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

December 18, 2025

Ms. Kelly Scanlon, Administrator
Springfield Health & Rehab
105 Chester Road
Springfield, VT 05156

Provider ID #: 475025

Dear Ms. Scanlon:

Enclosed is a copy of your acceptable plans of correction for the complaint investigation conducted on **November 19, 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: 475025	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 11/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Springfield Health & Rehab	105 Chester Road , Springfield, Vermont, 05156

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F0000	INITIAL COMMENTS An unannounced onsite complaint investigation of # 2658425 was conducted by the Division of Licensing and Protection on 11/4/2025 through 11/14/2025 to determine compliance with 42 CFR Part 483 requirements for Long Term Care Facilities. On 11/14/ 2025, the survey team identified and notified the facility of deficiencies at the immediate jeopardy (IJ) level for F600 related to neglect, F635 admission orders, F656 Comprehensive care plan, and F689 accidents, hazards, and supervision. The facility is licensed for 96 beds and had a census of 71 at the time of the survey. This IJ determination also results in substandard quality of care.	F0000	Springfield Center for Living and Rehabilitation provides this plan of correction without admitting or denying the validity or existence of the alleged deficiencies. The plan of correction is prepared and executed solely because it is required by federal and state law.	
	An onsite visit to assess the removal of the immediate jeopardy was conducted on 11/18/2025. The facility had completed sufficient corrective actions to remove the immediate jeopardy for F600. F635, F656, and F689 by implementing an admission process and checklist, educating staff regarding the admission process, care planning, and accident hazards and supervision; and initiating audits of new admissions and care plans, but the non-compliance with requirements remains.			
F0552 SS = D	An onsite extended survey was conducted from 11/18/2025, with offsite record review through 11/19/2025, due to the substandard quality of care identified on 11/14/2025 related to neglect; accidents, hazards, and supervision; and significant medication errors. There were no additional citations identified during the extended survey. 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.	F0552	The facility could not retroactively correct the deficiency as it relates to Resident #1. 1. Residents residing in the facility that receive psychotropic medications have the potential to be affected by the alleged deficient practice. 2. The facility's " Informed Consent" and " Antipsychotic Medication Use " policies were reviewed and education provided to	

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
Kelly Scanlon	Administrator	12/16/25

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F0552 SS = D	Continued from page 1 §483.10(c)(4) The right to be informed, in advance, of the care to be furnished and the type of care giver or professional that will furnish care. §483.10(c)(5) The right to be informed in advance, by the physician or other practitioner or professional, of the risks and benefits of proposed care, of treatment and treatment alternatives or treatment options and to choose the alternative or option he or she prefers. This REQUIREMENT is NOT MET as evidenced by: Based on interview and record review the facility failed to inform in advance of the risks and benefits of the proposed care, the treatment alternatives or other options for 1 of 5 sampled residents (Resident #1). This is a repeat deficiency for this facility, with the violation cited during a recertification survey dated 3/27/25. Findings include: Per record review Resident #1 was admitted with physician's orders for an antidepressant, Protriptyline (Vivactil) 10 mg twice daily, and an antipsychotic medication, Aripiprazole (Abilify) 15 mg daily. A consent form for antipsychotic medications was completed on and signed by the Resident's Guardian on 8/15/2025 listing the Aripiprazole as a prescribed medication. Further record review revealed a Consent for Antidepressant Medication form which was blank, it did not list the Protriptyline, and it was not signed by the Guardian. There was no documented evidence that the facility obtained informed consent for the Protriptyline. A physician's order dated 9/13/2025 for Quetiapine (Seroquel, an antipsychotic) 600 mg daily was initiated. A Psychotropic Medication Administration Disclosure form that includes the Abilify, Seroquel, and Protriptyline was completed by the Unit Manager on and states that the guardian gave verbal consent for the psychotropic medications on 9/16/2025 however, this was one month after the Protriptyline was initiated and three days after the Seroquel was initiated. Review of Resident #1's care plan revealed a focus initiated on 8/16/2025 of "[Resident] is at risk for complications related to the use of psychotropic drugs" with an intervention of "Provide informed consent to resident or healthcare decision maker Date Initiated: 08/16/2025."	F0552	all licensed nursing staff (RN's/LPNs) and prescribing providers on the above policies emphasizing that consents must be obtained before the initiation or dose increase of any psychotropic medication. 3. The DON or designee will conduct an audit on all residents currently receiving psychotropic medications to ensure a valid, documented informed consent " Psychotropic Medication Administration Disclosure Form" is on file for each resident with current medications in use. 4. The DON or designee will audit PCC dashboard " psychotropic medication ordered" daily to ensure a valid, documented informed consent " Psychotropic Medication Administration Disclosure Form" was put in place with any new psychotropic medications ordered. The DON or designee will also review physician notes with any changes in current psycotropic medications to ensure they documented consent was obtained from resident/patient and/or resident/patient representative prior to starting and new/changes in psychotropic medications four (4) weeks, then monthly for two (2) months to monitor effectiveness of the plan. 5. Results of the audits will be reported to the QAA committee x3 months at which time the QAA committee will determine further frequency of the audits. 6. Corrective action will be completed by December 19, 2025. **Tag F 552 POC accepted on 12/18/25 by S. Freeman/S. Stem**	

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F0552 SS = D	Continued from page 2 Per interview with the facility Administrator on 11/6/2025 at 3:30 PM the consent for antipsychotic form in the Resident's chart dated 8/15/2025 did not reflect the Protriptyline. The Administrator also confirmed that the Psychotropic Medication Administration Disclosure form had not been completed until 9/16/2025, after the initiation of the Protriptyline and Seroquel.	F0552		
F0580 SS = D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section.	F0580	The facility could not retroactively correct the deficiency as it relates to Resident #1. 1. Residents residing in the facility that have a change in condition have the potential to be affected by the alleged deficient practice. 2. The facility's " change in condition or status." policy was reviewed and education provided to all licensed nursing staff emphasizing abnormal lab results and treatment options . 3. The DON or designee will audit the 24 hour report daily including weekends for any change in conditions of resident four (4) weeks, then monthly for two (2) months to ensure to resident/patient and/or resident/patient representative have been notified and monitor effectiveness of the plan. 4. Results of the audits will be reported to the QAA committee x3 months at which time the QAA committee will determine further frequency of the audits. 5. Corrective action will be completed by December 19, 2025 **Tag F 580 POC accepted on 12/18/25 by S. Freeman/S. Stem**	

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F0580 SS = D	Continued from page 3 (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is NOT MET as evidenced by: Based on interview and record review the facility failed to notify the resident representative of a change in condition related to laboratory results and treatment options for one of three residents in the sample (Resident #1). This is a repeat deficiency for this facility, with the violation cited during a partial survey dated 3/3/25. Findings include: Based on record review Resident #1 had a court appointed guardian with the guardian's spouse listed as emergency contact #2 on their information sheet. A progress note dated 10/8/2025 states "The nurse received a fax from the Springfield lab of a urine culture. The nurse sent the culture results to the [Nurse Practitioner]. The Resident was evaluated by OT [occupational therapy] and determined the resident is not safe to take anything orally other than a [tablespoon] of water every so often for comfort. Based on OTs evaluation the nurse attempted to call the [guardian] to talk about the results of the culture and talk about options regarding [antibiotic] treatment. The nurse left a voicemail for the [guardian] to call the nurse back." Another progress note dated 10/8/1025 states "The nurse tried calling the [guardian's] phone but was not home just [spouse]. [Spouse] had questions regarding the resident being sent out to a different [facility] or hospital. The nurse did not talk with the [spouse] about the urine as [they] are not the resident's legal guardian." Per phone interview with Resident #1's guardian and their spouse on 11/4/2025 at 2:00 PM communication with	F0580		

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F0580 SS = D	Continued from page 4 the facility was not good and they did not return her/his calls even after s/he was told that someone will call back. The facility did not consistently share information regarding the Resident's condition. S/he stated that one nurse had hung up on her/him when s/he had called to ask questions about the Resident's condition. Review of the facility policy titled Notification of change in condition or status states " 1. The nurse will notify the resident's attending Physician or physician on call when there has been a (an)... d. significant change in the resident's physical/emotional/mental condition; e. need to alter the resident's medical treatment significantly;" Per interview on 11/4/2015 at 3:15 PM the facility Administrator confirmed that Resident #1's guardian's spouse was emergency contact #2 and should have been updated regarding the positive results and treatment. The Administrator also confirmed that the nursing progress note reflected that the Nurse had not notified the Guardian's spouse of the results of the Resident's urine as she should have.	F0580		
F0600 SS = SQC-J	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is NOT MET as evidenced by: Based on interview and record review, the facility failed protect a resident's right to be free from neglect by failing to provide services to the resident that are necessary to avoid physical harm, pain, mental anguish and emotional distress for 1 of 5 residents in	F0600	The facility could not retroactively correct the deficiency as it relates to Resident #1. 1. Residents residing in the facility have the potential to be affected by the alleged deficient practice. 2. The facility's " Abuse, Neglect and Exploitation" policy was reviewed and education has been provided to all staff emphasizing failure to provide necessary services. 3. The facility's " Reconciliation of Medication on Admission and "Admission Process " policy was reviewed and education has been provided to licensed Nursing staff RN's/ LPN's, UM, and DON. 4. New processes implemented: A. Hard copy documents containing discharge orders for transcription “not faxes” will not be uploaded into PCC until	

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F0600 SS = SQC-J	Continued from page 5 the applicable sample (Resident #1). This deficient practice rose to the immediate jeopardy level due to the facility's failure to provide necessary services, which resulted in antipsychotic medication withdrawal, repeated falls with major head injury, and death. This is a repeat deficiency for this facility, with the violation cited at immediate jeopardy during a partial survey dated 3/3/25. Findings include: Per record review Resident #1 was admitted to the facility for short term rehab after a fall at their home resulting in a distal radius fracture and multiple fractured ribs. Additional diagnoses included left third finger fracture, urinary tract infection (UTI), osteoporosis, frequent falls, schizophrenia, major depressive disorder, narcolepsy with cataplexy (sudden weakness or limping of the muscles) recurrent UTIs, and hypertension. Review of the hospital discharge orders dated 8/15/2025 revealed physicians' orders for Keflex 500 mg every 12 hours for 4 days, then resume nitrofurantoin (Macrobid) 100mg daily. Guaifenesin 600mg twice daily, sliding scale insulin lispro with blood sugars 4 times daily, lidocaine patch 2 patches daily, and Quetiapine (Seroquel) 600mg at bedtime. None of these orders were implemented on admission to the facility. Not identifying and ordering the medications listed resulted in Resident #1 not receiving antibiotic therapy needed to prevent infection, not being monitored for effective diabetic management, and not receiving an antipsychotic necessary to treat schizophrenia causing exacerbation of symptoms increasing the risks of falls and other safety risks. Per interview on 11/4/2025 at 3:19 PM with the facility Administrator after the facility became aware that Resident #1 did not have their long-term order of Seroquel 600 mg daily on 9/12/2025, the facility had identified that the information that had arrived at the facility with the Resident had been scanned into the electronic health record excluding every other page. It was at this time that the facility realized that the hospital discharge orders had not been appropriately reconciled. The Administrator confirmed that the missed order Seroquel was a medication error however, the facility did not review the entire discharge summary to ensure there were no other orders that should have been implement that were not. Per interview with a Licensed Practical Nurse on	F0600	it arrives at the facility with patients upon admission and once reviewed for entirety and accuracy. Education has been provided to Admission director on new process. B. Admission checklist re-implemented on all new admissions to include two nurse reviewing orders. Education provided to the licensed nursing staff RN, LPN, UM and DON on the new process. C. Referral review process has been updated to ensure the facility can adequately provide all services ordered for newly admitting/readmitting patients/residents such as IV therapy. 5. The DON or designee will audit admission/readmissions four (4) weeks, then monthly for two (2) months to ensure nothing is being missed and monitor effectiveness of the plan. 6. The facility's "Accidents and Incidents" and " Managing Falls and Fall Risk" policy was reviewed and education has been provided to licensed Nursing staff (RN's/LPNs), UM, DON. 7. Initial audit was completed on all residents fall care plans to ensure interventions are in place for at risk diagnoses. 8. The DON or designee will audit all new falls for (4) weeks, then monthly for two (2) months to ensure interventions are being put in place to reflect current needs and to monitor effectiveness of the plan. 9. Results of the audits will be reported to the QAA committee x3 months at	

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F0600 SS = SQC-J	Continued from page 6 11/13/2025 at 5:10 PM she is typically the nurse who does the second check on admission orders and finishes the admission process because she works evenings. When asked about the process of obtaining and reconciling admission orders she stated that she compares the medication list to what has been entered in the electronic health record by another nurse. When asked if she reviews the rest of the information that comes from the hospital, she stated that she does try to read through it but does not always get to it. Per interview with the facility Administrator on 11/12/2025 at 11:30 AM she confirmed that once the facility identified there were missing pages to the discharge paperwork from the hospital and there was a medication error as a result, they did not further review it to ensure there were no additional orders that had been missed. Therefore, the sliding scale with insulin, the antibiotics for treatment of UTI and prophylaxis, and the lidocaine patches were not identified until the surveyor identified the errors. Per interview on 11/13/2025 at 5:30 PM the Regional Assistant Director of Nursing (RADON) stated that the process for admission medication reconciliation involves review of the medication list that comes from the hospital. The RADON confirmed that it is not practice to review all of the information that comes from the hospital stating, "sometimes we get a packet this thick" holding up fingers about an inch apart "we can't possibly read all of that." The RADON stated again "we just review the medication list." Per interview with Resident #1's Primary Physician on 11/14/25 at 2:30 PM she had been made aware that the Resident's Seroquel had not been ordered on admission when it was identified on 9/13/2025, but she was not aware that the other medications had been missed in the admission process. The Physician confirmed that the discharge summary that was used to admit Resident #1 only included every other page of information, and that the expectation is that the Unit Manager and/or admissions person review the complete discharge summary. The Food and Drug Administration's (FDA's) Boxed Warning states that some commonly reported Seroquel withdrawal symptoms can occur include nausea, vomiting, anxiety, irritability, agitation or restlessness, panic-like symptoms, and rebound mood swings. Rebound symptoms include mania or hypomania, depression, Psychotic symptoms, and severe insomnia. When it is stopped abruptly -especially at higher doses such as 300-800 mg the sudden loss of receptor blockade can	F0600	which time the QAA committee will determine further frequency of the audits. 10. . Corrective action will be completed by December 19, 2025. **Tag F 600 POC accepted on 12/18/25 by S. Freeman/S. Stem**	

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F0600 SS = SQC-J	Continued from page 7 cause the body to "rebound" and over-respond until it readjusts. "Acute withdrawal symptoms such as insomnia, nausea, and vomiting have been reported following abrupt cessation of quetiapine (Seroquel). It is recommended that, where possible, the dose be tapered gradually." Review of physician's orders revealed that on 8/17/25 a Registered Nurse entered an order for fingerstick (a method for testing blood sugars) once daily. Review of Resident #1's blood sugars between 8/17- 10/9 revealed that the resident experienced 10 episodes of hyperglycemia (High blood sugar) which would have required the administration of the sliding scale insulin had it been ordered per the hospital discharge orders. There is no way to determine if the Resident had other hyper/hypoglycemia episodes because the blood sugars were not completed as directed in the discharge orders. Per the National Library of Medicine "Diabetes increases the risk of cardiovascular and microvascular complications but also increases the risk of common geriatric syndromes, including cognitive impairment, depression, falls, polypharmacy, persistent pain, and urinary incontinence." Further review of the hospital discharge orders for admission dated 8/15/2025 revealed an antibiotic order for Keflex 500 mg every 12 hours for 4 days to treat the UTI, then resume nitrofurantoin (Macrobid) 100 mg daily for prophylaxis, Additional orders were 2 lidocaine patches daily for pain. Review of admission orders revealed that neither of these orders were implemented on admission to the facility. A Nurse Practitioner Progress Note dated 10/8/2025 reveals "Resident... is seen today for UTI. Resident had a urine done and is positive for Hemolytic Strep Group B. [S/he] remains unresponsive. [S/he] was recently in the ER and given IV fluids and has since returned. Potential for discharge tomorrow to sister facility for ongoing care - confirmation is pending." An order was written on 10/8/2025 for "Rocephin Inject 1 gram intramuscularly one time a day for UTI for 5 Days mix with lidocaine." The Resident received one dose on 10/8/2025 and was transferred to another nursing facility on 10/9/2025. An Admission Fall Risk Assessment completed on 8/15/2025 was noted to have several inaccuracies and reflected that Resident #1 had a diminished safety awareness, impaired mobility with continence, required the use of an assistive device, 1-2 falls in the past 3 months, takes 1-2 high risk medications, no change in medication and/or change in dosage in the past five days 1-2 predisposing diseases/conditions. However, the	F0600		

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F0600 SS = SQC-J	Continued from page 8 Resident was actually prescribed 4 of the high-risk medications which included antihypertensives, antiseizure, hypoglycemics, and psychotropics. Although unbeknownst to the facility, the Resident did have a change in medications as they were not receiving their long-term dose of Seroquel 600 mg (antipsychotic), sliding scale insulin, and the antibiotic that was prescribed during their hospital stay. The Resident also had 4 predisposing diseases/conditions rather than 1-2 which included hypertension, osteoporosis, fractures, and dementia. The Fall Risk care planning section of the assessment was not completed. Review of Resident #1's care plan reflects a care plan focus of risk for falls due to cognitive loss, lack of safety awareness, history of falls. The care plan interventions implemented on the baseline care plan included providing Resident with opportunities for choice, assist to organize belongings for a clutter-free environment in the resident's room and consistent furniture arrangement, engage in simple, structured activities of their preference: that avoid overly demanding tasks. The care plan focus and/or interventions did not address the increased fall and safety risks due to diagnoses such as narcolepsy with cataplexy, osteoporosis, and fractures and did not include the use of high-risk medications including antihypertensives, antiseizure, hypoglycemics, and psychotropics. During an interview on 11/6/2025 at 1:17 PM the Regional Assistant Director of Nursing confirmed that Resident #1's care plan did not address safety or fall risk concerns related to narcolepsy with cataplexy. When asked if narcolepsy with cataplexy should be on the care plan for safety risks, she stated that the care plan addresses falls and that not every diagnosis would be in the care plan. A care plan focus initiated on 8/16/2025 of at risk for decreased ability to perform ADLs (activities of daily living) related to dementia. Interventions included X1 assist for transfers that was implemented on 8/16/2025. This intervention was then revised on 8/16/2025 when ambulation status was replaced with X1 assist for transfers. There was no longer an indication for ambulation status on the care plan. On 8/18/2025 three days after admission and three days of the missing Seroquel administration, s/he began experiencing hallucinations and then began exhibiting anxious, angry, resistive and combative behaviors which were not her/his baseline. These behaviors continued to occur. Review of Provider's Progress Notes, the	F0600		

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F0600 SS = SQC-J	Continued from page 9 provider was notified on 8/22, 8/25, and 9/12 of medication refusals. The care plan was not updated regarding safety risks or interventions to prevent accidents and hazards related to the change in condition. A Progress note dated 9/9/2025 reveals that Resident #1 had weakness of their right and left lower extremities and left upper extremity, their balance was unsteady, and they were anxious, hallucinating, and wandering. The progress note also states "Safety concerns: resident often observed self-transferring without calling for assistance from staff." A Progress Note dated 9/10/2025 states "resident observed multiple times by staff throughout [evening] wandering and responding to internal stimuli. resident observed stating "dad she wont let me do it, and bill is not going to let me sleep. resident easily redirected by staff. resident assisted with toileting and clothing." There is no documented evidence that any additional care plan interventions related to self-ambulation with unsteady balance, wandering, hallucinations, and falls or safety precautions including increased supervision were implemented. A Skilled Note dated 9/10/2025 states "Mental Status: Anxious, Pleasant, Delusions (misconceptions or beliefs that are firmly held, contrary to reality). Wandering. Comments: [s/he] has auditory hallucinations that [s/he] is talking to '[her/his] father', he tells [her/him] what to do and what not to do... Concerns: gets mad at staff, swings [her/his] cast trying to hit us..." Review of Resident #1's care plan revealed that it did not address hallucinations first documented on 8/18/2025 and there were no safety interventions put in place related to resistive, combative behaviors until 9/18/2025. Per Progress Note dated 9/11/2025 Resident #1 was found at 12:45 AM lying in bed with a cut and swelling on the left side of their forehead. The Resident stated that s/he "got up, froze, and fell flat, then got up and layed on her/his bed." The incident report identifies predisposing factors as ambulation without assist, wanderer, and history of falls. A progress note dated 9/11/2025 reflects that at 12:30 PM the Resident was sent to the hospital emergency department for evaluation of the head wound and complaints of left foot pain. The Resident returned to the facility on 9/12/2025 with diagnoses of right and left subdural hematomas, a minimal intraventricular hemorrhage, and fracture of the foot with a walking boot in place. On 9/11/2025 a care plan intervention of "Hung a "call,	F0600		

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F0600 SS = SQC-J	Continued from page 10 don't fall" sign in [Resident's] room to remind [Resident] to call for assistance with transfers" was added to the fall risk care plan. There were no revisions to the care plan to address the increased fall risks, increased supervision, or interventions associated with the subdural hematoma and fractured foot with a walking boot or wandering. On 9/13/2025 a physician's order for Seroquel 600 mg was initiated. According to the FDA's prescribing recommendation for starting Seroquel (Resident #1 had not received Seroquel for 30 days, since 8/15/25), "Day 1: 25mg twice daily. Day 2-3: Increase increments of 25 - 50 mg divided doses (two or three times per day), to reach a total of 300 - 400 mg/day by day 4. Further adjustments should be in increments of 25 - 50 mg twice daily, with intervals of not less than 2 days between dose changes." "Risks of starting Seroquel at 600 mg without gradual dose increase include: Orthostatic blood pressure (drop in blood pressure when standing up) dizziness, sedation, impaired motor coordination, blood sugar alterations." All listed risks increase the risks for falls and safety risks. Further review of Resident #1's care plan reveals a focus dated 8/16/2025 of risk for complications related to the use of psychotropic drugs however, it did not address fall or safety risks associated with the use of psychotropic medications or specific interventions to manage fall and safety risks. it was also not updated after the 9/13/2025 addition of Seroquel. A Nursing Progress Note dated 9/14/2025 read "Resident was rude to staff. [S/he] walked to the bathroom by [her/himself] and the nurse took the wheelchair to [her/him]. [S/he] refused to eat [their] food. [S/he] only ate 1 cup of ice cream with [her/his] meds and put [her/himself] to bed." The Resident continued to self-ambulate with no additional interventions implemented to prevent or protect them from falls and injury. A Nurse Practitioner's Progress Note dated 9/17/2025 states "Psychiatric: Appropriate mood and affect, does not appear to be reacting to any internal psychotic stimuli… Assessment & Plan: SCHIZOPHRENIA, UNSPECIFIED Mood is stable/improved. Continue with Seroquel 600mg at bedtime, Aripiprazole 15mg daily and Protriptyline 10mg BID." Per Nursing Progress Note dated 9/17/2025 the Resident was found on the floor after an unwitnessed fall at the nurse's station. A Nursing Progress Note states "[S/he] was drowsy. [S/he] was uncooperative with [the Nurse]. [S/he] was assisted onto [her/his] wheelchair and	F0600		

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F0600 SS = SQC-J	Continued from page 11 wheeled into [her/his] room and transferred onto [her/his] bed. On assessment, there was a bump on top of [her/his] head (parietal lobe), the size of a coin-10 cents." A progress note written by a Nurse Practitioner stated, "When the staff spoke with the family they requested the patient be sent to the ER because the patient had brain bleed last week after a fall per nursing." Okay to send to ER." The Resident was transferred to the hospital for evaluation. Review of a CAT scan (computed tomography scan, which uses x-rays and computer processing to create detailed cross-sectional images of the body) dated 9/17/2025 reveals that the Resident's intercranial hemorrhage was stable with no significant change. The Resident's fall risk care plan was updated on 9/18/25 to include an intervention of "Med review by MD" this intervention was later revised on 9/23/2025 to "When rounding offer and assist with alternative sitting options such as sitting up in W/C [wheelchair], Laying in bed as [s/he] will allow and tolerate." A Post Event Note dated 9/22/2025 reveals that the Resident is supposed to be non-weight bearing on left foot until cleared, but they were often found walking with their walker down the hall. The care plan was also updated on 9/18/2025 to reflect a focus of "[Resident] is resistive to care related to: Cognitive Loss/Dementia." However, the need for increased supervision related to the Resident's self-ambulating and self-toileting, a fractured foot with a non-weight bearing status, and other risks was not addressed in the care plan. A facility incident report dated completed on10/2/2025 states "Heard choking coming from [resident's] room. I went in to evaluate. [Resident] was lying on [her/his] back vomiting pale green and choking. [Her/his] eyes were watering face was red and [s/he] was not speaking." The documented description states "I sat [Resident] up to 90 degrees assisted with clearing vomit from [her/his] mouth did some deep breathing with [her/him] [s/he] was able to regulate breathing wipe tears and relax." Per review of a Nurse Practitioner's progress not dated 10/2/2025 states "History of present illness: Resident is seen and examined today via telehealth…Resident is an 85-year-old [female/male] with a pmhx [past medical history] of dementia and shizophrenia who is seen today for vomiting since last night, Increased weakness, and lethargy. [S/he] does have a known brain bleed." Review of a Nursing Progress note dated 10/2/2025 reads "10/2/2025 19:42 resident returned to facility via medical transport. resident transferred via stretcher	F0600		

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F0600 SS = SQC-J	Continued from page 12 to bed. resident drowsy upon arrival. resident skin color normal and no new skin alterations observed to body at this time. band aid to left AC observed from s/p IV meds received in ER. resident speaking low but able to understand and be understood. resident denies any pain or discomfort at the present time. Upon checking discharge summary from hospital, observed a diagnosis of aspiration pneumonia due to findings of "possible left lateral infiltrate." to Xray. resident also is to continue on Zosyn and albuterol, but no complete orders stated in summary. call placed to Springfield ER for clarification of orders and scripts to be faxed over. unable to speak with nurse at the present time, was told to call back since nurse is unavailable at this present time. Unit manager notified." Another progress note written by the Nurse Practitioner on 10/2/2025 at 10:14:00 PM states "Patient returned from ER diagnosed with possible aspiration PNA- given Zosyn, albuterol Nebulizer and Zofran and discharged back to facility. On nurse review of ER notes it states to continue Zosyn, but no orders were sent with patient on discharge. Nurse calling back to ER to get clarification and then will call provider back. Another Nursing Progress Note date 10/3/2025 at 2:00 AM states "no fax received, call placed to springfield ER. [name omitted] RN states "Someone would have to come and pick up the orders because our provider cannot send it in on our end." "there is an order here for Zosyn 3.375gm 50ml/hr q6hrs x4 doses. "there is no order for albuterol at this time, your in house provider will have to order it." call placed to on-call [name omitted] and notified her of ER recommendations. new order given." A Nurse Practitioner (NP) note dated 10/3/25 at 2:00 AM reveals orders to "Give dose of Zofran 4mg now-continue PRN [as needed] as ordered DuoNeb Q [every] 4hours PRN for SOB [shortness of breath] /wheezing Place on 2L O2 [oxygen]continuous until reevaluated by primary provider Place peripheral IV [intravenous line], if unable then okay to place midline. Monitor vital signs every shift x 3 days. Continue to monitor and notify on call provider of any changes or concerns. [follow-up] primary provider." Nursing Progress Note 10/3/2025 at 7:15 AM "unit manager notified in house [NP] about residents status and issues during shift. order given to send resident back to ER for iv doses of zosyn and evaluation of change in condition. 911 called. report called into [name omitted] RN. notified POA [power of attorney] of	F0600		

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F0600 SS = SQC-J	Continued from page 13 residents change in condition and order to be transferred back to ER. POA acknowledged understanding." Review of physicians orders reveals an order written on 10/3/2025 that reads "Place Peripheral IV, if unable then okay to place midline for IV ATB [antibiotic therapy." On 10/3/25 a Progress Note written by the Nurse Practitioner reads "Resident is an 85 year old [female/male] with a pmhx of dementia and shizophrenia who is seen today for vomiting since last night, increased weakness, and lethargy. She does have a known brain bleed which was not evaluated in the ER yesterday. Today she continues to decline with vomiting, lethargy, and weakness with worsening confusion." Another Nurse Practitioner Progress Note dated 10/3/2025 "Concern for progressive bleeding based on symptoms. Instructed nursing to send resident back to the ER as [s/he] is a full code and continued decline." Per interview with the facility Administrator on 11/4/2025 at 10:30 AM the facility does not provide IV therapy and is not able to administer IV antibiotics. The Administrator confirmed that after the Resident returned to the facility orders for IV Zosyn were given and the next morning the Resident was sent back to the hospital to receive the Zosyn because they were unable to administer it there. Review of Resident #1's care plan revealed an updated intervention added 10/2 and revised on 10/3/25 of "Aspiration 10/2- Send out for evaluation on decline and possible aspiration pneumonia." This was not updated with appropriate interventions when the Resident returned from the hospital. A care plan focus initiated on 10/4/2025 of "[Resident's] care decision maker has expressed desire for palliative/comfort care measures only related to" (does not address) with a goal of "[Resident] will have the highest possible level of comfort x90 days. However, there were no interventions put in place until 10/7/2025 which included "Encourage and allow time for verbalization of feelings of fear, anxiety, or depression and provide support", Provide medication as ordered and monitor effectiveness and monitor for side effects and report to physician/advanced practice practitioner as indicated", and "Provide preventative skin care per skin plan of care." On 10/7/2025 Resident #1 returned to the hospital and was diagnosed with a worsening hematoma including an	F0600		

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F0600 SS = SQC-J	Continued from page 14 Uncal hernia according to the National Library of Medicine "Uncal herniation occurs when rising intracranial pressure causes portions of the brain to flow from one intracranial compartment to another; this is a life-threatening neurological emergency..." Resident #1 was transferred to another facility on 10/9/2025 where s/he would be closer to family and died on 10/10/1025. Per review of Resident #1's death certificate s/he died on 10/10/2025. The manner of death was listed as "Accident." The date and time of the accident states "September 11, 2025 / ~8:00 PM." How injury occurred is listed as "Fall(s) from Standing Height" and the cause of death was documented as "Complications of Acute on Chronic Subdural Hemorrhage (Days to Weeks) due to B. Blunt Force Trauma of Head (Weeks) September 11, 2025 / ~8:00 PM." During an interview on 11/4/2025 at 3:19 PM the facility Administrator confirmed that when family was notified on 9/12/2025 of the increased behaviors the Resident had been experiencing such as refusals of medications, combativeness with care, and hallucinations, they questioned whether or not s/he had been getting the right medications specifically the Seroquel. It was at this time that the facility realized that the hospital discharge orders had not been appropriately reconciled and only every other page had been available at the time. The Administrator confirmed that the missed Seroquel was a medication error however, the facility did not implement an incident report per policy. Per interview with the facility Administrator on 11/12/2025 at 11:30 AM she confirmed that once the facility identified there were missing pages to the discharge paperwork from the hospital, they did not review it to ensure there were not additional orders that had been missed. Therefore, the sliding scale with insulin, the antibiotics, and the lidocaine patches were not identified until the surveyor identified the errors. Per phone interview with Resident #1's Primary Physician on 11/14/25 at 2:30 PM she had been made aware that the Resident's Seroquel had not been ordered on admission when it was identified, but she was not aware that the other medications had been missed in the admission process. The Physician stated that it is not best practice to be checking blood sugars four times daily on an elderly person, however she did not address that because she had missed it. The Physician confirmed that the discharge summary that was used to admit Resident #1 only included every other page of	F0600		

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F0600 SS = SQC-J	Continued from page 15 information, and that the expectation is that the Unit Manager and/or admissions person review all of the discharge summary. When asked if she knew that the Resident had returned to the facility with orders for IV therapy and the facility could not provide IV therapy, she stated that she did not. The Primary Physician also stated that she felt the family did not understand how serious the critical diagnoses related to the subdural hematoma versus an uncal herniation that was identified on the third CAT scan were. When asked if she had communicated with the guardian about the Resident's condition, she stated "no, I did not." An email written by the Primary Physician dated 11/14/2025 4:51 PM responding to a question posed during the 11/14/25 interview regarding accepting the Resident back to the facility with orders for IV antibiotic therapy that they could not provide she responded "I know you were concerned that the resident was knowingly taken back to the facility with an IV antibiotic the facility could not provide, but the nurse was given notification of the need for IV Zosyn after the resident was already transported back to the facility." However, once the Resident returned to the facility the Nurse obtained orders from the NP for the IV Zosyn. Ref. F635, F656, F689, F760	F0600		
F0635 SS = K	Admission Physician Orders for Immediate Care CFR(s): 483.20(a) §483.20(a) Admission orders At the time each resident is admitted, the facility must have physician orders for the resident's immediate care. This REQUIREMENT is NOT MET as evidenced by: Based on interview and record review, the facility failed to accurately reconcile physician orders needed to provide necessary care and services on admission, once the facility identified an issue with the admission orders, they failed to review the rest of the discharge summary for other potential missed orders for 1 of 3 residents in the sample (Resident #1). All residents admitting or readmitting to the facility are at risk for serious injury or death as a result of noncompliance. This deficient practice rose to the immediate jeopardy level due to the facility's failure to provide accurate admission orders, which resulted in	F0635	The facility could not retroactively correct the deficiency as it relates to Resident #1. 1. Residents admitting or readmitting to the facility have the potential to be affected by the alleged deficient practice. 2. The facility's " Reconciliation of Medication on Admission " and "Admission Process" policy was reviewed and education has been provided to licensed Nursing staff RN/ LPN. 3. New processes implemented: A. Hard copy documents containing discharge orders for transcription “not faxes” will not be uploaded into PCC until it arrives at the facility with patients upon admission and once reviewed for	

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F0635 SS = K	Continued from page 16 Resident #1 experiencing antipsychotic withdrawal and worsening psychiatric symptoms including refusal of medications and care, unmonitored and untreated blood sugars, increased risk for developing a urinary tract infection, falls resulting in a subdural hematoma that worsened over time resulting in death. This is a repeat deficiency for this facility, with the violation cited during a recertification survey dated 3/27/25. Findings include: Per record review Resident #1 was admitted to the facility for short term rehab after a fall at their home resulting in a distal radius fracture and multiple fractured ribs. Additional diagnoses included left third finger fracture, urinary tract infection (UTI), osteoporosis, frequent falls, schizophrenia, narcolepsy with cataplexy (sudden weakness or limping of the muscles), recurrent UTIs, and hypertension. Review of the hospital discharge orders dated 8/15/2025 revealed physicians' orders for Keflex 500 mg every 12 hours for 4 days, then resume nitrofurantoin (Macrobid) 100mg daily. Guaifenesin 600mg twice daily, sliding scale insulin lispro with blood sugars 4 times daily, lidocaine patch 2 patches daily, and Quetiapine (Seroquel) 600mg at bedtime. None of these orders were implemented on admission to the facility. The Food and Drug Administration's (FDA's) Boxed Warning states that some commonly reported Seroquel withdrawal symptoms can occur include nausea, vomiting, anxiety, irritability, agitation or restlessness, panic-like symptoms, and rebound mood swings. Rebound symptoms include mania or hypomania, depression, Psychotic symptoms, and severe insomnia. When it is stopped abruptly -especially at higher doses such as 300-800 mg the sudden loss of receptor blockade can cause the body to "rebound" and over-respond until it readjusts. "Acute withdrawal symptoms such as insomnia, nausea, and vomiting have been reported following abrupt cessation of quetiapine (Seroquel). It is recommended that, where possible, the dose be tapered gradually." On 8/18/2025 three days after admission and three days of the missing Seroquel administration, Resident #1 began experiencing hallucinations and then began exhibiting anxious, angry, and combative behaviors which were not her/his baseline. A Skilled Note dated 8/18/2025 states Hallucinations (perceptual experiences in the absence of real external sensory stimuli). Comments: resident observed talking to internal stimuli at times while at nursing station." A Psychiatry Note	F0635	for entirety and accuracy. Education has been provided to Admission director on new process. B. Admission checklist re-implemented on all new admissions to include two nurse reviewing orders. Education provided to the licensed nursing staff RN, LPN, UM and DON on the new process. 4. The DON or designee will audit admission/readmissions four (4) weeks, then monthly for two (2) months to ensure nothing is being missed and monitor effectiveness of the plan. 5. Results of the audits will be reported to the QAA committee x3 months at which time the QAA committee will determine further frequency of the audits. 6. Corrective action will be completed by December 19, 2025. **Tag F 635 POC accepted on 12/18/25 by S. Freeman/S. Stem**	

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F0635 SS = K	Continued from page 17 dated 8/19/2025 states Resident is pleasant, with occasional non distressful hallucinations with talking to others not there." An Administration Note dated 8/22/2025 states "Resident refused to take [her/his] meds, stating that [s/he] does not take meds. Various approaches were used without success. Provider on call [name omitted] was informed who also tried without success. Resident refused dinner, drink and [vital signs]. [S/he] was hallucinating." An Administration Note dated 8/23/2025 states "refused care and [vital signs]."A Progress note date 9/9/2025 reveals that Resident #1 was anxious, hallucinating, and wandering. The progress note also states "Safety concerns: resident often observed self-transferring without calling for assistance from staff." A Progress Note dated 9/10/2025 states "resident observed multiple times by staff throughout [evening] wandering and responding to internal stimuli. resident observed stating "dad she wont let me do it, and bill is not going to let me sleep. resident easily redirected by staff. resident assisted with toileting and clothing." A Skilled Note dated 9/10/2025 states "Mental Status: Anxious, Pleasant, Delusions (misconceptions or beliefs that are firmly held, contrary to reality). Wandering. Comments: [s/he] has auditory hallucinations that [s/he] is talking to '[her/his] father', he tells [her/him] what to do and what not to do... Concerns: gets mad at staff, swings [her/his] cast trying to hit us..." Per Progress Note dated 9/11/2025 Resident #1 was found at 12:45 AM lying in bed with a cut and swelling on the left side of their forehead. The Resident stated that s/he "got up, froze, and fell flat, then got up and layed on her/his bed." The incident report identifies predisposing factors as ambulation without assist, wanderer, and history of falls. A progress note dated 9/11/2025 reflects that at 12:30 PM the Resident was sent to the hospital emergency department for evaluation of the head wound and complaints of left foot pain. The Resident returned to the facility on 9/12/2025 with diagnoses of subdural hematoma and fracture of the foot with a walking boot in place. A Progress Note dated 9/12/2025 states "resident's [guardian and spouse] called facility asking for an update on residents' condition since returning from hospital today. informed [guardian] that resident refused all [evening] medications at the present time and continues to be confused and agitated when approached by staff. resident also refused dinner during shift and [Nurse Practitioner (NP)] was notified as well. [Guardian and Spouse] expressed concerns about	F0635		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475025	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 11/19/2025

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F0635 SS = K	Continued from page 18 resident's state of mind when [s/he] is not medicated and has questions for the primary doctor in regard to [her/him] current medication regime. informed [Guardian and Spouse] to call on Monday and speak with unit manager about any medication concerns so they can be relayed to in house provider. also informed them that nursing would continue to monitor resident for any changes in [her/his] LOC or worsening in [her/his] condition and report to the on-call NP throughout weekend. [Guardian and Spouse] acknowledged understanding and asked if they could attempt to talk with resident to encourage [her/him] to take [their] medications tonight. [Guardian] attempted to talk with resident over the phone and resident stated to [Guardian] "no I will not take that and its between me and god." informed [Guardian] that staff would continue to encourage resident and notify them with any changes." On 9/13/2025 a physician's order for Seroquel 600 mg was initiated. According to the FDA's prescribing recommendation for starting Seroquel (Resident #1 had not received Seroquel for 30 days, since 8/15/25), "Day 1: 25mg twice daily. Day 2-3: Increase increments of 25 - 50 mg divided doses (two or three times per day), to reach a total of 300 - 400 mg/day by day 4. Further adjustments should be in increments of 25 - 50 mg twice daily, with intervals of not less than 2 days between dose changes." "Risks of starting Seroquel at 600 mg without gradual dose increase include: Orthostatic blood pressure (drop in blood pressure when standing up) dizziness, sedation, impaired motor coordination, blood sugar alterations." A Provider Progress Note dated 9/16/2025 states "[S/he] was restarted on [her/his] Seroquel 600mg at bedtime and has had a marked improvement in [her/his] mood. [S/he] is more appropriate and able to make [her/ his] needs known. [S/he] offers no complaints." A Provider Note dated 9/18/25 states "Per nursing, [Resident's] family strongly requested that [Resident] be restarted on Seroquel 600 mg daily, which [s/he] apparently had been on in the past. This medication was restarted on 9/13/2025. Per nursing, [s/he's] been sleeping more, but no other adverse effects have been noted. [S/he] has a significant history of falls at baseline, with and without the Seroquel." Per Nursing Progress Note dated 9/17/2025 the Resident was found on the floor after an unwitnessed fall at the nurse's station. A Nursing Progress Note states "[S/he] was drowsy. [S/he] was uncooperative with [the Nurse]. [S/he] was assisted onto [her/his] wheelchair and wheeled into [her/his] room and transferred onto	F0635		

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F0635 SS = K	Continued from page 19 [her/his] bed. On assessment, there was a bump on top of [her/his] head (parietal lobe), the size of a coin-10 cents." The Resident was transferred to the hospital for evaluation. Further review of the hospital discharge orders revealed a sliding scale Insulin (a specific dose to be administered according to the results of blood sugar) Lispro with blood sugars 4 times daily. The discharge paperwork stated that the sliding scale had been implemented due to elevated blood sugar readings. Review of Resident #1"s physicians orders after admission to the facility revealed that an order for finger sticks (a method used to obtain blood sugars) once in the AM was entered on 8/17/2025. Review of Resident #1's daily blood sugars revealed that between 8/17/25- 10/9/25 the blood sugars were obtained during the evening or night shift as opposed to morning on 8 occasions, and the resident experienced 10 documented episodes of hyperglycemia (blood glucose above which would have required the administration of the sliding scale insulin. There is no way to determine if the Resident was experiencing hyper or hypoglycemia (high or low blood sugars) or would have required sliding scale coverage the other three times per day because the blood sugars were not ordered or obtained. Further review of the hospital discharge orders for admission dated 8/15/2025 revealed an antibiotic order for Keflex 500 mg every 12 hours for 4 days to treat the UTI, then resume nitrofurantoin (Macrobid) 100 mg daily for prophylaxis, Additional orders were 2 lidocaine patches daily for pain. Review of admission orders revealed that neither of these orders were implemented on admission to the facility. A Nurse Practitioner Progress Note dated 10/8/2025 reveals "Resident... is seen today for UTI. Resident had a urine done and is positive for Hemolytic Strep Group B. [S/he] remains unresponsive. [S/he] was recently in the ER and given IV fluids and has since returned. Potential for discharge tomorrow to sister facility for ongoing care - confirmation is pending." On 10/3/2025 Resident #1 returned to the hospital and was diagnosed with a worsening hematoma including an Uncal hernia according to the National Library of Medicine "Uncal herniation occurs when rising intracranial pressure causes portions of the brain to flow from one intracranial compartment to another; this is a life-threatening neurological emergency..." Resident #1 was transferred to another facility on 10/9/2025 where s/he would be closer to family and died on 10/10/1025. Per review of Resident #1's death	F0635		

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F0635 SS = K	Continued from page 20 certificate s/he died on 10/10/2025. The manner of death was listed as "Accident." The date and time of the accident states "September 11, 2025 / ~8:00 PM." How injury occurred is listed as "Fall(s) from Standing Height" and the cause of death was documented as "Complications of Acute on Chronic Subdural Hemorrhage (Days to Weeks) due to B. Blunt Force Trauma of Head (Weeks) September 11, 2025 / ~8:00 PM." Per phone interview with Resident #1's guardian and their spouse on 11/4/2025 at 2:00 PM Resident #1 has a long history of mental illness including schizophrenia, depression, and narcolepsy with cataplexy and it took doctors several years to find the best combination of medications which included Abilify, Protriptyline, and Seroquel. They became very concerned when nursing staff notified them on 9/12/2025, a Friday that the Resident had been refusing medications and care. According to the Guardian this is a behavior that occurs when the Resident is not taking her/his medications correctly. The Guardian stated that they asked if s/he had been taking her/his Protriptyline and Seroquel and the nurse informed them that s/he did not have an order for Seroquel. The Guardian then requested a meeting with the physician to discuss the medications and the nurse with whom they were speaking with informed them that they could contact the unit manager on Monday and discuss it then the unit manager would talk with the provider. When they asked to speak with the physician the Nurse informed them that the physicians only communicate with the facility staff not the families. Review of the facility policy titled Admission Process states "The facility will obtain the appropriate physician orders from the discharging facility, if applicable. The RN/LPN [Registered Nurse/Licensed Practical Nurse] will verify the admission orders with the attending physician. The RN/LPN will reconcile medication orders with the physician based on the discharge instructions from the transferring facility." Per interview with the facility Administrator on 11/4/2025 at 3:19 PM when the family was notified on 9/12/2025 of the increased behaviors the Resident had been experiencing such as refusals of medications and hallucinations, they questioned whether or not s/he had been getting the right medications. It was at this time that the facility realized that the hospital discharge orders had not been appropriately reconciled and only every other page had been available at the time. Per interview with the Regional Assistant Director of Nursing (RADON) on 11/6/2025 at approximately 4:30 PM it is the expectation that nursing staff reconcile	F0635		

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F0635 SS = K	Continued from page 21 medications using the discharge medication list. Staff are not expected to review the entire discharge summary or other information that comes from the hospital. The RADON confirmed that the missed medications on Resident #1's hospital discharge summary should have been ordered on admission and were not. Per interview with the facility Administrator on 11/12/2025 at 11:30 AM she confirmed that once the facility identified there were missing pages to the discharge paperwork from the hospital, they did not review the rest of the summary to ensure that there were not additional orders that had been missed. Therefore, the sliding scale with insulin, the antibiotics, and the lidocaine patches were not identified until the surveyor identified the errors. Per interview with Resident #1's Primary Physician on 11/14/25 at 2:30 PM she had been made aware that the facility staff and herself had only reviewed every other page of the hospital discharge summary on the Resident's admission and that an order for Seroquel had been omitted as a result. However, she had not been aware that the other medications had been missed in the admission process. The Physician stated that it is not best practice to be checking blood sugars four times daily on an elderly person, but that had not been addressed because it had been missed. The Physician confirmed that the expectation is that the Unit Manager and/or admissions person review the discharge summary in its entirety. Per interview with the facility Medical Director on 11/18/2025 at 10:10 AM confirmed that when a Resident is admitted from the hospital, it is important and their expectation that nursing staff review the discharge packet that comes with the resident. The Medical Director stated you need to know as much as possible about your patient. We should have a good idea of the patient, and the medication lists don't tell you the whole picture. You can build off the medication list but you should not rely solely on it." Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a	F0635 F0656	The facility could not retroactively correct the deficiency as it relates to Resident #1. 1. All residents residing in the facility have the potential to be affected by the alleged deficient practice. 2. The facility's " Comprehensive Person-Centered Care Plan" policy was reviewed	

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F0656 SS = J	Continued from page 22 resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is NOT MET as evidenced by: The facility failed to develop a care plan or implement interventions specific to the safety risks associated with narcolepsy with cataplexy (sudden weakness or limping of the muscles), risk factors for the use of antipsychotic medications, implement care plan interventions to monitor blood glucose 4 times daily and administer insulin on a sliding scale for a	F0656	and education has been provided to licensed Nursing staff RN/ LPN, and all departments involved in the development of plan of care for residents. 3. Initial audit was completed on all residents residing in the facility to ensure they have a Person-Centered Comprehensive care plan in place that reflect current diagnosis and current needs. 4. The DON or designee will audit admission/readmissions four (4) weeks, then monthly for two (2) months to ensure a Person-Centered Care Plan has been put into place and reflect current diagnosis and current needs and to monitor effectiveness of the plan. 5. Results of the audits will be reported to the QAA committee x3 months at which time the QAA committee will determine further frequency of the audits. 6. Corrective action will be completed by December 19. 2025 **Tag F 656 POC accepted on 12/18/25 by S. Freeman/S. Stem**	

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F0656 SS = J	Continued from page 23 diabetic who was admitted with physician orders to do so, identify safety/fall risk related to complications of the diagnosis of a subdural hematoma for 1 of 3 residents in the sample (Resident #1). This deficient practice rose to the immediate jeopardy level due to the facility's failure to ensure care plans are developed and implemented, which resulted in Resident #1 experiencing a fall that resulted in a head injury with a subdural hematoma that worsened over time and resulted in death. This is a repeat deficiency for this facility, with the violation cited during a partial survey dated 3/3/25.	F0656		
	Findings include: Per record review Resident #1 was admitted to the facility for short term rehab after a fall at their home resulting in a distal radius fracture and multiple fractured ribs. Additional diagnoses included left third finger fracture, urinary tract infection (UTI), osteoporosis, frequent falls, schizophrenia, narcolepsy with cataplexy (sudden weakness or limping of the muscles), recurrent UTIs, and hypertension.			
	Review of the hospital discharge summary dated 8/15/2025 revealed physicians' orders for Keflex 500 mg every 12 hours for 4 days, then resume nitrofurantoin (Macrobid) 100mg daily. Guaifenesin 600mg twice daily, sliding scale insulin lispro with blood sugars 4 times daily implemented due to elevated blood sugar readings, lidocaine patch 2 patches daily, and Quetiapine (Seroquel, an antipsychotic) 600mg at bedtime. Review of the facility admission provider orders and the August 2025 medication administration record revealed that these orders were not Implemented on admission to the facility. Review of Resident #1's care plan revealed a focus initiated on 8/16/2025 of "at risk for MDRO [Multi Drug Resistant Organism] colonization/infection due to history of MRSA" and "at risk for infection/sepsis, Limited mobility, HX of UTI's, history of MRSA" initiated on 8/16/2025. The care plan does not reflect the actual urinary tract infection that the resident was admitted with, or interventions related to the treatment of an actual UTI. Review of Resident #1"s physicians orders after admission to the facility revealed that an order for finger sticks (a method used to obtain blood sugars) once in the AM was entered on 8/17/2025. The Resident's plan of care does not address the use of sliding scale insulin or finger sticks 4 times per day. Review of			

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F0656 SS = J	Continued from page 24 Resident #1's daily blood sugars revealed that between 8/17/25- 10/9/25 the resident experienced 13 documented episodes of hyperglycemia (blood glucose above which would have required the administration of the sliding scale insulin). There is no way to determine if the Resident was experiencing hyper or hypoglycemia (high or low blood sugars) or would have required sliding scale coverage the other three times per day because the blood sugars were not ordered or obtained. Further review of hospital discharge orders included Quetiapine (Seroquel, an antipsychotic) 600mg at bedtime for schizophrenia. According to the hospital records Resident #1 has been on Seroquel 600 mg since 9/1/2023. Review of the facility documentation including physician's orders and the August medication administration record (MAR) revealed that the Seroquel 600 mg was not ordered on admission. Review of the Resident's care plan reveals that the plan of care did not identified risks associated with or management of withdrawal symptoms caused by abrupt cessation of Seroquel. The Food and Drug Administration's (FDA's) Boxed Warning states that some commonly reported Seroquel withdrawal symptoms can occur include nausea, vomiting, anxiety, irritability, agitation or restlessness, panic-like symptoms, and rebound mood swings. Rebound symptoms include mania or hypomania, depression, Psychotic symptoms, and severe insomnia. When it is stopped abruptly -especially at higher doses such as 300-800 mg the sudden loss of receptor blockade can cause the body to "rebound" and over-respond until it readjusts. "Acute withdrawal symptoms such as insomnia, nausea, and vomiting have been reported following abrupt cessation of quetiapine (Seroquel). It is recommended that, where possible, the dose be tapered gradually." An Admission Fall Risk Assessment completed on 8/15/2025 was noted to have several inaccuracies and reflected that Resident #1 had a diminished safety awareness, impaired mobility with continence, required the use of an assistive device, 1-2 falls in the past 3 months, takes 1-2 high risk medications, no change in medication and/or change in dosage in the past five days 1-2 predisposing diseases/conditions. The Fall Risk care planning section of the assessment was not completed. The Resident was actually prescribed 4 of the high-risk medications which included antihypertensives, antiseizure, hypoglycemics, and psychotropics. Although unbeknownst to the facility, the Resident did have a change in medications as they were not receiving their long-term dose of Seroquel 600	F0656		

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F0656 SS = J	Continued from page 25 mg (antipsychotic), sliding scale insulin, and the antibiotic that was prescribed during their hospital stay. The Resident also had 4 predisposing diseases/condition rather than 1-2 which included hypertension, osteoporosis, fractures, and dementia. Review of Resident #1's care plan reflects a care plan focus of risk for falls due to cognitive loss, lack of safety awareness, history of falls. The care plan interventions implemented on the baseline care plan included provide Resident with opportunities for choice, assist to organize belongings for a clutter-free environment in the resident's room and consistent furniture arrangement, engage in simple, structured activities of their preference; that avoid overly demanding tasks. The care plan focus and/or interventions did not address the increased fall and safety risks due to diagnoses such as narcolepsy with cataplexy, osteoporosis, and fractures or the use of high-risk medications including antihypertensives, antiseizure, hypoglycemics, and psychotropics. During an interview on 11/6/2025 at 1:17 PM the Regional Assistant Director of Nursing confirmed that Resident #1's care plan did not address safety or fall risk concerns related to narcolepsy with cataplexy. When asked if narcolepsy with cataplexy should be on the care plan for safety risks, she stated that the care plan addresses falls and that not every diagnosis would be in the care plan. A care plan focus initiated on 8/16/2025 of at risk for decreased ability to perform ADLs (activities of daily living) related to dementia. Interventions included X1 assist for transfers that was implemented on 8/16/2025. This intervention was then revised on 8/16/2025 when ambulation status was replaced with X1 assist for transfers. There was no longer an indication for ambulation status on the care plan. On 8/18/2025 three days after admission and three days of the missing Seroquel administration, s/he began experiencing hallucinations and then began exhibiting anxious, angry, and combative behaviors which were not her/his baseline. These behaviors continued to occur. Review of Provider's Progress Notes, the provider was notified on 8/22, 8/25, and 9/12 of medication refusals. The care plan was not updated regarding safety risks or interventions to prevent accidents and hazards related to the change in condition. A Progress note date 9/9/2025 reveals that Resident #1 had weakness of their right and left lower extremities and left upper extremity, their balance was unsteady,	F0656		

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F0656 SS = J	Continued from page 26 and they were anxious, hallucinating, and wandering. The progress note also states "Safety concerns: resident often observed self-transferring without calling for assistance from staff." A Progress Note dated 9/10/2025 states "resident observed multiple times by staff throughout [evening] wandering and responding to internal stimuli. resident observed stating "dad she wont let me do it, and bill is not going to let me sleep. resident easily redirected by staff. resident assisted with toileting and clothing." There is no documented evidence that any additional care plan interventions related to falls or safety precautions including increased supervision were implemented. A Skilled Note dated 9/10/2025 states "Mental Status: Anxious, Pleasant, Delusions (misconceptions or beliefs that are firmly held, contrary to reality). Wandering. Comments: [s/he] has auditory hallucinations that [s/he] is talking to '[her/his] father', he tells [her/him] what to do and what not to do... Concerns: gets mad at staff, swings [her/his] cast trying to hit us..." Review of Resident #1's care plan revealed that it did not address hallucinations first documented on 8/18/2025 and there were no safety interventions put in place related combative behaviors until 9/18/2025. Per Progress Note dated 9/11/2025 Resident #1 was found at 12:45 AM lying in bed with a cut and swelling on the left side of their forehead. The Resident stated that s/he "got up, froze, and fell flat, then got up and layed on her/his bed." The incident report identifies predisposing factors as ambulation without assist, wanderer, and history of falls. A progress note dated 9/11/2025 reflects that at 12:30 PM the Resident was sent to the hospital emergency department for evaluation of the head wound and complaints of left foot pain. The Resident returned to the facility on 9/12/2025 with diagnoses of subdural hematoma and fracture of the foot with a walking boot in place. On 9/11/2025 a care plan intervention of "Hung a "call, don't fall" sign in [Resident's] room to remind [Resident] to call for assistance with transfers" was added to the fall risk care plan. There were no revisions to the care plan to address the increased fall risks and interventions associated with the subdural hematoma and fractured foot with a walking boot or wandering. On 9/13/2025 a physician's order for Seroquel 600 mg was initiated. According to the FDA's prescribing recommendation for starting Seroquel (Resident #1 had not received Seroquel for 30 days, since 8/15/25), "Day	F0656		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 475025	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 11/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F0656 SS = J	Continued from page 27 1: 25mg twice daily. Day 2-3: Increase increments of 25 - 50 mg divided doses (two or three times per day), to reach a total of 300 - 400 mg/day by day 4. Further adjustments should be in increments of 25 - 50 mg twice daily, with intervals of not less than 2 days between dose changes." "Risks of starting Seroquel at 600 mg without gradual dose increase include: Orthostatic blood pressure (drop in blood pressure when standing up) dizziness, sedation, impaired motor coordination, blood sugar alterations." All listed risks increase the risks for falls and safety risks. Further review of Resident #1's care plan reveals a focus dated 8/16/2025 of risk for complications related to the use of psychotropic drugs however, it did not address fall or safety risks associated with the use of psychotropic medications or specific interventions to manage fall and safety risks. it was also not updated after the 9/13/2025 addition of Seroquel. A Nursing Progress Note dated 9/14/2025 read "Resident was rude to staff. [S/he] walked to the bathroom by [her/himself] and the nurse took the wheelchair to [her/him]. [S/he] refused to eat [their] food. [S/he] only ate 1 cup of ice cream with [her/his] meds and put [her/himself] to bed." The Resident continued to self-ambulate with no additional interventions to prevent or protect them from falls and injury, Per Nursing Progress Note dated 9/17/2025 the Resident was found on the floor at the nurse's station. A Nursing Progress Note states "[S/he] was drowsy. [S/he] was uncooperative with [the Nurse]. [S/he] was assisted onto [her/his] wheelchair and wheeled into [her/his] room and transferred onto [her/his] bed. On assessment, there was a bump on top of [her/his] head (parietal lobe), the size of a coin-10 cents." The Resident was transferred to the hospital for evaluation. The Resident's fall risk care plan was updated on 9/18/25 to include an intervention of "Med review by MD" this intervention was later revised on 9/23/2025 to "When rounding offer and assist with alternative sitting options such as sitting up in W/C [wheelchair], Laying In bed as [s/he] will allow and tolerate." A Post Event Note dated 9/22/2025 reveals that the Resident is supposed to be non-weight bearing on left foot until cleared, but they were often found walking with their walker down the hall. The need for increased supervision related to the Resident's self-ambulating and self-toileting and other risks was not addressed in the care plan. Nursing Progress notes reveal that on 10/2/2025 Resident #1 was found in bed choking on vomit. S/he was	F0656		

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F0656 SS = J	Continued from page 28 sent to the hospital for evaluation and returned. On 10/3/2025 Resident #1 returned to the hospital and was diagnosed with a worsening hematoma including an Uncal hernia according to the National Library of Medicine "Uncal herniation occurs when rising intracranial pressure causes portions of the brain to flow from one intracranial compartment to another; this is a life-threatening neurological emergency..." Upon return to the facility the care plan was not updated to reflect the Resident's care needs related to the diagnosis of the worsening subdural hemorrhage and uncal herniation. The Resident was transferred back to the facility on 10/3/2025 on comfort measures and on 10/16/2025 was transferred to a skilled nursing facility closer to the family and died. Resident #1 was transferred to another facility on 10/9/2025 where s/he would be closer to family and died on 10/10/1025. Per review of Resident #1's death certificate s/he died on 10/10/2025. The manner of death was listed as "Accident." The date and time of the accident states "September 11, 2025 / ~8:00 PM." How injury occurred is listed as "Fall(s) from Standing Height" and the cause of death was documented as "Complications of Acute on Chronic Subdural Hemorrhage (Days to Weeks) due to B. Blunt Force Trauma of Head (Weeks) September 11, 2025 / ~8:00 PM." Per interview with Resident #1's Primary Physician on 11/14/25 at 2:30 PM she had been made aware that the Resident's Seroquel had not been ordered on admission when it was identified, but she was not aware that the other medications had been missed in the admission process. The Physician stated that it is not best practice to be checking blood sugars four times daily on an elderly person, however she did not address that because she had missed it. The Physician confirmed that the discharge summary that was used to admit Resident #1 only included every other page of information, and that the expectation is that the Unit Manager and/or admissions person review all of the discharge summary. Ref. F635	F0656		
F0689 SS = SQC-J	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	F0689	The facility could not retroactively correct the deficiency as it relates to Resident #1. 1. All residents residing in the facility have the potential to be affected by the alleged deficient practice.	

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F0689 SS = SQC-J	Continued from page 29 §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 interview and record review the facility failed to effectively assess a resident's risks, implement, monitor, and modify interventions when necessary to prevent falls with major injury resulting in death. The facility also failed to provide necessary treatment of clinical conditions which put the resident at an increased risk of safety and accidents. The facility also failed identify and address potential accident hazards related to the resident's clinical condition. As a result, the resident experienced a recuring UTI, a decline in behavioral health, hyperglycemic episodes, medication withdrawal, and increased fall risk for 1 of 3 Residents in the sample (Resident #1). This deficient practice rose to the immediate jeopardy level due to the facility's failure to prevent falls, which resulted in Resident #1 sustaining two falls resulting in a subdural hematoma that worsened over time resulting in death. This is a repeat deficiency for this facility, with the violation cited during partial surveys, dated 6/12/24, 10/18/24, 3/3/25 (at immediate jeopardy), and 5/28/25. Findings include: Per record review Resident #1 was admitted to the facility for short term rehab after a fall at their home resulting in a distal radius fracture and multiple fractured ribs. Additional diagnoses included left third finger fracture, urinary tract infection (UTI), osteoporosis, frequent falls, schizophrenia, major depressive disorder, narcolepsy with cataplexy (sudden weakness or limping of the muscles) recurrent UTIs, and hypertension. Review of the hospital discharge orders dated 8/15/2025 revealed physicians' orders for Keflex 500 mg every 12 hours for 4 days, then resume nitrofurantoin (Macrobid) 100mg daily. Guaifenesin 600mg twice daily, sliding scale insulin lispro with blood sugars 4 times daily, lidocaine patch 2 patches daily, and Quetiapine (Seroquel) 600mg at bedtime. None of these orders were implemented on admission to the facility. Review of physician's orders revealed that on 8/17/25 a	F0689	2. The facility's "Accidents and Incidents" and " Managing Falls and Fall Risk" policy was reviewed and education has been provided to licensed Nursing staff (RN's/LPNs), UM, DON emphasizing also on how to complete a fall risk assessment correctly to ensure all risk factors are captured. 3. Initial audit was completed on all residents fall care plans to ensure interventions are in place for at risk diagnoses. 4. The DON or designee will audit all new falls for (4) weeks, then monthly for two (2) months to ensure interventions are being put in place and all risk factors are being captured to reflect current needs and to monitor effectiveness of the plan. 5. Results of the audits will be reported to the QAA committee x3 months at which time the QAA committee will determine further frequency of the audits. 6. Corrective action will be completed by December 19. 2025. **Tag F 689 POC accepted on 12/18/25 by S. Freeman/S. Stem**	

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F0689 SS = SQC-J	Continued from page 30 Registered Nurse entered an order for fingerstick (a method for testing blood sugars) once daily. Review of Resident #1's blood sugars between 8/17- 10/9 revealed that the resident experienced 10 episodes of hyperglycemia (High blood sugar) which would have required the administration of the sliding scale insulin. There is no way to determine if the Resident had other episodes of hyperglycemia because the blood sugars were not completed as directed in the discharge orders. Per the National Library of Medicine "Diabetes increases the risk of cardiovascular and microvascular complications but also increases the risk of common geriatric syndromes, including cognitive impairment, depression, falls, polypharmacy, persistent pain, and urinary incontinence." Per interview with Resident #1's Primary Physician on 11/14/25 at 2:30 PM she had been made aware that the Resident's Seroquel had not been ordered on admission when it was identified, but she was not aware that the other medications had been missed in the admission process. The Physician stated that it is not best practice to be checking blood sugars four times daily on an elderly person, however she did not address that because she had missed it. The Physician confirmed that the discharge summary that was used to admit Resident #1 only included every other page of information, and that the expectation is that the Unit Manager and/or admissions person review all of the discharge summary. During an interview on 11/6/2025 at 1:17 PM the Regional Assistant Director of Nursing when asked if the diagnosis or narcolepsy with cataplexy should be identified on the care plan as a safety or fall concern, she stated that the Resident had an at risk for falls care plan that addressed fall risks, and not all diagnoses are on the care plan. The RADON confirmed that the care plan did not address fall or safety concern related to the diagnosis of narcolepsy with cataplexy. An Admission Fall Risk Assessment completed on 8/15/2025 was noted to have several inaccuracies and reflected that Resident #1 had a diminished safety awareness, impaired mobility with continence, required the use of an assistive device, 1-2 falls in the past 3 months, takes 1-2 high risk medications, no change in medication and/or change in dosage in the past five days 1-2 predisposing diseases/conditions. The Fall Risk care planning section of the assessment was not completed. The Resident was actually prescribed 4 of the high-risk medications which included antihypertensives, antiseizure, hypoglycemics, and psychotropics. Although unbeknownst to the facility,	F0689		

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F0689 SS = SQC-J	Continued from page 31 the Resident did have a change in medications as they were not receiving their long-term dose of Seroquel 600 mg (antipsychotic), sliding scale insulin, and the antibiotic that was prescribed during their hospital stay. The Resident also had 4 predisposing diseases/condition rather than 1-2 which included hypertension, osteoporosis, fractures, and dementia. Review of Resident #1's care plan reflects a care plan focus of risk for falls due to cognitive loss, lack of safety awareness, history of falls. The care plan interventions implemented on the baseline care plan included provide Resident with opportunities for choice, assist to organize belongings for a clutter-free environment in the resident's room and consistent furniture arrangement, engage in simple, structured activities of their preference: that avoid overly demanding tasks. The care plan focus and/or interventions did not address the increased fall and safety risks due to diagnoses such as narcolepsy with cataplexy, osteoporosis, and fractures or the use of high-risk medications including antihypertensives, antiseizure, hypoglycemics, and psychotropics. During an interview on 11/6/2025 at 1:17 PM the Regional Assistant Director of Nursing confirmed that Resident #1's care plan did not address safety or fall risk concerns related to narcolepsy with cataplexy. When asked if narcolepsy with cataplexy should be on the care plan for safety risks, she stated that the care plan addresses falls and that not every diagnosis would be in the care plan. A care plan focus initiated on 8/16/2025 of at risk for decreased ability to perform ADLs (activities of daily living) related to dementia. Interventions included X1 assist for transfers that was implemented on 8/16/2025. This intervention was then revised on 8/16/2025 when ambulation status was replaced with X1 assist for transfers. There was no longer an indication for ambulation status on the care plan. On 8/18/2025 three days after admission and three days of the missing Seroquel administration, s/he began experiencing hallucinations and then began exhibiting anxious, angry, and combative behaviors which were not her/his baseline. These behaviors continued to occur. Review of Provider's Progress Notes, the provider was notified on 8/22, 8/25, and 9/12 of medication refusals. The care plan was not updated regarding safety risks or interventions to prevent accidents and hazards related to the change in condition. A Progress note date 9/9/2025 reveals that Resident #1	F0689		

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F0689 SS = SQC-J	Continued from page 32 had weakness of their right and left lower extremities and left upper extremity, their balance was unsteady, and they were anxious, hallucinating, and wandering. The progress note also states "Safety concerns: resident often observed self-transferring without calling for assistance from staff." A Progress Note dated 9/10/2025 states "resident observed multiple times by staff throughout [evening] wandering and responding to internal stimuli. resident observed stating "dad she wont let me do it, and bill is not going to let me sleep. resident easily redirected by staff. resident assisted with toileting and clothing." There is no documented evidence that any additional care plan interventions related to falls or safety precautions including increased supervision were implemented. A Skilled Note dated 9/10/2025 states "Mental Status: Anxious, Pleasant, Delusions (misconceptions or beliefs that are firmly held, contrary to reality). Wandering. Comments: [s/he] has auditory hallucinations that [s/he] is talking to '[her/his] father', he tells [her/him] what to do and what not to do... Concerns: gets mad at staff, swings [her/his] cast trying to hit us..." Review of Resident #1's care plan revealed that it did not address hallucinations first documented on 8/18/2025 and there were no safety interventions put in place related combative behaviors until 9/18/2025. Per Progress Note dated 9/11/2025 Resident #1 was found at 12:45 AM lying in bed with a cut and swelling on the left side of their forehead. The Resident stated that s/he "got up, froze, and fell flat, then got up and layed on her/his bed." The incident report identifies predisposing factors as ambulation without assist, wanderer, and history of falls. A progress note dated 9/11/2025 reflects that at 12:30 PM the Resident was sent to the hospital emergency department for evaluation of the head wound and complaints of left foot pain. The Resident returned to the facility on 9/12/2025 with diagnoses of subdural hematoma and fracture of the foot with a walking boot in place. On 9/11/2025 a care plan intervention of "Hung a "call, don't fall" sign in [Resident's] room to remind [Resident] to call for assistance with transfers" was added to the fall risk care plan. There were no revisions to the care plan to address the increased fall risks and interventions associated with the subdural hematoma and fractured foot with a walking boot or wandering. On 9/13/2025 a physician's order for Seroquel 600 mg was initiated. According to the FDA's prescribing	F0689		

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F0689 SS = SQC-J	Continued from page 33 recommendation for starting Seroquel (Resident #1 had not received Seroquel for 30 days, since 8/15/25), "Day 1: 25mg twice daily. Day 2-3: Increase increments of 25 - 50 mg divided doses (two or three times per day), to reach a total of 300 - 400 mg/day by day 4. Further adjustments should be in increments of 25 - 50 mg twice daily, with intervals of not less than 2 days between dose changes." "Risks of starting Seroquel at 600 mg without gradual dose increase include: Orthostatic blood pressure (drop in blood pressure when standing up) dizziness, sedation, impaired motor coordination, blood sugar alterations." All listed risks increase the risks for falls and safety risks. Further review of Resident #1's care plan reveals a focus dated 8/16/2025 of risk for complications related to the use of psychotropic drugs however, it did not address fall or safety risks associated with the use of psychotropic medications or specific interventions to manage fall and safety risks. it was also not updated after the 9/13/2025 addition of Seroquel. A Nursing Progress Note dated 9/14/2025 read "Resident was rude to staff. [S/he] walked to the bathroom by [her/himself] and the nurse took the wheelchair to [her/him]. [S/he] refused to eat [their] food. [S/he] only ate 1 cup of ice cream with [her/his] meds and put [her/himself] to bed." The Resident continued to self-ambulate with no additional interventions to prevent or protect them from falls and injury, Per Nursing Progress Note dated 9/17/2025 the Resident was found on the floor at the nurse's station. A Nursing Progress Note states "[S/he] was drowsy. [S/he] was uncooperative with [the Nurse]. [S/he] was assisted onto [her/his] wheelchair and wheeled into [her/his] room and transferred onto [her/his] bed. On assessment, there was a bump on top of [her/his] head (parietal lobe), the size of a coin-10 cents." The Resident was transferred to the hospital for evaluation. The Resident's fall risk care plan was updated on 9/18/25 to include an intervention of "Med review by MD" this intervention was later revised on 9/23/2025 to "When rounding offer and assist with alternative sitting options such as sitting up in W/C [wheelchair], Laying in bed as [s/he] will allow and tolerate." A Post Event Note dated 9/22/2025 reveals that the Resident is supposed to be non-weight bearing on left foot until cleared, but they were often found walking with their walker down the hall. The need for increased supervision related to the Resident's self-ambulating and self-toileting and other risks was not addressed in the care plan.	F0689		

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F0689 SS = SQC-J	Continued from page 34 Nursing Progress notes reveal that on 10/2/2025 Resident #1 was found in bed choking on vomit. S/he was sent to the hospital for evaluation and returned. On 10/3/2025 Resident #1 returned to the hospital and was diagnosed with a worsening hematoma including an Uncal hernia according to the National Library of Medicine "Uncal herniation occurs when rising intracranial pressure causes portions of the brain to flow from one intracranial compartment to another; this is a life-threatening neurological emergency..." Resident #1 was transferred to another facility on 10/9/2025 where s/he would be closer to family and died on 10/10/1025. Per review of Resident #1's death certificate s/he died on 10/10/2025. The manner of death was listed as "Accident." The date and time of the accident states "September 11, 2025 / ~8:00 PM." How injury occurred is listed as "Fall(s) from Standing Height" and the cause of death was documented as "Complications of Acute on Chronic Subdural Hemorrhage (Days to Weeks) due to B. Blunt Force Trauma of Head (Weeks) September 11, 2025 / ~8:00 PM." During an interview on 11/4/2025 at 3:19 PM when the facility Administrator confirmed that family was notified on 9/12/2025 of the increased behaviors the Resident had been experiencing such as refusals of medications and hallucinations, they questioned whether or not s/he had been getting the right medications. It was at this time that the facility realized that the hospital discharge orders had not been appropriately reconciled and only every other page had been available at the time. The Administrator confirmed that the missed Seroquel was a medication error however, the facility did not implement an incident report per policy. Per interview with the facility Administrator on 11/12/2025 at 11:30 AM she confirmed that once the facility identified there were missing pages to the discharge paperwork from the hospital, they did not review it to ensure there were not additional orders that had been missed. Therefore, the sliding scale with insulin, the antibiotics, and the lidocaine patches were not identified until the surveyor identified the errors. Ref. F635	F0689		
F0726 SS = D	Competent Nursing Staff CFR(s): 483.35(a)(3)(4)(d) §483.35 Nursing Services	F0726	1. All residents residing in the facility have the potential to be affected by the alleged deficient practice.	

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F0726 SS = D	Continued from page 35 The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.71. §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. §483.35(d) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is NOT MET as evidenced by: Based on interview and record review the facility failed to ensure that one of five nurses, an agency nurse in the applicable sample had received training and competencies needed to provide care for the residents who reside in the facility. This is a repeat deficiency for this facility, with the violation cited during a recertification survey dated 3/27/25. Findings include: Per review of 5 nurse's education and training files to determine if they had the training and skill set to perform an admission the facility was unable to locate the employee training and competency files of an agency staff nurse. Per interview with the facility Administrator on	F0726	2. Education provided to the Administrator, DON and Nurse Educator on the required training and competencies that need to be completed for all new hires and agency staffing. 3. Initial audit was completed on all current employee files to include agency staffing to ensure the required training and competencies have been completed. 4. The DON or designee will audit all newly hired employees and new agency staffing for (4) weeks, then monthly for two (2) months to ensure the required training and competencies have been completed and to monitor effectiveness of the plan. 5. Results of the audits will be reported to the QAA committee x3 months at which time the QAA committee will determine further frequency of the audits. 6. Corrective action will be completed by December 19, 2025 **Tag F 726 POC accepted on 12/18/25 by S. Freeman/S. Stem**	

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F0726 SS = D	Continued from page 36 11/4/2025 at approximately 4:00 PM the agency nurse no longer works there, and they had a recent change in the education department. The Administrator confirmed that they were not able to find the agency nurses file that consists of training and competencies required to provide care to the residents who live there.	F0726		
F0760 SS = SQC-H	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is NOT MET as evidenced by: Based on interview and record review, the facility failed to ensure residents were free from significant medication errors for 1 of 3 sampled residents (Resident #1). This deficient practice resulted in harm; Resident #1 had antipsychotic medication withdrawal, increased behavior health distress exhibited by hallucinations, resistive and combativeness with care, and medication refusals; unmonitored and untreated blood sugars; increased risk of urinary tract infection resulting in a hemolytic Strep Group B urinary tract infection, and increased risk for and repeated falls with major head injury, and death. This is a repeat deficiency for this facility, with the violation cited during two recent partial surveys dated 3/3/25 and 5/28/25. Findings include: Per record review Resident #1 was admitted to the facility on 8/15/2025 for short term rehab after a fall at their home resulting in a distal radius fracture and multiple fractured ribs. Hospital diagnoses included a urinary tract infection (UTI). Per review of hospital documentation, while in the hospital s/he had a change in mental status that was attributed to acute metabolic encephalopathy likely caused by the UTI and was started on an antibiotic to be continue for 4 days after discharge and then another antibiotic prophylactically thereafter. Prior diagnoses include osteoporosis, frequent falls, schizophrenia, narcolepsy with cataplexy (a chronic neurological disorder characterized by excessive daytime sleepiness and sudden, involuntary muscle weakness), and recurrent UTIs. Hospital discharge orders included Quetiapine	F0760	The facility could not retroactively correct the deficiency as it relates to Resident #1. 1. Residents residing in the facility that receive medication have the potential to be affected by the alleged deficient practice. 2. The facility's " Reconciliation of Medication on Admission ", "Admission Process" and "Medication Errors" policy was reviewed and education has been provided to licensed Nursing staff RN/ LPN. 3. New processes implemented: A. Hard copy documents containing discharge orders for transcription “not faxes” will not be uploaded into PCC until it arrives at the facility with patients upon admission and once reviewed for entirety and accuracy. Education has been provided to Admission director on new process. B. Admission checklist re-implemented on all new admissions to include two nurse reviewing orders. Education provided to the licensed nursing staff RN, LPN, UM and DON on the new process. 4. The DON or designee will audit admission/readmissions four (4) weeks, then monthly for two (2) months to ensure nothing is being missed and monitor effectiveness of the plan.	

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F0760 SS = SQC-H	Continued from page 37 (Seroquel, an antipsychotic) 600mg at bedtime for schizophrenia. According to the hospital records Resident #1 has been on Seroquel 600 mg since 9/1/2023. Review of the facility documentation including physician's orders and the August Medication Administration Record (MAR) revealed that the Seroquel 600 mg was not ordered on admission. The Food and Drug Administration's (FDA's) Boxed Warning states that some commonly reported Seroquel withdrawal symptoms can occur include nausea, vomiting, anxiety, irritability, agitation or restlessness, panic-like symptoms, and rebound mood swings. Rebound symptoms include mania or hypomania, depression, Psychotic symptoms, and severe insomnia. When it is stopped abruptly -especially at higher doses such as 300-800 mg the sudden loss of receptor blockade can cause the body to "rebound" and over-respond until it readjusts. "Acute withdrawal symptoms such as insomnia, nausea, and vomiting have been reported following abrupt cessation of quetiapine (Seroquel). It is recommended that, where possible, the dose be tapered gradually." Review of progress notes written since admission reveal that on 8/18/2025 Resident #1 began experiencing hallucinations which increased over time and also began exhibiting behaviors. A Skilled Note dated 8/18/2025 states Hallucinations (perceptual experiences in the absence of real external sensory stimuli). Comments: resident observed talking to internal stimuli at times while at nursing station." A Psychiatry Note dated 8/19/2025 states Resident is pleasant, with occasional non distressful hallucinations with talking to others not there." An Administration Note dated 8/22/2025 states "Resident refused to take [her/his] meds, stating that [s/he] does not take meds. Various approaches were used without success. Provider on call [name omitted] was informed who also tried without success. Resident refused dinner, drink and [vital signs]. [S/he] was hallucinating." An Administration Note dated 8/23/2025 states "refused care and [vital signs]." A Skilled Note dated 9/8/2025 states "Disorganized Thinking, Oriented to: Person...Mental Status: Anxious, Depressed, Angry, Hallucinations (perceptual experiences in the absence of real external sensory stimuli). Delusions (misconceptions or beliefs that are firmly held, contrary to reality). Physical Behaviors (Hitting, Kicking, ect.) Verbal Behaviors (Screaming, Cursing, etc.) Wandering. Resident/ Care Giver Education: a cast should not be used to hit people Comments: when [s/he] is hallucinating or attempting to	F0760	5. The DON or designee will audit the missed medication report in PCC four (4) weeks, then monthly for two (2) months to ensure nothing is being missed and monitor effectiveness of the plan. 6. Results of the audits will be reported to the QAA committee x3 months at which time the QAA committee will determine further frequency of the audits. 7. Corrective action will be completed by December 19, 2025. **Tag F 760 POC accepted on 12/18/25 by S. Freeman/S. Stem**	

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F0760 SS = SQC-H	Continued from page 38 hit, stay away from [her/him] until [s/he] calms down..." A Skilled Note dated 9/10/2025 states "Mental Status: Anxious, Pleasant, Delusions (misconceptions or beliefs that are firmly held, contrary to reality) Wandering. Comments: [s/he] has auditory hallucinations that [s/he] is talking to '[her/his] father', he tells [her/him] what to do and what not to do. today [s/he] took [her/his] pills without difficulty. pleasant and cooperative. Therapy: Physical Therapy, while outside of physical therapy functionality has improved. Safety Concerns: gets mad at staff, swings [her/his] cast trying to hit us Comments: no [complaint of] pain or discomfort." An Administration Note dated 9/10/2025 states "resident observed multiple times by staff throughout [hour of sleep] wandering and responding to internal stimuli. resident observed stating "dad she wont let me do it, and bill is not going to let me sleep. resident easily redirected by staff. resident assisted with toileting and clothing." A Nursing Progress Note dated 9/12/2025 states "resident refused all medications at the present time. On-call NP notified. no new orders from NP at this time. resident allowed blood glucose to be checked, and insulin was administered per order. residents awake, alert and oriented x1 at the present time. resident continues to respond to internal stimuli stating, "dad no, I won't take that medicine." resident unable to be redirected at the present time. call light within reach. safety rounds in progress." A Nursing Progress Note dated 9/12/2025 states "resident's [guardian and spouse] called facility asking for an update on residents' condition since returning from hospital today. informed [guardian] that resident refused all [hour of sleep] medications at the present time and continues to be confused and agitated when approached by staff. resident also refused dinner during shift and [Nurse Practitioner, (NP)] was notified as well. [Guardian and spouse] expressed concerns about resident's state of mind when [s/he] is not medicated and has questions for the primary doctor in regard to [her/his] current medication regime. informed [Guardian and spouse] to call on Monday and speak with unit manager about any medication concerns so they can be relayed to in house provider. also informed them that nursing would continue to monitor resident for any changes in [her/his] [level of conciseness] or worsening in [her/his] condition and report to the on-call NP throughout weekend. [Guardian and spouse] acknowledged understanding and asked if	F0760		

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F0760 SS = SQC-H	Continued from page 39 they could attempt to talk with resident to encourage [her/him] to take her medications tonight. [Guardian] attempted to talk with resident over the phone and resident stated to [Guardian "no I will not take that and its between me and god." informed [Guardian] that staff would continue to encourage resident and notify them with any changes..." A nurse Progress Note dated 9/13/2025 states that Resident #1 "has been vomiting, babbling, and has removed [her/his] catheter. [S/he] is not at baseline and I am unable to fully evaluate [her/his] situation Returned from Springfield ED [Emergency Department] on 09/12/2025 with [diagnoses] of stable brain bleed, broken foot and urinary retention." The Nurse spoke with the Nurse Practitioner and sent the Resident back to the ED. A Nursing Progress Note dated 9/14/2025 states "Resident was rude to staff. [S/he] walked to the bathroom by [her/himself] and the nurse took the wheelchair to [her/him]. [S/he] refused to eat [her/his] food. [S/he] only ate 1 cup of ice cream with [her/his] meds and put [her/himself] to bed. An Administration Note dated 9/14/2025 "Swinging and hitting staff with [her/his] cast when care is being attempted." A Regulatory Note written by a NP dated 9/17/2025 states "Resident was recently readmitted back to the facility. [S/he] was restarted on [her/his] Seroquel 600mg for [her/his] mood disorder and has since had a marked improvement in [her/his] overall mood. [S/he] is feeling well. More conversant and appropriate." A Physician's Progress Note dated 9/18/2025 states "Per nursing, [the Resident's] family strongly requested that [s/he] be restarted on Seroquel 600 mg daily, which [s/he] apparently had been on in the past. This medication was restarted on 9/13/2025. Per nursing, she's been sleeping more, but no other adverse effects have been noted. [S/he] has a significant history of falls at baseline, with and without the Seroquel... Schizophrenia: Continue protriptyline 10 mg twice daily and aripiprazole 15 mg daily. Seroquel restarted for delusions at family's strong request." According to the FDA's prescribing recommendation for starting Seroquel "Day 1: 25mg twice daily. Day 2-3: Increase increments of 25 - 50 mg divided doses (two or three times per day), to reach a total of 300 - 400	F0760		

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F0760 SS = SQC-H	Continued from page 40 mg/day by day 4. Further adjustments should be in increments of 25 - 50 mg twice daily, with intervals of not less than 2 days between dose changes." "Risks of starting Seroquel at 600 mg without gradual dose increase include: Orthostatic blood pressure (drop in blood pressure when standing up) dizziness, sedation, impaired motor coordination, blood sugar alterations." Further review of the hospital discharge orders date 8/15/2025 revealed a sliding scale insulin (a specific dose to be administered according to the results of blood sugar) Lispro with blood sugars 4 times daily. The discharge paperwork stated that the sliding scale had been implemented due to elevated blood sugar readings. Review of Resident #1"s physicians orders after admission to the facility revealed that an order for finger sticks (a method used to obtain blood sugars) once in the AM was entered on 8/17/2025. Review of Resident #1's daily blood sugars revealed that between 8/17/25- 10/9/25 the blood sugars were obtained during the evening or night shift as opposed to morning on 8 occasions, and the resident experienced 10 documented episodes of hyperglycemia (blood glucose above which would have required the administration of the sliding scale insulin. There is no way to determine if the Resident was experiencing hyper or hypoglycemia (high or low blood sugars) or would have required sliding scale coverage the other three times per day because the blood sugars were not ordered or obtained. Further review of the hospital discharge orders dated 8/15/2025 revealed an antibiotic order for Keflex 500 mg every 12 hours for 4 days to treat the UTI, then resume nitrofurantoin (Macrobid) 100 mg daily for prophylaxis, Additional orders were 2 lidocaine patches daily for pain. Review of admission orders revealed that neither of these orders were implemented on admission to the facility. On 10/8/2025 a Nurse Practitioner wrote a progress note stating "Resident is an 85 year old [female/male] seen today for UTI. Resident had a urine done and is positive for Hemolytic Strep Group B. [S/he] remains unresponsive. [S/he] was recently in the ER and given IV fluids and has since returned..." An order was written on 10/8/2025 for Rocephin Inject 1 gram intramuscularly one time a day for UTI for 5 Days mix with lidocaine. The Resident received one dose on 10/8/2025 and was transferred to another nursing facility on 10/9/2025. Per review of Resident #1's death certificate s/he died on 10/10/2025 at another facility. The manner of death was listed as "Accident." The date and time of the accident states "September 11, 2025 / ~8:00 PM". how injury occurred is listed as "Fall(s) from Standing	F0760		

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F0760 SS = SQC-H	Continued from page 41 Height" and the Cause of death was documented as "Complications of Acute on Chronic Subdural Hemorrhage (Days to Weeks) due to B. Blunt Force Trauma of Head (Weeks)" September 11, 2025 / ~8:00 PM" Review of the facility policy titled Medication Errors last revised 1/2024 reveals a Policy Statement that states "In the event of a medication error, the facility will act promptly to assess for adverse consequences, notify the physician, carry out follow-up orders as directed by the physician, and address the root cause error." The policy also states "4. The attending physician is notified promptly of any significant error or adverse consequence. a. The physician's orders are implemented, and the resident is monitored closely for 24 to 72 hours or as directed. 5. The following information is documented in an incident report: a. Factual description of the error or adverse consequence. b. Name of Physician and time notified. c. Physician's subsequent orders." Per interview with the facility Administrator on 11/4/2025 at 3:19 PM when the family was notified on 9/12/2025 of the increased behaviors the Resident had been experiencing such as refusals of medications and hallucinations, they questioned whether or not s/he had been getting the right medications. It was at this time that the facility realized that the hospital discharge orders had not been appropriately reconciled and only every other page had been available at the time. The Administrator confirmed that the missed Seroquel was a medication error however, the facility did not implement an incident report per policy. Per interview with the facility Administrator on 11/12/2025 at 11:30 AM, she confirmed that once the facility identified there were missing pages to the discharge paperwork from the hospital, they did not review it to ensure there were not additional orders that had been missed. Therefore, the sliding scale with insulin, the antibiotics, and the lidocaine patches were not identified until the surveyor identified the errors. Per interview with Resident #1's Primary Physician on	F0760		

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F0760 SS = SQC-H	Continued from page 42 11/14/25 at 2:30 PM, she had been made aware that the Resident's Seroquel had not been ordered on admission when it was identified, but she was not aware that the other medications had been missed in the admission process. The Physician stated that it is not best practice to be checking blood sugars four times daily on an elderly person, however she did not address that because she had missed it. The Physician confirmed that the expectation is that the Unit Manager and/or admissions person review all of the discharge summary to ensure that all orders are noted.	F0760		