on 8/28/25 and was to be discontinued on 9/27/25. Per record review of the Medication Administration Record, Resident #4 has received the prn [as needed] medication three times. Per record review of the facility's "Pharmacy Services" policy [last revised 11/18/24] states, "e. Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that...4.PRN orders for psychotropic drugs are limited to 14 days... If the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order." An interview was conducted with the Unit Manager on 9/9/25 at 2:15 PM. The Unit Manager confirmed the order was for thirty days with no rationale documented, stating "We were under the impression that after 14 days they could just renew the prescription for 30 days and then 60 days and then 90 days. I think that's what our policy is."	F0605		
F0607 SS = D	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(5)(ii)(iii) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95,	F0607		

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F0607 SS = D	Continued from page 16 §483.12(b)(4) Establish coordination with the QAPI program required under §483.75. §483.12(b)(5) Ensure reporting of crimes occurring in federally-funded long-term care facilities in accordance with section 1150B of the Act. The policies and procedures must include but are not limited to the following elements. §483.12(b)(5)(ii) Posting a conspicuous notice of employee rights, as defined at section 1150B(d)(3) of the Act. §483.12(b)(5)(iii) Prohibiting and preventing retaliation, as defined at section 1150B(d)(1) and (2) of the Act. This REQUIREMENT is NOT MET as evidenced by: Based on interview and record review the facility failed to ensure that their policies related to screening for abuse had been implemented for 1 of 5 Employees reviewed (Licensed Nursing Assistant #1). This is a repeat deficiency for this facility, with violations cited during the previous recertification survey dated 11/6/24 and partial survey dated 7/24/25. Findings include: Based on interview and record review, the facility failed to ensure that their policies related to screening for abuse had been implemented for 1 of 5 employees reviewed (Employee #1). The detailed findings are as follows: Licensed Nursing Assistant (LNA) #1, who was a contracted LNA, was hired on 9/3/2025. There was no evidence in the employee file that the Adult Registry review was conducted as required. The facility policy titled Prevention of Abuse Prohibition states that the facility will comply with and review the Vermont Abuse and Child Protection Registry. Per interview on 9/10/2025 at 5:16 PM the Director of Nursing (DON) provided a copy of an Adult Abuse Registry dated 9/10/2025 stating that Employee #1 had no findings in the Adult Abuse Registry. The DON confirmed that LNA #1 the Adult Abuse Registry check had not been conducted per policy, prior to the LNA working on the floor and that the Adult Abuse Registry	F0607	1. Employee #1, background check was verified, and the abuse registry screening was completed on 9-10-2025. 2. An audit of current contracted employees was conducted to verify that background checks and the adult and child abuse screening were completed prior to hire, no other contracted employees were identified. 3. The employee and contracted employee hiring policy was reviewed to ensure the completion of the required background checks and the adult and child abuse registry screen is conducted before an employee is scheduled to work. 4. The HR Director will conduct random audits of 10% of new hires to include contracted hires each month to validate all pre-hire background checks are documented as completed. Audits will be conducted weekly for 4 weeks, then monthly for 3 months and reviewed in the monthly QAPI meeting for substantial compliance. 5. Compliance date: 10-14-2025. **Tag F0607 POC accepted on 10/27/25 by J. Schneckenburger/S. Stem**	

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F0607 SS = D	Continued from page 17 check that had been provided was ran that day, 9/10/2025.	F0607		
F0657 SS = D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and record review, the facility failed to ensure resident's care plans were updated with pertinent information related to their care for two of 30 sampled residents (Residents #40 and #97). Findings include: 1.) Per review of Resident #40's medical record, s/he has diagnoses of Parkinson's Disease, hypertension, and muscle weakness. Resident #40 is dependent on staff for hygiene and needs substantial/maximal assistance with ADLs [Activities of Daily Living]. As of 6/16/25,	F0657	1. Resident # 40 care plan was updated on 10-06-2025 to reflect the usage of footrest. Resident # 97 has expired. Resident #135 was discharged. 2. Other Residents have the potential for being affected by the deficient practice. Care plans were reviewed to reflect current clinical goals and interventions by Unit Managers and MDS Coordinator. 3. Re-education provided to nursing staff regarding care plan requirements with an emphasis on timely updates and resident involvement by Nurse Educators 10-10-2025. 4. MDS Coordinator will randomly audit 5 care plans weekly using a resident list generated by the Director of Nursing based on incidents and change of conditions that occurred in the last 7 days. Audits will be conducted weekly for 4 weeks, then monthly for 3 months and reviewed in the monthly QAPI meeting for substantial compliance. 5. Compliance date: 10-14-2025. **Tag F0657 POC accepted on 10/27/25 by J. Schneckenburger/S. Stem**	

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F0657 SS = D	Continued from page 18 Resident #40 has a BIMS [Brief Interview of Mental Status] score of 0, indicating Resident #40 has cognitive impairment. Per record review of a post fall evaluation on 5/30/25 states, "Date / Time of Fall: 05/30/2025 2:38 PM Fall was witnessed. Who witnessed fall: LNA [Licensed Nursing Assistant]. Fall occurred in the hallway. Activity at the time of fall: Being pushed down the hallway in w/c [wheelchair], put foot down on carpet while being pushed and fell out of w/c. Reason for the fall was evident... Did an injury occur as a result of the fall: Yes. Injury details: Hematoma (R) [right] upper forehead, c/o [complain of] (R) rip and hip pain. Did fall result in an ER [Emergency Room] visit/hospitalization: Yes." A rehab screen request note from 5/30/25 states, "Leg wrests [sic] were not in use at time of fall. LNA was pushing resident down the hallway when [s/he] out [his/her feet down and fell headfirst out of the chair. Staff do report that even with footrests on [s/he] puts [his/her] feet down and doesn't keep them on the footrests. [S/he] also leans forward in current w/c. [S/he] had a hematoma to the right forehead, c/o right hip and rib pain. Sent to ED [Emergency Department], no sig [significant] findings." Per record review of a general nursing note dated 6/3/25 states, "s/p [status post] fall 5/30. Plan of care reviewed with interdisciplinary team. Education provided to LNA regarding transport of resident. Therapy screen also placed as per nursing staff even with footrests on w/c [wheelchair] resident often puts her feet down and has poor positioning in w/c at times. Resident was seen at the ED with no significant findings." Per record review of a general nursing note dated 9/4/25 at 4:22 PM states, "Resident needed to be brought back to room for toileting. LNA had footrests in her hand and did not have enough room in the hallway to put footrests on the wheelchair as EVS [environmental services] cart was in the hallway and to make room in the hall, LNA pushed the wheelchair down past the EVS cart to put foot rests on. As she was pushing wheelchair, resident leaned forward and fell out of chair. PT [Physical Therapy] screen placed for broada chair." Per record review of Resident #40's care plan, there are no interventions related to using footrests to prevent the resident from falling documented after the fall on 5/30/25 or 9/4/25.	F0657		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475045	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/12/2025

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F0657 SS = D	Continued from page 19 Per interview with the Unit Manager on 9/9/25 at approximately 2:30 PM she confirmed that Resident #40's care plan did not include any information related to using footrests as an intervention to prevent accidents. 2. Per record review, Resident #97 has diagnoses include dementia behavioral disturbance and agitation, and major depressive disorder. Resident #97's care plan reveals that s/he is at risk for elopement, alteration in psychosocial wellbeing, and re-traumatization. A 8/21/25 nursing note reveals that Resident #97 was involved forcefully pushed and grabbed by another resident (Resident #135) and Resident #97 showed "visible signs of anxiety including crying and verbally expressed anxiety and fear following physical altercation due to past trauma history." Progress notes after this event show that Resident #97 is anxious, agitated, argumentative, and could be difficult to redirect. An 8/29/25 progress note reveals that Resident #97 was near Resident #135's room and they had a verbal exchange. A 9/1/25 progress note reveals that Resident #97 "was tearful this evening. Requesting to have locks on [his/her] door so [Resident #135] couldn't go in there in the night. 'I need a lock, what if [s/he] comes in while I am sleeping? I don't feel safe with [him/her] here, I shouldn't have to hide out in my room all day to get away from [him/her].'" A 9/1/25 room transfer note reveals that Resident #97 was moved to a different unit that day for "roam control" and states that s/he "has been roaming often which cause negative engagement with other residents on [his/her] current living unit." Progress notes following Resident #97's room transfer show that s/he continues to have episodes of wandering, agitation, and aggressive verbal behavior that has impacted other residents. Per observation on 9/10/25 at 10:03 AM through 10:16 AM Resident #97 was observed sitting in the common area repetitively yelling and swearing while other residents were in the common area. A 9/10/25 social service note reveals that Resident #97 had an altercation with another resident shortly after the above observation. A facility investigation summary	F0657		

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F0657 SS = D	Continued from page 20 dated 9/12/25 reveals that Resident #97 hit Resident #45, which was observed by staff. Resident #97 was then transferred back to his/her previous room on the memory care unit on 9/10/25. Resident #97's care plan related to wandering was updated on 8/22/25 following the first incident s/he had with Resident #135 on 8/21/25. There were no additional interventions related to Resident #97's psychosocial or trauma care plans that addressed the impact the 8/21/25 had on him/her. Resident #97's elopement, psychosocial, or trauma care plans were not revised following his/her room transfer or 9/1/25, even after s/he showed increased behaviors. There were no new interventions put into place following the room transfer on 9/10/25 to address the impact that Resident #135 had on him/her. Per interview on 9/10/25 at 3:20 PM, the Director of Nursing confirmed that Resident #97 should have care plan revisions for new interventions to ensure their safety immediately. Per interview on 9/10/25 at 3:53 PM, the Unit Manager confirmed that while the care plan focus was updated following the 8/21/25 event, there were no new interventions after 8/22/25.	F0657		
F0689 SS = D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and record review the facility failed to ensure residents were free from accidents and hazards for two of 30 sampled residents (Residents #40 and #45). Findings include: 1.) Per review of Resident #40's medical record s/he has diagnoses of Parkinson's Disease, hypertension, and muscle weakness. Resident #40 is dependent on staff for	F0689		

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F0689 SS = D	Continued from page 21 hygiene and needs substantial/maximal assistance with ADLs [Activities of Daily Living]. As of 6/16/25, Resident #40 has a BIMS [Brief Interview of Mental Status] score of 0, indicating Resident #40 has cognitive impairment. Per record review of a post fall evaluation on 5/30/25 states, "Date / Time of Fall: 05/30/2025 2:38 PM Fall was witnessed. Who witnessed fall: LNA [Licensed Nursing Assistant]. Fall occurred in the hallway. Activity at the time of fall: Being pushed down the hallway in w/c [wheelchair], put foot down on carpet while being pushed and fell out of w/c. Reason for the fall was evident...Did an injury occur as a result of the fall: Yes. Injury details: Hematoma (R) [right] upper forehead, c/o [complain of] (R) rip and hip pain. Did fall result in an ER [Emergency Room] visit/hospitalization: Yes." Per record review of a therapy note on 6/3/25 states, "Therapy screen request received from nursing s/p fall on 5/30; LNA was pushing resident down the hall, resident unable to hold her feet up and got caught on the carpet, fell out of chair headfirst...Chart reviewed and discussed the resident with nursing. Resident is functionally at baseline; may benefit from broda chair to combat forward leaning and poor LE [lower extremity] support. Therapy to look into getting resident a broda chair. Therapy continues to recommend the following: recline when fatigued/leaning forward and PRN [as needed] use of footrests, i.e., when mobilizing resident..." A rehab screen request note from 5/30/25 at 3:00 PM states, "Leg wrests [sic] were not in use at time of fall. LNA was pushing resident down the hallway when she out her feet down and fell headfirst out of the chair. Staff do report that even with footrests on [s/he] puts [his/her] feet down and doesn't keep them on the footrests. [S/he] also leans forward in current w/c. [S/he] had a hematoma to the right forehead, c/o right hip and rib pain. Sent to ED, no sig [significant] findings." Per record review of a general nursing note written on 9/4/25 at 4:22 PM states, "Resident needed to be brought back to room for toileting. LNA had footrests in her hand and did not have enough room in the hallway to put footrests on the wheelchair as EVS [environmental services] cart was in the hallway and to make room in the hall, LNA pushed the wheelchair down past the EVS cart to put footrests on. As she was pushing wheelchair, resident leaned forward and fell out of chair. PT [physical therapy] screen placed for	F0689	1. Resident # 40 safety interventions were implemented, and the care plan was updated on 10-7-2025. a. Resident # 97 has expired. b. Resident # 135 was discharged. 2. Other Resident identified at risk for the deficient practice. Safety interventions implemented as needed. 3. Staff were educated on accident prevention, fall risk assessments and safety care plans by the Nurse Educators on 10-10-2025. Residents that have experienced safety related incidents in the last 30 days have been reviewed by the IDT to ensure care plans are current to prevent accidents and hazards. Daily huddles review safety incidents that have occurred in the last 24 hours, and care plans are reviewed for current interventions. Weekly falls meetings review all falls that have occurred in the last 7 days for further root cause identification, intervention, and care plan updates. 4. MDS Coordinator will randomly audit 5 care plans weekly using a resident list generated by the Director of Nursing based on incidents and changes of conditions that occurred in the last 7 days. Audits will be conducted weekly for 4 weeks, then monthly for 3 months and reviewed in the monthly QAPI meeting for substantial compliance. 5. Compliance date: 10-14-2025. **Tag F0689 POC accepted on 10/27/25 by J. Schneckenburger/S. Stem**	

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F0689 SS = D	Continued from page 22 broada [sic] chair." Per interview with the Unit Manager on 9/10/25 at 10:00 AM she stated footrests were not on when Resident #40 was in his/her wheelchair during the second fall on 9/4/25. She stated, "The LNA [Licensed Nursing Assistant] had them in her hand, but they were not on. She was trying to maneuver the resident around a housekeeping cart." The Unit Manager confirmed that both falls were the result of not having footrests on the wheelchair stating, "The same thing happened both times." 2. Per record review, Resident #97 has diagnoses include dementia behavioral disturbance and agitation, and major depressive disorder. Resident #97's care plan reveals that s/he is at risk for elopement, alteration in psychosocial wellbeing, and re-traumatization. s/HE has a the following care plan focus, "[Resident #97] has behavior problem r/t [related to] h/o [history of] behaviors, impaired cognition, refusals of care. [Resident #97] does at times think [s/he's] joking when [s/he] uses a dry sense of humor and raises [his/her] voice but can become offensive to others. A lot of past trauma with the death of two children and being abused at a young age [Resident #97] is triggered easily," revised on 8/22/25. The last behavior intervention was added on 6/23/25. Nursing notes dated 8/21/25 through 9/1/25 reveal that Resident #97 had an altercation with Resident #135 on 8/21/25, was displaying anxious, agitated, wandering behaviors, argumentative, and could be difficult to redirect. A 9/1/25 room transfer note reveals that Resident #97 was moved to a different unit that day for "roam control" and states that s/he "has been roaming often which cause negative engagement with other residents on [him/her] current living unit." Progress notes following Resident #97's room transfer show that s/he continues to have episodes of wandering, agitation, and aggressive verbal behavior that has impacted other residents. Per observation on 9/10/25 at 10:03 AM through 10:16 AM Resident #97 was observed sitting in the common area repetitively yelling and swearing while other residents were in the common area. A 9/10/25 social service note reveals that Resident #97 had an altercation with another resident shortly after	F0689		

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F0689 SS = D	Continued from page 23 the above observation. A facility investigation summary dated 9/12/25 reveals that Resident #97 hit Resident #45, which was observed by staff. Resident #45 was in a wheelchair. Resident #97's care plan related to wandering was updated on 8/22/25 following the first incident s/he had with Resident #135 on 8/21/25. There were no additional interventions added to Resident #97's care plan related to his/her wandering or behavior, even after s/he showed increased behaviors. Per interview on 9/10/25 at 3:53 PM, the Unit Manager confirmed that while the care plan focus was updated following the 8/21/25 event, there were no new interventions after 8/22/25.	F0689		
F0690 SS = D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent	F0690	1. Resident # 3 treatment record was updated to reflect Residents output on 10-06-2025. a. Resident # 27 treatment record was updated to reflect Residents output on 10-06-2025. 2. Residents with foley catheters care plans were reviewed by the Nurse Managers and treatment record was updated to reflect the resident's output on 10-06-2025. 3. Nursing Staff were educated by the Nurse Educators regarding the importance of tracking and documenting urine output which provides a key insight into kidney function and overall fluid balance and influences the risk for urinary tract infections on 10-10-2025. 4. An audit of urine output documentation for catheterized residents will be conducted weekly for 4 weeks by the unit managers, then monthly for 3 months and reviewed in the monthly QAPI meeting for substantial compliance. 5. Compliance Date: 0-14-2025. **Tag F0690 POC accepted on 10/27/25 by J. Schneckenburger/S. Stem**	

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F0690 SS = D	Continued from page 24 of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is NOT MET as evidenced by: Per observation, interview, and record review, the facility failed to ensure that residents with urinary catheters received appropriate treatment and services to prevent urinary tract infections for 2 of 2 sampled residents (Resident #3 & 27). Findings include: Per record review, Resident #3 reveals medical diagnoses which include:Urinary tract infection (an infection in any part of the urinary system);Neuromuscular Dysfunction of Bladder (the nerves that carry messages back and forth between the bladder and the spinal cord and brain don't work the way they should);Acute Kidney Failure (when the kidneys suddenly can't filter waste products from the blood);Retention of Urine (bladder doesn't completely empty when urinating); andChronic Kidney Disease (a long-term condition where the kidneys do not work as well as they should)Resident #3 has orders for an indwelling Foley catheter (a tube that is maintained in the bladder to drain urine constantly). It is connected to a collection bag that requires frequent emptying. Further record review revealed Resident had a Urinary Tract Infection (UTI) diagnosed on 7/25/25 after a foley catheter change resulted in Resident's output "draining cloudy yellow urine", with a volume of 1300 mL (milliliters), and a fever. According to the Cleveland Clinic, the normal range for 24-hour urine volume is 800 to 2,000 milliliters per day, and healthy urine should be light yellow, like the color of light straw or lemonade(https://my.clevelandclinic.org/health/body/urine). Review of the Care Plan (revised 8/27/25) has a Focus area for an indwelling Foley catheter related to the Resident's urinary retention, and the intervention states "Document intake [of fluids] and output [of urine] as per facility policy," which was initiated on 2/9/24 with a revision on 2/12/25. Per interview on 9/10/25 at 2:45 PM, the Nurse Manager stated tracking urinary outputs is a Licensed Nursing Assistant's (LNA) task and would run a report to capture the output data documented for the Resident. Per interview on 9/10/25 at 3:51 PM, the Nurse Manager confirmed that the indwelling Foley catheter output was	F0690		

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F0690 SS = D	Continued from page 25 not located in Residents' charts or being tracked, and she was evaluating other Residents' charts for orders to track output. 2. Per record review, Resident #27 reveals medical diagnoses which include:Obstructive and Reflux Uropathy (occurs when urine cannot drain through the urinary tract);Acute Kidney Failure (when the kidneys suddenly can't filter waste products from the blood); andRetention of Urine (bladder doesn't completely empty when urinating)Resident #27 has orders for an indwelling Foley catheter (a tube that is maintained in the bladder to drain urine constantly). It is connected to a collection bag that requires frequent emptying. In the Electronic Health Record (EHR), there is no documentation of the Resident's output of urine. Per Nurse.com, "Urine output provides key insights into kidney function and overall fluid balance. A sudden or gradual decrease in urine output, known as oliguria, can be one of the earliest signs that the kidneys are not filtering waste and maintaining fluid balance as they should" (https://www.nurse.com/blog/acute-kidney-injury-urine-output-warning-sign/).	F0690		
F0695 SS = E	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 interview and record review the facility failed to provide respiratory care in accordance with professional standards for five of five residents (Residents #86, #97, #94, #136, and #34). Findings include: 1. Per record review, Resident #86 has diagnoses that include acute and chronic respiratory failure, obstructive sleep apnea, and dependence on supplemental oxygen. A 7/18/25 admission note states that Resident #86 has the following active problem requiring attention "Recent acute on chronic respiratory failure	F0695		

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F0695 SS = E	Continued from page 26 requires BiPAP [Bilevel Positive Airway Pressure; a non-invasive ventilation treatment] and 1 to 2 L [liters] of oxygen. [S/He] will continue with respiratory support with BiPAP machine we will continue oxygen 1 to 2L." Resident #86 had the following physician orders "Standing Order Other: O2 (oxygen) @ 2LPM via NC [nasal canula] PRN [as needed] to maintain O2 sat of above 90% May administer oxygen prn via NC/mask to maintain SP02 [peripheral oxygen saturation] of >90%; If requiring more than 2L notify provider. 2LNC (May wean as tolerated)," and "BIPAP: Apply at HS [at bedtime] as per home settings every night shift for Sleep Apnea." Per record review, Resident #86's does not have a care plan related to his/her respiratory status, including interventions for oxygen use or a BiPAP machine. Resident #86's MAR (medication administration record) for September 2025 does not show documentation of when or how much oxygen s/he was using under the oxygen order. 2. Per record review, Resident #97 has chronic obstructive pulmonary disease with (acute) exacerbation. Resident #97 has the following care plan focus, "[Resident #97] is at risk for shortness of breath r/t deficiencies or abnormalities of pulmonary function (COPD)," initiated on 6/23/25. Multiple progress notes reveal that Resident #97 has shortness of breath during September. Vitals signs show four oxygen stats for Resident #97; 61% on 9/1/25, 91% on 9/2/25, 81% on 9/3/25, and 80% on 9/9/25. Resident #97 has the following physician order "Standing Order Other: O2 (oxygen) @ 2LPM via NC PRN to maintain O2 sat of above 88% May administer oxygen prn via NC/mask to maintain SP02 of >88%; If requiring more than 2L notify provider." Per record review, Resident #97's care plan does not include interventions for oxygen use. Resident #97's MAR for September 2025 does not show documentation of when or how much oxygen s/he was using under the oxygen order. 3. Per record review, Resident #94 has diagnoses that include COPD, chronic respiratory failure with hypoxia, and dependence on supplemental oxygen. Resident #94 has the following care plan focus, "[Resident #94] is at risk for shortness of breath r/t [related to] deficiencies or abnormalities of pulmonary function (COPD)," initiated on10/28/24. A 9/4/25 provider note	F0695	1. Physician order was obtained and care plan updated to reflect current oxygen and BiPap at bedtime for Resident # 86 on 9-9-2025 by the Unit Manager. a. Resident # 97 expired. b. Physician order was obtained and care plan update to reflect current oxygen use for Resident # 136 on 9-9-2025 by the Unit Manager. c. Physician order was obtained and care plan updated to reflect current oxygen use for Resident # 34 on 9-9-2025. by the Unit Manager. d. Physician order was obtained and care plan updated to reflect current oxygen use for Resident # 94 on 9-9-2025 by the Unit Manager. 2. Facility audit of Residents that receive oxygen therapy, orders reviewed to reflect appropriate documentation of oxygen use and care plans reviewed and updated by the Unit Managers. 3. The protocol for PRN oxygen use was reviewed and revised to ensure a complete provider order before initiating oxygen therapy. Medication record documentation includes continuous, and pm oxygen use in alignment with the provider orders. Appropriate signage is in place. Staff re-educated by the Nurse Educator on 10-10-2025. 4. Audits will be conducted weekly for 4 weeks, then monthly for 3 months and reviewed in the monthly QAPI meeting for substantial compliance. 5. Compliance date: 10-14-2025. **Tag F0695 POC accepted on 10/27/25 by J. Schneckenburger/S. Stem**	

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F0695 SS = E	Continued from page 27 states "Will need to watch for increasing O2 requirements." Resident #94 had the following physician orders "Standing Order Other: O2 (oxygen) @ 2LPM via NC PRN to maintain O2 sat of above 90% May administer oxygen prn via NC/mask to maintain SP02 of >90%; If requiring more than 2L notify provider." Per record review, Resident #94's care plan does not include interventions for oxygen use. Resident #94's MAR for September 2025 does not show documentation of when or how much oxygen s/he was using under the oxygen order. 4. Per record review, Resident #136 has diagnoses that include hypertension and history of cardiac arrest. Per interview on 9/9/25 at 1:37 PM, Resident #136 explained that his/her oxygen tank was empty and s/he does use it as needed. Resident #136 has the following physician order "Standing Order Other: O2 (oxygen) @ 2LPM via NC PRN to maintain O2 sat of above 90% May administer oxygen prn via NC/mask to maintain SP02 of >90%; If requiring more than 2L notify provider." Per record review, Resident #136's care plan does not include interventions for oxygen use. Resident #136's MAR for September 2025 does not show documentation of when or how much oxygen s/he was using under the oxygen order. Per interview on 9/9/25 at 2:01 PM, the Unit Manager confirmed that residents should have a care plan if they use oxygen and/or Bipap/CPap machines. She confirmed that Residents #86, #94, #97, and #136's care plans did not include the use of oxygen as an intervention. She stated that Residents #86 and #94's orders should not be PRN as there are on continuous oxygen. She confirmed that she cannot see a way to verify when and how much O2 was administered for these 4 residents based on the MAR. 5. Per record review, Resident #34 has diagnoses that include: Chronic Respiratory Failure with Hypercapnia (a condition that occurs when the lungs cannot get enough oxygen into the blood or eliminate enough carbon dioxide from the body);	F0695		

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F0695 SS = E	Continued from page 28 Interstitial Pulmonary Disease (refers to a group of chronic lung disorders characterized by inflammation and scarring that make it hard for the lungs to get enough oxygen); Chronic Obstructive Pulmonary Disease (COPD is a lung disease characterized by limited airflow); Acute and Chronic Respiratory Failure with Hypoxia (low oxygen in the blood); Bronchiectasis (a condition that occurs when the tubes that carry air in and out of your lungs get damaged, causing them to widen and become loose and scarred); and Heart Failure (failure of the heart to provide sufficient blood flow caused by an impairment of the heart's pumping function) During observations on 9/8/25 at 11:30 AM, Resident #34 was wearing a nasal canula connected to an operational oxygen concentrator (takes air from your surroundings, extracts oxygen, and filters it into purified oxygen to breathe). Resident confirmed s/he uses oxygen to assist with their breathing. Resident #34 has orders for "O2 (oxygen) @ 2LPM (liters per minute) via NC (nasal canula) PRN (as needed) to maintain O2 sat (saturation; a measurement of oxygen in blood) of above 90% May administer oxygen prn via NC/mask to maintain SP02 [saturation of peripheral oxygen] of >90%; If requiring more than 2L [liter] notify provider. 2-4 Liter prn to O2 sat 90-92% continuous." A Discharge Summary dated 8/13/25 for Resident #34 states the following: "3 liters per minute nasal canula 24 hours *At nighttime 2L bled into CPAP" with a start date of 3/18/16. Further review of the electronic health record (EHR) revealed that oxygen usage was not documented for the Resident. Per interview on 9/9/25 at 4:30 PM, Nurse Manager confirmed oxygen orders and documentation are not in the EHR, and s/he is evaluating orders for all residents on the unit receiving continuous oxygen.	F0695		
F0761 SS = D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals	F0761		

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F0761 SS = D	Continued from page 29 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 and interview, the facility failed to store drugs in accordance with currently accepted professional principles for 1 of 30 sampled residents. Findings include: Per observation on 9/8/25 at approximately 3:00 PM, the following medications were found in Resident #86's room: Clotrimazole External Cream 1 % (Clotrimazole (Topical)), Tacrolimus External Ointment 0.1 % (Tacrolimus (Topical)) and Hydrocortisone External Cream 2.5 % (Hydrocortisone (Topical)). Resident #86 had a roommate. Per interview on 9/8/25 at 3:04 PM, a Licensed Practical Nurse stated that Resident #86 did not have a medication self-administration assessment completed to determine if s/he could have medications in his/her room. She stated that if s/he did, the medications should be in a lock box. Per interview with the Unit Manager on 9/9/25 at 3:54 PM, she confirmed that Resident #86 did not have a medication self-administration assessment and shouldn't have the medications in his/her room. To have medications in the room, a resident would need a medication self-administration assessment determining	F0761	1. Resident # 86 was assessed by the Provider and the Assistant Nurse Manager, and it was determined that Resident #86 is not cognitively able to self-administer his medications. Medications removed from Residents room. 2. Residents who request the autonomy to self – administer medications will be assessed by the Provider and the Unit Managers to deem safe and appropriate to administer medications. Facility policy reviewed. 3. Re-education provided to Nursing staff on self-administration protocols, proper labeling and storage of drugs and biologicals, and ensuring no drugs are left at the bedside by the Nurse Educators 10-10-2025. 4. The Assistant Nurse Manager/ Charge nurse will make daily rounds to ensure that no drugs or biologicals are at the bedside. Any identified concerns will be reported during morning huddle and communicated to the Director of Nursing Services. Audits will be conducted weekly for 4 weeks, then monthly for 3 months and reviewed in the monthly QAPI meeting for substantial compliance. 5. Compliance Date: 10-14-2025. **Tag F0761 POC accepted on 10/27/25 by J. Schneckenburger/S. Stem**	

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F0761 SS = D	Continued from page 30 it to be appropriate and a lock box to place the medications in.	F0761		
F0810 SS = D	Assistive Devices - Eating Equipment/Utensils CFR(s): 483.60(g) §483.60(g) Assistive devices The facility must provide special eating equipment and utensils for residents who need them and appropriate assistance to ensure that the resident can use the assistive devices when consuming meals and snacks. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and record review facility failed to ensure a resident was provided adaptive devices used to promote adequate hydration for one of one (Resident #2). Findings include: Per record review, Resident #2 was admitted to the facility with diagnoses that include type 2 diabetes mellitus, essential tremor, and mild cognitive impairment. Review of Resident #2's care plan reveals that s/he has a swallowing problem related to a medical decline and that s/he had choked on a meatball. Care plan interventions include the use of a 2 handled mug with spouted lid. The care plan also indicates a focus initiated on 1/25/2021 of an alteration in fluid balance related to immunosuppressive medication use, history of renal transplant, uropathy, indwelling foley catheter, history of aspiration pneumonia, and diabetes. Interventions include "Encourage to drink fluids of choice and ensure access to favorite beverages, diet ginger ale with small amount of cranberry for color." The care plan also states recommend seated in Broda chair for meals. Items within reach, set up is required (meats cut, containers opened). Resident should be squared up to table (not placed at an angle) to allow optimal functional with self-feeding. adaptive equipment used 2 handled mug w/spouted lid; rim plate; rocker/swivel spoon; straw. Per observations made on 9/8/2025 at 12:30 PM, Resident # 2 was observed during lunch in the day room. Her/His tray had a red two handled mug with a spouted lid, 8oz glass of milk, one can of ginger ale with a straw, a coffee mug, a chocolate ice cream, and a plate with a hamburger cut in half, potato wedges, and a vegetable medley. He/She made five attempts to drink coffee from a mug without a lid and/or straw, contents spilled onto	F0810	1. Resident # 2 has been provided with adequate cups to accommodate fluids served and supervision and coaching while Resident is eating his meals. 2. Other residents have the potential to be affected by the deficient practice. Nursing staff and dietary staff were provided education by the Nurse Educators and Dietician on 10-10-2025. 3. A list of residents that requires use of assistive devices at meals was validated by provider orders and is included in the resident meal tickets. Adequate supplies of assistive devices are maintained in the kitchen and validated by the Rehabilitation Director. At each meal the Dietary staff will ensure adequate assistive devices are on the meal trays. As nursing staff, meal assistance will be provided to the residents to facilitate use of the device. 4. Rehabilitation Director will conduct random audits weekly of 5 residents to ensure assistive devices are utilized per the provider's order. Audits will be conducted weekly for 4 weeks, then monthly for 3 months and reviewed in the monthly QAPI meeting for substantial compliance. 5. Compliance Date: 10-14-2025. **Tag F0810 POC accepted on 10/27/25 by J. Schneckenburger/S. Stem**	

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F0810 SS = D	Continued from page 31 tray and clothing protector. A tremor was noted of bilateral upper extremities. Four staff members were present in the day room assisting other residents. At 12:40 PM, Resident #2 attempted to pick up a sandwich and hold it over the plate. At 12:43 PM he/she placed the sandwich back on the plate; 0% of the meal was consumed. At 12:46 PM, Resident # 2 picked up the spoon and chocolate ice cream and spilled the contents on his/her lap and attempted to bring the spoon with ice cream to his/her mouth again, and again it spilled on his/her lap. At 12:51 PM the Resident began using her/his \fingers to eat the ice cream. As s/he reached for the glass of milk, it spilled onto tray. 0% of the drinks were consumed. At 12:53 PM, Resident #2, used the 2 handled mug with the spouted lid to drink. Resident #2 began using her/his fingers to eat the ice cream. The Resident then used a fork to pick up a potato wedge, took a bite and the remainder fell onto the Resident's lap. At 1:01 PM the Resident attempted to drink out of a cup with no lid or straw and spilled it onto the clothing protector and tray. At 1:05 PM when asked if s/he was thirsty, Resident #2 stated yes. At this time the two Licensed Nursing Assistants (LNAs) who were in the room assisting other residents were made aware that the Resident was having difficulty with and that s/he was thirsty. The LNA confirmed that the Resident was supposed to have covered drinks but only gets one cup on her/his tray. On 9/9/2025 at 8:34 AM, Resident# 2 was observed at breakfast in day room. The food on his/her plate was cut by staff. One mug with two handles and spouted lid with orange juice. A carton of milk, a glass of cranberry juice, a can of ginger ale with a straw, and a cup of coffee were on the tray without a two handled mug with spouted lid that the resident was care-planned for. Four staff members in dining area were assisting other residents. On 9/10/2025 at 8:36 AM, Resident #2 was observed at breakfast in day room. One cup with 2 handles and spouted lid with cranberry juice. The following drinks on the tray were not in the care planned two handled spouted mugs: One open carton of milk with no straw or lid, a can of ginger ale with no straw and a cup of coffee with no lid and no straw. During an interview on 9/10/2025 at 8:53 AM with a Licensed Practical Nurse (LPN) who is familiar with Resident #2, the LPN stated that the Resident "should have at least two or three of those cups." The LPN proceeded to call the kitchen and requests two more two handled mugs with spouted lids. The LPN stated, "The	F0810		

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F0810 SS = D	Continued from page 32 kitchen said they out are of the mugs, but they do need to provide them." Per interview with the Dietary Supervisor on 9/10/2025 at 9:01 AM, she reported that she had sent two additional mugs to the floor 5 minutes prior to interview, and they have many two handled cups with spouted lids. Staff can call the kitchen to have them brought to the floor. She stated, "It is the floors responsibility to transfer beverages into modified cups and let us know if they need more than the one provided on the tray." During interview on 9/10/2025 at 2:47 PM, the Speech Language Pathologist confirmed that residents with adaptive equipment for eating/drinking should have multiple cups for different beverages. On 9/10/2025 at 3:01 PM, the Registered Nurse Unit Manager stated that her expectation is two adaptive cups to be on meal trays for residents. One for hot beverages and one for cold beverages.	F0810		
F0812 SS = F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is NOT MET as evidenced by:	F0812	1. Storage of food items has been corrected to be in accordance with food safety and storage standards. Outdated foods and unlabeled foods have been discarded. Prepared foods are properly covered, dated and stored. Dry storage and food supplies are dated and properly stored. Walk-in refrigerator and freezer items are properly dated and stored. 2. Dietary Staff and Cooks have been educated on the proper labelling, dating and storing of foods by the Dietary Manager on 10-10-2025. Dietary staff and cooks have been educated on their assignments related to the cleaning schedules by the Dietary Manager on 10-10-2025. 3. Kitchen cleaning schedules have been created for daily, weekly and monthly cleaning to include kitchen equipment, floors, ceiling, and dish room. The facility environmental team has been educated on the cleaning areas under their responsibility in particular the ceiling and vents. 4. Audits will be conducted weekly for 4 weeks, then monthly for 3 months and reviewed in the monthly QAPI meeting for substantial compliance. 5. Compliance Date: 10-14-2025. **Tag F0812 POC accepted on 10/27/25 by J. Schneckenburger/S. Stem**	

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F0812 SS = F	Continued from page 33 Based on observation and interview, the facility failed to store food in accordance with professional standards for food service safety and failed to maintain a sanitary kitchen. This has the potential to impact all residents. Findings include: 1. A kitchen tour was conducted with the Dietary Manager on 9/8/253 at 9:42 AM. Per observation of the kitchen prep area, the following items were found improperly stored: Harissa seasoning with no date, Expired black sesame dated 3/11/24, White sesame marked 6/18 (no year), Expired sesame seed dated 6/21/24, Marjoram dated11/30/23, Bay leaves dated 5/6/24, All spice dated 11/27/24, The Dietary Manager stated that spices should be discarded a year after opening and confirmed that the above spices were expired. Per observation of the walk in refrigerator, the following items were found improperly stored: A container of Jello with no labels or dates, A container of beef stew with no labels or dates, A container of cream cheese frosting with no use by date, A container of expired buttercream frosting marked good through 9/3/25, A container of expired cooked pasta marked good through 9/7/25, A container of expired purred veggies marked good through 8/27/25, A package of tofu- open and not covered marked good through 8/18/25, A used onion wrapped with no labels or dates,	F0812		

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F0812 SS = F	Continued from page 34 A container of expired sauerkraut marked good through 9/2/25, A container of expired steamed veggies marked good through 8/20/25, A container of expired steamed veggies marked good through 9/5/25, Per observation of the walk in freezer, the following items were found improperly stored: A container of expired ice cream dated 6/24/24, A sheet pan of expired pizza dated 4/26/25, A box of potatoes open to air, A box of hashbrowns open to air, A box of pizza shells open to air, A box of hamburger patties open to air, The Dietary Manager stated that prepared and open food should be labeled with the date it was opened or made and the date that it should be discarded, and containers and packages should be sealed. He confirmed that the above items were either expired or improperly stored. Per observation of the dry storage area, the following items were found improperly stored: A box of gram cracker crumbs open to air, Multiple loaves of undated bread. The Dietary Manager explained that they do not label the loaves of bread with dates. Per interview on 9/10/25 at 9:46 AM, a Dietary Staff stated that there are no dates on the bread and there is no way of knowing what its expiration or use by date is. Per interview at 9:49 AM with a second Dietary Staff, she explained that bread should be labeled with orange tags to indicate the use by date and confirmed that the loaves of bread were not dated. 2. During the initial kitchen tour on 9/8/25 and again on 9/10/25. multiple areas of the ceiling in the prep areas and the dish room were observed to be covered with thick dust.	F0812		

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F0812 SS = F	Continued from page 35 The Dietary Manger revealed that the housekeeping staff should be cleaning these areas, and it hadn't been done in a couple months.	F0812		