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A 000	INITIAL COMMENTS An unannounced Federal complaint survey was conducted at the facility from 07/15/2026 to 07/21/2026. The facility's census was 303 on the first day and 293 on the last day of survey. The sample size was 12 patients. Deficiencies were cited related to the investigation of intakes DC~00014081, DC~00014239, and DC~00014339. No deficiencies were cited related to the investigation of intake DC~00014151. Incidental findings were identified.	A 000		
A 130	PATIENT RIGHTS:PARTICIPATION IN CARE PLANNING CFR(s): 482.13(b)(1) The patient has the right to participate in the development and implementation of his or her plan of care. This STANDARD is not met as evidenced by: Based on hospital policy review, medical record review, and interview, the facility ' s nursing staff failed to assess language needs for the development and participation in care for three (3) out of 10 patients sampled (Patient #1, #3, and #4). Findings Include: A review of the facility ' s ' Patient Rights and Responsibilities ' policy, last revised 09/17/2024, revealed: "B. Patient Rights: n) Have language interpreter and translation services arranged by the Hospital." A review of Patient #1 ' s medical record from 04/26/2026 revealed that they presented to the facility ' s Emergency Department at 12:20 AM for	A 130		

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

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evaluation of hemoptysis [coughing up blood]."

Further review of Patient #1 ' s Patient Demographic Face sheet revealed: "Patient Language: Spanish."

Further review of Patient #1 ' s Triage revealed under language assessment: "Preferred Language: English."

Patient #1 was admitted to the facility for treatment of suspected Tuberculosis.

Further review of Patient #1 ' s History and Physical from 04/26/2026 at 10:06 AM revealed: "On evaluation, the patient was alert and oriented. [Patient #1] prefers to communicate in Spanish...."

A review of Patient #3 ' s medical record from 06/01/2026 revealed that they presented to the facility ' s Emergency Department at 12:38 PM for evaluation of rectal pain.

Further review of Patient #3 ' s Patient Demographic Face sheet revealed: "Patient Language: Spanish."

Further review of Patient #3 ' s Triage assessment revealed no documentation of a language assessment conducted.

A review of Patient #4 ' s medical record from 06/02/2026 revealed that they presented to the facility ' s Emergency Department at 12:54 AM for evaluation post fall.

Further review of Patient #4 ' s Patient Demographic Face sheet revealed: "Patient

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A 130	Continued From page 2 Language: Wolof." Further review of Patient #4 ' s Triage assessment revealed no documentation of a language assessment conducted. On 07/16/2026 at approximately 10:00 AM the surveyor conducted a face to face interview with Employee #4 Emergency Department Educator. Employee #4 confirmed that language assessments are to be done on all patients during triage. Employee #4 confirmed that the Emergency Department can utilize interpreter services for patients with identified languages other than English.	A 130		
A 168	PATIENT RIGHTS: RESTRAINT OR SECLUSION CFR(s): 482.13(e)(5) §§482.13(e)(5) - The use of restraint or seclusion must be in accordance with the order of a physician or other licensed practitioner who is responsible for the care of the patient and authorized to order restraint or seclusion by hospital policy in accordance with State law. This STANDARD is not met as evidenced by: Based on hospital policy review, medical record review, and interview, the facility's nursing staff deployed restraints without an order for two out of two patients sampled (Patient #9 and #13). Findings Include: A review of the facility's 'Restraint and Seclusion' policy, last revised 09/17/2024, revealed: "Policy: F. The use of restraint must be in accordance with the order of a physician or licensed independent practitioner (LIP) who is responsible	A 168		

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for the care of the patient and is authorized to order restraints by hospital policy and medical staff by-laws." and "J. Orders: 2. Non-Violent/Non-Self-destructive: a. Physician orders for restraint that is not used for the management of violent behavior shall remain in effect until: 1.The patient's behavior or situation no longer requires restraint..."

A review of Patient #9's medical record from 01/11/2026 to 02/18/2026 revealed they were admitted for an Occipital Lobe Abscess and Ventriculitis.

Further review of Patient #9's orders revealed the following:

-On 01/12/2026 at 4:20 AM there is an order placed for "Restraint Nonviolent." The restraint type ordered is soft limb left and right upper extremities and mittens right and left upper extremities. The order is renewed on 01/12/2026 at 8:33 AM.

-On 01/21/2026 at 6:31 AM there is an order placed for "Restraint Nonviolent." The restraint type ordered is soft limb left and right upper extremities. The order is discontinued on 01/28/2026 at 8:23 AM.

-On 01/30/2026 at 10:12 AM there is an order placed for "Restraint Nonviolent." The restraint type ordered is soft limb left and right upper extremities.

Further review of Patient #9's Restraint Monitoring from 01/12/2026 to 02/08/2026 revealed the following:

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-From 01/16/2026 at 8:00AM to 01/17/2026 at 4:00 PM there is documentation of Patient #9 being restrained for nonviolent behavior with the restraint type deployed documented as "Lap belt." There is no documentation of an updated order to include this restraint type.

-On 01/17/2026 at 10:00 PM Patient #9 is documented as released from restraints with them documented as discontinued.

-On 01/18/2026 at 2:00 PM Patient #9 is documented as placed in restraints for nonviolent behavior with documentation of initiating lap belt, soft limb restraints to left and right upper extremities, and mittens to left and right upper extremities. There is no documentation of an order for restraints for this event. Patient #9 is documented as released from restraints on 01/18/2026 at 8:00 PM.

-On 01/21/2026 at 7:00 AM Patient #9 is documented as restrained for nonviolent behavior with the restraint type documented as soft limb left and right upper extremities.

-From 01/22/2026 at 8:00 AM to 01/23/2026 at 8:00 AM there is documentation of inclusion of mittens to right and left upper extremities. There is no documentation of updated orders to include this restraint type. There is no documentation of discontinuation of restraints.

A review of Patient #13's medical record reveals they were admitted from 01/15/2026 to 02/07/2026 for subarachnoid hemorrhage (brain bleed) after a fall at home.

Further review of Patient #13's medical record

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revealed the following restraint documentation:

-On 01/16/2026 at 08:00 AM Patient #13 is documented as placed in non violent restraints with documentation of initiating mittens and soft limb restraints on the right and left upper extremities. There is no documentation of an order for restraints for this event. There is no documentation of discontinuation.

-On 01/16/2026 at 12:00 PM Patient #13 is documented as placed in non violent restraints with documentation of initiating soft limb restraints on the right and left upper extremities. There is no documentation of an order for restraints for this event. There is no documentation of discontinuation.

-On 01/16/2026 at 02:00 PM Patient #13 is documented as reassessed in non violent restraints on the right and left upper extremities with soft limb restraints. There is no documentation of an order for restraints for this event. There is no documentation of discontinuation. On 01/16/2026 at 03:45 PM Patient #13 is documented as released from restraints with them documented as discontinued. There is no documentation of an order for restraints for this event.

On 07/21/2026 at approximately 1:00 PM the surveyor conducted a face to face interview with Employee #6 Critical Care Educator. Employee #6 confirmed that if a restraint is discontinued and then re-initiated, a new order must be obtained. Employee #6 confirmed the ordered restraint type must match what is applied and if another restraint type is needed then the order is to be updated.

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A 175	PATIENT RIGHTS: RESTRAINT OR SECLUSION CFR(s): 482.13(e)(10) The condition of the patient who is restrained or secluded must be monitored by a physician, other licensed practitioner or trained staff that have completed the training criteria specified in paragraph (f) of this section at an interval determined by hospital policy. This STANDARD is not met as evidenced by: Based on hospital policy review, medical record review, and interview, the facility's nursing staff failed to monitor restraints per policy for two out of two patients sampled (Patient #9 and #13). Findings Include: A review of the facility's 'Restraint and Seclusion' policy, last revised 09/17/2024, revealed: K. Ongoing Monitoring: 2. Non-Violent/Non- Self Destructive: Documentation of Monitoring: Episodes of restraint shall be documented as indicated on currently approved assessments, ... circulation ....." A review of Patient #9's medical record from 01/11/2026 to 02/18/2026 revealed they were admitted for an Occipital Lobe Abscess and Ventriculitis. Further review of Patient #9's nursing progress note from 1/30/2026 at 5:40 PM revealed: "Patient AXO [alert and oriented] to self. Uncooperative and constantly removes tele lids [s/p] and attempts to remove IV [intravenous] access. Team was informed and an order was placed for soft restraints. Same initiated..." There is no documentation of restraint monitoring conducted for Patient #9's restraint event from	A 175		

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A 175	Continued From page 7 1/30/2026. There is no documentation of duration Patient #9 was restrained. A review of Patient #13's medical record reveals they were admitted from 01/15/2026 to 02/07/2026 for subarachnoid hemorrhage (brain bleed) after a fall at home. Further review of Patient #13's medical record revealed the following restraint documentation: -On 01/18/2026 at 08:00 PM there is no documentation of non violent restraint type. -On 01/20/2026 at 09:04 AM, 12:30 PM and 01:40 PM there is no documentation of non violent restraint type. -On 01/20/2026 at 08:02 PM there is no documentation of Patient #13's non violent restraint circulation monitoring assessment. -On 01/20/2026 at 10:00 PM there is no documentation of non violent restraint type. On 07/21/2026 at approximately 1:00 PM the surveyor conducted a face to face interview with Employee #6 Critical Care Educator. Employee #6 confirmed that restraints for non violent behavior are to be monitored every four hours.	A 175		
A 395	RN SUPERVISION OF NURSING CARE CFR(s): 482.23(b)(3) A registered nurse must supervise and evaluate the nursing care for each patient. This STANDARD is not met as evidenced by: Based on hospital policy review, medical record	A 395		

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review, and interview, the facility's nursing staff failed to conduct assessments per policy for five (6) out of 12 patients sampled (Patient #2, #5, #6, #9, #13 and #14).

Findings include:

A review of hospital policy 'Documentation of Patient Assessment and Patient Care Planning' revision date 09/18/2024 revealed: "Policy: A. Comprehensive Assessment. 2. Assessment and Reassessment of a Patient During Hospitalization. a). A nurse should document a complete assessment at least once per shift ...."

A review of hospital policy 'Venipuncture for Placement and Rotation of Peripheral Intravenous (through the vein) Catheter (plastic tube) [for Continuous Infusion or Saline Lock]' review date November 2024 revealed: "IV Policy. Remove the short peripheral catheter if it is no longer included in the plan of care or has not been used for 24 hours or more".

A review of "Assessment in the ED (Emergency Department)" guideline, no date, revealed that Non-vertical care patients, ESI (emergency service index) 3 are to received a full head to toe assessment that includes pain. Further review revealed reassessments are to be conducted every three (3) hours at a minimum. Further review revealed vital signs are to be assessed a minimum of every three hours and within one hour of discharge, admission, or handoff of care.

A review of hospital policy revealed: 'Pain Management'. "III. Policy. A. Patients have the right to appropriate assessment and management of their pain. D. Reassessment of

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Pain. 1. Reassessment and reassessment documentation should continue to be performed at regular intervals, as indicated: a). Within 60 minutes after any medication administration, known as the "Med Effect" in the medical record. b. Within 60 minutes after any non-pharmacologic intervention (e.g. (example given): reposition, heat, ice, ..."

A review of hospital policy revealed: 'Fall Prevention'. "IV. Policy. d. For inpatient and observation patients in an inpatient bed, a RN (registered nurse) will use the Morse scale [Appendix B]. The Morse Fall Scale is a rapid and simple method of assessing a patient's likelihood of falling. V. Procedure: b. The in-patient risk assessment will be performed: ii. Once a shift. iii. With any changes in condition that alters the safety or gait of the patient. iv. After a fall ....and "Intervention strategies are based on the level of fall risk determined by the fall risk assessment and the nurse's clinical judgment."

Review of the medical record showed Patient #2 presented to the Emergency Department (ED) on 04/24/2026 at 05:11 PM with a diagnosis of otitis media (ear infection).

Further review of Patient #2's medical record reveals ESI 3.

Further review of Patient #2's medical record reveals nursing assessment completed at 06:00 PM. There is no documentation of nursing reassessments after 06:00 PM.

Further review of Patient #2's medical record reveals on 04/24/2026 at 07:00 PM pain assessment recorded ten out of ten.

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A 395	Continued From page 10 Further review of Patient #2's medial record revealed on 04/24/2026 from 10:00 PM to 04/25/2026 at 01:00 AM there is no documentation of Q3 hour pain assessments. Further review of Patient #2's medical record on 04/24/2026 reveals intravenous catheter placed at 11:00 PM. There is no nursing assessment documentation for removal of intravenous catheter access prior to discharge. Further review of Patient #2's medical record reveals on 04/25/2026 there is no documentation of pain reassessment "med effect" after pain medications provided at 01:25 AM. Further review of Patient #2 medical record reveals they were discharged from the facility on 04/25/2026 at 02:11 AM. Further review of Patient #2's medical record revealed they presented to the ED on 04/30/2026 09:11 AM with a diagnosis of ear pain. Further review of Patient #2's medical record reveals ESI 3 on 04/30/2026. Further review of Patient #2's medical record reveals on 04/30/2026 at 09:24 AM and 09:55 AM no pain interventions for recorded pain assessments of ten out of ten. Further review of Patient #2's medical record reveals on 04/30/2026 there is no documentation of a nursing assessment.	A 395		

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Review of the medical record showed Patient #5 presented to the ED on 07/11/2026 at 03:51 PM as an interfacility transfer with a diagnosis of stroke.

Further review of Patient #5's medical record revealed intravenous catheter placed at 4:02 PM.

Further review of Patient #5's medical record revealed they were discharged from the facility on 07/12/2026 at 3:02 AM.

Further review of Patient #5's medical record revealed on 07/12/2026 there is no nursing assessment documentation for removal of intravenous (IV) catheter access prior to discharge.

A review of Patient #6's medical record from 07/15/2026 to 07/21/2026 revealed they were presented to the facility's Emergency Department on 07/15/2026 for treatment of rhabdomyolysis, lactic acidosis, and hypernatremia after a fall.

Further review of Patient #6's Triage assessment revealed Patient #6 was screened as high risk for falls. Further review revealed no documentation of interventions in response to Patient #6's fall risk assessment.

A review of Patient #9's medical record from 01/11/2026 to 02/18/2026 revealed they were admitted for an Occipital Lobe Abscess and Ventriculitis.

Further review of Patient #9's orders revealed the following:

-On 01/15/2026 at 5:40 AM Patient #9 is

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ordered to have Neurological Assessments conducted every two hours.

Further review of Patient #9's Neurological Assessments revealed the following:

-On 01/18/2026 from 12:30 PM to 4:00 PM there is no documentation of every two hour assessments conducted.

-On 01/19/2026 from 2:00 PM to 8:00 PM there is no documentation of every two hour assessments conducted.

Further review of Patient #9's Fall Assessments revealed no documentation of Shift Morse Fall Risk Assessment conducted for the night shift on 01/16/2026.

A review of Patient #13's medical record from 01/15/2026 to 02/07/2026 revealed they were admitted on 01/15/2026 for subarachnoid hemorrhage (brain bleed) after a fall at home.

Further review of Patient #13's medical record revealed an order on 01/29/2026 at 06:00 AM for Q1 (every one) hour nursing Neurology assessments.

Further review of Patient #13's neurology assessments from 1/29/2026 to 1/30/2026 revealed the following:

-On 01/29/2026 from 04:00 PM to 19:59 PM there is no documentation of hourly nursing neurology assessment.

-On 01/30/2026 at 12:00 AM and from 06:00 AM to 07:59 AM there is no documentation of hourly nursing neurology assessment.

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A 395	Continued From page 13 Further review of Patient #13's medical record revealed on 01/20/2026 Patient #13 had an unwitnessed fall and was found on their left side. Further review of Patient #13's medical record reveals on 02/02/2026 from 08:00 AM to 08:00 PM there is no Morse Fall Scale score documentation. Further review of Patient #13's medical record reveals on 02/07/2027 Morse Fall Scale score is low risk and history of falls is documented no. A review of Patient #14's medical record from 07/20/2026 to 07/21/2026 reveals they were admitted on 07/03/2026 at 07:00 PM with a diagnosis of Left BKA (below the knee amputation). Further review of Patient #14's medical record revealed on 07/03/2026 initial Morse Fall Scale assessment was screened as moderate risk for falls. Further review of Patient #14's medical record reveals on 07/10/2026 from 08:00 AM to 08:00 PM (day shift) there is no documentation of a shift nursing assessment. Further review of Patient #14's medical record reveals on 07/17/2026 from 08:00 AM to 07/17/2026 08:00 PM (day shift) there is no Morse Fall Scale fall risk documentation. Further review of Patient #14's medical record reveals Patient #14 fell on 07/17/2026 at 03:45 PM.	A 395		

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Further review of Patient #14's Morse Fall Risk assessments from 07/18/2026 to 07/20/2026 revealed the prompt history of falls within the last six months is documented as no.

On 07/15/2026 at approximately 02:00 PM the surveyor conducted a face-to-face interview with Employee #4, Emergency Department Educator. Employee #4 confirmed peripheral IV catheters are discontinued during discharged and documented in the patient's medical record. Employee #4 confirmed that nursing staff are to document fall risk interventions in the electronic medical record for patients screened as high risk for falls. Employee #4 confirmed that patients in the Emergency Department are to receive nursing assessment and that the ED assessment guideline is to be followed at a minimum for assessments and reassessments.

On 07/20/2026 at approximately 03:00 PM the surveyor conducted a face-to-face interview with Employee #5, Medical/Surgical Educator. Employee #5 confirmed the Morse Fall Scale fall risk assessments are completed each shift. [C(1.1]Employee #5 confirmed hourly neurology assessments documentation are to be documented every hour.

On 07/17/2026 at approximately 2:00 PM the surveyor conducted a face to face interview with Employee #6 Critical Care Educator. Employee #6 reviewed Patient #9's medical record and confirmed the missing every two hour neurological assessments.

On 07/21/2026 at approximately 12:30 PM the surveyor conducted a face-to-face interview with Employee #11, Nurse Educator. Employee #11

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A 395	Continued From page 15 confirmed assessment documentation for history of fall in the last six months is documented as "no" for Patient #14 medical record from 07/18/2026 to 07/20/2026 despite having a fall on 07/17/2026.	A 395		
A 398	SUPERVISION OF CONTRACT STAFF CFR(s): 482.23(b)(6) All licensed nurses who provide services in the hospital must adhere to the policies and procedures of the hospital. The director of nursing service must provide for the adequate supervision and evaluation of all nursing personnel which occur within the responsibility of the nursing service, regardless of the mechanism through which those personnel are providing services (that is, hospital employee, contract, lease, other agreement, or volunteer). This STANDARD is not met as evidenced by: Based on hospital policy review, medical record review, and interview, the facility's nursing staff failed to titrate continuous sedation medications per order for two (2) out of 14 patients sampled (Patient #3 and Patient #6). Findings Include: A review of the facility ' s ' Medication Administration ' policy last revised 09/13/2024, revealed: "Standardized medication administration times will be used for scheduled medications...Scheduled medications will be administered within 1 hour before or 1 hour after their scheduled administration time." and "I. Before administration, the individual administering the medication will confirm the following through bar code scanning and manual confirmation: 6. Identify the appropriate time-critical administration	A 398		

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status. Verify that the medication is being administered at the proper time, in the prescribed dose, and by the correct route."

A review of Patient #3 ' s medical record from 06/01/2026 revealed that they presented to the facility ' s Emergency Department at 12:38 PM for evaluation of rectal pain. Patient #3 ' s pain was assessed as 10 out of 10 on a numerical scale.

Further review of Patient #3 ' s orders revealed ibuprofen (pain medication) 600 milligrams (mg) ordered at 3:27 PM.

Further review of Patient #3 ' s Medication Administration Record (MAR) revealed no documentation of administration of Patient #3 ' s ordered ibuprofen.

A review of Patient #6 ' s medical record from 07/15/2026 to 07/21/2026 revealed they were admitted on 07/15/2026 for treatment of rhabdomyolysis, lactic acidosis, and hypernatremia.

Further review of Patient #6 ' s orders revealed the following:

-Insulin Lispro injection every six hours placed on 07/16/2026 at 12:00 AM.

- Dexmedetomidine (sedative medication) 0.4 mcg/kg/hr (micrograms per kilograms per hour) infusion placed on 07/16/2025 at 2:20 AM. Further review revealed titration instruction of start infusion at 0.4 mcg/kg/hr and increase 0.2mcg/kg/hr every 30 minutes to maintain a RASS (Richmond Agitation-Sedation Scale) of 0.

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A 398	Continued From page 17 Further review of Patient #6 ' s Medication Administration Record from 07/15/2026 to 07/16/2026 revealed the following: -On 07/15/2026 at 11:35 PM Patient #6 ' s Dexmedetomidine infusion is documented as infusing at 0.4mcg/kg/hr. -On 07/16/2026 at 3:00 AM Patient #6 ' s Dexmedetomidine infusion is documented as infusing at 1.4mcg/kg/hr, above the ordered titration limit. -On 07/16/2026 at 6:00 PM there is no documentation of ordered Insulin Lispro administered. On 07/16/2026 at approximately 10:00 AM the surveyor conducted a face to face interview with Employee #4 Emergency Department Educator. Employee #4 reviewed Patient #3 ' s medical record and confirmed no documentation of ordered ibuprofen administered. On 07/17/2026 at approximately 2:00 PM the surveyor conducted a face to face interview with Employee #6 Critical Care Educator. Employee #6 reviewed Patient #6 ' s medical record and confirmed missing documentation of administration of Insulin Lispro. Employee #6 confirmed that Patient #6 ' s Dexmedetomidine titration from 0.4mcg/kg/hr to 1.4 mcg/kg/hr was above the ordered 0.2mcg/kg/hr limit.	A 398		
A 749	INFECTION CONTROL PROGRAM CFR(s): 482.42(a)(2) The hospital infection prevention and control program, as documented in its policies and	A 749		

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procedures, employs methods for preventing and controlling the transmission of infections within the hospital and between the hospital and other institutions and settings;
This STANDARD is not met as evidenced by:

Based on hospital policy review, medical record review, supporting documentation review, and interviews, the facility ' s Occupational Health staff failed to ensure fit testing prior to an employee providing direct patient care for a patient requiring airborne isolation for one (1) out of eight (8) patients sampled (Patient #1).

Findings Include:

A review of the facility's ' Employee Health Service ' policy, last revised 09/03/2024, revealed: "2. All HCW [health care workers] are required to complete an annual physical and TB [tuberculosis] screening during the designated month. a) The annual assessment, TB screening and fit test for all employees must be completed by the last day of the designated month."

A review of the facility ' s ' Transmission Based Isolation Precaution ' policy, last revised 09/08/2024, revealed: "C. Airborne Precautions: 4. Use of Personal Protective Equipment: b) All staff who enter airborne isolation rooms must be fit tested for N95 mask yearly or as designated by Employee Health policy."

A review of Patient #1 ' s medical record from 04/26/2026 revealed that they presented to the facility ' s Emergency Department at 12:20 AM for evaluation of hemoptysis [coughing up blood]."

Further review of Patient #1 ' s medical provider note revealed: "Given patient also with over 1

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week of low energy, general malaise, must consider and rule out tuberculosis given increased number of cases within the surrounding region." and "Immediately following our initial conversation I was concerned for TB and moved the patient from room 30 to a negative pressure room, notified his nurse as well as the charge nurse and put [Patient #1] on precautions."

Further review of Patient #1 ' s orders revealed an order of Airborne Isolation placed.

Further review of Patient #1 ' s medical record revealed Employee #16 was listed as Patient #1 ' s Attending Physician during their presentation for suspected tuberculosis infection in the facility ' s Emergency Department.

A review of Employee #16 ' s occupational health file revealed no documentation of an annual fit test conducted.

On 07/16/2026 at approximately 2:00 PM the surveyor conducted a face to face interview with Employee #14 Manager Employee Health Services. Employee #14 reported that Attending Physicians have an outside organization that manages their health files but will submit documentation of the Attending Physicians compliance with employee health policies.

On 07/21/2026 at approximately 2:30 PM the surveyor conducted a telephone interview with Employee #2 Quality and Accreditation Manager. Employee #2 confirmed that no FIT test was identified for Employee #16.