STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055002	A. Building B. Wing	02/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Country Manor Healthcare	11723 Fenton Avenue Lake View Terrace, CA 91342

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents were treated with respect and dignity including the right to be free from physical restraints (any manual method, physical or mechanical device, material or equipment that is attached or adjacent to the resident's body that he or she cannot easily remove that restricts freedom of movement or normal access to one's body) for three of three sampled residents (Resident 29, 9, and 77) reviewed for physical restraints by failing to: 1.Ensure Residents 29 and 9 did not have wedge pillows (firm, triangular-shaped foam cushion used to elevate parts of the body) tucked under the residents' fitted sheets on the right and left side of the body while in bed. 2.Ensure Resident 77's restraint bilateral wedgesˆtucked under the sheets had a/an:ˆ a. Physician's orderˆ b. Informed consentˆ(voluntary agreement to accept treatment and/or procedures after receiving educationˆregardingˆthe risks, benefits, and alternatives offered)ˆfrom the resident and/or representative.ˆ c. Physical restraint assessmentˆ(a safety check performed by healthcare staff toˆdetermineˆif, how, and why a patient's freedom of movement should be temporarily limited)ˆfor its safe use.ˆ d. Comprehensive Care planˆ(a document describing agreed goals of care, and outlining planned medical,ˆnursingˆand allied health activities for a patient).ˆ These deficient practices had the potential to result in the restriction of residents` freedom of movement, a decline (to become lower in amount or less in number) in physical functioning, psychosocial harm, physical harm from entrapment (the state of being caught in or as in a trap), and death of residents. Findings: a. During a review of Resident 29's admission Record (AR), the AR indicated Resident 29 was originally admitted to the facility on [DATE], and was most recently readmitted on [DATE], with diagnoses that included Parkinson's Disease (a progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movements) with dyskinesia (a movement disorder characterized by involuntary, erratic, and uncontrollable body movements), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), and encephalopathy (an alteration in consciousness due to brain dysfunction). During a review of Resident 29's History and Physical (H&P) dated 8/6/2025, the H&P indicated Resident 29 did not have the capacity to understand and make decisions. During a review of Resident 29's Minimum Data Set (MDS – resident assessment tool) dated 8/29/2025, the MDS indicated the resident was able to understand others and make himself understood. The MDS further indicated the resident was dependent on staff for eating, oral and personal hygiene, toileting, bathing, dressing, and mobility. During a review of Resident 29's Interdisciplinary (IDT) Progress Note, dated 5/28/2025, the IDT Progress Note indicated the resident had a fall on 5/10/2025 while attempting to get up. The IDT Progress Note indicated to increase rounding and monitor the resident. (continued on next page)

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 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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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 29's care plan (CP) on risk for falls initiated on 3/3/2025, the CP indicated interventions that included the resident needs a safe environment, check and meet needs, and to encourage the resident to participate in activities that promote strengthening and improved mobility. The CP further indicated that the resident may have a standard-height bed due to steady improvement and safety awareness. During an observation on 2/10/2026 at 9:50 a.m., inside Resident 29's room, observed Resident 29 lying in bed with foam wedge pillows tucked under the fitted sheet on both sides of the resident that extended from the legs up to the lower back. Observed Registered Nurse (RN) 3 at Resident 29's bedside. RN 3 stated he (RN 3) provided treatment to Resident 29. Observed RN 3 then exit the room. Resident 29 did not respond to the surveyor. Observed the bilateral foam wedge pillows remained under the fitted sheet. During a concurrent observation and interview on 2/10/2026 at 2:55 p.m., observed Resident Family Member (RFM) 1 at Resident 29's bedside. Observed bilateral foam wedges remained in place under the fitted sheet. RFM 1 stated the wedge pillows are under the sheet to keep Resident 29 from falling out of the bed. RFM 1 stated Resident 29 was getting stronger and was able to move his body. During an interview on 2/10/2026 at 3:05 p.m. with Certified Nursing Assistant (CNA) 3, CNA 3 stated she (CNA 3) was assigned to care for Resident 29. CNA 3 stated Resident 29 had bilateral wedges placed under the fitted sheet, but she (CNA 3) was not really sure why the resident needed the wedges. During a concurrent interview and record review on 2/10/2026 at 3:10 p.m. with RN 1, RN 1 reviewed Resident 29's physician orders, Bed Safety Evaluation dated 11/28/2025, and CPs. RN 1 stated wedges are used to position residents that are at risk for skin conditions. RN 1 stated she (RN 1) was not sure what the facility process was for providing foam wedges to residents. RN 1 stated Resident 29 did not have a physician's order or care plan to place foam wedges on the resident's bed. During a concurrent interview and observation on 2/10/2026 at 3:15 p.m. with Licensed Vocational Nurse (LVN) 3, LVN 3 stated she was caring for Resident 29. LVN 3 stated a single wedge may be used on top of the sheet for resident positioning. LVN 3 stated foam wedges placed on both sides of the body and tucked under the sheet to prevent movement and falls is considered a restraint because the resident cannot remove the wedges and the wedges are preventing the resident from moving freely. LVN 3 stated the use of restraints requires an assessment, informed consent, and a physician's order. LVN 3 walked to Resident 29's room and stated Resident 29 should not have bilateral wedges tucked under the sheets while in bed, but he did. LVN 3 stated when Resident 29 had bilateral wedges used to prevent movement there was the potential that the resident would feel anxious. During a follow-up interview on 2/11/2026 at 12:35 p.m. with RFM 1, RFM 1 stated the facility staff had not previously explained that the bilateral foam wedges could restrict Resident 29's freedom of movement. RFM 1 stated Resident 29 never liked the foam wedges and Resident 29 did not need them. During an interview on 2/11/2026 at 2:19 p.m. with the Director of Staff Development (DSD), the DSD stated foam wedges are only provided to residents with a physician's order and are only used for positioning. The DSD stated the wedges are designed to be used on top of the sheets, so it is easily removed and not locked in place. The DSD stated when a foam wedge is secured in place under a (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	sheet it hinders a resident's movement potentially resulting in skin issues, safety issues, or emotional distress. During a follow-up interview on 2/12/2026 at 7:55 a.m. with RN 3, RN 3 stated on 2/10/2026 he (RN 3) did not notice Resident 29 had bilateral foam wedges tucked under the sheets. RN 3 stated foam wedges placed under the sheet is considered a restraint and he (RN 3) should have noticed the wedges and removed them, but he did not. During a concurrent interview and record review on 2/12/2026 at 11:57 a.m. with the Director of Nursing (DON), the DON reviewed the policy and procedure (P&P) for restraints. The DON stated wedges are a positioning tool that requires an evaluation for the need of the wedge and a physician's order. The DON stated the wedge itself is not a restraint, but it could be used as a restraint if the wedge is placed under a fitted sheet because it limits the resident's voluntary movement and limits them from getting out of bed easily. The DON stated when a resident has a wedge used as a restraint, the resident may attempt to get over the wedge leading to a higher risk of injury from falls. The DON stated when the staff placed bilateral wedges under Resident 29's fitted sheet, the wedges were used as a restraint. The DON stated the facility P&P for restraints was not followed potentially resulting in increased risk for injury from falls and depression leading to a decline in Resident 29. A review of the facility policy and procedure titled, Use of Restraints, last reviewed 1/16/2026, indicated, Restraints shall only be used for the safety and well-being of the resident(s) and only after other alternatives have been tried unsuccessfully. Restraints shall only be used to treat the resident's medical symptom (s) and never for discipline or staff convenience, or for the prevention of falls. When the use of restraints is indicated, the least restrictive alternative will be used for the least amount of time necessary, and the ongoing re-evaluation for the need for restraints will be documented. Policy Interpretation and Implementation. I. Physical Restraints are defined as any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily, which restricts freedom of movement or restricts normal access to one's body. 2. The definition of a restraint is based on the functional status of the resident and not the device. If the resident cannot remove a device in the same manner in which the staff applied it given that resident's physical condition (i.e., side rails are put back down, rather than climbed over), and this restricts his/her typical ability to change position or place, that device is considered a restraint. Practices that inappropriately utilize equipment to prevent resident mobility are considered restraints and are not permitted. 5. Restraints may only be used if/when the resident has a specific medical symptom that cannot be addressed by another less restrictive intervention AND a restraint is required to: a. treat the medical symptom; b. protect the resident's safety; and c. help the resident attain the highest level of his/her physical or psychological well-being. Prior to placing a resident in restraints, there shall be a pre-restraining assessment and review to determine the need for restraints. 9. Restraints shall only be used upon the written order of a physician and after obtaining consent from the resident and/or representative (sponsor). 14. Residents and/or surrogate/sponsor shall be informed about the potential risks and benefits of all options under consideration, including the use of restraints, not using restraints, and the alternatives to restraint use. b. During a review of Resident 9's AR, the AR indicated the facility originally admitted Resident 9 on 8/24/2018, and readmitted in the facility on 3/3/2025, with diagnoses including dementia (a progressive state of decline in mental abilities), psychosis (a severe mental condition in which thought, and emotions are so affected that contact is lost with reality), and history of falling. During a review of Resident 9's History and Physical (H&P) dated 3/4/2025, the H&P indicated (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident 9 had fluctuating capacity to understand and make decisions. During a review of Resident 9's MDS, dated [DATE], the MDS indicated Resident 9 had severely impaired cognition (mental action or process of acquiring knowledge and understanding) and was unable to understand and make his needs known. The MDS further indicated Resident 9 was totally dependent on staff with all activities of daily living (ADLs - routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). During a review of Resident 9's Order Summary Report dated 2/12/2026, the Order Summary Report did not indicate a physician's order for the use of wedge pillows tucked under the fitted sheet. During a review of Resident 9's fall risk evaluations dated 3/3/2025, 5/26/2025, 8/26/2025, and 11/24/2025, the fall risk evaluations indicated Resident 9 was at risk for falls. During a review of Resident 9's CP on risk for further falls and injury initiated on 8/25/2018 last revised on 3/26/025, the CP indicated to remind CNA to frequently monitor resident for assistance and use of appropriate devices as ordered as a few of the interventions to minimize the risk for falls. During a concurrent observation and interview on 2/10/2026 at 10:07 a.m. inside Resident 9's room with CNA 1, CNA 1 stated she (CNA 1) was not assigned to Resident 9 and there was a wedge pillow tucked under the fitted sheet on the left side of the bed. CNA 1 stated she (CNA 1) did not know why the pillow was placed under the fitted sheet. During another observation on 2/10/2026 at 2:56 p.m. inside Resident 9's room with CNA 2, Resident 9 was observed in bed asleep with wedge pillows tucked under the fitted sheet on both sides of Resident 9's legs. CNA 2 stated he (CNA 2) placed the wedge pillows under the fitted sheets so the pillows will not slide down as Resident 9 always moves his legs. CNA 3 stated he (CNA 2) did know that it is considered a restraint. During a concurrent observation and interview on 2/10/2026 at 3 p.m. inside Resident 9's room with the DON, the DON stated the wedge pillows were tucked under the fitted sheet for patient positioning. The DON stated the facility is not using the wedge pillows as a restraint, but it can be considered a restraint if tucked under the fitted sheet. The DON stated the wedge pillows can be placed on top of the sheet. During a follow up concurrent interview and record review on 2/12/2026 at 11:57 a.m. with the DON, Resident 9's physician's orders, restraint assessment, and informed consent, and the facility's P&P titled, Use of Restraints, were reviewed. The DON stated that the use of wedge pillows has come into use in the facility because they have been looking for an intervention to position residents using regular pillows and wedge pillows. The DON stated that there should be an order for the use of wedge pillows to be used as a positioning device. The DON stated there should have been an evaluation for the need of the wedge pillows. The DON stated the facility does not consider the wedge pillow a restraint, but it could be considered a restraint if placed under fitted sheet because it limits the patient from voluntary movement and limits them from getting out of bed easily. The DON stated the resident may attempt to get over the wedge if unable to remove it which may lead to higher risk of injury from falls. The DON stated the staff should not have placed or tucked the bilateral wedge pillows under the fitted sheet. The DON stated the process for using a restraint in the facility is to complete a restraint assessment, obtain consent from the resident representative, and obtain a physician's order. The DON stated the facility P&P was not followed for restraints when there was no (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	restraint order, consent, or evaluation for the use of the wedge pillows under the fitted sheet as it placed Resident 9 at risk for restriction of movements which may lead to a decline in physical functioning, psychosocial harm, and physical harm from entrapment. During a review of the facility's P&P titled, Use of Restraints, last reviewed on 1/16/2026, the P&P indicated that restraints shall only be used to treat the resident's medical symptom(s) and never for discipline or staff convenience, or for the prevention of falls. When the use of restraints is indicated, the least restrictive alternative will be used for the least amount of time necessary, and the ongoing re-evaluation for the need of restraints will be documented. The P&P further indicated: - Physical Restraints are defined as any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily, which restricts freedom of movement or restricts normal access to one's body. - The definition of restraint is based on the functional status of the resident and not the device. If the resident cannot remove a device in which manner the staff applied it given that resident's physical condition, and this restricts his/her typical ability to change position or place, that device is considered a restraint. - Practices that inappropriately utilize equipment to prevent resident mobility are considered restraints and are not permitted. - Prior to placing a resident in restraints, there shall be a pre-restraining assessment and review to determine the need for restraints. - Restraints shall only be used upon the written order of a physician and after obtaining consent from the resident and/or representative. c. During a review of Resident 77's AR, the AR indicated the facility admitted the resident on 4/22/2025, with diagnoses including traumatic subdural hemorrhage (a life-threatening brain injury where blood leaks from torn vessels and pools between the brain's surface and its outer covering (the dura), usually caused by a severe blow to the head, fall, or car crash), history of falling, and nondisplaced Type II dens fracture (occur when the cervical spine is hyper flexed (bent severely backward) or hyperextended (bent severely forward)). During a review of Resident 77's H&P, dated 12/15/2025, the H&P indicated the resident was oriented to person only, had ongoing confusion, disorientation, fatigue (extreme tiredness), and frequent agitation (a state of severe restlessness or inner tension). During a review of Resident 77's MDS, dated [DATE], the MDS indicated the resident rarely to never had the ability to make self-understood and understand others and had severely impaired cognition. The MDS indicated the resident was dependent on mobility and ADLs. During a review of Resident 77's Order Summary Report (OSR), dated 2/11/2026, the OSR did not indicate any order for wedge pillows. During a review of Resident 77's Fall Risk Evaluation (FRE), dated 1/6/2026, the FRE indicated the resident was at risk for falls. During a review of Resident 77's CP Report regarding the resident being at risk for falls related to psychoactive drug (substances that, when taken in or administered into one's system, affect mental processes, e.g. perception, consciousness, cognition or mood and emotions) use, unaware of safety needs related to dementia (a progressive state of decline in mental abilities), vision/hearing problems, and history of falls with injury, initiated on 5/5/2025, the CP indicated an intervention of resident needs a safe environment with even floors free from spills and/or clutter, adequate, glare-free light, a working and reachable call light, bed in low position at night, alarms/floor mats if ordered, handrails on walls, and personal items within reach. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview on 2/10/2026 at 2:47 p.m., with CNA 4, inside Resident 77's room, observed Resident 77's bed had both upper side rails up and a bilateral wedge pillow placed at the middle of bed tucked under the sheets. CNA 4 stated the resident was a fall risk and the wedge was used to prevent the resident from getting out of bed to prevent falls. CNA 4 stated placing the wedge under the sheets makes it hard for the resident to remove them. During a concurrent observation, interview, and record review on 2/10/2026 at 3 p.m., with LVN 1, inside Resident 77's room, observed Resident 77's bed had both upper side rails up and a bilateral wedge pillow placed at the middle of bed tucked under the sheets. LVN 1 stated the wedge tucked under the sheets were used to prevent the resident from getting out of bed and falling. LVN 1 stated the wedge pillows were used as a physical restraint. LVN 1 also stated the wedges were also used to turn the resident. LVN 1 reviewed Resident 77's Diagnoses, H&P, MDS, OSR, Informed Consents, and CPs. LVN 1 stated there was no physician's order, informed consent, restraint assessment, and a care plan on the use of restraint bilateral wedges tucked under the sheets on Resident 77. LVN 1 stated it was important to have the physician's order, informed consent, restraint assessment, and a care plan on the use of wedge as a restraint to ensure its safe use and to honor the resident's right to agree or disagree with the proposed treatment. During an interview on 2/12/2026 at 11:57 a.m., with the DON, the DON stated they are supposed to have an order from the doctor for wedges tucked under the sheet to prevent falls to the resident. The DON stated the wedge pillow itself is not a restraint. However, if they placed them under the sheets, it becomes a restraint and it can limit the patient from getting out of bed easily. The DON stated the height of the fall will be increased due to the placement of bilateral wedges when a resident climbs up on them, which increases the risk of falls with injuries. The DON stated that the resident can potentially feel depressed and emotionally affected because they cannot move freely. During a review of the facility's recent P&P titled, Use of Restraints, last reviewed on 1/16/2026, the P&P indicated restraints shall only be used to treat the resident's medical symptom(s) and never for discipline or staff convenience, or for the prevention of falls. When the use of restraints is indicated, the least restrictive alternative will be used for the least amount of time necessary, and the ongoing re-evaluation for the need of restraints will be documented. Policy Interpretation and Implementation 1. Physical restraints are defined as any manual method or physical mechanical device, material or equipment attached orˆadjacent toˆthe resident's body that the individual cannot remove easily, which restricts freedom of movement or restricts normal access to one's body.ˆˆ 2. If the resident cannot remove a device in the same manner in which the staff applied it given that resident's physical condition (i.e., side rails are put back down, rather than climbed over), and this restricts his/her typical ability to change position or place, that device is considered a restraint.ˆ 6. Prior to placing a resident in restraints, thereˆshall be a pre-restrainingˆassessment ˆˆand review toˆdetermineˆthe need for restraints.ˆˆ 18. Care plans shall also include the measures taken so systematicallyˆ During a review of the facility's Physical Restraints Record of Informed Consent (IC), last revised on 8/2012, the IC indicated it will only be considered to treat a medical condition or symptom that endangers my physical safety or safety of other residents will: 1. Only be used as a last resort measure after a trial period where less restrictive measures have been taken and proven to be unsuccessful; 2. Only be used upon the written order of my attending physician; 3. Only be used upon written consent or the written consent of my representative (sponsor); and 4. Only be used when the benefits of a restraint outweigh the risks of not using the restraint. During a review of the facility's recent P&P titled, Care Plans, Comprehensive Person-Centered, last (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	reviewed on 1/16/2026, the P&P indicated a comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. Policy Interpretation and Implementation 1. The interdisciplinary team (IDT), in conjunction with the resident and his/her family or legal representative, develops and implements a comprehensive, person-centered care plan for each resident. 2. The comprehensive, person-centered care plan is developed within seven (7) days of the completion of the required MDS assessment (Admission, Annual, or Significant Change in Status), and no more than 21 days after admission.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility's licensed nursing staff failed to provide care in accordance with professional standards of care to: 1. One of one sampled resident (Resident 4) reviewed for insulin (a hormone that removes excess sugar from the blood, can be produced by the body or given artificially via medication) use by failing to rotate (a method to ensure repeated injections are not administered in the same area) subcutaneous (sq, beneath the skin) insulin administration sites. The deficient practice had the potential for adverse effect (unwanted, unintended result) of the same site subcutaneous administration of insulin such as excessive bruising, lipodystrophy (abnormal distribution of fat) and cutaneous amyloidosis (is a condition in which clumps of abnormal proteins called amyloids build up in the skin). 2. One of three sampled residents (Resident 4) during random Medication Administration observation facility task by failing to flush the gastrostomy tube (g-tube, a flexible, soft tube inserted directly through the skin of the abdomen into the stomach) in between medications with 15-30 milliliters (ml, a unit of volume) of water while administering Prostat (is used to treat men who have symptoms of an enlarged prostate gland) and ferrous sulfate (a common, inexpensive iron supplement used to treat or prevent iron-deficiency anemia by restoring low iron levels in the blood) on 2/11/2026. The deficient practice had the potential for adverse effects of the medication such as drug-to-drug interactions (occurs when a medication's effect is changed by the presence of another drug, herb, food, or drink, causing it to work differently than intended) that can be harmful to the resident. Cross reference F760. Findings: 1. During a review of Resident 4's admission Record (AR), the AR indicated the facility admitted the resident on 2/22/2024, and readmitted the resident on 9/15/2024, with diagnoses including moderate protein-calorie malnutrition (a nutritional status in which reduced availability of nutrients leads to changes in body composition and function), dysphagia (difficulty swallowing), and type two (2) diabetes mellitus (DM, a disorder characterized by difficulty in blood sugar control and poor wound healing). During a review of Resident 4's History and Physical (H&P), dated 3/19/2025, the H&P indicated the resident did not have the capacity to understand and make decisions. During a review of Resident 4's Minimum Data Set (MDS, a resident assessment tool), dated 1/6/2026, the MDS indicated the resident had the ability to make self-understood and understand others and had severely impaired cognition (a profound loss of mental functioning where a person can no longer take care of themselves or live independently). The MDS indicated the resident was on a high-risk drug class hypoglycemic medication (a type of medicine used toˆlower high blood sugar (glucose) levelsˆin people with type two diabetes). During a review of Resident 4's Order Summary Report (OSR), dated 10/1/2025, the OSR indicated an order of Humulin R Solution 100 unit per milliliter (unit/ml, measures how concentrated or strong the insulin is, telling how many units of insulin are packed into a single milliliter of liquid) (Insulin Regular Human) Inject as per sliding scale (a simple, pre-set chart used to determine how much short-acting insulin to inject before meals or at bedtime based on current blood sugar levels): if 70 - 150 = none; 151 - 200 = 2 units; 201 - 250 = 4 units; 251 - 300 = 6 units; 301 - 350 = 8 units; 351 - 400 = 10 units. If blood sugar (BS) greater than (>) 400 give 12 units and call MD, subcutaneously two times a day related to type two diabetes mellitus without complications, call MD If BS less than (<) 70 give Glucogel one tube, eight ounces (oz, a small, common unit of weight used in the U.S. and British systems for measuring items like food, letters, or precious metals) orange juice (OJ) or light snack if alert and able to take orally, if altered level of consciousness (ALOC) give Glucagon one ampule (amp, a small, sealed glass vial used to hold a single dose of liquid medication or chemicals, usually for injection) intramuscular (IM, delivering medication directly deep into a muscle, rather than just under the skin or into a vein) recheck BS and call MD. Rotate injection site. Give Humalog @ least 5-10 minutes before breakfast and before dinner. During a review of Resident 4's Location of Administration Report (LAR) of Insulin for 11/2025 to 2/2026, the LAR indicated Humulin (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R was administered subcutaneously on: 11/1/2025 at 4:52 p.m. on the Abdomen - Left Lower Quadrant (LLQ) 11/5/2025 at 4:34 p.m. on the Abdomen - LLQ 11/17/2025 at 6:10 a.m. on the Abdomen - LLQ 11/28/2025 at 6:11 a.m. on the Abdomen - LLQ 12/24/2025 at 4:50 p.m. on the Upper arm (rear) (left) 12/27/2025 at 5:38 a.m. on the Upper arm (rear) (left) 2/2/2026 at 4:38 p.m. on the Abdomen - LLQ 2/4/2026 at 4:52 p.m. on the Abdomen - LLQ During a review of Resident 4's Care Plan (CP) Report regarding the resident having a history of diabetes mellitus and potential for glycemic reaction (the effect that food or meal has on blood sugar (glucose) levels after consumption), initiated on 3/19/2025, the CP indicated an intervention of diabetes medication as ordered by doctor. Monitor/document for side effects and effectiveness. During a concurrent interview and record review on 2/12/2026, at 9:18 a.m., with Registered Nurse (RN) 1, reviewed Resident 4's Diagnoses, H&P, MDS, OSR, LAR and CP. RN 1 stated there was an order for Humulin R with sliding scale for the resident. RN 1 stated there were multiple occasions that the licensed staff did not rotate the insulin administration sites of the resident. RN 1 stated licensed nurses should rotate insulin administration sites on Resident 4 to prevent skin irritation and lipodystrophy on the resident. RN 1 stated there is a potential for hypo (low)/hyperglycemia (high blood sugar level in the blood) on Resident 4 due to abnormal absorption of insulin if injected on the site of lipodystrophy. During an interview on 2/12/2026, at 11:57 a.m., with the Director of Nursing (DON), the DON stated the licensed staff should have rotated the site of insulin administration on Resident 4. The DON stated the failure of the licensed staff to rotate insulin administration site could lead to the resident developing lipodystrophy on the frequented site of administration that could lead to poor absorption of the insulin leading to hypo/hyperglycemia to resident. During a review of the facility's recent policy and procedure (P&P) titled, Insulin Administration, last reviewed on 1/16/2026, the P&P indicated to provide guidelines for the safe administration of insulin to residents with diabetes. Steps in the Procedure (insulin Injections via Syringe) 16. Select injection site. a. Insulin may be injected into the subcutaneous tissues of the upper arm, and the anterior or lateral areas of the thighs and abdomen. Avoid the area approximately 2 inches around the navel. b. Injection site should be rotated, preferably within the same general area (abdomen, thigh, upper arm). During a review of the facility-provided Highlights of Prescribing Information (HPI) on the use of Humulin-R, with initial U.S. approval in 1982, the HPI indicated subcutaneous injection: inject subcutaneously 30 minutes before a meal into the thigh, upper arm, abdomen, or buttocks. Rotate injection sites to reduce the risk of lipodystrophy and localized cutaneous amyloidosis. 2. During a review of Resident 4's AR, the AR indicated the facility admitted the resident on 2/22/2024, and readmitted the resident on 9/15/2024, with diagnoses including moderate protein-calorie malnutrition, dysphagia, and type two diabetes mellitus. During a review of Resident 4's H&P, dated 3/19/2025, the H&P indicated the resident did not have the capacity to understand and make decisions. During a review of Resident 4's MDS, dated [DATE], the MDS indicated the resident had the ability to make self-understood and understand others and had severely impaired cognition. The MDS indicated that the resident has a feeding tube (a soft, flexible tube used to deliver liquid nutrition, fluids, and medication directly into the stomach or small intestine). During a review of Resident 4's OSR, the OSR indicated an order for: 12/20/2024 Prostat 30 cubic centimeters (cc, a commonly used unit of volume that corresponds to the volume of a cube that measures 1 cm x 1 cm x 1 cm) three times a day for Supplement chart amount consumed in percentage (%). 9/15/2024 Enteral Feed (a method of delivering liquid nutrition directly into the stomach or small intestine) Order every shift ENTERAL ORDER: May give 30-50 cc of fluids via Enteral Tube (a soft, flexible tube placed directly into the stomach or small intestine to deliver liquid nutrition, fluids, or medication when a person cannot eat or drink enough by mouth) pre and post medication administration. 11/14/2025 Ferrous Sulfate Oral Solution 220 (44 Fe) milligrams per five (5) milliliters (mg/ml, measures the concentration or strength of a liquid medication) (Ferrous Sulfate). Give 10 milliliters (ml, a unit of volume) via gastrostomy tube (g-tube, a medical feeding device placed through a small incision in the abdomen directly into the stomach) three times a day (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	related to anemia (a condition where the body does not have enough healthy red blood cells), unspecified (D64.9) (10ml = 440mg]. During a review of Resident 4's CP Report titled, Needs tube feeding due to impaired swallowing and poor oral intake, initiated on 7/2/2024, the CP indicated an intervention to flush g-tube with water as ordered. During an observation and interview on 2/11/2026, at 8:01 a.m., with Licensed Vocational Nurse (LVN) 1, during Medication Administration Facility Task, observed LVN 1 administer Prostat and ferrous sulfate via g-tube without flushing the tubing with 30-50 ml of water in between medications. LVN 1 stated he should have flushed the medications in between to prevent drug interactions that can be harmful to the resident. During a concurrent interview and record review on 2/12/2026, at 9:40 a.m., with RN 1, reviewed Resident 4's Diagnoses, OSR, and CP. RN 1 stated Resident 4 had orders for Prostat, ferrous sulfate, and flushing of the g-tube when administering medications. RN 1 stated LVN 1 should have flushed the g-tube with 30 ml of water as ordered in between the administration of Prostat and ferrous sulfate. RN 1 stated the failure of LVN 1 to flush the Prostat and ferrous sulfate medications in between with 30 ml of water can lead to adverse effects and potential chemical drug interactions that can harm the resident. During an interview on 2/12/2026, at 11:57 a.m., with the DON, the DON stated LVN 1 should have flushed the g-tube of Resident 4 in between medication administration of Prostat and ferrous sulfate to prevent clogging of the g-tube and potential drug interactions that can harm the resident. During a review of the facility's recent P&P titled. Enteral Tube Medication Administration Procedures, last reviewed on 1/16/2026, the P&P indicated oral medication(s) are administered through an enteral tube in a safe and accurate manner.ˆ Procedure: 7. Flush the tube with 30 ml of water prior to medication administration. 8. Administer the medication and flush the tube with water.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. Based on interview and record review, the facility failed to ensure residents were free of any significant medication errors (means the observed or identified preparation or administration of medications or biologicals which are not in accordance with the prescriber's order, manufacturer's specifications, and accepted professional standards) for one of one sampled resident (Resident 4) reviewed for insulin (a hormone that removes excess sugar from the blood, can be produced by the body or given artificially via medication) use by failing to rotate (a method to ensure repeated injections are not administered in the same area) subcutaneous (sq, beneath the skin) insulin administration sites. The deficient practice had the potential for adverse effect (unwanted, unintended result) of the same site subcutaneous administration of insulin such as excessive bruising, lipodystrophy (abnormal distribution of fat) and cutaneous amyloidosis (is a condition in which clumps of abnormal proteins called amyloids build up in the skin). Cross reference F658. Findings: During a review of Resident 4's admission Record (AR), the AR indicated the facility admitted the resident on 2/22/2024, and readmitted the resident on 9/15/2024, with diagnoses including moderate protein-calorie malnutrition (a nutritional status in which reduced availability of nutrients leads to changes in body composition and function), dysphagia (difficulty swallowing), and type two (2) diabetes mellitus (DM, a disorder characterized by difficulty in blood sugar control and poor wound healing). During a review of Resident 4's History and Physical (H&P), dated 3/19/2025, the H&P indicated the resident did not have the capacity to understand and make decisions. During a review of Resident 4's Minimum Data Set (MDS, a resident assessment tool), dated 1/6/2026, the MDS indicated the resident had the ability to make self-understood and understand others and had severely impaired cognition (problems with a person's ability to think, learn, remember, use judgement, and make decisions). The MDS indicated the resident was on a high-risk drug class hypoglycemic medication (a group of drugs used to help reduce the amount of sugar present in the blood). During a review of Resident 4's Order Summary Report (OSR), dated 10/1/2025, the OSR indicated an order of Humulin R Solution 100 units per milliliters (unit/ml, measures the concentration or strength of the insulin, not the volume of the dose itself) (Insulin Regular Human) Inject as per sliding scale (a personalized, pre-set chart used to determine an insulin dose based on a blood sugar reading right before a meal or bedtime): if 70 - 150 = none; 151 - 200 = 2 units; 201 - 250 = 4 units; 251 - 300 = 6 units; 301 - 350 = 8 units; 351 - 400 = 10 units. If blood sugar (BS) greater than (>) 400 give 12 units and call MD, subcutaneously two times a day related to type two diabetes mellitus without complications (E11.9) call MD If BS less than (<) 70 give Glucogel one tube, eight ounces (oz, a small, standard unit of weight) orange juice (OJ) or light snack if alert and able to take orally, if altered level of consciousness (ALOC) give Glucagon 1ampule (amp, a small, sealed glass vial used to hold a single dose of a sterile liquid, typically medication for injection) intramuscular (IM, a technique used to deliver medication^deep into the muscles) recheck BS and call MD. Rotate injection site. Give Humalog @ least 5-10 minutes before breakfast and before dinner. During a review of Resident 4's Location of Administration Report (LAR) of Insulin for 11/2025 to 2/2026, the LAR indicated Humulin R was administered subcutaneously on: 11/1/2025 at 4:52 p.m. on the Abdomen - Left Lower Quadrant (LLQ) 11/5/2025 at 4:34 p.m. on the Abdomen - LLQ 11/17/2025 at 6:10 a.m. on the Abdomen - LLQ 11/28/2025 at 6:11 a.m. on the Abdomen - LLQ 12/24/2025 at 4:50 p.m. on the Upper arm (rear) (left) 12/27/2025 at 5:38 a.m. on the Upper arm (rear) (left) 2/2/2026 at 4:38 p.m. on the Abdomen - LLQ 2/4/2026 at 4:52 p.m. on the Abdomen - LLQ During a review of Resident 4's Care Plan (CP) Report regarding the resident having a history of diabetes mellitus and potential for glycemic reaction (the effect that food or meal has on blood sugar (glucose) levels after consumption), initiated on 3/19/2025, the CP indicated an intervention of diabetes medication as ordered by doctor. Monitor/document for side effects and effectiveness. During a concurrent interview and record review on 2/12/2026, at 9:18 a.m., with Registered Nurse (RN) 1, reviewed (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident 4's Diagnoses, H&P, MDS, OSR, LAR and CP. RN 1 stated there was an order for Humulin R with sliding scale for the resident. RN 1 stated there were multiple occasions that the licensed staff did not rotate the insulin administration sites of the resident. RN 1 stated licensed nurses should rotate insulin administration sites on Resident 4 to prevent skin irritation and lipodystrophy on the resident. RN 1 stated there is a potential for hypo (low)/hyperglycemia (high blood sugar level in the blood) on Resident 4 due to abnormal absorption of insulin if injected on the sites of lipodystrophy. RN 1 stated not rotating insulin administration site is a medication error. During an interview on 2/12/2026, at 11:57 a.m., with the Director of Nursing (DON), the DON stated the licensed staff should have rotated the site of insulin administration on Resident 4. The DON stated the failure of the licensed staff to rotate insulin administration site could lead to the resident developing lipodystrophy on the frequented site of administration that could lead to poor absorption of the insulin leading to hypo/hyperglycemia to resident. The DON stated she considers insulin as a significant medication. The DON stated the licensed staff not rotating insulin administration sites constitutes as a medication error because they did not follow the physician's order and as a professional nurse, they should be rotating insulin administration sites. During a review of the facility's recent policy and procedure (P&P) titled, Adverse Consequences and Medication Errors, last reviewed on 1/16/2026, the P&P indicated the interdisciplinary team monitors medication usage in order to prevent and detect medication-related problems such as adverse drug reactions (ADRs) and side effects. Medication Errors 1. A medication error is defined as the preparation or administration of drugs or biological which is not in accordance with the physician's orders, manufacturer specifications, or accepted professional standards and principles of the professional(s) providing services. During a review of the facility's recent P&P titled, Insulin Administration, last reviewed on 1/16/2026, the P&P indicated to provide guidelines for the safe administration of insulin to residents with diabetes. Steps in the Procedure (insulin Injections via Syringe) 16. Select injection site. a. Insulin may be injected into the subcutaneous tissues of the upper arm, and the anterior or lateral areas of the thighs and abdomen. Avoid the area approximately two inches around the navel. b. Injection site should be rotated, preferably within the same general area (abdomen, thigh, upper arm). During a review of the facility-provided Highlights of Prescribing Information (HPI) on the use of Humulin-R, with initial U.S. approval in 1982, the HPI indicated subcutaneous injection: inject subcutaneously 30 minutes before a meal into the thigh, upper arm, abdomen, or buttocks. Rotate injection sites to reduce the risk of lipodystrophy and localized cutaneous amyloidosis.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. Based on observation, interview, and record review the facility failed to follow the menu and did not meet nutritional needs of 15 of 85 residents on pureed texture diets (diet with pudding like consistency foods used for individuals with difficulty chewing or swallowing) when Cook1 did not follow the recipe for the amount of thickening powder when preparing the pureed vegetables to be served for lunch service as observed on 2/10/2026. This failure had the potential to result in difficulty in eating, chewing, and swallowing to the residents and decreased food and nutrient intake resulting to unintended (not done on purpose) weight loss. Findings: During a review of the facility's daily spreadsheet titled Winter Menus, dated 2/10/2026, the spreadsheet indicated residents on pureed and International Dysphagia Diet Standardization 4 ([IDDSI] a global standard to describe texture modified foods and thickened drinks for individuals with swallowing difficulties in all ages, in all settings) Level 4 (pureed foods with extremely thick fluids) portions would get the following food items: - Pureed Italian Lasagna one (1) cup (c - a unit of measurement) - Pureed Seasoned Broccoli half (1/2 - a unit of measurement) c or scoop number 12 - Pureed Garlic Bread 1/2 slice or scoop number 24 - Peanut Butter Cup Pudding scoop number 12 - Milk four (4) ounces (oz -a unit of measurement) During a concurrent observation and interview on 2/10/2026 at 11:19 a.m. at the food preparation area, observed [NAME] 1 in the presence of Dietary Supervisor (DS) pouring a white colored powder into the container of pureed Italian Lasagna without using a measuring tool. [NAME] 1 stated the white colored powder that he (Cook 1) was pouring was thickening powder and they do not use a measuring spoon to thicken the pureed diet to determine if it was too runny. [NAME] 1 stated he (Cook 1) just checks if the pureed diet consistency is acceptable by doing the spoon tilt test (a test used to determine the stickiness of foods and the ability of the food to hold together by tilting the spoon). [NAME] 1 stated the facility usually uses potato powder to thicken pureed diet, but the facility ran out of it as the delivery earlier in the day did not arrive as expected so they used the food thickener instead as indicated in the recipe. During a concurrent interview and record review on 12/11/2026 at 10:20 a.m., recipe for Pureed IDDSI Level #4 Meats dated 2025 was reviewed with [NAME] 2. [NAME] 2 stated the recipe indicated that stabilizer such as instant potato, non- fat dry milk, or commercial instant food thickener can be used, and the recipe indicated the amount of stabilizer to be used in tablespoon depending on the number of servings needed. The recipe further indicated: - Add stabilizer to increase the density of the pureed food if needed. breaded items or casseroles may not need stabilizer. If using commercial food thickener, check the can for directions on usage, otherwise see the recommended amount of stabilizer. - The finished pureed item should be smooth and free of lumps, hold its shape, while not being too firm or sticky, and should not weep. The finished pureed item must pass IDDSI level 4 testing requirements. [NAME] 2 stated they did not follow the recipe regarding the amount of food thickener to be used because it does not work, the consistency gets too thick if they follow the recipe. [NAME] 2 stated they should have used a measuring spoon, one tablespoon at a time, as indicated in the recipe to ensure that the pureed diet that will be served to the residents on pureed diet is not too thick or sticky. During an interview on 2/12/2026 at 10:47 a.m. with the Registered Dietitian (RD), the RD stated pureed diet was used for those residents with chewing and swallowing problems. The RD stated the reason for following the recipe is to ensure the food that the residents on pureed diet receive, will be the correct one and safe for them to consume. The RD stated if [NAME] 1 did not follow the recipe regarding the amount of food thickener to be used, the pureed diet can end up being too formed or sticky. The RD stated [NAME] 1 should have followed the recipe for the amount of food thickener to be used on the pureed Italian lasagna by using the measuring spoon as indicated in the recipe and not by pouring the food thickener from the can so it would not end up being too sticky and formed which can cause choking as there might be some lumps from too much food thickener. During a review of the facility's policy (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	and procedure (P&P) titled, Menu Planning, last reviewed on 1/16/2026, the P&P indicated that the menus are planned to meet nutritional needs of residents in accordance with established national guidelines, physician's orders, and to the extent in accordance with the most recent recommended dietary allowances. The P&P further indicated: - The facility's diet manual and the diets ordered by the physician should mirror the nutritional care provided by the facility. - Standardized recipes adjusted to appropriate yield shall be maintained and used in food preparation.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to ensure safe and sanitary food storage and food preparation practices in the kitchen by: 1. Failing to ensure seven (7) clear food storage bins were stacked wet in the storage area next to the dishwashing area. 2. Failing to ensure a container of grated white cheese labeled parmesan cheese was found inside Refrigerator two (2) with a lid was tightly sealed inside Refrigerator 2. 3. Failing to discard two (2) tomatoes with black spots and two (2) tomatoes with white fluffy material inside a clear vegetable bin. 4. Failing to discard one (1) head of lettuce with brown discoloration on the leaves and bottom part inside a vegetable bin. 5. Failing to discard a tub of unopened beef bouillon seasoning with a received date of 9/17/2025 and an expiration of 2/5/2026 and remained in the dry storage room. 6. Failing to ensure that during lunch service on 2/10/2026, the peanut butter cup pudding temperature was not between 43 degrees Fahrenheit (F - a unit of measurement for temperature) to 45 degrees F. These failures had the potential to result in harmful bacterial growth and cross contamination (transfer of harmful bacteria from one place to another) that could lead to foodborne illness (a disease caused by consuming food or drinks that are contaminated by germs or chemicals) in 82 out of 85 medically compromised residents who received food from the kitchen. Findings: During an initial kitchen tour on 2/11/2026 at 7:49 a.m. with the Dietary Supervisor (DS), observed the following in the dishwashing area, dry storage room, and Refrigerator 2: 1. 7 clear food storage bins were stacked wet in the storage area next to the dishwashing area. 2. A container of grated white cheese labeled parmesan cheese was found inside Refrigerator 2 with a lid was tightly sealed inside Refrigerator 2. 3. 2 tomatoes with black spots and 2 tomatoes with white fluffy material inside a clear vegetable bin. 4. 1 head of lettuce with brown discoloration on the leaves and bottom part inside a vegetable bin. 5. A tub of unopened beef bouillon seasoning with a received date of 9/17/2025 and an expiration of 2/5/2026 remained in the dry storage room. 6. During lunch service on 2/10/2026, the peanut butter cup pudding temperature was observed between 43 degrees Fahrenheit (F - a unit of measurement for temperature) to 45 degrees F. a. During a concurrent observation and interview on 2/10/2026 at 7:49 a.m. with the Dietary Supervisor (DS) in the dishwashing area drying rack, the DS stated the pans were not air dried and the dietary staff should not be stacking the pans wet before storing it. The DS stated it was important to air dry so that the moisture would not stick to the pan before storing it. The DS stated that bacteria can grow, causing residents to become potentially sick. b. During a concurrent observation and interview on 2/10/2026 at 7:55 a.m. of Refrigerator 2 with the DS, the DS stated that the lid for the parmesan cheese should be tightly sealed. The DS stated that after use, the dietary staff should ensure that the containers lid was tightly sealed to ensure that bacteria will not go inside the container, contaminate the cheese, and can potentially cause the residents to get sick. c. During a concurrent observation and interview on 2/10/2026 at 8 a.m., inside the walk-in refrigerator with the DS, the DS stated that 2 tomatoes with black spots and 2 tomatoes with white fluffy material were inside the vegetable bin containing a total of 18 tomatoes. The DS stated the black spots and white fluffy material on the tomatoes were molds and he will discard all the tomatoes in the bin as they were already contaminated. The DS stated the dietary staff assigned to receive delivery was supposed to check the tomatoes in the walk-in refrigerator and discard any tomatoes molds. The DS stated the dietary staff should have discarded all the tomatoes in the bin, including tomatoes with molds. The DS stated the residents can get sick if the tomatoes were used and consumed. d. During a concurrent observation and interview on 2/10/2026 at 8:10 a.m., inside the walk-in refrigerator with the DS, the DS stated that 1 head of lettuce inside another vegetable bin had brown discoloration all over the leaves at the bottom. The DS the lettuce was already showing signs of spoilage and should have been discarded by the dietary staff assigned in receiving the deliveries. The DS stated the dietary staff should have discarded the lettuce with brown discoloration all over the leaves and the (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	bottom part as the residents can get sick if the lettuce showing signs of spoilage was consumed. e. During a concurrent observation and interview on 2/10/2026 at 8:18 a.m. inside the dry storage room with the DS, observed a container of an unopened beef bouillon seasoning with a received date of 9/17/2025 and an expiration of 2/5/2026 remained in the dry storage room. The DS stated he did not realize that the delivery they received on 9/17/2025 for the bouillon seasoning had an expiration date of less than 1 year upon delivery on 9/17/2025. The DS stated he checks the dry storage room for any expired items and that during delivery the dietary staff assigned should have ensured that the expiration date was beyond 1 year upon delivery. The DS stated if residents were served with an expired food item, it placed the residents at risk for foodborne illnesses and they could get sick. f. During a concurrent observation and interview on 2/10/2026 at 12:04 p.m., Dietary Aid (DA) 1 checked the temperature for the peanut butter cup pudding to be served as dessert for lunch service and the thermometer indicated 45 degrees F. DA 1 used another thermometer and the temperature registered at 45 degrees. DA 1 stated the dessert cart containing the peanut butter cup pudding was just removed from the walk-in refrigerator. DA 1 stated she did not know why the temperature was between 43 degrees F to 45 degrees F. DA 1 stated cold food temperature should be at least 41 degrees F and below. DA 1 stated the peanut butter cup pudding has milk and if the temperature does not meet the required temperature, the residents can get sick. During a review of the facility's policy and procedure (P&P) titled, Dishwashing, last reviewed on 1/16/2026, the P&P indicated dishes are to be air dried in racks before stacking and storing. During a review of the facility's P&P titled, Storage of Food and Supplies, last reviewed on 1/16/2026, the P&P indicated that food and supplies will be stored properly and in a safe manner. The P&P further indicated that all food products will be used per the times specified in the Dry Food Storage Guidelines. The storage times in the guidelines are intended to be on the safe side. No food will be kept longer than the expiration date on the product. During a review of the facility provided Dry Good Storage Guidelines dated 2023, the Dry Good Storage Guidelines indicated that bouillon cubes, base, or granules can be stored unopened on the shelf for one year. During a review of the facility's P&P titled, Labeling and Dating of Foods, last reviewed on 1/16/2026, the P&P indicated that newly opened food items will need to be closed and labeled with an open date that follows various guideline. The P&P further indicated that leftovers will be covered, labeled, and dated. During a review of Food Code 2022, dated 1/18/2023, the Food Code 2022 indicated, 3-501.16 Time/Temperature Control for Safety Food, Hot and Cold Holding. Bacterial growth and/or toxin production can occur if time/temperature control for safety food remains in the temperature Danger Zone of 5 degrees Centigrade (C - a unit of measurement for temperature) to 57 degrees C (41 degrees F to 135 degrees F) too long. Up to a point, the rate of growth increases with an increase in temperature within this zone. Beyond the upper limit of the optimal temperature range for a particular organism, the rate of growth decreases. Operations requiring heating or cooling of food should be performed as rapidly as possible to avoid the possibility of bacterial growth. Maintaining TCS foods under the cold temperature control requirements prescribed in this code will limit the growth of pathogens that may be present in or on the food and may help prevent foodborne illness. All microorganisms have a defined temperature range in which they grow, with a minimum, maximum, and optimum. An understanding of the interplay between time, temperature, and other intrinsic and extrinsic factors is crucial to selecting the proper storage conditions for a food product. Temperature has dramatic impact on both the generation time of an organism and its lag period. When considering growth rate of microbial pathogens, time and temperature are integral and must be considered together. Increases in storage and/or display temperature will decrease the shelf life of refrigerated foods since the higher the temperature, the more permissive conditions are for growth. During a review of Food Code 2022, dated 1/18/2023, the Food Code 2022 3-305 Preventing contamination from the premises indicated, 3-305.11 Food Storage. (A) Except as specified in subparagraph (B) and (C) of this section, FOOD shall be protected from contamination by storing the FOOD: (1) In a clean, dry location; (2) Where it is not exposed to splash, dust, or other contamination; and (3) At least 15 cm (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	(6 inches) above the floor. During a review of Food Code 2022, dated 1/18/2023, the Food Code 2022 indicated, 3-307.11 Miscellaneous Sources of Contamination. Food shall be protected from contamination that may result from a factor or source not specified under subparts 3-391 - 3-306.

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure necessary care was provided consistently for one (1) of two (2) sampled residents (Resident 9) reviewed for hospice services (a program designed to provide a caring environment for meeting the physical and emotional needs of the terminally ill) by: 1. Failing to ensure Hospice Aid (HA) visited Resident 9 two (2) times per week as indicated in the Team Care Plan and calendar of visits. 2. Failing to ensure the HA provided visitation notes to the facility from 12/26/2025 to 2/9/2026. These deficient practices had the potential to negatively affect Resident 9's physical comfort and psychosocial well-being resulting in the delay or lack of necessary hospice care and services. Findings: During a review of Resident 9's admission Record (front page of the chart that contains a summary of basic information about the resident), the admission Record indicated the facility originally admitted Resident 9 on 8/24/2018 and readmitted in the facility on 3/3/2025 with diagnoses including dementia (a progressive state of decline in mental abilities), psychosis (a severe mental condition in which thought, and emotions are so affected that contact is lost with reality), and history of falling. During a review of Resident 9's History and Physical (H&P - a comprehensive assessment of a resident's medical condition), dated 3/4/2025, the H&P indicated Resident 9 had fluctuating capacity to understand and make decisions. During a review of Resident 9's Minimum Data Set (MDS - a resident assessment tool), dated 11/24/2025, the MDS indicated Resident 9 had severely impaired cognition (mental action or process of acquiring knowledge and understanding) and was unable to understand and make his needs known. The MDS further indicated Resident 9 was totally dependent on staff with all activities of daily living (ADLs - routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). During a review of Resident 9's Order Summary Report, dated 2/12/2026, the Order Summary Report indicated a physician's order, dated 12/17/2025, to admit Resident 9 in the facility under the care of Hospice Provider (HP) 1 for routine level of care with a primary diagnosis of Alzheimer's Disease (a disease characterized by a progressive decline in mental abilities). During a concurrent interview and record review on 2/12/2026 at 9:11 a.m. with Registered Nurse (RN) 1, Resident 9's progress note was reviewed. RN 1 stated Resident 9 was readmitted in the facility under the care of HP 1 after transferring to the hospital on [DATE] with a primary diagnosis of Alzheimer's Disease. During a concurrent interview and record review on 12/12/2026 at 9:14 a.m. with RN 4, Resident 9's hospice binder, including HP 1's Team Care Plan, dated 1/26/2026, calendar of visits, sign-in sheet, and clinical notes were reviewed. RN 4 stated: - HP 1's Team Care Plan indicated HA visits are 2 times per week for 13 weeks starting 12/26/2026. - HP 1's calendar of visits indicated Resident 9's HA visits were scheduled for 12/26/2025, 12/29/2025, 12/31/2025, 1/5/2025, 1/5/2026, 1/12/2026, 1/14/2026, 1/19/2026, 1/22/2026, 1/26/2026, 1/28/2026, 2/2/2026, 2/4/2026, 2/9/2026, and 2/11/2026. RN 4 stated that HP 1's sign in sheets did not indicate the HA visited Resident 9 on 1/28/2026 and 2/11/2026. RN 4 stated the HA should have visited Resident 9 as indicated in the calendar of visits to ensure Resident 9's needs were met to prevent delay in the provision of hospice care the resident needs. - The HA visit notes were not in the hospice binder and Resident 9's clinical record on all the visit dates. RN 4 stated that HP 1's HA was supposed to complete and place the visit notes in the binder as soon as the visit was completed to ensure the facility staff were aware of the services provided to Resident 9 to prevent delay in providing the necessary care the resident needed. During an interview on 2/12/2026 at 11:20 a.m. with the Director of Nursing (DON), the DON stated hospice providers have a schedule of visits provided to the facility and should be followed accordingly. The DON stated if HP 1 staff are not able to visit as scheduled, it should be indicated in the notes or in the calendar on the day that the scheduled visit will be replaced. The DON stated the HA notes were supposed to be part of the resident's medical record and should be (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	readily available in the hospice binder and can be uploaded in the electronic health record (EHR). The DON stated HP 1's HA should have visited Resident 9 on 1/28/2026 and 2/11/2026 as scheduled to ensure Resident 9's needs and services required were met. The DON stated the HA notes should have been readily available in Resident 9's medical record regardless of if it is in paper or in the EHR so the facility staff would be aware of the services provided to the resident by HP 1's staff. The DON stated these findings placed Resident 9 at risk for a delay in the provision of end-of-life care and services the resident needed. During a review of the facility's policy and procedure (P&P) titled, Hospice Program, last reviewed on 1/16/2026, the P&P indicated: - It is the general responsibility of the hospice to manage the resident's care as it relates to the terminal illness and related conditions including providing medical direction, nursing and clinical management of the terminal illness. - It is the responsibility of the facility to meet the resident's personal care and nursing needs in coordination with the hospice representative, and to ensure that the level of care provided is appropriately based on the individual resident's need which includes communicating with the hospice provider (and documenting such communication) to ensure that the needs of the resident are addressed and met 24 hours per day. - Coordinated care plans for residents receiving hospice services will include the most recent hospice plan of care as well as the care and services provided by our facility (including the responsible provider and discipline assigned to specific tasks) in order to maintain the residents' highest practicable physical, mental and psychosocial well-being.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases (an infectious illness caused by germs that can spread from person to person, or from animals to humans), and infections by failing to: 1. Ensure theˆCertified Nursing Assistants (CNAs)ˆwore a gown while providing direct care to Resident 44, who was on an enhanced barrier precautionˆ(EBP,ˆinfection control measures in nursing homes requiring staff to wear gowns and gloves during high-contact care (e.g., bathing, dressing, changing linens) to prevent the spread of germs, specifically antibiotic-resistant bacteria.ˆ 2. Ensure Resident 68's soiled incontinence brief was notˆleft on top of the bed for one of two sampled residents (Resident 68) reviewed for infection control during random rounds. Thisˆdeficient practiceˆhad the potential to cause cross-contamination (transfer of bacteria or other contaminants from one surfaceˆorˆsubstanceˆto another because of unsanitary handling procedures) of infection among residents and staff.ˆ 3. Ensure dryer temperatures were checked and recorded in the dryer temperatures log for three of three dryers on 2/7/2026 according to the facility's policy and procedure. This deficient practice had the potential to result in the spread of infections among residents, staff, and visitors. Findings: a. During a review of Resident 44's admission Record (AR), the AR indicated the facility admitted the resident on 8/23/2023, and readmitted the resident on 2/6/2026, with diagnoses including cholelithiasisˆ(hardened pieces of bile that form in your gallbladder or bile ducts), hypertensive heart diseaseˆ(damage caused to the heart by long-term high blood pressure, forcing it to work too hard), and normal pressure hydrocephalusˆ(a treatable brain disorder involving excess fluid buildup in the brain's ventricles, causing them to enlarge and disrupt brain function, despite relatively normal pressure readings).ˆ During a review of Resident 44's History and Physical (H&P), dated 11/15/2025, the H&Pˆindicatedˆthe resident had the capacity to understand and make decisions.ˆ During a review of Resident 44's Minimum Data Set (MDS, a resident assessment tool), dated 12/30/2025, the MDS indicated the resident had the ability to make self-understood and understand others and hadˆmoderately impaired cognitionˆ(memory loss, language issues, skewed judgment, and decreased problem-solving abilities are observed).ˆˆ During a review of Resident 44's Order Summary Report (OSR), dated 2/6/2026, the OSR indicated an order of on enhanced barrier precautions due to wound care.ˆ During a review of Resident 44's Care Plan (CP) Report titled, On enhanced barrier precautions related to respiratory disease (pneumonia,ˆan infection/inflammation in the lungs), at risk for infection, initiated on 2/7/2026, the CP indicated an intervention to educate the resident/family member about wound and indwelling catheterˆ(a soft, flexible tube inserted into the bladder to continuously drain urine into a collection bag outside the body)ˆcare techniques, signs and symptoms of infection and the importance of maintaining good hygiene and to wear gloves, gown, and mask before providing activities of daily living living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves), respiratory treatment care.ˆ During a concurrent observation and interview on 2/10/2026 at 12:25 p.m., withˆCertified Nursing Assistant (CNA)ˆ1 and CNA 2, inside Resident 44's room,ˆobservedˆCNA 1 and CNA 2 wore gloves and boosted the resident up in bed to prepare the resident to eatˆhis lunch. CNA 1ˆassistedˆthe (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	resident while eating by opening all the contents in the resident's lunch tray ready for the resident to eat. CNA 1ˆstatedˆthe resident was on an enhanced barrier precaution due to wounds. CNA1 stated she (CNA1) and CNA 2 should have worn a gown while repositioning the resident in bed andˆassistingˆthe resident while eating his lunch tray to prevent the spread of infection to staff and other residents. CNA 1ˆstatedˆshe (CNA1) had a training on enhanced barrier precaution and whatˆpersonal protective equipment (PPEs,ˆclothing and equipment that is worn or used to provide protection against hazardous substances and/or environments)ˆto wear when taking care of a resident with the EBP isolation. CNA 1ˆstatedˆshe (CNA1) just forgot to wear the gown.ˆ During an interviewˆon 2/12/2026, at 9:38 a.m., withˆRegistered Nurse (RN)ˆ1, RN 1 stated CNA 1 and CNA 2 should have worn a gown while repositioning the resident to eat for lunch on 2/10/2026. RN 1ˆstatedˆwearing the gloves, gown, and the mask when providing direct care to residents on enhanced barrier precaution protects the residents and the staff from the spread of infection.ˆˆ During an interview on 12/12/2026, at 11:57 a.m., with theˆDirector of Nursing (DON), the DONˆstatedˆCNA 1 and CNA 2 should have worn a gown while repositioning Resident 44 in bed to eat his lunch. The DONˆstatedˆthe staff should wear a gown, mask, and gloves when providing direct care to residents on enhanced barrier precaution to prevent the spread of infections in the facility. The DONˆstatedˆall the staff in the facility wereˆtrained on enhanced barrier precaution especially on whatˆPPEsˆtoˆwear when providing direct care to residents.ˆ During a review of the facility's recent policy and procedureˆ(P&P)ˆtitled, Enhanced Barrier Precautions, last reviewed on 1/16/2026, the P&Pˆindicatedˆenhanceˆbarrier precautions (EBPs) areˆutilizedˆto prevent the spread of multi-drug-resistant organisms (MDROs) to residents.ˆˆ Policy Interpretation and Implementationˆ 1. Enhanced barrier precautions (EBOs) are used as an infection prevention and control interventions to reduce the spread of multi-drug-resistant organisms (MDROs) to residents.ˆ 2. EBPs employ targeted gown and glove use during high contact resident care activities when contact precautions do not otherwise apply.ˆ a. Gloves and gown are applied prior to performing the high contact resident care activity (as opposed to before entering the room).ˆ 3. Examples of high-contact resident care activities requiring the use of gown and gloves for EBPs include:ˆ c. transferring.ˆ b. During a review of Residentˆ68's AR, the AR indicated the facilityˆoriginallyˆadmitted the resident onˆ6/5/2025, and readmitted the resident onˆ12/17/2025, with diagnoses includingˆalcohol use,ˆtraumatic subdural hemorrhage (a type of bleeding nearˆtheˆbrain thatˆis life threatening andˆcan happen after aˆblow to the head), and abnormalities of gait and mobility.ˆ During a review of Residentˆ68's H&P, datedˆ6/6/2025, the H&Pˆindicatedˆtheˆresident didˆnot have the capacity to understand and make decisions.ˆ (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Residentˆ68's MDS, dated [DATE], the MDS indicated the residentˆwas ableˆunderstand others and make his needs knownˆand hadˆanˆintact cognition. The MDS further indicated Resident 68ˆwas always incontinent of bowel and bladder andˆrequiredˆsubstantial/maximalˆassistance with ambulation andˆsupervisionˆor touching assistance to partial/moderate assistance withˆallˆotherˆADLs. During a review of Residentˆ68's CP titled, Residentˆrequiresˆassistanceˆwith ADL functionˆsecondary to decrease in functional mobilityˆinitiatedˆon 6/13/2025, and last revised on 9/23/2025, the CPˆindicatedˆthat Resident 68ˆrequiredˆmaximalˆassistanceˆby two staff for toileting. During an observationˆonˆ2/11/2026 atˆ9:48ˆa.m.,ˆinside Resident 68's room,ˆobservedˆan incontinence brief that was rolled upˆon top of the bed on the foot part.ˆˆ During aˆconcurrent observation and interview on 2/11/2026ˆat 10:01 a.m. inside Resident 68's room with Registered Nurse (RN) 1, RN 1ˆstatedˆthat Resident 68'sˆsoiledˆincontinence brief wasˆrolled up and left on top of the bed. RNˆstatedˆthat prior to providing ADL care to the residents, the Certified Nursing Assistants (CNA) are supposedˆto place the soiled incontinence brief inside a plastic bag after providing ADL care to the residentsˆinstead of leaving the incontinence brief on top of the bedˆand discarded.ˆRN 1ˆstatedˆthat the CNA should haveˆplaced the soiled incontinence brief inside a plastic bag and discard after providing ADL care Resident 68.ˆRN 1ˆstatedˆthat the incontinence brief was soiled andˆcontaminated the bed sheets and placed Resident 68 at risk forˆacquiringˆinfection from the contaminated bed sheets.ˆˆ During an interview on 2/12/2026 atˆ11:10 a.m. with the DON, the DONˆstated thatˆafter providing ADL care to the residents includingˆchangingˆtheˆincontinence briefs, the CNAs are supposed to place the soiled incontinence brief inside a plastic bag and discard afterˆtheˆincontinence care was completed. The DON statedˆthe CNAˆassigned to Resident 68 should haveˆplaced the soiled incontinence brief inside a plastic bag and discard in the designated binˆinstead of leaving it on top of the bed as theˆsoiled incontinence brief contaminated the bed sheets as it wasˆan infection control issue and placed Resident 68 at risk for acquiring infection from the contaminated bed sheets.ˆ During a review of the facility's P&Pˆtitled, Policies and Practices – Infection Control, last reviewed on 1/16/2026,ˆthe P&P indicatedˆthe facility's infection control policies and practices are intended to facilitate maintaining a safe, sanitary and comfortable environment and toˆhelpˆprevent and manage transmission of disease and infection.ˆThe P&P furtherˆindicated:ˆ - The facility'sˆobjectivesˆof their infection control policies and practices are:ˆ a. To prevent, detect, investigate, and control infections in the facility;ˆ b. Toˆmaintainˆa safe, sanitary, and comfortable environmentˆfor personnel residents, visitors, and theˆgeneral public;ˆ c. Toˆestablishˆguidelines for the availabilityˆand accessibility of supplies and equipment necessary for standard and transmission-based precautions;ˆ - All personnel will be trained on infection control policies and practices upon hire and periodically thereafter, including where and how to find and use pertinent procedures and equipment related (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	infection control. The depth of employee training shall beˆappropriate toˆthe degree of direct resident contact and job responsibilities.ˆ c. During a concurrent interview and record review on 2/11/2026 at 2:33 p.m. with Laundry Staff (LS) 1, reviewed facility's dryer temperature log. LS 1 stated there was no entry on 2/7/2026 for morning shift in the dryer temperature log and this section was left blank. LS 1 stated after she (LS 1) checks the dryer temperature and records it in the logbook. During an interview on 2/12/2026 at 11:28 a.m. with LS 2, LS 2 stated she (LS 2) worked on 2/7/2026 during the morning shift. LS 2 stated her responsibilities included checking the dryer temperature three times on her shift and documenting the temperatures for each dryer and making sure the temperatures are correct. LS 2 stated every time they check the dryer temperature of each dryer; they are supposed to document it in the logbook and make sure that the hot temperature and every cycle is working. LS 2 stated when she (LS 2) did not document it, she (LS 2) did not do it. LS 2 stated she (LS 2) forgot to document the temperature because in the morning shift it gets busy, but she (LS 2) is responsible for checking and documenting it. During an interview on 2/12/2026 at 11:36 a.m. with the Maintenance Supervisor (MS), the MS stated the laundry staff are required to record the dryer temperature log three times in their shift. The MS stated the dryer temperature log was confusing, so he (MS) made a new log to make sure there are no missing spaces. During an interview on 2/12/2026 at 3:39 p.m. with the DON, the DON stated the dryer temperature checks are done to have an accurate temperature and to prevent molds and bacterial growth. The DON stated when it is not done there is potential for bacterial growth and mold. During a review of the facility's P&P titled, Laundry – Dryer Temperature Checking and Recording, last reviewed and approved on 1/16/2026, the P&P indicated that Sanitization Standards: Dryer temperatures must be adequate to ensure items are dried thoroughly to prevent mold or bacterial growth. Monitoring and Maintenance. Documentation of regular maintenance, cleaning, and testing of laundry equipment. Temperature checks are done three times per shift on a daily basis and is documented on the Dryers Temperature Log. During a review of the facility's P&P titled, Infection Control Program, last reviewed and approved on 1/16/2026, the P&P indicated that the facility shall establish an infection control program designed to provide a safe, sanitary and comfortable environment for residents and staff to help prevent the development and transmission of disease and infection. Surveillance of employees and residents will include. infection control checklists in each department.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. Based on observation, interview, and record review, the facility failed to keep the call light (an alerting device for nurses or other nursing personnel to assist a patient when in need) within reach of one of two sampled residents (Resident 26) reviewed under environment task. The deficient practice had the potential to prevent residents from summoning health care worker for help when needed. Findings: During a review of Resident 26's admission Record (AR), the AR indicated the facility admitted the resident on 3/1/2019, and readmitted the resident on 4/22/2025, with diagnoses including schizoaffective disorder (a mental illness that can affect thoughts, mood, and behavior), drug induced dyskinesia (a drug-induced movement disorder in which sudden, uncontrollable movements happen in the face and body because of prolonged use of medication, typically anti-psychotic drugs [prescription medications used to treat serious mental health conditions]), and mild cognitive impairment (a slight, noticeable decline in memory or thinking skills that is greater than normal age-related changes but not severe enough to interfere with daily independence). During a review of Resident 26's History and Physical (H&P), dated 4/23/2025, the H&P indicated the resident did not have the capacity to understand and make decisions. During a review of Resident 26's Minimum Data Set (MDS, a resident assessment tool), dated 12/22/2025, the MDS indicated the resident had the ability to make self-understood and understand others and had intact cognition (a person's brain is functioning normally, without any significant decline in mental abilities such as memory, thinking, reasoning, or judgment). The MDS indicated the resident was needing supervision assistance to being independent on mobility and activities of daily living (ADLs, activities such as bathing, dressing and toileting a person performs daily). During a review of Resident 26's Order Summary Report (OSR), dated 4/22/2025, the OSR indicated that the resident was given orientation to facility room using call light for assistance. During a review of Resident 26's Fall Risk Evaluation (FRE), dated 12/22/2025, the FRE indicated the resident was not at risk for falls. However, a plan to encourage the resident to use call light for assistance, appropriate footwear when ambulation, and provision of safe environment such as room free from clutter, adequate light, and working call light was put in place. During a review of Resident 26's Care Plan (CP) Report regarding the resident was at risk for falls related to psychoactive drug use, decrease safety judgment related to cognitive impairment, initiated on 4/3/2024, the CP indicated an intervention to provide the resident with a safe environment with even floors free from spills and/or clutter, adequate, glare-free light; a working and reachable call light, the bed in low position at night; alarms/floor mats if ordered, handrails on walls, personal items within reach. During a concurrent observation and interview on 2/10/2026 at 9:42 a.m., with Licensed Vocational Nurse (LVN) 1, inside Resident 26's room, observed the call light was resting on the floor at the left side of the resident's bed. LVN 1 stated the call light of the resident should always be within the resident's reach because the resident is a fall risk and can fall while reaching for the call light sustaining an injury such as fracture (aˆbroken bone). During an interview and record review on 2/12/2026 at 9:33 a.m., with Registered Nurse (RN) 1, reviewed the photograph of Resident 26's call light placement on 2/10/2026. RN 1 stated the call light was on the floor and the resident can fall while reaching for it. RN 1 stated the policy of the facility is to always keep the call light within the reach of the resident so they can call for help when they need it. RN 1 stated the failure of the staff to keep the call light within the reach of the resident can result to the resident unable to call for help when needed and can fall while reaching the call light on the floor and sustain an injury such as a fracture. During an interview on 2/12/2026 at 11:57 a.m., with the Director of Nursing (DON), the DON stated the call light of Resident 26 should always be within the resident's reach so they can make their needs known. The DON stated it was the responsibility of the Certified Nursing Assistants (CNA's) and Charge Nurses to keep the call light within the reach of the resident. The DON stated the CNAs and the Charge Nurses should be checking them when they are doing their patient safety rounds every 2 hours, checking the placement of the call light if it is within the (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident's reach. The DON stated the failure of the staff to keep the call light within the resident's reach had violated their policy on call system and could result to resident unable to ask for help when needed and could fall while reaching for the call light sustaining injuries such as a fracture. During a review of the facility's recent policy and procedure (P&P) titled, Call System, Resident, last reviewed on 1/16/2026, the P&P indicated residents are provided with a means to call staff for assistance through a communication system that directly calls a staff member or a centralized work station.ˆ Policy Interpretation and Implementation 1. Each resident is provided with a means to call staff directly for assistance from his/her bed, from toileting/bathing facilities and from the floor.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observation, interview, and record review, the facility failed to honor the resident's right to a safe, clean, comfortable, and homelike environment, including but not limited to receiving treatment and support for daily living safely for one of two sampled residents (Resident 77) reviewed under environment facility task by failing to ensure there were no signs of wear and tear on the resident's floor mat (a cushioned floor pad designed to help prevent injury should a person fall), as evidenced by cracks and holes on Resident 77`s left floor mat. The deficient practice had violated the resident's right to a safe, clean, comfortable, and homelike environment. Findings: During a review of Resident 77's admission Record (AR), the AR indicated the facility admitted the resident on 4/22/2025, with diagnoses including traumatic subdural hemorrhage (a kind of intracranial hemorrhage, which is the bleeding in the area between the brain and the skull), history of falling, and nondisplaced type II dens fracture (a broken neck bone (specifically the C2 vertebra) at its base, which has not shifted out of its normal position). During a review of Resident 77's H&P, dated 12/15/2025, the H&P indicated the resident was oriented to person only, had ongoing confusion, disorientation, fatigue (extreme tiredness), and frequent agitation (a state of severe restlessness or inner tension). During a review of Resident 77's Minimum Data Set (MDS, a resident assessment tool), dated 1/6/2026, the MDS indicated the resident rarely to never had the ability to make self-understood and understand others, had impaired vision, and had severely impaired cognition (a profound, advanced, and often permanent loss of mental functioning that severely limits a person's ability to think, remember, or reason). The MDS indicated the resident was dependent on mobility and activities of daily living (ADLs, activities such as bathing, dressing and toileting a person performs daily). During a review of Resident 77's Order Summary Report (OSR), dated 6/27/2025, the OSR indicated that the resident may have floor mats at the sides of the bed as a less restrictive measure for falls and for injury prevention. During a review of Resident 77's Fall Risk Evaluation (FRE), dated 1/6/2026, the FRE indicated the resident was at risk for falls. During a review of Resident 77's Care Plan (CP) Report regarding the resident was at risk for falls related to psychoactive drug (substances that, when taken in or administered into one's system, affect mental processes, e.g. perception, consciousness, cognition or mood and emotions) use, unaware of safety needs related to dementia (a progressive state of decline in mental abilities), vision/hearing problems, and history of falls with injury, initiated on 5/5/2025, the CP indicated an intervention of resident needs a safe environment with even floors free from spills and/or clutter, adequate, glare-free light, a working and reachable call light, the bed in low position at night, alarms/floor mats if ordered, handrails on walls, and personal items within reach. During a concurrent observation and interview on 2/10/2026 at 9:51 a.m., with Registered Nurse (RN) 1, inside Resident 77's room, observed Resident 77's floor mat at the left side of the bed with cracks and holes on them. RN 1 stated there should be no cracks and holes on the resident's floor mat as it compromises its use and it was not home-like to see worn and torn floor mats on the residents' room that can affect the resident by feeling depressed and sad. During an interview on 2/12/2026, at 11:57 a.m., with the Director of Nursing (DON), the DON stated Resident 77's floor mat should not have any cracks or holes in them because it compromise the purpose of the floor mat on providing a soft, safe landing surface for the resident to fall into and it does not promote a home-like environment. The DON stated if there are holes and cracks on the resident's floor mat it can affect the resident psychologically as it can make the resident feel sad and not happy. During a review of the facility's recent policy and procedure (P&P) titled, Homelike Environment, last reviewed on 1/16/2026, the P&P indicated residents are provide with a safe, clean, comfortable and homelike environment and encouraged to use their personal belongings to the extent possible. Policy Interpretation and Implementation 2. The facility staff and management maximize, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting. These characteristics (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	include: a. clean, sanitary and orderly environment. During a review of the facility-provided Floor Mat (FM) 1 Information, indicated a bedside fall mat is a safety solution designed to cushion falls and minimize the risk of serious injury. Bedside Floor Mats Guidelines, (1) Bedside floor mats must have a physician's order; (2) Bedside Floor mats need consent; (3) Bed Safety assessment must be completed; (4) Bedside floor mats must be included in the care plan. All bedside floor mats must be clear of any obstruction or clutter in order to maintain its purpose and function.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to develop and implement a comprehensive care plan (CP - a plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs) for one of one sampled resident (Resident 37) reviewed for antibiotic (a type of medication used to treat infection) use by failing to develop and implement a CP addressing Resident 37`s use of micafungin (medication used to treat fungal infections) and isavuconazonium sulfate (Cresemba-medication used to treat fungal infections). This deficient practice had the potential to result in delays in the delivery of necessary care and services. Findings: During a review of Resident 37's admission Record (AR), the AR indicated that the facility originally admitted the resident on 12/4/2025, and readmitted on [DATE], with diagnoses including pneumonia (an infection/inflammation in the lungs), acute respiratory failure (serious condition that suddenly develops when the lungs cannot get enough oxygen into the blood) with hypoxia (low levels of oxygen in the body), and pancytopenia (a condition marked by a dangerous drop in all three major blood cell types-red cells [oxygen transport], white cells [infection fighting], and platelets [clotting]-due to bone marrow failure or destruction). During a review of Resident 37's History and Physical (H&P), dated 1/10/2026, the H&P indicated the resident had the capacity to understand and make decisions. During a review of Resident 37's Minimum Data Set (MDS- a resident assessment tool), dated 1/14/2026, the MDS indicated the resident had the ability to make self-understood and understand others. The MDS indicated the resident required substantial assistance on activities of daily living (ADLs- activities such as bathing, dressing, and toileting a person performs daily) on toileting hygiene and shower/bathe self and on mobility including sit to stand, chair/bed-to-chair transfer, and toilet transfer. During a review of Resident 37's orders, the orders indicated the following: - Micafungin sodium-sodium chloride intravenous (through the vein) solution 150-0.9 milligrams (mg- a unit of measurement) per 150 milliliters (ml- a unit of measurement) percent (%- one per hundred), use 150 mg intravenously one time a day for multifocal (affecting multiple areas of one or both lungs) pneumonia for 28 Days, dated 1/10/2026; - Isavuconazonium sulfate oral capsule 186 mg (Cresemba), give two (2) capsules by mouth one time a day for multifocal pneumonia until 3/08/2026 11:59 p.m., dated 1/14/2026. During a concurrent interview and record review on 2/12/2026 at 12:43 p.m. with Registered Nurse (RN) 1, reviewed Resident 37's care plans. RN 1 stated there was no care plan developed addressing the use of micafungin and Cresemba. RN 1 stated when Resident 37 was started on micafungin and Cresemba, a care plan should have been developed and implemented. RN 1 stated that a care plan is used as a tool to monitor the resident and has interventions and goals of care. RN 1 stated the care plan is catered to the resident to see if the resident is getting better or not and is a tool to provide the appropriate care that is needed. RN 1 stated the potential outcome of not developing a care plan is that staff will not be able to monitor the adverse effects (undesired or harmful effects) of the medications. RN 1 stated they monitor the use of micafungin and Cresemba for the duration of its use and for three (3) days after completion of the medication. During an interview on 2/12/2026 at 3:27 p.m. with the Director of Nursing (DON), the DON stated the care plan is a communication tool to address the resident's care and ensure care is provided to the resident. The DON stated monitoring of adverse effects is one of the interventions the licensed nurse perform on the use of antifungal medications. During a review of the facility's policy and procedure (P&P) titled, Care Plans, last reviewed and approved on 1/16/2026, the P&P indicated that A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. The comprehensive, person-centered care plan is developed within seven (7) days of the completion of the required MDS assessment., and no more than 21 days after admission. The comprehensive, (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	person-centered care plan: a. includes measurable objectives and timeframes. c. includes the resident's stated goals upon admission and desired outcomes;. and e. reflects currently recognized standards of practice for problem areas and conditions.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. Based on observation, interview, and record review, the facility failed to provide care consistent with professional standards of practice to prevent pressure ulcer/injury (ulcers that happen on areas of the skin that are under pressure from lying in bed, sitting in a wheelchair, or wearing a cast for a long period) for one of one sampled resident (Resident 3) reviewed for pressure ulcers by failing to set the low air loss mattress (LALM, a special type of air mattress that uses a constant, gentle flow of air through microscopic holes to keep the skin dry and prevent pressure wounds) according to the resident's weight. The deficient practice had the potential for development and worsening of pressure ulcers/injuries to residents. Findings: During a review of Resident 3's admission Record (AR), the AR indicated the facility admitted the resident on 3/1/2010, and readmitted the resident on 1/28/2025, with diagnoses including osteomyelitis of vertebra (a serious infection of the spine bones (vertebrae), often caused by bacteria or fungi that travel through the bloodstream, following surgery, or from nearby tissue), sacral (anything relating to theˆsacrum, which is the large, triangular bone at the very base of the spine, situated between the hip bones just above the tailbone) and sacrococcygeal area (theˆvery bottom of the spine, specifically where the tailbone (coccyx) connects to the base of the triangle-shaped bone (sacrum) located just above it), pressure ulcer of sacral region stage 4 (full-thickness skin and tissue loss with exposed muscle, tendon, ligament, cartilage, or bone), and protein-calorie malnutrition (a serious condition caused by a severe lack of both calories (energy) and protein in the diet, or an inability of the body to properly use them). During a review of Resident 3's History and Physical (H&P), dated 2/20/2025, the H&P indicated the resident did not have the capacity to understand and make decisions. During a review of Resident 3's Minimum Data Set (MDS, a resident assessment tool), dated 12/16/2025, the MDS indicated the resident sometimes had the ability to make self-understood and understand others and had severely impaired cognition (problems with a person's ability to think, learn, remember, use judgement, and make decisions). The MDS indicated the resident was dependent on mobility and activities of daily living (ADLs, activities such as bathing, dressing and toileting a person performs daily). The MDS indicated the resident was at risk for developing pressure injuries and had an unhealed stage four (4) pressure injury with pressure reducing device for bed as one of skin and ulcer/injury treatments. During a review of Resident 3's Order Summary Report (OSR), dated 11/27/2025, the OSR indicated an order that the resident may have low air loss mattress for skin integrity maintenance and wound care management. Check every (Q) shift for placement and function. Every shift. During a review of Resident 3's Braden Scale (BS) for Predicting Pressure Sore Risk, dated 9/17/2025, the BS indicated the resident was at moderate risk for developing pressure injury. During a review of Resident 3's Weights and Vitals Summary (WVS), dated 2/4/2026, the resident's weight was 111 pounds (lbs., the plural abbreviation for pound, a unit of weight). During a review of Resident 3's Care Plan (CP) Report titled, Pressure Ulcer Stage four (4), Sacro coccyx full thickness tissue loss with exposed bone, tendon, and muscle, initiated on 7/18/2025, the CP indicated an intervention to use pressure reducing device: Low Air Loss Mattress. During an observation on 2/10/2026 at 10:02 a.m., observed Resident 3`s LALM was set at two (2) and on an alternate setting (a feature where the air-filled cells inside the mattress inflate and deflate in a repeating, programmed cycle). A photograph was taken for reference. During a concurrent interview and record review on 2/12/2026 at 7:58 a.m., with Registered Nurse (RN) 3, reviewed Resident 3's Medical Diagnoses, H&P, MDS, OSR, BS, WVS, and CP. RN 3 stated there was an order for Resident 3 to have low air loss mattress for skin integrity maintenance but the order did not indicate a specific setting. RN 3 stated they set the LALM according to the resident's weight if there is no specific order from the MD. RN 3 stated the resident's latest weight was 111 lbs. and he needed to check the manufacturer's specification on what the setting should be. RN 3 stated that on the photo taken of the LALM machine of Resident 3, the LALM was set at two (2). RN 3 stated after reviewing the Manufacturer's Specification it indicated the LALM should be set at one (1) per (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident's weight. RN 3 stated the failure of the licensed staff to follow the Manufacturer's Specification to set the LALM on one (1) had predisposed the resident to worsening of the current pressure injury and a potential for development of a new pressure injury on Resident 3. RN 3 stated the charge nurses, and the RN supervisors are responsible for ensuring the setting of the LALM is accurate and per physician's order. During an interview on 2/12/2026, at 11:57 a.m., with the Director of Nursing (DON), the DON stated the licensed staff should have set the LALM of Resident 3 according to the resident's weight per Manufacturer's Specification. The DON stated the resident's weight of 111 lbs. should be set to one (1) per the Operations Manual. The DON stated the failure of the staff to set the LALM according to resident's weight can lead to further worsening of the pressure injury or development of new ones. During a review of the facility's recent policy and procedure (P&P) titled, Pressure Reduction and Relief, last reviewed on 1/16/2026, the P&P indicated it is the policy of this facility to utilize pressure reducing/relieving devices the resident's clinical condition, under the direction of a physician. During a review of the facility-provided Owner's Manual (OM) Low Air Loss Mattress (LALM) 1, undated, the OM indicated under Control Unit Settings: 5. Comfort Level: For best possible pressure management, maximize immersion and envelopment by initially setting the COMFORT LEVEL on the control panel to the softest selection appropriate for the patient, in accordance with the stated weight limits:^ -For patients up to 120 lbs., begin with level one (1) (Max. Immerse).

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. Based on observation, interview, and record review, the facility failed to ensure one of one sampled resident (Resident 22) received appropriate services to prevent a decline (to become lower in amount or less in number) in range of motion (ROM - full movement potential of a joint) by failing to provide a safe and appropriate Restorative Nursing Aide program (RNA - nursing aide program that help residents to maintain their function and joint mobility) for active assistive range of motion exercises (AAROM - use of muscles surrounding the joint to perform the exercise but requires some help from a person or equipment) to Resident 22's left lower extremity (part of the body that includes theˆhip, knee, ankle, and foot) in accordance with the physician's order and care plan. This deficient practice had the potential for Resident 22 to develop ROM limitations such as contractures (a stiffening/shortening at any joint, that reduces the joint's range of motion). Findings: During a review of Resident 22's admission Record (AR), the AR indicated that the facility admitted the resident on 5/3/2023, with diagnoses including hemiplegia (inability to move one side of the body) and hemiparesis (weakness on one side of the body) following cerebral infarction (commonly known as stroke, caused by a blockage in a blood vessel in the brain, leading to brain damage) affecting right dominant side, moyamoya disease (a rare condition in which the blood vessels that supply blood to the brain become narrowed), and dysphagia (difficulty swallowing). During a review of Resident 22's History and Physical (H&P), dated 5/1/2025, the H&P indicated that the resident can make needs known but cannot make medical decisions. During a review of Resident 22's Minimum Data Set (MDS- a resident assessment tool), dated 1/22/2026, the MDS indicated that the resident usually makes self-understood and has the ability to usually understand others. The MDS indicated the resident with functional limitation impairments in ROM on both lower extremities. The MDS indicated the resident required substantial/maximal assistance with mobility which included rolling left and right, sit to lying, lying to sitting on side of bed, and dependent on staff with sit to stand, chair/bed-to-chair transfer, toilet transfer, and tub/shower transfer. During a review of Resident 22's Order Summary Report (OSR), dated 2/2/2026, the OSR indicated RNA for AAROM exercises to bilateral (both sides) lower extremities (BLE), five (5) times per week or as tolerated, every day shift every Monday, Tuesday, Wednesday, Thursday, Friday for maintenance. Monitor for participation and/or change in condition. Report to charge nurse accordingly. During a review of Resident 22's Care Plan (CP) titled, Resident requires assistance with activities of daily living (ADLs - activities such as bathing, dressing and toileting a person performs daily) functions secondary to:. 2/2/2026 - RNA for AAROM exercises to BLE five times per week or as tolerated, initiated 5/4/2023, the CP indicated the resident will improve current level of function. The CP indicated interventions Physical Therapy (PT)/Occupational Therapy (OT) evaluation and treatment as per physician orders. During a review of Resident 22's CP titled, Resident requires RNA program for maintenance:. 2/2/2026 - RNA for AAROM exercises to BLE five times per week or as tolerated, initiated 8/8/2023, the CP indicated the resident will maintain maximum joint mobility. The CP indicated interventions meds as ordered, monitor for pain and joint stiffness. During an observation on 2/12/2026 at 10:21 a.m. with Restorative Nursing Assistant (RNA) 1, in Resident 22's room, Resident 22 was observed lying in bed with left foot sole against the footboard (a vertical panel attached to the foot of a bed frame). RNA 1 performed ROM exercises to the left hip and knee. RNA 1 performed turning the sole of the foot laterally, away from the midline. RNA 1 did not perform flexion (bending) and circumduction (rotating the foot in full circle in clockwise and counterclockwise direction) ROM exercises on the left ankle and foot. RNA 1 performed ROM exercises to the left toes. RNA 1 performed ROM exercises to the right hip and knee. Resident 22 complained of right leg pain, and RNA 1 stopped providing ROM exercises. During an interview on 2/12/2026 at 10:27 a.m. with RNA 1, RNA 1 stated Resident 22 did not have any exercises restrictions that she (Resident 22) could not perform. RNA1 stated she (RNA (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1) adjusts the exercises depending on what and how much the resident can tolerate. RNA 1 stated she (RNA 1) forgot to perform the left ankle rotation. RNA 1 stated she (RNA 1) thinks she (RNA 1) performed the left ankle flexion. RNA 1 stated she (RNA 1) should have provided the exercises on the left ankle, but she (RNA 1) forgot. RNA 1 stated ROM exercises are provided to maintain the resident's movement and prevent contractures. RNA 1 stated not providing the ROM exercises had the potential for the resident to develop contractures. During an interview on 2/12/2026 at 3:12 p.m. with the Director of Nursing (DON), the DON stated the RNA administers the ROM exercises to the residents that are on RNA program. The DON stated the residents are evaluated by physical therapist (PT), PTs provide recommendation for RNA program and the resident's attending physician will order RNA program if it is appropriate for the resident. The DON stated the exercises should have been provided to Resident 22 to maintain their range of motion. The DON stated when the exercises are not provided the resident can experience any contracture, injuries such as muscle strains and joint sprains if it is not done. During a review of the facility's policy and procedures (P&P) titled, Restorative Nursing Services, last reviewed and approved on 1/16/2026, the P&P indicated that Residents will receive restorative nursing care as needed to help promote optimal safety and independence. The P&P indicated that Restorative goals may include but are not limited to supporting and assisting the resident in:. d. participating in the development and implementation of his/her plan of care. During a review of the facility's P&P titled, Range of Motion Exercises, last reviewed and approved on 1/16/2026, the P&P indicated that the purpose of this P&P is: - To improve the resident's joints through as full a range of motion as possible. - To improve or maintain joint mobility and muscle strength. - To prevent contractures. - To increase strength and activity tolerance. - To reduce pain. - To prevent complications of immobility. 9. Ankle a. Dorsiflexion (backward bending and contracting of the foot)/Plantar Flexion (pointing the foot downwards) . b. Circumduction.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the resident environment was free of accident hazards for two of five (5) sampled residents (Residents 26 and 77) reviewed for accidents by failing to ensure: 1. Resident 26's call light (a button, cord, or device in a hospital room or nursing home that allows a patient to alert nurses or caregivers to need assistance) was within reach and there were no banana peels on the floor in Resident 26`s room. 2. Resident 77 did not have furniture or equipment on top of the floor mat (a cushioned floor pad designed to help prevent injury should a person fall). The deficient practices increased the risk of accidents such as slips, trips, and falls with injuries for the residents. Findings: 1. During a review of Resident 26's admission Record (AR), the AR indicated the facility admitted the resident on 3/1/2019, and readmitted the resident on 4/22/2025, with diagnoses including schizoaffective disorder (a mental illness that can affect thoughts, mood, and behavior), drug induced dyskinesia (a drug-induced movement disorder in which sudden, uncontrollable movements happen in the face and body because of prolonged use of medication, typically anti-psychotic drugs (prescription medications used to treat serious mental health conditions)), and mild cognitive impairment (a condition in which people have more memory or thinking problems than other people their age). During a review of Resident 26's History and Physical (H&P), dated 4/23/2025, the H&P indicated the resident did not have the capacity to understand and make decisions. During a review of Resident 26's Minimum Data Set (MDS, a resident assessment tool), dated 12/22/2025, the MDS indicated the resident had the ability to make self-understood and understand others and had intact cognition (having a sound mind or sharp thinking). The MDS indicated the resident was needing supervision assistance to being independent on mobility and activities of daily living (ADLs, activities such as bathing, dressing and toileting a person performs daily). During a review of Resident 26's Order Summary Report (OSR), dated 4/22/2025, the OSR indicated that the resident was given orientation to facility room using call light for assistance. During a review of Resident 26's Fall Risk Evaluation (FRE), dated 12/22/2025, the FRE indicated the resident was not at risk for falls. However, a plan to encourage to use call light for assistance, appropriate footwear when ambulation, and provision of safe environment such as room free from clutter, adequate light, and working call light was put in place. During a review of Resident 26's Care Plan (CP) Report regarding the resident was at risk for falls related to psychoactive drug (substances that, when taken in or administered into one's system, affect mental processes, e.g. perception, consciousness, cognition or mood and emotions) use, decrease safety judgment related to cognitive impairment, initiated on 4/3/2024, the CP indicated an intervention to provide the resident with a safe environment with even floors free from spills and/or clutter, adequate, glare-free light; a working and reachable call light, the bed in low position at night; alarms/floor mats if ordered, handrails on walls, personal items within reach. During a concurrent observation and interview on 2/10/2026, at 9:42 a.m., with Licensed Vocational Nurse (LVN) 1, inside Resident 26's room, observed the call light was resting on the floor at the left side of the resident's bed with banana peels on the floor pathway. LVN 1 stated the call light of the resident should always be within the resident reach and there should be no banana peels on the floor as the resident can step on them and slip causing them to fall and sustain an injury such as a fracture (aˆbroken bone). During an interview and record review on 2/12/2026 at 9:25 a.m., with Registered Nurse (RN) 1, reviewed the photograph of Resident 26's call light placement on 2/10/2026. RN 1 stated the call light was on the floor and there were banana peels on the resident's pathway. RN 1 stated the policy of the facility is to always keep the call light within the reach of the resident so they can call for help when they need it and there should be no clutter or hazards on the resident's environment. RN 1 stated the failure of the staff to keep the call light within reach and no banana peels on the floor can result to resident unable to call for help when needed and (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	can slip and fall due to the banana peel on the resident's pathway and sustain an injury such as a fracture. During an interview on 2/12/2026 at 11:57 a.m., with the Director of Nursing (DON), the DON stated the call light of Resident 26 should always be within the resident's reach and no environmental hazards such as a banana peel on the resident's pathway. The DON stated it was the responsibility of the Certified Nursing Assistants (CNA) and Charge Nurses to keep the call light within the reach of the resident and ensure there's no hazards such as banana peels on the floor. The DON stated the CNAs and the Charge Nurses should be checking them when they are doing their patient safety rounds every two hours, checking the placement of the call light if it is within the resident's reach and no clutter or hazards on the resident's pathway. The DON stated the failure of the staff to keep the call light within the resident's reach and ensure no banana peel was on the floor had violated their policy on call system and Safety Precautions and could result to resident unable to ask for help when needed and could slip and fall sustaining injuries such as a fracture. During a review of the facility's recent policy and procedure (P&P) titled, Safety Precautions, General, last reviewed on 1/16/2026, the P&P indicated all personnel shall follow general safety precautions established by this facility. Policy Interpretation and Implementation 9. Do not leave equipment or supplies in passageways or exits. 20. Follow manufacturer's directions when using chemicals, equipment, and other supplies. 22. Pick up debris from the floor. Wipe up spills as soon as practical. During a review of the facility's recent P&P titled, Safety and Supervision of Residents, last reviewed on 1/16/2026, the P&P indicated our facility strives to make an environment as free from accident hazards as possible. Resident safety and supervision and assistance to prevent accidents are facility-wide priorities.ˆ Policy Interpretation and Implementation 4. Employees shall be trained on potential accident hazards and demonstrate competency on how to identify and report accident hazards and try to prevent avoidable accidents. Resident Risks and Environment 1. Due to their complexity and scope, certain resident risk factors and environment hazards are addressed in dedicated policies and procedure. These risk factors and environment hazards include the following: a. Bed safety; c. Falls. During a review of the facility's recent P&P titled, Falls and Fall Risk, Managing, last reviewed on 1/16/2026, the P&P indicated based on previous evaluations and current data, the staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling. Fall Risk Factors 1. Environmental factors that contribute to the risk of falls include: d. obstacles in the foot path. 2. During a review of Resident 77's AR, the AR indicated the facility admitted the resident on 4/22/2025, with diagnoses including traumatic subdural hemorrhage (a life-threatening, emergency brain injury where blood leaks from torn vessels and collects between the brain and its outer, protective membrane (the dura), usually following a significant head injury), history of falling, and nondisplaced type II dens fracture (a break at the base of the peg (odontoid process) of the second neck vertebra (C2), where the bone is cracked but has not moved out of its normal position). During a review of Resident 77's H&P, dated 12/15/2025, the H&P indicated the resident was oriented to person only, had ongoing confusion, disorientation, fatigue (extreme tiredness), and frequent agitation (a state of severe restlessness or inner tension).During a review of Resident 77's MDS, dated [DATE], the MDS indicated the resident rarely to never had the ability to make self-understood and understand others, had impaired vision, and had severely impaired cognition (problems with a person's ability to think, learn, remember, use judgement, and make decisions). The MDS indicated the resident was dependent on mobility and ADLs. During a review of Resident 77's OSR, dated 6/27/2025, the OSR indicated an order that the resident may have floor mats at the sides of the bed as a less restrictive measure for falls and for injury prevention. During a review of Resident 77's FRE, dated 1/6/2026, the FRE indicated the resident was at risk for falls. During a review of Resident 77's CP Report regarding the resident was at risk for falls related to psychoactive drug use, unaware of safety needs related to dementia (a progressive state of decline in mental abilities), vision/hearing problems, and history of falls with injury, initiated on 5/5/2025, the CP indicated an intervention of resident needs a safe environment with even floors free from spills (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and/or clutter, adequate, glare-free light, a working and reachable call light, the bed in low position at night, alarms/floor mats if ordered, handrails on walls, and personal items within reach. During a concurrent observation and interview on 2/10/2026 at 9:51 a.m., with RN 1, inside Resident 77's room, observed Resident 77's floor mat at the right side of the bed with a trash can on top of it. RN 1 stated there should be no objects or equipment on top of the floor mat because it is defeating its purpose of providing a soft, safe landing mat when the resident rolls down from the bed. RN 1 stated when the resident falls/rolls down from the bed, the resident with hit the object on top of the mat that can cause injuries to the resident such as bruising, bumps, and even fracture. During an interview on 2/12/2026 at 11:57 a.m., with the DON, the DON stated Resident 77's floor mat should not have any objects on top of them because it compromises the purpose of the floor mat on providing a soft, safe landing surface for the resident to fall into. The DON stated if there are equipment or furniture on top of the floor mat, the resident will hit the objects on top of the floor mat and can cause injuries to the resident such as fracture or lacerations (a torn, ragged, or jagged cut in the skin caused by trauma, such as a fall, impact with a blunt object, or a sharp edge). During a review of the facility-provided Floor Mat (FM) 1 Information, indicated a bedside fall mat is a safety solution designed to cushion falls and minimize the risk of serious injury. Bedside Floor Mats Guidelines, (1) Bedside floor mats must have a physician's order; (2) Bedside Floor mats need consent; (3) Bed Safety assessment must be completed; (4) Bedside floor mats must be included in the care plan. All bedside floor mats must be clear of any obstruction or clutter in order to maintain its purpose and function. During a review of the facility's recent P&P titled, Safety Precautions, General, last reviewed on 1/16/2026, the P&P indicated all personnel shall follow general safety precautions established by this facility. Policy Interpretation and Implementation 9. Do not leave equipment or supplies in passageways or exits. 20. Follow manufacturer's directions when using chemicals, equipment, and other supplies. 22. Pick up debris from the floor. Wipe up spills as soon as practical. During a review of the facility's recent P&P titled, Safety and Supervision of Residents, last reviewed on 1/16/2026, the P&P indicated our facility strives to make an environment as free from accident hazards as possible. Resident safety and supervision and assistance to prevent accidents are facility-wide priorities.ˆ Policy Interpretation and Implementation 4. Employees shall be trained on potential accident hazards and demonstrate competency on how to identify and report accident hazards and try to prevent avoidable accidents. Resident Risks and Environment 1. Due to their complexity and scope, certain resident risk factors and environment hazards are addressed in dedicated policies and procedure. These risk factors and environment hazards include the following: a. Bed safety; c. Falls. During a review of the facility's recent P&P titled, Falls and Fall Risk, Managing, last reviewed on 1/16/2026, the P&P indicated based on previous evaluations and current data, the staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling. Fall Risk Factors 1. Environmental factors that contribute to the risk of falls include: d. obstacles in the foot path.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents received appropriate treatment and services to prevent urinary tract infections (UTI, an infection in the bladder/urinary tract) for one sampled resident (Resident 5) reviewed for UTIs by failing to ensure Resident 5 did not use a urinal labeled for Resident 42, a discharged resident. This deficient practice had the potential to result in UTIs in Resident 5. Findings: a. During a review of Resident 5's admission Record (AR), the AR indicated the facility admitted the resident on 1/16/2026, with diagnoses that included acute and chronic venous hypertension (sudden worsening of a long-term condition in which the flow of superficial or deep venous blood is impaired) with ulcer (shallow, slow-healing open sores) of bilateral (both) lower extremities, methicillin-resistant staphylococcus aureus (MRSA - a bacteria that does not respond to antibiotics), and an open wound on the left thigh. During a review of Resident 5's Minimum Data Set (MDS - resident assessment tool), dated 1/21/2026, the MDS indicated the resident was able to understand others and able to make himself understood. The MDS further indicated the resident was dependent on staff for toileting and mobility including rolling to the left and right, moving from lying to sitting at the side of the bed, moving from sitting to standing, and transfers. During a review of Resident 5's History and Physical (H&P), dated 1/16/2026, the H&P indicated the resident was recently hospitalized due to sepsis (a life-threatening blood infection). The H&P further indicated the resident had the capacity to understand and make decisions. b. During a review of Resident 42's AR, the AR indicated the facility admitted the resident on 1/13/2026, with diagnoses that included bacteriuria (presence of bacteria in the urine). During a review of Resident 42's MDS, dated [DATE], the MDS indicated the resident was totally dependent on staff for toileting. During a review of Resident 42's CP titled, (Resident 42) has UTI. initiated 1/16/2025, the CP indicated a goal that the UTI would resolve. During a concurrent observation and interview on 2/10/2026 at 10:02 a.m., observed Resident 5 awake and lying in bed. Observed a urinal hanging from the left side of Resident 5's bed that was labeled with Resident 42's name. Observed certified nursing assistant (CNA) 3 entered Resident 5's room and stood at the left side of the resident's bed with the urinal in plain sight. Resident 5 stated he (Resident 5) needed a spare urinal and took Resident 42's urinal a couple of days ago when the resident was discharged . Observed CNA 3 then exited Resident 5's room leaving the urinal labeled for Resident 42 within of reach Resident 5. During a follow up interview on 2/10/2026 at 10:07 a.m., CNA 3 stated Resident 5 had a urinal labeled for Resident 42. CNA 3 stated Resident 5 indicated he was using Resident 42's urinal. CNA 3 stated Resident 42 was discharged three days prior, and Resident 5 must have been using Resident 42's urinal for a few days. CNA 3 stated Resident 5 should not be using another resident's urinal because there was a risk for getting an infection. During an interview on 2/11/2026 at 2:19 p.m. with the Director of Staff Development (DSD), the DSD stated the facility process when a resident discharges is the room should be secured and cleaned to prevent cross contamination (the process by which bacteria or other microorganisms are unintentionally transferred from one substance or object to another, with harmful effect) between residents. The DSD stated urinals are used for only one resident and are changed every Sunday and as needed. The DSD stated urinals are labeled with the resident's name. The DSD stated CNAs and licensed nurses (LN) make initial rounds on residents that includes ensuring urinals are correctly labeled. The DSD stated CNA 3 did not make initial rounds to check Resident 5's urinal resulting in the resident having a urinal labeled for Resident 42. During a concurrent interview and record review on 2/12/2026 at 11:57 a.m. with the Director of Nursing (DON), the DON reviewed the facility policy and procedures (P&P) regarding standard precautions and urinals. The DON stated urinals are used only by one resident. The DON stated the facility process is that urinals are labeled with the Resident's name. The DON stated she (DON) was made aware that (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident 5 was using Resident 42's urinal. The DON stated the CNAs should have identified that Resident 5 had a urinal labeled for Resident 42 while doing their rounds and removed the urinal, but they did not. The DON stated the facility P&P was not followed when Resident 5 had a urinal labeled for Resident 42 potentially resulting in a UTI in Resident 5. A review of the facility policy and procedure titled, Standard Precautions, last reviewed 1/16/2026, indicated, Standard precautions are used in the care of all residents regardless of their diagnoses, or suspected or confirmed infection status. Standard precautions presume that all blood, body fluids, secretions, and excretions (except sweat), non-intact skin and mucous membranes may contain transmissible infectious agents. Policy Interpretation and Implementation. I. Standard precautions apply to the care of all residents in all situations regardless of suspected or confirmed presence of infectious diseases . 2. Personnel are trained in the various aspects of standard precautions to ensure appropriate decision-making in various clinical situations. 5. Resident-Care Equipment. a. Resident-care equipment soiled with blood, body fluids, secretions, and excretions are handled in a manner that prevents skin and mucous membrane exposure. and transfer of microorganisms to other residents and environments. b. Reusable equipment is not used for the care of more than one resident . c. Single use items are properly discarded. A review of the facility policy and procedure titled, Bedpan / Urinal, Offering / Removing, last reviewed 1/16/2026, indicated, The purpose of this procedure is to provide the resident with bedpan and/or urinal assistance. Preparation. Assemble the equipment and supplies as needed. If the resident prefers to keep a urinal at his bedside, check it frequently.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on observation, interview, and record review, the facility failed to provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of residents by failing to ensure licensed nurses (LN) completed documentation indicating reconciliation (a system of recordkeeping that ensures an accurate inventory of medications that have been received, dispensed, administered, and wasted) of controlled medications (medication considered to have a strong potential for abuse and may also lead to physical or psychological dependence) at every change of shift on the Narcotic Check Sheet form in one of two medication carts (Station 1 Medication Cart) observed during the Medication Storage and Labeling task. This deficient practice had the potential for inaccurate reconciliation of controlled medication and placed the facility at potential for inability to readily identify loss and drug diversion (illegal distribution of prescription drugs for their use for unintended purposes) of controlled medications. Findings: During a Medication Storage observation on 2/11/2026 at 11:46 a.m., Licensed Vocational Nurse (LVN) 2 reviewed the Station 1 Medication Cart Narcotic Check Sheets for 2/2026. LVN 2 stated narcotics are controlled substances that are very addictive and have a high risk for abuse leading to diversion. LVN 2 stated it was important to clearly manage narcotics to know who has handled the medication. LVN 2 stated at the beginning and end of each shift the oncoming and outgoing LN together count the narcotics in the medication cart when the responsibility for the cart is given to the oncoming LN. LVN 2 stated both LNs document that the count was completed on the Narcotic Check Sheet. LVN 2 reviewed the Narcotic Check Sheets for 2/2026 and noted the following: -On 2/10/2026 at 3 p.m., the outgoing and incoming LN signatures were not indicated. -On 2/10/2026 at 11 p.m., the outgoing LN signature was not indicated. LVN 2 stated if the narcotic count was not documented on the Narcotic Check Sheet, then it was considered to have not been done. LNV 2 stated LVN 1 was assigned to the Station 1 Medication Cart on 2/10/2026. During a concurrent interview and record review on 2/11/2026 at 12:10 p.m., LVN 1 reviewed the Station 1 Medication Cart Narcotic Check Sheet for 2/2026. LVN 1 stated the Narcotic Check Sheet is used to document when the narcotics are counted by the incoming and outgoing LN. LVN 1 stated the importance of signing the Narcotic Check Sheet is to document that the count was completed, and both parties agree that the narcotic count was correct and there were no discrepancies (lack of similarities). LVN 1 reviewed the Narcotic Check Sheet and stated he (LVN 1) forgot to sign the Narcotic Check Sheet on 2/10/2026 at 3 p.m. with the incoming LN because it was a crazy shift. LVN 1 stated when the Narcotic Check Sheet was not completed then it was in question if the count was done or if the count was correct when the Medication Cart was endorsed to the next shift potentially resulting in missing narcotic medication. During a concurrent interview and record review on 2/12/2026 at 11:57 a.m., the Director of Nursing (DON) reviewed the facility policy and procedure (P&P) regarding controlled substances. The DON stated the facility process is the Narcotic Check Sheet is part of the controlled drug reconciliation process that occurs at the change of every shift by the incoming and outgoing LN. The DON stated it was important to document the reconciliation because there is a high risk for addiction and theft of controlled substances. The DON stated the LNs did not follow the P&P when the Narcotic Check Sheet was not completed potentially resulting in unidentified discrepancies resulting in missing narcotics. A review of the facility policy and procedure titled, Controlled Substances, last reviewed 1/16/2026, indicated, The facility complies with all laws, regulations, and other requirements related to handling, storage, disposal, and documentation of controlled medications. Handling Controlled Substances . Only authorized licensed nursing and/or pharmacy personnel have access to controlled drugs maintained on premises. Storing Controlled Substances . Controlled substances are separately locked in permanently affixed compartments,. The charge nurse on duty maintains the keys to controlled substances containers. (continued on next page)

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	055002	A. Building B. Wing	02/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Country Manor Healthcare	11723 Fenton Avenue Lake View Terrace, CA 91342

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Director of Nursing services maintains a set of back-up keys for all medication storage areas including keys to controlled substance containers. Dispensing and Reconciling Controlled Substances. Nursing staff count controlled medication inventory at the end of each shift, using these records to reconcile the inventory count. The nurse coming on duty and the nurse going off duty make the count together and document and report any discrepancies to the director of nursing services. The director of nursing services documents irreconcilable discrepancies in a report to the administrator. If a major discrepancy or a pattern of discrepancies occurs, or if there is apparent criminal activity, the director of nursing notifies the administrator and consultant pharmacist immediately. The administrator, consultant pharmacist, and/or director of nursing services determine whether other action(s) are needed, e.g., notification of police or other enforcement personnel.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure safe provision of pharmaceutical services (the procuring, manufacturing, compounding, dispensing, distributing, storing and administering of drugs, biologicals and chemicals) by failing to: 1. Ensure the medication disposition record contained the signature of witnesses when Eliquis (apixaban - an anticoagulant [blood thinner]) medication for Resident 24 was disposed and destroyed reviewed during medication storage task in one of one medication room (Med room [ROOM NUMBER]). This deficient practice had the potential to result in medication diversion (illegal transfer of prescription drugs) and unauthorized use. 2. Perform the quality check control solution test (a quality check that verifies the accuracy of the glucometer [medical device used to measure the concentration of sugar in the blood] and test strips using a liquid with a known glucose [sugar] concentration) and repeat the test for one of three medication carts (Med Cart 1) when the quality check log sheet indicated a result of 343, a result outside of the high results range. This deficient practice had the potential to result in inaccurate blood sugar readings for residents on blood sugar monitoring. Findings: a. During a review of Resident 24's admission Record (AR), the AR indicated that the facility admitted the resident on 1/29/2025 with diagnoses including Alzheimer's disease (a disease characterized by a progressive decline in mental abilities), pain in right and left leg, and hypotension (low blood pressure). During a review of Resident 24's History and Physical (H&P - a comprehensive assessment of a resident's medical condition), dated 7/2/2025, the H&P indicated that the resident does not have the capacity to understand and make decisions. During a concurrent observation and interview on 2/11/2026 at 10:12 a.m. with Registered Nurse (RN) 4 in Med room [ROOM NUMBER], RN 4 stated discontinued non-controlled medications (medications that are generally considered safe for use without strict government monitoring) are placed under the locked cabinet for destruction. RN 4 stated the medication destruction log indicated Resident 24's Eliquis with nine (9) quantities left and was discontinued. RN 4 stated Resident 24's Eliquis discontinued medication was not in the cabinet and was already destroyed. RN 4 stated medication is destroyed in the presence of two licensed nurses and when destroyed, the two licensed nurses are to sign the medication destruction log that it was done and witnessed. RN 4 stated the medication destruction log for Resident 24's Eliquis did not have a signature from the two licensed nurses who destroyed the medication. During an interview on 2/12/2026 at 3:08 p.m. with the Director of Nursing (DON), the DON stated their facility's process in medication destruction is for two licensed nurses to count the remaining quantities in the medication container and place the medication label sticker on the logbook. The licensed nurses write in the quantity, name of medication, resident's name, the date of destruction, and sign the log. The DON stated the signature of the licensed nurses is with charge nurse and RN supervisor. The DON stated the licensed nurses' signature should have been signed upon destroying the medications. The DON stated the purpose of this is for accountability and traceability to ensure that the medication was destroyed. The DON stated that when the licensed nurses did not record their signature, there is potential for diversion, no proof that the medication was destroyed, and created a gap in documentation. During a review of the facility's policy and procedure (P&P) titled, Discarding and Destroying Medications, last reviewed and approved on 1/16/2026, the P&P indicated that The medication disposition record contains, as a minimum, the following information:. i. Signature of witnesses. b. During a concurrent observation, interview, and record review on 2/11/2026 at 12:56 p.m. with Licensed Vocational Nurse (LVN) 2, observed Med Cart 1's glucometer memory record and reviewed the glucometer diabetes (a disorder characterized by difficulty in blood sugar control and poor wound healing) care system quality control log sheet for Med Cart 1 for the month of 2/2026. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	LVN 2 stated the memory only shows the month and date and no year. LVN 2 stated for the following dates: - 2/10/2026, the log sheet indicated low 96 and high 246; - The memory record indicated 1/5, no timestamp, and a result of 96 with no control icon; - The memory record indicated 1/7, no timestamp, and a result of 246 with a control icon; - 2/11/2026, the log sheet indicated low 96 and high 343; - The memory record indicated 1/5, timestamped at 1:54 p.m., result 96, with no control icon; - The memory record indicated 3/27, timestamped at 7:21 a.m., result 343, with no control icon. LVN 2 stated the date and time format had not been set in the glucometer and did not show the actual date and time. LVN 2 stated she does not know why the other control testing readings did not show the control icon. During a concurrent interview and record review on 2/12/2026 at 2:45 p.m., with RN 5, the glucometer diabetes care system quality control log sheet for Med Cart 1, for the month of 2/2026, was reviewed. RN 5 stated she is the charge nurse today, 2/12/2026, for Med Cart 1. RN 5 stated when the glucometer control solution test result is out of range, either in the high or low ranges, then a repeat control solution test is done. RN 5 stated they will keep repeating the test and figure out what the problem is and should not be used when the result is out of range. RN 5 stated the glucometer log indicated 343 out of range for the high control solution range and was accepted. RN 5 stated the test result should not be accepted. RN 5 stated if she encountered this result during the control solution testing, she would get another glucometer and another set to make sure it is working. RN 5 stated she would not use the glucometer because she could get wrong blood sugar readings and cause medication error for residents in terms of not getting their accurate blood sugar readings to the correct dosage of their insulin (a hormone that removes excess sugar from the blood, can be produced by the body or given artificially via medication). RN 5 stated the residents could experience hypoglycemia (low blood sugar) or hyperglycemia (high blood sugar) and possibly death. During an interview on 2/12/2026 at 3:18 p.m. with the DON, the DON stated when the control testing result is out of range control, the test results should not be accepted, and the test must be repeated. The DON stated the quality check is done to calibrate the glucometer to ensure it will give a correct result. The DON stated that when the glucometer quality check control test solution reading is out of range, there is the potential for wrong insulin dose administration and may cause hypoglycemia and/or hyperglycemia. During a review of the facility-provided Blood GlucoseˆMonitoring Systemˆ(BGMS) 1's User Instruction Manual (UIM), revised 6/2022, the UIM indicated that the Meter Set-Up included Before using the [BGMS 1] for the first time, set the time and date. Do not perform a blood glucose test until you have performed the meter set-up. In the set-up mode, there are menu options for. time, date, and QC [quality checks] reminder. Quality Checks - Use [Control Solutions 1 (CS 1)] to check if: - The meter and test strips are working correctly as a system. - You are testing correctly. There are two levels of control solution: Normal and High. Performing a Control Solution Test. Step 2. Press the Back or Forward button one time to enter the control solution mode. If you do not enter the control solution mode, the control solution result will not be valid. Using the control solution mode will also flag the result in memory. This prevents the result from being part of the averages. Troubleshooting - If the control solution test result is out-of-range, check the following and repeat the test:. DO NOT USE the system to test your blood glucose until the control solution result is within range. Meter Memory - The [BGMS 1] stores up to 500 test results. When more than 500 test results have been performed, the meter drops the oldest result each time you add a new result. When you recall test results from Memory, the most recent test result is always shown first. The meter will first show the date and result number position. It will then show the date and time. During a review of CS 1 manufacturer's instruction, revised 12/2023, the manufacturer's instruction indicated the control solution ranges: Level 1: 85 - 107 Level 2: 213 - 265

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to implement its policy for antibiotic (medication used to treat infection) stewardship (efforts in long-term care facilities to ensure that antibiotics are used only when necessary and appropriate [means prescribing the right drug at the right dose at the right time for the right duration]) program for one of one sampled resident (Resident 37) reviewed for antibiotic use by failing to monitor Resident 37's adverse effects (undesired or harmful effects) of isavuconazonium sulfate (also known as Cresemba - an antifungal medication used to treat fungal infection) and micafungin (an antifungal medication) while receiving the medication. This deficient practice had the potential for Resident 37 to experience unmonitored adverse reactions. Findings: During a review of Resident 37's admission Record (AR), the AR indicated that the facility originally admitted the resident on 12/4/2025 and readmitted on [DATE], with diagnoses including pneumonia (an infection/inflammation in the lungs), acute respiratory failure (serious condition that suddenly develops when the lungs cannot get enough oxygen into the blood) with hypoxia (low levels of oxygen in the body), and pancytopenia (a condition marked by a dangerous drop in all three major blood cell types-red cells [oxygen transport], white cells [infection fighting], and platelets [clotting]-due to bone marrow failure or destruction). During a review of Resident 37's History and Physical (H&P - a comprehensive assessment of a resident's medical condition), dated 1/10/2026, the H&P indicated the resident had the capacity to understand and make decisions. During a review of Resident 37's Minimum Data Set (MDS - a resident assessment tool), dated 1/14/2026, the MDS indicated the resident had the ability to make self-understood and understand others. The MDS indicated the resident required substantial assistance on activities of daily living (ADLs - activities such as bathing, dressing, and toileting a person performs daily) on toileting hygiene and shower/bathe self and on mobility including sit to stand, chair/bed-to-chair transfer, and toilet transfer. During a review of Resident 37's orders, the orders indicated the following: -ˆMicafungin sodium-sodium chloride intravenous (through the vein) solution 150-0.9 milligrams (mg - a unit of measurement for weight) per 150 milliliters (ml - a unit of measurement for volume) percent (% - one per hundred), use 150 mg intravenously one time a day forˆmultifocalˆ(affecting multiple areas of one or both lungs) pneumonia for 28 Days, dated 1/10/2026;ˆ -ˆIsavuconazoniumˆsulfateˆoralˆcapsule 186ˆmg (Cresemba), giveˆtwo (2)ˆcapsulesˆby mouth one time a day forˆmultifocalˆpneumoniaˆuntil 3/08/2026ˆ11:59ˆp.m., datedˆ1/14/2026.ˆ During a review of Cresemba Prescribing Information, revised 4/2025, the Prescribing Information indicated warnings and precautions that included: - Hepatic [relating to the liver] Adverse Drug Reactions. cases of severe hepatic adverse drug reactions including hepatitis [inflammation of the liver tissue], cholestasis [condition where the flow of bile (digestive fluid) from the liver is slowed or blocked] or hepatic failure including death. Anaphylactic reactions (a life-threatening allergic reaction that happens very quickly). including dyspnea (shortness of breath), hypotension (low blood pressure), generalized erythema (superficial reddening of the skin) with flushing, and urticaria (itchy, raised red bumps on the skin) have been reported in such cases often soon after the initiation of treatment. Severe skin reactions, such as Stevens-Johnson_syndrome (a rare but serious skin reaction that's usually caused by taking certain medicines). During a review of micafungin drug information, dated 2/1/2026, the drug information indicated the side effects included most common: anxiety [an intense, persistent feeling of fear, dread, or unease that goes beyond normal nervousness], black, tarry stools, bleeding gums, bloating or swelling of the face, arms, hands, lower legs, or feet, cold sweats, coma [a state of prolonged loss of consciousness], confusion, cool, pale skin, cough, decreased frequency or amount of urine. less common: agitation, back pain, bone pain, changes in skin color, pain, tenderness, or swelling of the foot or leg, chest pain, discomfort, or tightness. rare: dizziness, headache, nervousness, pounding in the ears. During a concurrent interview and record review on 2/12/2026 at 12:19 p.m. with Registered (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Nurse (RN) 1, Resident 37's physician orders and nursing progress notes, from 2/6/2026 to 2/11/2026, were reviewed. RN 1 stated when residents are started on antibiotics, the facility monitors for any adverse effects and is documented in the nursing progress notes. RN 1 stated the licensed nurses would document either no adverse effects or the assessment such as vital signs input in the vital sign sheet, fever, and gastrointestinal (GI - stomach and intestines) problems. RN 1 stated the nursing progress notes dated 2/8/2026 and timestamped at 3:53 p.m. and 10:54 p.m., 2/9/2026 and timestamped at 3:41 p.m., 2/10/2026 and timestamped at 4:26 p.m., and 2/11/2026 and timestamped at 7:26 a.m. and 2:25 p.m., on multiple shifts did not specify in their assessments that there were no adverse effects on the use of micafungin and Cresemba. During an interview on 2/12/2026 at 3:27 p.m. with the Director of Nursing (DON), the DON stated that Cresemba should be monitored for adverse effects. The DON stated licensed nurses complete their documentation for adverse effects monitoring in the progress notes. The DON stated if the resident experiences adverse effects the licensed nurses will complete a change of condition. The DON stated if the resident is free from any adverse effects the licensed nurses would document that there are no adverse effects on the medication. The DON stated when the adverse effects monitoring of the medications is not done it could delay the identifying of medication related complications related to the use of Cresemba. During a review of the facility's policy and procedure (P&P) titled, Infection Control Program, last reviewed and approved on 1/16/2026, the P&P indicated that The facility shall establish an infection control program designed to provide a safe, sanitary and comfortable environment for residents and staff to help prevent the development and transmission of disease and infection. Residents will be provided with the following:. infection monitoring and treatment for infectious disease. During a review of the facility's P&P titled, Adverse Consequences and Medication Errors, last reviewed and approved on 1/16/2026, the P&P indicated The interdisciplinary team monitors medication usage in order to prevent and detect medication-related problems such as adverse drug reactions and side effects. 1. An ?adverse consequence' refers to an unwanted, uncomfortable, or dangerous effect that a drug may have, such as a decline in mental or physical condition, or functional or psychosocial status. An adverse consequence may include: a. Adverse drug/medication reaction; b. side effect;. 3. Residents receiving medication are monitored for adverse consequences. During a review of the facility's P&P titled, Charting and Documentation, last reviewed and approved on 1/16/2026, the P&P indicated that All services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional or psychosocial condition, shall be documented in the resident's medical record. The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care. 7. Documentation of procedures and treatments will include care-specific details, including:. d. how the resident tolerated the procedure/treatment.