STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165310	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/28/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Heritage Specialty Care	**200 Clive Drive SW , Cedar Rapids, Iowa, 52404**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	INITIAL COMMENTS Correction date: _____ The following deficiencies resulted from the facility's annual recertification survey and investigation of complaints #2805862-C, # 2963131-C, #2976802-C, #3001104-C, and facility reported incidents #2797383-I and #2964333-I, conducted May 04, 2026 to May 28, 2026. See Code of Federal Regulations (42CFR) Part 483, Subpart B-C.	F0000		
F0812 SS = E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is NOT MET as evidenced by:	F0812		

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

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

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F0812 SS = E	Continued from page 1 Based on observations, staff interviews, and facility policy review, the facility failed to prepare food in accordance with professional standards for food safety to reduce the risk of food borne illness. The facility reported a census of 127 residents. Findings include: During continuous observation on 5/6/25 from 11:00 AM to 11:24 AM, Staff C, Dietary Cook washed her hands and used two towels to remove a steam pan of rice and then a steam pan of pork stir fry from the convection oven. The two towels were placed on the preparation table surface. Staff C scooped the proper amount of rice and pork stir fry for 7 pureed meals. Staff C wiped her hand on one of the towels on the preparation table. Staff C opened a bread bag and donned gloves. Staff C (with gloved hands) used tongs to place 5 slices of bread on a cutting board. Staff C operated the robo coupe with gloved hand used a scoop to add more of the liquid from the pork stir fry. With the same gloved hands, Staff C operated the robo coupe. With the same gloved hands, Staff C used tongs to remove 2 additional slices of bread from the bread bag. Staff C, placed her gloved hands on the sides of the stacked bread slices to straighten the stack of bread slices. Staff C held a knife in her right hand placing it in the middle on the stack of bread slices. Staff C placed her left gloved hand with her palm on the top slices and fingers around the edges. Staff C applied pressure to the top of the stack of bread as she pushed the knife down the stack. Staff C, sliced two additional times through the stack of bread while holding the stack of bread with her gloved left hand. Staff C turned off the robo coup and measured out 3 cups of the pureed rice and pork stir fry and left the remaining pureed mixture in the bowl of the robo coupe. Staff C replaced the bowl of the robo coupe back on the base and pushed on the blade touching the pureed mixture with right gloved hand. Staff C removed her right-hand glove and donned a clean glove. Staff C added the bread to the robo coupe using tong. Staff C with gloved hand stopped the robo coupe and measured out an additional 3 cups of the mixture to a second measuring cup. Staff C replaced the bowl to the base of the robo coupe and again pushed the blade down touching the pureed mixture with her gloved hand. Staff C removed her right glove. Staff C donned a glove on her right hand. Staff C used a rubber spatula and scraped the sides of the bowl of the robo coupe. Staff C held the rubber spatula in her right hand used her left hand to scrape off the rubber end of the spatula and again scraped the pureed mixture in the robo coupe.	F0812		

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F0812 SS = E	Continued from page 2 On 5/6/25 at 11:24 AM, Staff C, didn't recall touching the bread or the pureed mixture with gloved hands that touched multiple nonfood surfaces. On 5/6/25 at 11:25 AM, Staff E, Dietary Cook reported she observed the staff member cutting bread slices with gloved hands that came in contact with other surfaces. On 5/6/26 at 11:27 AM, the Regional Dietician reported Staff C shouldn't have touched the bread, pushed the robo coupe blade down or scrape off a rubber spatula with gloved hands that had touched nonfood surfaces when preparing pureed meals. Review of the employee file for Staff C contained a Job Description for the position of Cook, which listed Staff C's date of hire as 1/26/26. The Job Description directed staff to handle and prepare food in a sanitary manner, and to maintain strict compliance with established policy/practices/standards for food preparation and storage. Staff C signed the Job Description on 5/6/26. Review of the Order Listing Report with a date of 5/5/26 listed 6 residents with pureed diet texture. Review of the Food Preparation and Service facility policy revised April 2019 directed staff to adhere to proper hygiene and sanitary practices to prevent the spread of food borne illness.	F0812		
F0628 SS = D	Discharge Process CFR(s): 483.15(c)(2)(iii)(3)-(6)(8)(d)(1)(2); 483.21(c)(2) §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including	F0628		

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F0628 SS = D	Continued from page 3 contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to	F0628		

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F0628 SS = D	Continued from page 4 allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to	F0628		

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F0628 SS = D	Continued from page 5 effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following:	F0628		

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F0628 SS = D	Continued from page 6 (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). This REQUIREMENT is NOT MET as evidenced by: Based on clinical record review, facility document review, and staff interview, the facility failed to notify the Long-Term Care Ombudsman of a discharge for 3 of 6 residents reviewed (Resident #13, Resident #122, and Resident #126). The facility reported a census of 127 residents. Findings include: 1. Review of the electronic health record (EHR) Clinical Census information for Resident #13 revealed an entry of hospital paid leave effective 3/28/26. A Progress Note dated 3/29/26 at 6:34 AM documented Resident #13 had been admitted to the hospital. Review of the Notice of Transfer Form to Long Term Care Ombudsman lacked Resident #13's 3/28/26 hospitalization. 2. Review of the EHR Clinical Census information for Resident #126 revealed an entry of hospital paid leave effective 2/24/26 and an entry of stop billing effective 2/28/26. A Progress Note dated 2/24/26 at 1:56 PM documented Resident #126 had been sent to the emergency room for surgical opinion. The Progress Notes lacked documentation Resident #126 had been admitted to the hospital. A Progress Note dated 2/27/26 at 12:00 PM documented Resident #126 was being discharged. Review of the Notice of Transfer Form to Long Term Care Ombudsman lacked Resident #126's 2/24/26	F0628		

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F0628 SS = D	Continued from page 7 hospitalization and the 2/28/26 discharge. During an interview on 5/6/26 at 9:42 AM, Staff A, Interim Social Services reported Resident #13 and Resident #126 had not been included on the Notice of Transfer Form to Long Term Care Ombudsman. During an interview on 5/6/26 at 12:05 PM, the Administrator revealed the facility lacked a policy and acknowledged Resident #13 and #126 should have been included in the notifications to the LTC Ombudsman. 3. Review of the EHR Clinical Census information for Resident #122 revealed an entry of hospital unpaid leave effective 3/26/26. A Progress Note dated 3/26/26 at 6:50 PM documented Resident #122 had been admitted to the hospital. The Notice of Transfer Form to Long Term Care Ombudsman lacked Resident #122's 3/26/26 hospitalization.	F0628		
F0641 SS = D	Accuracy of Assessments CFR(s): 483.20(g)(h)(i)(j) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. §483.20(h) Coordination. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. §483.20(i) Certification. §483.20(i)(1) A registered nurse must sign and certify that the assessment is completed. §483.20(i)(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. §483.20(j) Penalty for Falsification. §483.20(j)(1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a	F0641		

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F0641 SS = D	Continued from page 8 resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. §483.20(j)(2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is NOT MET as evidenced by: Based on clinical record review, staff interviews, and facility policy review the facility failed to complete the Minimum Data Set (MDS) assessments to accurately reflect resident condition for a feeding tube, and to accurately reflect Preadmission Screening and Resident Review Level II for 2 of 4 residents reviewed (Resident #3 and Resident #105). The facility reported a census of 127 residents. Findings Include: 1. The Minimum Data Set (MDS) assessment for Resident #3 dated 8/23/25 showed Resident #3 was not considered by the state level II Preadmission Screening and Resident Review (PASRR) process to have serious mental illness and/or intellectual disability or a related condition. The MDS listed diagnoses of depression and Post Traumatic Stress Disorder (PTSD). Resident #3's chart held the Notice of PASRR Level II Outcome dated 3/27/25. The Level II directed Resident #3 needed the level of services provided in a nursing facility and needed specialized services for behavioral health and/or developmental condition. On 5/07/26 at 12:10 PM, Staff G, MDS Coordinator confirmed according to the MDS dated 8/23/25 for Resident #3, not considered by the state level II Preadmission Screening and Resident Review (PASRR). Staff G confirmed the MDS failed to show serious mental illness, intellectual disability or other related conditions. Staff G confirmed the assessment failed to show the completion of the Level II. Staff G opened the Level II dated 3/27/25. Staff G reported the facility expected the MDS accurate. 2. The Care Plan Report for Resident #105 with a revision date of 2/27/26 identified a Focus Area for tube feeding. Staff were directed to check for placement and gastric contents/residual volume per	F0641		

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F0641 SS = D	Continued from page 9 facility protocol and record (initiated 2/26/26). Resident #105's MDS assessment dated 4/7/26 included a Brief Interview for Mental Status (BIMS) of 5 out of 15, indicating severe cognitive impairment. MDS Section K Swallowing/Nutritional Status for Resident #105 lacked documentation of a feeding tube. MDS Section Z Assessment Administration documented, in part, [staff who completed the assessment] certified the accompanying information accurately reflects resident assessment information for this resident. Staff B, Registered Nurse (RN) signed the completed Section K Swallowing/Nutritional Status on 4/9/26. Review of the Hospital Progress to Discharge Summary dated 4/1/26, documented Resident #105 had a Left PEG tube (a flexible feeding tube inserted through the abdomen into the stomach to deliver nutrition, fluids, and medications directly) with site c/d/i (clean, dry, intact). The Order Review History Report electronically signed by the Physician on 4/1/26 included the following: a. Enteral Feed Order every shift Flush feeding tube with at 50ML of water before and after administration of feedings on hold from 04/06/2026 11:08 AM to 04/06/2026 4:51 PM b. Enteral Feed Order five times a day Formula Type / Strength: 1.5 Osmolyte 290 ML 5 times daily c. Enteral Feed Order three times a day Check Residual every shift if less than 30ML note in progress note. On hold from 04/06/2026 11:08 AM to 04/06/2026 16:51 During an observation on 5/6/26 at 9:57 AM, Staff C, Registered Nurse (RN) provided Resident #105 with 50 ML of water before and after administration of feeding and 290 ML of Osmolyte feeding. Staff C acknowledged Resident #105 had the feeding tube since admission. On 5/6/26 at 1:16 PM, Staff B, MDS Coordinator Registered Nurse (RN) verbalized she was responsible for completing the MDS. Staff B acknowledged Resident #105 has had a feeding tube since his original admission on 2/26/26. Staff B verbalized the MDS assessment dated 4/7/26 was inaccurately coded. On 5/6/26 at 1:21 PM, the Administrator voiced the expectation was the MDS should accurately reflect	F0641		

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F0641 SS = D	Continued from page 10 the resident condition. The MDS Completion and Submission Timeframes facility policy revised July 2017 revealed the Assessment Coordinator or designee is responsible for ensuring that resident assessments are submitted to [redacted] system in accordance with current Federal and State Guidelines.	F0641		
F0698 SS = D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is NOT MET as evidenced by: Based on observation, interview, and record review, the facility failed to ensure post dialysis assessments and fistula assessments were consistently completed in accordance with physician orders, facility policy, and the comprehensive care plan for 1 of 2 residents reviewed for dialysis (Resident #84). The facility reported a census of 127 residents. Findings include: Review of the Minimum Data Set (MDS) assessment for Resident #84 dated 2/27/26 revealed a Brief Interview for Mental Status score of 15 out of 15, which indicated intact cognition. Per this assessment, the resident had a diagnosis of dependence on renal dialysis, and received dialysis while a resident. Review of Resident #84’s Care Plan focus area dated 5/6/25 revealed the resident received hemodialysis related to end stage renal disease (ESRD), and had an arteriovenous (AV) fistula to the left upper extremity (LUE). The Intervention dated 5/6/25 revealed staff to listen to and feel the dialysis site (the fistula) to ensure it was functioning correctly. This was required before dialysis, after dialysis, and on days without dialysis. During an observation and interview on 5/5/2026 at 8:17 AM, Resident #84 explained that while nurses checked her vital signs before she left for dialysis, they often failed to check her afterward or on days	F0698		

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F0698 SS = D	Continued from page 11 when she didn't have an appointment. Resident #84 pulled up her left sleeve and showed the fistula site. She expressed that this worried her because she was afraid of medical complications. In a follow-up interview the next day on 5/6/2026 at 8:32 AM, she noted that no one had checked her dialysis access site at all the previous day. She felt ignored. Review of Resident #84's electronic medical records showed the following present on the resident's April 2026 Supplemental Documentation Record: a. Complete the Dialysis Evaluation prior to dialysis, post dialysis and on non-dialysis days. every day shift every Tues, Thurs, Sat, Sun. b. Complete the Dialysis Evaluation prior to dialysis, post dialysis and on non-dialysis days. two times a day every Mon, Wed, Fri. Records revealed the following: On 4/16/2026 and 4/26/2026 (non-dialysis days), nurses signed off the assessment was done, but the actual evaluation data was missing. On 4/17/2026 (dialysis day), the facility failed to perform the required check after the resident returned from treatment. During an interview on 5/06/2026 at 9:11 AM Staff F, LPN (Licensed Practical Nurse) confirmed that staff were expected to evaluate dialysis residents every day. This included checking the dialysis site for a "thrill" and "bruit" (the vibration and sound that indicate the site was working properly) and vital signs. Staff F stated that these checks were supposed to happen before and after every dialysis appointment. During an interview on 5/06/2026 at 12:25 PM, the Director of Nursing (DON) stated that all staff had received online training for dialysis care. The DON acknowledged that while nurses were supposed to assess residents both before and after their appointments, the post-dialysis checks did not always happen. The DON also mentioned that daily checks on non-dialysis days only occurred if a doctor specifically ordered them, and any missed checks should have been documented as refused or noted if the resident was out of the building Review of the facility policy titled “End-Stage Renal Disease, Care of a Resident with” last revised September 2010 revealed staff caring for residents with ESRD, including residents receiving dialysis care outside of the facility, shall be trained in the	F0698		

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F0698 SS = D	Continued from page 12 care and special needs of these residents. Education and training of staff includes, specifically....the type of assessment data that is to be gathered about the resident's condition on a daily or per shift basis.	F0698		
F0741 SS = D	Sufficient/Competent Staff-Behav Health Needs CFR(s): 483.40(a)(1)(2) §483.40(a) The facility must have sufficient staff who provide direct services to residents 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 §483.71. These competencies and skills sets include, but are not limited to, knowledge of and appropriate training and supervision for: §483.40(a)(1) Caring for residents with mental and psychosocial disorders, as well as residents with a history of trauma and/or post-traumatic stress disorder, that have been identified in the facility assessment conducted pursuant to §483.71, and §483.40(a)(2) Implementing non-pharmacological interventions. This REQUIREMENT is NOT MET as evidenced by: Based on observation, clinical record review, and interviews the facility failed to address trauma history, PTSD triggers, signs of distress, non-pharmacological interventions, or medication in assessments and care plans for 1 of 1 residents reviewed for Post Traumatic Stress Disorder (PTSD) (Resident #112). The facility reported a census of 127 residents. Findings include: Admission paperwork for Resident #112 scanned to the facility on 2/20/2026 documented the resident took 1 milligram (mg) of prazosin at bedtime for chronic PTSD with trauma related nightmares. Resident #112's care plan with an admission date of 3/02/2026 did not include focus areas, goals, or interventions for PTSD, nightmares, trauma, or prazosin.	F0741		

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F0741 SS = D	Continued from page 13 The Minimum Data Set (MDS) for Resident #112 dated 3/08/2026 documented a Brief Interview for Mental Status score of 3/15 which indicated severe cognitive impairment. MDS diagnoses included non-Alzheimer's dementia, anxiety disorder, and depression. The box for PTSD was not checked. A document titled Progress Notes dated 4/07/2026 revealed the resident's provider conducted a regulatory visit at the facility. The past medical history did not include PTSD. The task section of the Electronic Health Record (EHR) included monitoring behavior symptoms. A 30 day look back revealed that on 4/13/2026 the resident was documented crying, yelling, pushing, and grabbing. On 04/16/2026 the facility documented the resident yelled/screamed. The resident's Medication Administration Record (MAR) for May 2026 retrieved 5/04/2026 at 1:47 PM documented the resident received prazosin HCl oral capsule 1 mg by mouth one time a day for chronic PTSD with night terrors. The MAR did not include behavior monitoring. On 5/04/2026 at 11:04 AM observed the resident call out from her bed with the sound ah ah ah ah ah ah. Her speech was mostly garbled then she clearly stated her head hurt. The resident closed her eyes and called out again in a higher pitch. Her head moved back and forth on the pillow. On 5/06/26 at 7:42 AM heard resident hum then call out with a loud, repetitive sound. After about a minute she yelled, ahhhhhhhh. At 9:12 AM on 5/07/2026 Staff I, Licensed Practical Nurse (LPN) indicated staff monitor for agitation, aggressive behavior, and residents seeking a lot of attention. She reported Resident #112 yelled and screamed sometimes when she was out of her room and called out when she was in bed, and she didn't really know what caused it. She stated it was addressed with scheduled and as needed medications. She was not aware of a PTSD diagnosis or nightmares/night terrors. She would address it by sitting with a resident and reassure them if she knew it was happening. During an interview on 5/07/2026 at 9:23 AM Staff J, Certified Nurses Aide (CNA) stated she watched residents for threatening, combative, sexual, emotional, and health changes and reported them to the nurse. Staff J reported it was normal for this	F0741		

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F0741 SS = D	Continued from page 14 resident to call out. She wasn't sure what caused it. When asked if she was aware of the resident's PTSD diagnosis or night terrors, she stated she didn't know about that because she didn't work at night. She didn't think it happened during the day, only when she did that 'screaming out thing' maybe. On 5/07/2026 at 10:04 AM Staff K, Assistant Director of Nursing (ADON) confirmed the resident's EHR did not include a diagnosis of PTSD. Because the resident was on a medication for PTSD, the ADON stated she would expect it to show on the list of diagnoses, the care plan, the MDS, and hospice information. She thought the facility would be responsible for identifying triggers, monitoring mood and behaviors, would have regular behavior documentation, should know what led to the PTSD diagnosis, and have a plan for non-pharmacological interventions. She was unable to find that in the resident's EHR. On 5/07/2026 at 10:38 AM the DON confirmed the resident was on prazosin for chronic PTSD with night terrors. She reported the resident admitted to the facility from home and coordination could be difficult. She wasn't sure about the cause of the PTSD or triggers, and stated the social worker who would have addressed that was no longer there. At 12:22 PM, she stated they did locate the diagnosis on the admission orders and confirmed it did not get transferred to the resident's EHR.	F0741		
F0887 SS = D	COVID-19 Immunization CFR(s): 483.80(d)(3)(i)-(vii) §483.80 Infection control §483.80(d)(3) COVID-19 immunizations. The LTC facility must develop and implement policies and procedures to ensure all the following: (i) When COVID-19 vaccine is available to the facility, each resident and staff member is offered the COVID-19 vaccine unless the immunization is medically contraindicated or the resident or staff member has already been immunized; (ii) Before offering COVID-19 vaccine, all staff members are provided with education regarding the benefits and risks and potential side effects associated with the vaccine; (iii) Before offering COVID-19 vaccine, each resident or the resident representative receives education	F0887		

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F0887 SS = D	Continued from page 15 regarding the benefits and risks and potential side effects associated with the COVID-19 vaccine; (iv) In situations where COVID-19 vaccination requires multiple doses, the resident, resident representative, or staff member is provided with current information regarding those additional doses, including any changes in the benefits or risks and potential side effects, associated with the COVID-19 vaccine, before requesting consent for administration of any additional doses. (v) The resident or resident representative, has the opportunity to accept or refuse a COVID-19 vaccine, and change their decision; and (vi) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident representative was provided education regarding the benefits and potential risks associated with COVID-19 vaccine; and (B) Each dose of COVID-19 vaccine administered to the resident, or (C) If the resident did not receive the COVID-19 vaccine due to medical contraindications or refusal. (vii) The facility maintains documentation related to staff COVID-19 vaccination that includes at a minimum, the following: (A) That staff were provided education regarding the benefits and potential risks associated with COVID-19 vaccine; (B) Staff were offered the COVID-19 vaccine or information on obtaining COVID-19 vaccine; and (C) The COVID-19 vaccine status of staff and related information as indicated by the Centers for Disease Control and Prevention's National Healthcare Safety Network (NHSN). This REQUIREMENT is NOT MET as evidenced by: Based on interviews, record review, and policy review the facility failed to maintain documentation of staff screening and education regarding COVID vaccination, or maintain records of staff vaccination status. The facility reported a census of 127 residents.	F0887		

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F0887 SS = D	Continued from page 16 Findings include: On 5/07/2026 at 10:16 AM Staff K, Assistant Director of Nursing (ADON), stated she was the facility's infection preventionist. When asked when staff received education regarding COVID testing and vaccination, she stated the same provider who vaccinated residents could give the education to staff. Staff K did not have documentation of who received that education. She indicated she would have to see if there was COVID training in (redacted) their training platform or during orientation because she wasn't involved in all of that. During an interview on 5/07/2026 at 10:38 AM the Director of Nursing (DON) reported the staff received COVID education through (redacted) their training provider. The DON directed back to Staff K for documentation regarding COVID based on her role as infection preventionist. A document titled 2026 Annual CNA (Certified Nurses Aide) Training Schedule updated 02/16/2026 documented staff training by quarter. The list did not include COVID education. An email from the Administrator, dated 05/07/2026 at 11:39 AM included a COVID-19 fact sheet dated 1/31/2025. She indicated that was their COVID education. She did not include information about when staff were provided the education, who received it, how often, or how staff were screened. During an interview on 5/07/2026 at 12:19 PM Staff H, Certified Medication Aide (CMA) stated she had worked at the facility for about 2 years. She reported she was not asked by the facility for her vaccination status, was not offered the COVID vaccine or told where to get one, and the facility did not provide COVID education to her on paper or in person. She thought there might have been a training online but she couldn't remember when. During a follow up interview with Staff K on 5/07/2026 at 12:23 PM she stated she couldn't say if they had any additional documentation that staff were screened for vaccination eligibility, provided COVID education, were offered the vaccine or told where to get it, or if the facility administered the vaccine to any staff through their vaccination partner.	F0887		

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F0887 SS = D	Continued from page 17 A policy titled Coronavirus Disease (COVID-19) - Vaccination of Residents and Staff dated February 2021 indicated staff eligible to receive the COVID-19 vaccine were strongly encouraged to do so. Staff consent would be documented in the employee health record. Staff would be provided a fact sheet specific to the vaccine he or she will receive that explained risks and benefits, contraindications, and potential side effects or adverse reactions.	F0887		