STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055028	A. Building B. Wing	08/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Los Banos Post Acute	931 Idaho Ave. Los Banos, CA 93635

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents had a right to a dignified existence when three of 16 sampled residents (Resident 9, Resident 36, and Resident 43) did not have a dignity covering (a bag or holder designed to conceal and protect the catheter drainage bag [a bag that collects urine from a catheter, a tube inserted into the bladder to drain urine], restoring a sense of privacy and dignity for the user) on their catheter drainage bag. This failure had the potential to result in Resident 9, Resident 36, and Resident 43 experiencing embarrassment or shame due to loss of privacy and dignity. Findings: During a concurrent observation and interview on 8/4/2025 at 8:25 a.m. in Resident 9's room, Resident 9 was observed in bed wearing a gown. Resident 9 stated he had been in the facility for a couple of years. Resident 9 stated he had problems with his hands and knees. Resident 9 had hand contractures (a permanent tightening of the muscles, tendons, skin, and nearby tissues that causes the joints to shorten and become very stiff) in both hands. Resident 9 stated he could not get up and needed assistance with moving in bed. Resident 9 had a urinary catheter bag on the left side of Resident 9's lower bed frame without a dignity cover. During a review of Resident 9's admission Record (AR-a document that provides resident contact details, a brief medical history, level of functioning, preferences and wishes), dated 8/6/25, the AR indicated Resident 9 was admitted on [DATE] with diagnoses of paraplegia (paralysis [the loss of the ability to move and sometimes to feel anything] that occurs in the lower half of the body), chronic kidney disease (a gradual loss of kidney function where the kidneys cannot filter the blood as they should), obstructive and reflux uropathy (when urine cannot drain and backs up into the kidney), adult failure to thrive (a gradual decline in health usually due to one or more medical conditions), and encounter for palliative care (specialized care that focuses on providing relief from pain and other symptoms of a serious illness). During a review of Resident 9's Minimum Data Set (MDS-resident assessment tool which indicates physical and cognitive abilities), dated 6/20/25, the MDS section C indicated Resident 9 had a Brief Interview for Mental Status (BIMS-an assessment of cognitive function) score of 15 (0-7 severe cognitive impairment, 8-12 moderate cognitive impairment, 13-15 no cognitive impairment), which indicated Resident 9 was cognitively intact. During a review of Resident 9's Care Plan (CP), dated 8/6/25, the CP indicated, . maintain comfort and dignity . initiated: 3/21/25 . During a concurrent observation and interview on 8/4/25 at 2:13 p.m. with Certified Nursing Assistant (CNA) 2 in Resident 9's room, Resident 9's urinary catheter bag was observed without a dignity covering. CNA 2 stated she was unsure if residents' urinary catheter bags should have a privacy covering but felt it should have had one for Resident 9's privacy. During an interview on 8/4/25 at 2:16 p.m. with Licensed Vocational Nurse (LVN) 3, LVN 3 stated resident's catheter bags should have a dignity covering to protect the resident's privacy and dignity. LVN 3 stated not having a privacy covering could have affected the residents' dignity. During a concurrent observation and interview on 8/4/25 at 8:49 a.m. with Resident 36 in Resident 36's Room, Resident 36 was observed dressed in bed eating his meal. Resident 36 stated he had been at the facility for three years due to being unable to walk. Resident 36 had a urinary catheter bag on the right side of Resident 36's bed with no dignity covering. During a review of Resident 36's AR, dated 8/6/25, the AR indicated Resident 36 was initially admitted from an acute care hospital on 3/10/23 and re-admitted on [DATE] with diagnoses of hemiplegia (paralysis [the loss of the ability to move and sometimes to feel anything] of one side of the body) and hemiparesis (muscle weakness or partial paralysis on one side of the body that can affect the arms, legs, and facial muscles), neuromuscular dysfunction of bladder (neurogenic bladder - when a person lacks bladder control due to brain, spinal cord or nerve problems), cerebral infarction (damage to tissues in the brain due to a loss of oxygen to the area), and benign neoplasm of brain (an abnormal growth in the brain, which does not invade the surrounding brain tissue, or spread to the spinal cord). During a review of Resident 36's MDS, dated 6/24/25, the MDS section C indicated Resident 36 had a BIMS score of 15, which indicated Resident 36 was cognitively intact. During a review of Resident 36's Care Plan (CP), dated 8/6/25, the CP indicated . position catheter bag and tubing below the level of the bladder and away from entrance room door . initiated: 11/20/23. During an observation on 8/4/25 at 8:03 a.m. in Resident 43's room, Resident 43's catheter drainage bag was observed without a dignity covering. During a review of Resident 43's AR, dated 8/6/25, the AR indicated Resident 43 had a history of urinary retention (inability to completely empty the bladder) and urinary tract infections (a bacterial infection that affects any part of the urinary system, including the kidneys, bladder, ureters, and urethra)

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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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are fully informed and understand their health status, care and treatments. (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure five out of 16 sampled residents (Resident 4, Resident 8, Resident 11, Resident 28, and Resident 40) were informed, in advance, by the physician or other practitioner, of the risks and benefits of proposed treatment when: 1. Resident 8, Resident 11, Resident 28 and Resident 40 were receiving antipsychotic (a class of medications primarily used to treat psychosis, a mental state where individuals lose touch with reality, experiencing symptoms like hallucinations or delusions) and psychotropic (a drug or other substance that affects how the brain works and causes changes in mood, awareness, thoughts, feelings, or behavior) medications and did not sign an informed consent (a process in which a healthcare professional educates a patient about the risks, benefits, and alternatives of a given procedure or intervention). 2. Resident 4 and Resident 40 did not have a listed diagnosis on their consents for antipsychotic and psychotropic medications, and Resident 4's consent did not have the date the physician signed the consent. These failures had the potential to result in Resident 4, Resident 8, Resident 11, Resident 28, and Resident 40 taking medication against their will and not recognizing why the medications were being given and the potential side-effects (unintended or unwanted effects that can occur when taking a medicine) leading to illness or hospitalization. Findings: 1. During a review of Resident 8's admission Record (AR-a document that provides resident contact details, a brief medical history, level of functioning, preferences and wishes), dated 8/6/25, the AR indicated Resident 8 had a history of bipolar disorder (a mental illness that causes unusual shifts in mood, energy, thinking, and behavior). The AR indicated Resident 8 was her own responsible party (the individual authorized to make healthcare decisions). During a review of Resident 8's Minimum Data Set (MDS-resident assessment tool which indicates physical and cognitive abilities), the MDS indicated a Brief Interview for Mental Status (BIMS-an assessment of cognitive function) score of 15 (0-7 severe cognitive impairment, 8-12 moderate cognitive impairment, 13-15 no cognitive impairment) indicating Resident 1 had no cognitive impairment. During a concurrent interview and record review on 8/6/25 at 10:06 a.m. with Licensed Vocational Nurse (LVN) 1, Resident 8's Order Entry, dated 7/27/25, was reviewed. The Order Entry indicated, [brand name for quetiapine] (antipsychotic) Oral (by mouth) Tablet 25 mg (milligram - a unit of mass or weight) . Give 1 tablet by mouth two times a day for bipolar disorder. Resident 8's Medication Administration Record (MAR - a document used in healthcare facilities to track and record the administration of medications to patients), dated 8/6/25 was also reviewed. The MAR indicated Resident 8 had a dose of quetiapine at 8 a.m. LVN 1 stated she gave Resident 8 her dose of quetiapine. Resident 8's AR, dated 8/6/25, was also reviewed. LVN 1 stated Resident 8 was her own responsible party. LVN 1 stated she did not see a signed informed consent for quetiapine for Resident 8. LVN 1 stated an informed consent should have been signed by Resident 8 prior to giving quetiapine. LVN 1 stated it was important for Resident 8 to sign an informed consent for quetiapine to ensure she understood the risks, benefits, side-effects, and had autonomy over her care. LVN 1 stated she did not check to see if Resident 8 had signed an informed consent for quetiapine prior to giving the medication. LVN 1 stated it would be important to verify if Resident 8 had signed an informed consent prior to giving to ensure Resident 8 was not given a medication against her will. LVN 1 stated Resident 8 could have had a reaction to quetiapine without knowing or understanding the side-effects of the medication which could lead to illness or hospitalization. During an interview on 8/6/25 at 11:45 a.m. with Resident 8, Resident 8 stated she was taking quetiapine for bipolar disorder. Resident 8 stated facility staff did not review the risks, benefits, or side-effects of quetiapine with her. Resident 8 stated she did not sign an informed consent for quetiapine. Resident 8 stated, It makes me feel left out, and like I'm not a part of my care. During an interview on 8/7/25 at 2:58 p.m. with the Director of Nursing (DON), the DON stated Resident 8 should have signed an informed consent for quetiapine. The DON stated it was important for Resident 8 to sign an informed consent for quetiapine to ensure she understood the risks, benefits, and side-effects. The DON stated Resident 8 had a right to know what medications she was taking and be involved in her care. The DON stated if Resident 8 took quetiapine without signing an informed consent, she would not be aware of the side-effects or know what symptoms to look for if she had a reaction. The DON stated licensed nurses should be verifying an informed consent had been signed by residents prior to giving antipsychotic medications. During an observation on 8/4/25 at 8:43 a.m. in Resident 11's room, Resident 11 was observed in bed sleeping, wearing oxygen nasal cannula (a small plastic tube, which fits into the person's nostrils for providing

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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 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition (continued on next page)

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to complete a significant change of condition assessment (required assessment of cognitive and functional abilities) in resident status for one of eight sampled residents (Resident 9) when Resident 9 was admitted for hospice (end of life care) services. This failure resulted in Resident 9's change of condition to go unreported to direct care staff (all facility staff who directly provide program and/or nursing services to residents), the Registered Nurse, attending physician, family, interdisciplinary team members, and the Director of Nursing (DON) or Assistant Director of Nursing (ADON) and had the potential for Resident 9's care needs to not be met. Findings: During a concurrent observation and interview on 8/4/2025 at 8:25 a.m. in Resident 9's room, Resident 9 was observed in bed wearing a gown. Resident 9 stated he had been in the facility for a couple of years. Resident 9 stated he had problems with his hands and knees. Resident 9 had hand contractures (a permanent tightening of the muscles, tendons, skin, and nearby tissues that causes the joints to shorten and become very stiff) in both hands. Resident 9 stated he could not get up and needed assistance with moving in bed. During a review of Resident 9's admission Record (AR-a document that provides resident contact details, a brief medical history, level of functioning, preferences and wishes), dated 8/6/25, the AR indicated Resident 9 was admitted on [DATE] with diagnoses of paraplegia (paralysis [the loss of the ability to move and sometimes to feel anything] that occurs in the lower half of the body), chronic kidney disease (a gradual loss of kidney function where the kidneys cannot filter the blood as they should), obstructive and reflux uropathy (when urine cannot drain and backs up into the kidney), adult failure to thrive (a gradual decline in health usually due to one or more medical conditions), and encounter for palliative care (specialized care that focuses on providing relief from pain and other symptoms of a serious illness). During a review of Resident 9's Minimum Data Set (MDS-resident assessment tool which indicates physical and cognitive abilities), dated 6/20/25, the MDS section C indicated Resident 9 had a Brief Interview for Mental Status (BIMS-an assessment of cognitive function) score of 15 (0-7 severe cognitive impairment, 8-12 moderate cognitive impairment, 13-15 no cognitive impairment), which indicated Resident 9 was cognitively intact. During a review of Resident 9's Care Plan (CP), dated 8/6/25, the CP indicated, the resident has a terminal prognosis . admitted under [name of company] Hospice . date initiated: 3/21/25 . During a concurrent interview and record review on 8/7/25 at 9:55 a.m. with Licensed Vocational Nurse (LVN) 2, Resident 9's Order Summary Report (OSR), dated 8/6/25 indicated, . admit to [name of company] Hospice . order date 3/20/25 . LVN 2 stated Resident 9 had orders for hospice care on 3/20/25 and had a hospice consult on 3/25/25. LVN 2 stated she did not see a change of condition assessment (COC) completed for Resident 9. LVN 2 stated Resident 9 should have had a COC assessment when he transferred to hospice care. LVN 2 stated a COC assessment ensured Resident 9 was getting the appropriate treatment to have his needs met. During an interview on 8/7/25 at 3:44 p.m. with the Director of Nursing (DON), the DON stated a resident transitioning to hospice care was considered a change of condition and required a COC assessment, which consisted of a head-to-toe assessment for a change in the resident's condition or for a resident whose condition was declining. The DON stated Resident 9 should have had a COC assessment completed the same day Resident 9's status changed. The DON stated the COC should have been completed immediately so staff were more observant of Resident 9, and more focused on communicating with hospice staff and the hospice physician for changes in Resident 9's status to be sure his needs were being met. During a review of the facility's job description document titled, Licensed Vocational Nurse (LVN), dated 3/1/14, the document indicated, . complete initial and ongoing assessments by gathering data in a timely manner . proficiently and accurately monitor and report resident condition changes to the Registered Nurse, attending physician, family, interdisciplinary team members, and Director of Nursing or ADON . During a review of the facility's policy and procedure (P&P), titled, Change in a Resident's Condition or Status, dated 2/2021, indicated, . our facility promptly notifies the resident, his or her attending physician, and the resident representative of changes in the resident's medical/mental condition and/or status (e.g., changes in level of care . a [significant change] of condition is a major decline or improvement in the resident's status that . will not normally resolve itself . impacts more than one are of the resident's health status . if a significant change in the resident's physical or mental condition occurs, a comprehensive assessment of the resident's condition will be conducted .

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure a comprehensive person-centered care plan (CP - a detailed approach to care customized to an individual resident's needs) was developed and implemented for five of 16 residents (Resident 8, Resident 15, Resident 28, Resident 40, and Resident 52) when: 1. Resident 8's care plan was not developed and implemented for the administration and monitoring of anti-psychotic medication (a class of medications primarily used to treat psychosis, a mental state where individuals lose touch with reality, experiencing symptoms like hallucinations or delusions). This failure had the potential to result in Resident 8 receiving inadequate medication efficacy (the ability to produce a desired or intended result) and potential side effects to go undocumented and had the potential for Resident 8 to not have his mental and psychosocial needs met. 2. Resident 15 and Resident 28 did not have an individualized care plan developed and implemented for the use of (brand name for acetylsalicylic acid - ASA), an anti-platelet medication (medications that prevent blood cells from sticking together and forming blood clots) and placed Resident 15 and Resident 28 at risk of increased bruising and bleeding. This failure had the potential to result in Resident 15 and Resident 28 to go unmonitored for potential side effects of ASA and an increase in potential bruising and bleeding. 3. Resident 28, Resident 40 and Resident 52 did not have an individualized care plan developed and implemented for the use of side rails (adjustable metal or rigid plastic bars in various sizes that attach to the bed, and can be placed in a raised or lowered position) and bed assist rails (a bed rail used to assist the resident with repositioning or getting in and out of bed). This failure had the potential to result in Resident 28, Resident 40 and Resident 52 to be at risk of entrapment (resident caught, trapped, or entangled in the space in or about the bed and side rail), serious harm, injury, or death.Findings: 1. During a review of Resident 8's admission Record (AR-a document that provides resident contact details, a brief medical history, level of functioning, preferences and wishes), dated 8/6/25, the AR indicated Resident 8 had a history of bipolar disorder (a mental illness that causes unusual shifts in mood, energy, thinking, and behavior). During a concurrent interview and record review on 8/6/25 at 10:06 a.m. with Licensed Vocational Nurse (LVN) 1, Resident 8's Order Entry, dated 7/27/25, was reviewed. The Order Entry indicated, . [brand name for quetiapine] (antipsychotic) Oral (by mouth) Tablet 25 mg (milligram - a unit of mass or weight) . Give 1 tablet by mouth two times a day for bipolar disorder . LVN 1 stated Resident 8 did not have a care plan for her antipsychotic (a class of medications primarily used to treat psychosis, a mental state where individuals lose touch with reality, experiencing symptoms like hallucinations or delusions) medication. LVN 1 stated Resident 8 should have had a care plan for antipsychotic medication. LVN 1 stated an antipsychotic care plan would help to identify whether Resident 8 should continue the medication and potential side-effects. During an interview on 8/7/25 at 2:58 p.m. with the Director of Nursing (DON), the DON stated if a resident was taking an antipsychotic medication, there should be a care plan. The DON stated the licensed nurse should implement the care plan. The DON stated goals and interventions for Resident 8 would be difficult to identify without a care plan for antipsychotics. During a review of the facility's policy and procedure (P&P) titled, Care Plans, Comprehensive Person-Centered, dated 3/2022, 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 . During a review of the facility's P&P titled, Goals and Objectives, Care Plans, dated 4/2009, indicated, . care plans shall incorporate goals and objectives that lead to the resident's highest obtainable level of independence . care plan goals and objectives are . resident oriented . goals and objectives are entered on the resident's care plan so that all disciplines have access to such information and are able to report whether or not the desired outcomes are being achieved . 2. During a concurrent observation and interview on 8/4/25 at 8:11 a.m. in Resident 15's room, Resident 15 was observed dressed, in bed with side rails up on both sides of the head of the bed. Resident 15 stated he had been at the facility for one week due to a broken hip from falling off the bed at home. Resident 15 had small areas of bruising on his right arm, which Resident 15 stated he received from his fall. During a review of Resident 15's AR, dated 8/6/25, the AR indicated Resident 15 was admitted from an acute care hospital on 7/29/25 with diagnoses of intertrochanteric fracture of the left femur (a break in the upper bone of the thigh - hip), cerebral ischemia (insufficient blood flow to the brain resulting in damage to brain tissue), and muscle weakness. During a review of Resident 15's Minimum Data Set (MDS - a resident assessment tool used to identify cognitive [mental processes] and physical

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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 failed to meet professional standards of practice for two of 15 sampled residents (Resident 4 and 64), when: 1. Resident 4's tube feeding (TF - a liquid form of nutrition that is carried through your body through a flexible tube) flush (water that is pushed through the feeding tube to keep it clean and prevent clogs) bag was not labeled with the date and time it was hung for administration. This failure had the potential to result in Resident 4 receiving an expired tube feeding flush and placed Resident 4 at increased risk of food born illness (any illness resulting from ingesting contaminated/spoiled foods or liquids) and infection. 2. Resident 64 had a 6.2-pound weight gain and the facility did not notify the Registered Dietician (RD) and physician. This failure had the potential for the RD and physician to not be updated and making changes and recommendations for Resident 64's weight gain. Findings: 1. During a concurrent observation and interview on 8/4/25 at 2:21 p.m. with Licensed Vocational Nurse (LVN) 3, in Resident 4’s room, enteral feeding and fluid flush bag were observed infusing at a rate of 65 milliliters per hour (ml/hr. – a unit of measurement). Resident 4’s fluid bag for flushes was not labeled and had approximately 450 ml of fluid remaining in a 1000 ml bag. Resident 4’s enteral nutrition bottle was labeled with the date, time and initials of a nurse, with 1000 ml of fluid nutrition remaining. LVN 3 stated Resident 4 was scheduled to be disconnected from his fluid flush every four hours. LVN 3 stated the fluid flushes were connected to the tube feeding as a set and could not be hung separately, so a date was not required on the flush bag. LVN 3 stated a new set was hung every morning with a new flush bag and a new nutrition bottle. During a review of Resident 4’s “admission Record (AR - a summary of information regarding a patient which includes patient identification, past medical history, insurance status, care providers, family contact information and other pertinent information”, dated 8/6/25, the “AR” indicated Resident 4 was admitted to the facility on [DATE] with diagnosis of traumatic subarachnoid hemorrhage (bleeding in the space between the brain and the membrane that covers it, caused by an outside force, usually a violent blow to the head) with loss of consciousness, schizophrenia (a disorder that affects a person’s ability to think, feel, and behave clearly), dysphagia (difficulty swallowing), unspecified speech disturbances, symptoms and signs involving cognitive functions (functions involving thinking, reasoning and remembering) following cerebral infarction (damage to tissues in the brain due to a loss of oxygen to the area). During a review of Resident 4’s “Minimum Data Set (MDS - a resident assessment tool used to identify cognitive [mental processes] and physical functional level assessment)”, dated 5/9/25, the “MDS” section C indicated Resident 4 had a Brief Interview for Mental Status (BIMS - a test given by medical professionals to determine cognitive (involving the process of thinking, learning and understanding) understanding on a scale of 1-15) score of 3 (a score of 0-7 suggests severe cognitive impairment, 8-12 suggests moderately impaired, 13-15 suggests cognitively intact), which indicated Resident 4 was severely cognitively impaired. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 8/5/25 at 10:40 a.m. with LVN 1, Resident 4’s “Order Summary Report (OSR)”, dated 8/6/25 was reviewed. The “OSR” indicated, “… flush g-tube (gastric tube) 150 ml every 4 hours while on continuous feed for 20 hrs. …” LVN 1 stated Resident 4’s flush was hung at noon every day with a new enteral nutrition bottle and new fluids for flushing with 1000 ml of fluids. LVN 1 stated Resident 4’s flush bag should have been labeled with the date and time it was hung. LVN 1 stated a new 1000 ml bag of fluids should have been hung with each new bottle of enteral nutrition. LVN 1 stated the flush bag can be separated from the nutritional feeding. LVN 1 stated it was important for the flush bag to be labeled to be sure it was being changed and so staff knew how long it was up. LVN 1 stated the flush bag could have been a source of infection to Resident 4 since the flush and feeding went directly into Resident 4’s body. During an interview on 8/7/25 at 3:47 p.m. with the Director of Nursing (DON), the DON stated Resident 4’s fluid flush bag should have been labeled with the date, time and initials when it was hung. The DON stated the fluids should have been “fresh”, and she did not want “old” or expired fluids used for flushing Resident 4’s G-tube. The DON stated there was the possibility of contaminants going into the G-tube if “old” fluids were used. The DON stated using “old” fluids put Resident 4 at risk of getting an infection. During a review of the facility lesson plan document titled, “Meal Percentages and Documentation/G-Tube Head of Bed (HOB) 45 degrees”, dated 12/30/24, the document indicated, “… labeling and dating of G-tube supplies (syringe, formula, and water (h2o) spike set …” During a review of the facility’s job description document titled, “Licensed Vocational Nurse (LVN)”, dated 3/1/14, the document indicated, “…provide treatment administration in a proficient manner … proficiently provide and manage the care of technologically dependent residents, including but not limited to … enteral feeding tubes …” During a review of the facility’s policy and procedure (P&P) titled, “Enteral Nutrition”, dated 11/2018, the P&P indicated, “… adequate nutritional support through enteral nutrition is provided to residents as ordered … the nurse confirms that orders for enteral nutrition are complete … administration method … volume and rate of administration … instructions for flushing (solution, volume, frequency, timing and 24-hour volume) …” 2. During a review of Resident 64’s “admission Record” (AR-a document that provides resident contact details, a brief medical history, level of functioning, preferences and wishes), dated 8/7/25, the AR indicated Resident 64 was admitted to the facility on [DATE] with diagnoses) severe protein-calorie malnutrition (serious condition resulting from a deficiency in both calories and protein intake), chronic obstructive pulmonary disease (COPD- a chronic lung disease causing difficulty in breathing), muscle weakness, obstructive sleep apnea (a condition where breathing repeatedly stops and starts during sleep due to a blocked airway) and gastrostomy (an opening into the stomach from the abdominal wall, made surgically for the introduction of food). (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 64s “Minimum Data Set” (MDS-resident assessment tool which indicates physical and cognitive abilities), the MDS indicated a Brief Interview for Mental Status (BIMS-an assessment of cognitive function) score of 14 (0-7 severe cognitive impairment, 8-12 moderate cognitive impairment, 13-15 no cognitive impairment) indicating Resident 64 had no cognitive impairment. During a concurrent observation and interview on 8/4/25 at 3:40 p.m. in the room with Resident 64, Resident 64 was in bed, dressed and lying in bed. Family Member (FM) 1, FM 1 stated she was concerned about Resident 64’s weight loss. FM 1 stated Resident 64 was 130 pounds (lbs.-units of measurement) before coming to the facility. FM 1 sated Resident 64 was getting formula through a tube feeding (TF - a liquid form of nutrition that is carried through your body through a flexible tube). FM 1 stated she called Resident 64’s RD from outside the facility. FM 1 stated she did not realize the facility had a RD in the facility to address her concerns. During a concurrent interview and record review on 8/7/25 at 11:11 a.m. with the Restorative Nursing Assistant (RNA- specialized healthcare professional who works under the supervision of a nurse or therapist to help patients regain and maintain physical function after illness or injury) 1, Resident 64’s “Weights and Vital Summary dated 8/8/25 was reviewed. The Weights and Vital Summary indicate, on 8/1/25 his weight was 125.8 lbs. and on 8/6/25 and 8/6/25 was 132 lbs. The RNA stated Resident 64 had a weight gain of 6.2 lbs. in 5 days. The RNA stated she did not re-check his weight. The RNA stated she gave the weight log to the Assistant Director of Nursing (ADON) and the ADON should have notified the RD and physician. The RNA stated the ADON would have been notified the RD and physician when residents had significant weight changes. The RNA stated she should have re-checked his weight the same day but did not. The RNA stated it was important to recheck his weight to ensure his weight was accurate. The RNA stated an inaccurate reading could have caused Resident 64’s issues to not be addressed or missed diagnosis. During an interview on 8/7/25 at 3:57 p.m. with the ADON, the ADON stated she should have notified the physician about Resident 64’s weight gain. The ADON stated she had not had a chance to do the charting. The ADON stated she should have notified the RD and reviewed the weight gain. The ADON stated the RD and the physician should have been notified within 24 hours after obtaining Resident 64’s weight. The ADON stated it was important to notify the RD and physician in case there were changes needed to address issues like edema (excess of watery fluid collecting in the tissues). The ADON stated not notifying the physician and RD could have been detrimental to Resident 64’s health. During an interview on 8/7/25 at 4:01 p.m. with the DON, the DON stated the RNA should have reweighed Resident 64 to make sure it was accurate. The DON stated the RNA should have done it the same day if possible. The DON stated the ADON should have notified the physician and RD of the weight gain. The DON stated the 6.2 lbs. weight gain could have been from edema (swollen area) or indication of “systemic changes” and the physician should have been notified to make recommendation or changes in the intervention. The DON stated the physician would not have been given the chance to make changes if he was not notified of the weight gain. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 8/8/25 at 8:45 a.m. with the RD, the RD stated the ADON should have notified her of Resident 64’s weight gain. The RD stated the ADON emailed her twice a week regarding the changes in resident weight. The RD stated she was not notified of Resident 64’s weight gain. The RD stated the facility should recheck the weight. The RD stated the resident was not in the facility long enough to make a recommendation. The RD stated she would have asked to recheck his weigh and ask to check again next week. During a review of the facility’s policy and procedures (P&P) titled, “Nutrition (impaired)/Unplanned Weight Loss-Clinical Protocol” dated 9/2017, the P&P indicated, “…The staff will report to the physician significant weight gains or losses or any abrupt or persistent changes…”

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. (continued on next page)

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure personal hygiene for one of the seven sampled residents (Resident 48) when all 10 fingernails were long and had black particles underneath. This failure resulted in Resident 48 feeling worried she would injury or scratch herself and she preferred them short. Findings: During a review of Resident 48's admission Record (AR-a document that provides resident contact details, a brief medical history, level of functioning, preferences and wishes), dated 8/7/25, the AR indicated Resident 48 was admitted to the facility on [DATE] with diagnoses of type 2 diabetes mellitus (a chronic condition where the body doesn't properly use insulin, leading to elevated blood sugar levels), muscle weakness and malaise (tiredness). During a review of Resident 48s Minimum Data Set (MDS-resident assessment tool which indicates physical and cognitive abilities), the MDS indicated a Brief Interview for Mental Status (BIMS-an assessment of cognitive function) score of 12 (0-7 severe cognitive impairment, 8-12 moderate cognitive impairment, 13-15 no cognitive impairment) indicating Resident 48 had moderated cognitive impairment. During a review of Resident 48's MDS, the MDS indicated Section GG-Functional Abilities self-care score (a of 6: independent, 5: setup or clean-up assistance, 4: supervision or touching assistance, 3: partial/moderate assistance, 2: substantial/maximal assistance, 1: dependent) was 2 indicating Resident 48 required substantial/maximal assistance with upper body dressing. During a review of Resident 48's Care Plan Report (a document that outlines a patient's assessed health needs, the care and support they will receive, and the expected outcomes), dated 8/8/25, the Care Plan Report indicated, The patient presents with significant weakness and difficulty performing activities of daily living (ADL - basic self-care tasks that are essential for maintaining independence and quality of life) tasks. During an observation and interview on 8/4/25 at 12:21 p.m. in Resident 48's room, Resident 48 had 10 long fingernails with black particles embedded underneath the fingernails. Resident 48 stated the facility did not offer to cut her fingernails. Resident 48 stated she was worried the long fingernails could have injure or scratch her skin. Resident 48 stated she did not like her fingernails long. Resident 48 stated her fingernails were short at home and she would have liked them cut. During a current observation and interview on 8/4/25 at 2:23 p.m. with Certified Nursing Assistant (CNA) 1, CNA 1stated she was not sure when Resident 48 had her fingernails cut. CNA 1 stated Resident 48 was a diabetic and the nurses were responsible for cutting her fingernails. CNA 1 stated CNAs should have filed and cleaned the fingernails on Sundays. CNA 1 stated Resident 48 should have gotten them cut 8/3/25. CNA 1 stated Resident 48's fingernails looked dirty. CNA 1 stated Resident 48 could have scratched her skin and could have hurt herself. CNA 1 stated the scratches could have caused a skin infection. CNA 1 stated Resident 48 could have been embarrassed from the long fingernails. During a concurrent interview and record review on 8/5/25 at 11:10 a.m. with License Vocation Nurse (LVN) 1, LVN 1 stated Resident 48 fingernails should have been cut on Sundays and as needed. LVN 1 stated cutting fingernails were needed for proper hygiene and safety to prevent scratches to their thin skin. LVN 1 stated the CNA should have made sure fingernails were cleaned underneath. LVN 1 stated long fingernails could have caused fungal (common condition where fungi infect the nail, causing it to become discolored, thickened, and brittle) infections. LVN 1 started on 8/3/25, no logs were done for fingernails care. LVN 1 stated CNAs should have verbally notified the nurses that Resident 48 fingernails needed cutting. LVN 1 stated there was no documentation Resident 48's chart indicating nail care was done. During an interview on 8/7/25 with the Director of Nursing (DON) the DON stated, nurses were responsible for cutting fingernails for residents with diabetes. The DON stated CNAs should have informed the nurses about Resident 48's long fingernails. The DON stated Resident 48 had diabetes and was prone to getting an infection. The DON stated resident 48 with long fingernails could have scratched her skin and caused an infection which could lead to hospitalization. The DON stated nurses should have documented in the chart when the nail care was done. During a review of the facility's policy and procedures (P&P) tilted, Activities of daily Living (ADL), Supporting, dated 3/2018, the P&P indicated, .Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene.Appropriate care and services will be provided for residents who are unable to carry out ADLs independently.in accordance with the plan of care, including.hygiene (.grooming).

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate foot care. (continued on next page)

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	F687 - Foot Care Based on observation, interview, and record review the facility failed to provide foot care and treatment, in accordance with professional standards of practice for two of 16 sampled residents (Resident 32 and Resident 48) when Resident 32 and Resident 48 were diabetic (a condition where the body doesn't properly regulate blood sugar levels) and had long, overgrown toenails. This failure had the potential to result in Resident 32 and Resident 48 cutting their skin with their long toenails, leading to poor wound healing, infection, and hospitalization. Findings: During a review of Resident 32's admission Record (AR-a document that provides resident contact details, a brief medical history, level of functioning, preferences and wishes), dated 8/6/25, the AR indicated Resident 1 had a history of type 2 diabetes mellitus (a chronic condition where the body doesn't properly use insulin, leading to elevated blood sugar levels). During a review of Resident 32's Minimum Data Set (MDS-resident assessment tool which indicates physical and cognitive abilities), the MDS indicated a Brief Interview for Mental Status (BIMS-an assessment of cognitive function) score of 7 (0-7 severe cognitive impairment, 8-12 moderate cognitive impairment, 13-15 no cognitive impairment) indicating Resident 1 had severe cognitive impairment. During a review of Resident 48's AR dated 8/7/25, the AR indicated Resident 1 had a history of type 2 diabetes mellitus. During a review of Resident 48's MDS, the MDS indicated a BIMS score of 12 indicating Resident 48 had moderate cognitive impairment. During a review of Resident 48's Care Plan Report (a document that outlines a patient's assessed health needs, the care and support they will receive, and the expected outcomes), dated 8/8/25, the Care Plan Report indicated, The patient presents with significant weakness and difficulty performing activities of daily living (ADL - basic self-care tasks that are essential for maintaining independence and quality of life) tasks. During a concurrent observation and interview on 8/4/25 at 12:21 p.m. with Resident 48 in Resident 48's room, Resident 48's toenails on the left and right feet were long and growing past the top of the toes. Resident 48 stated she would like her toenails to be trimmed. Resident 48 stated she did not like her toenails long and she could scratch herself. During an observation on 8/4/25 at 12:37 p.m. in Resident 32's room, Resident 32's toenails on the left and right feet were long, growing past the top of the toes and curling under towards the skin. During a concurrent observation and interview on 8/4/25 at 2:26 p.m. with Certified Nursing Assistant (CNA) 4 in Resident 32's room, Resident 32's toenails were observed. CNA 4 stated Resident 32's toenails were long and needed to be trimmed. CNA 4 stated a podiatrist (a healthcare professional who specializes in the diagnosis and treatment of foot, ankle, and lower leg conditions) should trim Resident 32's toenails since she was diabetic. CNA 4 stated CNAs should notice if a resident needed their toenails trimmed during ADL care and inform the licensed nurse. CNA 4 stated the licensed nurse should contact the podiatrist. During a concurrent observation and interview on 8/5/25 at 9:41 a.m. with Licensed Vocational Nurse (LVN) 1, a photo of Resident 32's toenails that was taken on 8/4/25 was observed. LVN 1 stated Resident 32's toenails needed to be trimmed. LVN 1 stated Resident 32 was a diabetic and needed a referral to a podiatrist for foot care. LVN 1 stated licensed nurses should look at the resident's feet when they do assessments. LVN 1 stated CNAs should look at resident's feet during ADL care and report long toenails to licensed nurses. LVN 1 stated Resident 32's toenails could cut or scrape her skin, and wounds would be slow to heal due to Resident 32 being diabetic. During a concurrent interview and record review on 8/5/25 at 10:44 a.m. with LVN 1, Resident 32's Care Plan Report, dated 8/6/25, was reviewed. The Care Plan Report indicated, Focus: The resident has Diabetes Mellitus . diabetic foot ulcer history . Date initiated: 2/26/2025 . Interventions: Refer to podiatrist/ foot care nurse to monitor/ document foot care needs and to cut long nails. LVN 1 stated Resident 32 had a care plan for foot care but did not have a podiatry referral. LVN 1 stated referrals orders were made by the physician and referral appointments were made by the Social Services Director (SSD). During a concurrent interview and record review on 8/5/25 at 11:54 a.m. with the SSD, Resident 32's Care Plan Report, dated 8/6/25, was reviewed. The Care Plan Report indicated, Focus: The resident has Diabetes Mellitus . diabetic foot ulcer history . Date initiated: 2/26/2025 . Interventions: Refer to podiatrist/ foot care nurse to monitor/ document foot care needs and to cut long nails. The SSD stated she was not aware of Resident 32's Care Plan Report. The SSD stated, It looks like this resident got lost in the shuffle. The SSD stated Resident 32 and Resident 48 did not have podiatry referrals. During an interview on 8/7/25 at 2:58 p.m. with the Director of Nursing (DON), the DON stated CNAs should report long toenails on diabetic residents to the licensed nurses. The DON stated licensed nurses should report long toenails on diabetic residents to the physician or SSD to get a referral to podiatry

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure four of 16 sampled resident's (Residents 5, 28, 40, and 52) beds were assessed for appropriate bed dimensions, and followed the manufacturers' recommendations and specifications for installing and maintaining the resident's bed side rails (adjustable metal or rigid plastic bars in various sizes that attach to the bed, and can be placed in a raised or lowered position). This failure had the potential to cause entrapment (resident caught, trapped, or entangled in the space in or about the bed and side rail), serious harm, injury, or death to Residents 5, 28, 40, and 52. Findings: During an observation on 8/4/25 at 8:08 a.m. in Resident 5's room, Resident 5 was observed lying on her back with assist bars (a type of bed rail that provides a handhold) up on both sides of her bed. During a review of Resident 5's admission Record (AR-a document that provides resident contact details, a brief medical history, level of functioning, preferences and wishes), dated 8/6/25, the AR indicated Resident 5 was initially admitted to the facility from an acute care hospital on 3/8/22 with a diagnosis of cerebral palsy (a disorder that affect a person's ability to move and maintain balance and posture), and stroke (occurs when blood flow to the brain is disrupted). During a review of Resident 5's Minimum Data Set (MDS - a resident assessment tool used to identify cognitive [mental processes] and physical functional level assessment), dated 6/6/25, the MDS section C indicated Resident 5 had a Brief Interview for Mental Status (BIMS - a test given by medical professionals to determine cognitive (involving the process of thinking, learning and understanding) understanding on a scale of 1-15) score of 15 (a score of 0-7 suggests severe cognitive impairment, 8-12 suggests moderately impaired, 13-15 suggests cognitively intact), which suggested Resident 5 was cognitively intact. During an observation on 8/4/25 at 8:41 a.m. in Resident 28's Room, Resident 28 was observed dressed in a shirt, sleeping with assist bars up on both sides of his bed. Resident 28 did not wake up when his name was called out. During a review of Resident 28's AR, dated 8/6/25, the AR indicated Resident 28 was initially admitted to the facility from an acute care hospital on 9/8/2010 with a re-admission on [DATE] with diagnoses of hemiplegia (paralysis [the loss of the ability to move and sometimes to feel anything] of one side of the body) and hemiparesis (muscle weakness or partial paralysis on one side of the body that can affect the arms, legs, and facial muscles), unspecified dementia (loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life), aphasia (a disorder that makes it difficult to speak), and a history of falling. During a review of Resident 28's MDS, dated 6/5/25, the MDS section C indicated Resident 28 had a BIMS score of 3, which suggested Resident 28 was severely cognitively impaired. During a review of Resident 28's electronic chart, the electronic chart indicated no baseline assessment or bed assessment for bed rails was observed in Resident 28's chart. Resident 28's Order Summary Report (OSR), dated 3/8/21 was reviewed. The OSR indicated, . Resident is not capable of making and understanding his/her own decisions due to history of (H/o) cerebral vascular accident (CVA) and cognitive issues. Surrogate decision maker is his nephew.order date 3/8/21. stationary assist device bilateral (both sides) to serve as an enabler to promote independence .per resident wants bed against the wall. order date 4/3/25. During an observation on 8/4/25 at 8:49 a.m. in Resident 40's room, Resident 40's bed was observed to be made and had assist bars up at the head of the bed. Resident 40 was not present in his room. During an observation and interview on 8/5/25 at 11:11 a.m. in the hall outside of Resident 40's room, Resident 40 was observed dressed and in a wheelchair with a wrist splint on his left wrist. Resident 40 stated he had been at the facility for three years. Resident 40 stated he had ataxia, (poor muscle control that causes clumsy movements and can affect walking and balance, hand coordination, speech and swallowing, and eye movements) and could not walk or use his hands. Resident 40 stated he did not call staff for help as he was self-sufficient. During a review of Resident 40's AR, dated 8/6/25, the AR indicated Resident 40 was admitted on [DATE] with diagnoses of ataxia, delusional disorders (a mental condition with false beliefs or judgment about external reality), other symptoms and signs involving cognitive functions (functions involving thinking, reasoning and remembering) and awareness, anxiety disorder(a mental health disorder characterized by feelings of worry, anxiety, or fear that are strong enough to interfere with one's daily activities), muscle weakness, and need for assistance with personal care. During a review of Resident 40's MDS, dated 6/20/25, the MDS section C indicated Resident 40 had a BIMS score of 15, which indicated Resident 40 was cognitively intact. During a review or Resident 40's OSR, dated 8/6/25, the OSR indicated , stationary assist device bilateral to serve as an enabler to promote independence , order date

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. Based on interview and record reviews, the facility failed to ensure a Registered Nurse (RN) provided services for at least 8 consecutive hours a day for eight (5/3/25, 5/10/25, 5/31/25, 6/22/25, 6/24/25, 6/28/25, 7/6/27, 8/3/25) of 90 days sampled. This failure had the potential to result in residents not receiving services required to be provided by an RN . During an interview on 8/6/25 at 3:46 p.m. with the Staff Coordinator (SC), the SC stated no registered nurses (RN)were on working on 5/3/25, 5/10/25, 5/31/25, 6/22/25, 6/24/25, 6/28/25, 7/6/27, 8/3/25. The SC stated she was not responsible for making the schedule for the registered nurses. The SC stated the Director of Nurses (DON) was responsible for the nurse's schedule. During an interview on 8/7/25 at 4:33 p.m. with the DON, the DON stated it was hard to hire an RN. The DON stated having RN on schedule daily could have provided better quality of care for the residents. The DON stated it is important to have RN working. The DON stated a RN could have provided better quality of care to residents and assessments. The DON stated Registered nurses could have provided mediation through intravenous therapy (medical treatment that delivers fluids, medications, or blood products directly into a resident's vein) or peripherally inserted central catheter (PICC line -along, thin, flexible tube inserted into a vein, typically in the upper arm, and threaded into a large vein near the heart). The DON stated residents with IV and PICC line would have required an RN to provide care for antibiotics or other therapy. The DON stated we did not follow our policy and procedure. During an interview on 8/8/25 at 10:12 a.m. with the Administrator (ADM) the ADM stated , We have a revolving RNs. The ADM stated the facility was not able to keep an RN on schedule. The ADM stated staffing an RN for the facility was challenging. The ADM stated RN were more skilled and have higher education. The ADM stated it was important to have an RN each day to provide care for residents that required IV therapy and quality of care. The ADM stated it was in the process of hiring more RNs. During a review of the facility's policy and procedure (P&P) titled, Staffing, Sufficient and Competent Nursing dated 8/2022, the P&P indicated, Our facility provides sufficient numbers of nursing staff with appropriated skills and competency necessary to provide nursing and related care and services for all resident in according with resident care plans and the facility assessment.3. A registered nurse provides services at least eight (8) consecutive hours every 24 hours, seven (&) days a week. RNs may be scheduled more than eight (8) hours depending on the acuity needs of the resident.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. Based on observation, interview and record review, the facility failed to ensure medications in one of two surveyed medication carts were labeled and stored according to their Medication Labeling and Storage policy when: one vial of insulin (a hormone that lowers the level of sugar in the blood), and one bottle of melatonin (supplement commonly used to aid in sleep) did not have an open date or expiration date.This failure had the potential for residents to receive expired medication.During a concurrent observation and interview on 8/7/25 at 11:39 a.m. with Licensed Vocational Nurse (LVN) 2 at medication cart two, one vial of insulin and one bottle of melatonin did not have an open date, or an expiration date written on the bottle. LVN 2 stated, there must be an open date on all medication and a visible expiration date to prevent residents from receiving expired medications. During an interview on 8/7/25 at 1:45 p.m. with the Director of Nursing (DON), the DON stated, it is my expectation to have all medication dated with an open date and a visible expiration date. During a concurrent interview and record review on 8/7/25 at 12:10 p.m. with the Pharmaceutical Consultant (PC), the facilities policy and procedure (P&P) titled, Medication Label and Storage, dated 2/2023 was reviewed. The P&P indicated, . The medication label includes, at a minimum: expiration date . appropriate instructions and precautions . multi-dose vials that have been opened or assessed (e.g., needle punctured) are dated and discarded within 28 days . The PC stated his expectations were for the staff to label all medications with the date opened and a clear visible expiration date to prevent residents receiving ineffective, expired medications.

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. (continued on next page)

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Based on interview, and record review, the facility failed to ensure 58 out of 58 sampled residents had complete nutrition-focused physical exams (NFPE) completed when RD did not follow current standards of practice and the facility's job description titled, Registered Dietitian Nutritionist when she was a part-time remote employee.These failures resulted in incomplete nutrition-focused physical exams and placed residents at risk to not be accurately assessed by identifying nutritional needs.Findings: During an interview on 8/6/25 at 1:03 p.m. with the Dietary Services Manager (DSM) the DSM stated the RD was working remotely and came to the facility one time a month. The DMS stated the RD was not available in person and was available by phone or email. The DSM stated she communicated with the RD through email. The DSM stated the RD did not attend the interdisciplinary team meetings (IDT- a collaborative meeting involving various healthcare professionals to discuss and coordinate residents care) and she did not speak to residents and family members. The DSM stated she was responsible for gathering information regarding resident's food preferences and inputting it into the chart. The DSM stated the RD was responsible for assessing residents' diet. During an interview on 8/7/25 at 2:51 p.m. with the Assistant Director of Nursing (ADON), the ADON stated she worked as an ADON for three years. The ADON stated she emailed the RD the list of new admits. The ADON stated the RD was able to gather information for residents from facility charts and hospital records. The ADON stated the RD would have emailed her recommendation after she reviewed the residents chart. The ADON stated she reached out to the physician about the RD's recommendation. The ADON stated she was responsible for updating any recommendations and new physician orders (instructions given by a physician or other authorized healthcare profession such as a nurse practitioner or physician assistant, regarding the medical care and treatment) after she spoke with the physician. The ADON stated the RD had 72 hours to do her assessment. The ADON stated the RD came to the facility once a month to check on the kitchen but was not sure if she spoke to the residents or family members. The ADON stated the RD was not involved in the IDT meeting. During an interview on 8/7/25 at 4:12 p.m. with the Director of Nursing the DON stated the RD worked remotely. The DON stated the RD had access to the electronic medical records and should have reviewed the charts. The DON stated the RD should have emailed the recommendation to the ADON. The DON stated the RD did not do physical assessment in person and should have done it in person and the nutritional care plan (a document that outlines a patient's health conditions, current treatments, and other relevant information to guide their care) was not comprehensive for all the residents in the facility. The DON stated the RD did not follow professional standard of practice when she did not provide a physical assessment for the residents in person. The DON stated the RD did not provide care planning for nutrition intake and the nurses were the ones doing the care plan. The DON stated the RD could not have done an accurate assessment when she was not seeing the residents in person. The DON stated the RD could have missed things. The DON stated the RD did her 72 hours assessment however she did not visit them in person. The DON stated the RD come in once a month for kitchen duties and did not see the residents before 72 hours in person. The DON stated the RD could have missed early interventions for malnutrition by not seeing residents in person within 72 hours. The DON stated residents with malnutrition had potential for complications such as pressure ulcers and falls and weight loss. The DON stated the RD did not participate in the IDT meeting. DON stated the RD should have been involved in IDT and could have explained to the family member and residents more detailed information about their nutrition plan of care.During an interview on 8/8/25 at 9:45 a.m. with the RD, the RD stated she lived in Monterey County and worked full time at a hospital. The RD stated she worked roughly 40 hours a month as a part-time employee for the facility. The RD stated she checked on the kitchen staff and provided audits when she came into the facility. The RD stated she used a packet she received from a fellow RD to perform her job duties. The RD stated the packet included storage, services observation and tray line (food assembly system, typically used in hospitals and other large-scale food service settings, where meal trays are prepared in a linear, conveyor-belt style fashion). The RD stated she did dinning observation once in the facility and felt she was a distraction for the residents. The RD stated she worked most of the time after 8 p. m. and did not call family members and residents. The RD stated she could have performed her job better if she was on site. The RD stated having a RD on site would have painted a better picture of the residents and added value for the resident and family. The RD stated she did not participate in an IDT meeting. The RD stated she did not complete an in person physical assessment and residents' assessments were done by

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. Based on observation, interviews and record review, the facility failed to ensure Dietary [NAME] (DC) 1 was competent to carry out the functions of the food and nutrition services safely and effectively for 55 of 58 residents who received food from the kitchen when DC 1 could not demonstrate recalibration of the kitchen a thermometer according to the facility's policy and procedure (P&P) title, Thermometer Use and Calibration. This failure resulted in the facility to serve and prepare food without the food temperature taken on a calibrated thermometer for residents who obtained food from the kitchen and had the potential to cause foodborne illness (caused by consuming contaminated foods or beverages). Findings: During an observation and interview on 8/5/25 at 9:10 a.m. in the kitchen with Dietary [NAME] (DK) 1, DC 1 grabbed a cup filled the cup with ice water and inserted a thermometer into the cup with the stem (long narrow part) touching the bottom of cup. DC 1 stated it was fine for the stem of the thermometer to touch the bottom and the side of the cup when calibrating the thermometer. DC1 stated, there was no time frame to leave the thermometer in the ice water cup. DC 1 stated, I don't remember when the last time we had an in service. During an interview on 8/5/25 at 2:39 p.m. with DC 1, DC 1 stated the stem of the thermometer should not touch the bottom of the cup. DC 1 stated the stem touching the bottom of the cup could have caused false reading during the calibration process. DC 1stated food temperature could have been wrong. DC 1 stated the food could be served at the wrong temperature. DC 1 stated residents could have gotten sick from eating food. During a concurrent interview and record review on 8/6/2025 at 12:51p.m. with Dietary Service Manager (DSM), the facility's policy and procedure (P&P) titled, Thermometer Use and Calibration, dated 2023, the P&P indicated, .Checking the Accuracy and Calibrating.2. Put the thermometer stem into the ice water so that the sensing area is completely submerged.Do not let the stem touch the bottom or sides of the glass. The thermometer stem or probe must remain in the ice water one minute during calibration process. The DSM stated, the stem of the thermometer should not have touched the bottom or the side of the ice water cup. The DSM stated the stem touching the bottom of the ice water cup could have caused inaccurate reading during the thermometer calibration. The DSM stated inaccurately calibrating the thermometer could have caused wrong temperature readings when checking food temperature. The DSM stated food could have been undercooked or overcooked. The DSM stated overcooked food could lose nutritional and caloric value. The DSM stated undercooked food could have caused residents to get sick from foodborne illness. The DSM stated, We did not follow the policy and procedure. The DSM stated DC 1 was not competent. During an interview on 8/7/25 at 9:42 a.m. with the Registered Dietician (RD), the RD stated DC 1 should have gotten a cup of ice and filled it with water. The RD stated DC 1 should have put the thermometer stem into the ice water without touching the tip of the thermometer to the bottom or sides of the cup. The RD stated thermometer calibration was important for food safety. The RD stated inaccurate calibration of the thermometer could have caused false reading of food temperature. The RD stated accurate temperatures were needed to ensure the food was adequately cooked and was safe for residents to consume. The RD stated not calibrating thermometer could have been cause false reading for food and food could have been undercooked. The RD stated undercooked food could have caused foodborne illness. The RD stated DC 1 was not competent.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Based on observation, interview, and record review, the facility failed to ensure safe, sanitary food preparation, and storage practices were followed for 55 of 58 sample residents when:1.There was not an air gap (an unobstructed vertical space between the water outlet and the flood level of a fixture), under the food preparation sink. This failure had the potential to result in residents being exposed to contaminated water which could ultimately result in residents getting food born illness.2. A bin of dried macaroni pasta, an open bag of sausage, an open bag of tortillas and a prepared fruit salad were not labeled with open or used by date.3. The resident refrigerator had food that had been brought into the facility that was not labeled with a resident name, an open or used by date.These failures had the potential to cause food-borne illness (known as food poisoning, diseases caused by consuming food or beverages contaminated with harmful bacteria) and hospitalization for all residents receiving food from the kitchen. 1.During a concurrent observation and interview on 08/04/2025 at 10:31 a.m. with Dietary [NAME] (DC) 1, in the facility's kitchen, a three-compartment sink was observed without an air gap (an unobstructed vertical space between the water outlet and the flood level of a fixture). DC 1 stated the vegetables are cleaned in the three-compartment sink using food strainers. During an interview on 8/5/25 at 4:19 p.m. with the Dietary Service Manager (DSM), the DSM stated that the three-compartment sink is used to wash vegetables, and the sink does not have an air gap. During an interview on 8/6/25 at 12:51 p.m. with the Registered Dietitian (RD), the RD stated, the three-compartment sink should have an air gap, and it does not. The air gap is necessary to prevent sewage backing up into the sink and contaminating the food being prepared in the sink. RD stated if there is no air gap the contamination could potentially cause food born illness to the residents in the facility. During an interview on 8/7/25 at 3:20 p.m. with the Maintenance Director (MAINT), the MAINT stated, if food is being prepared in the sink, the sink should have an air gap, and the three-compartment sink does not have an air gap. During a review of the Food Code U.S Food and Drug Administration, dated 2022, indicated, . 5-202.13 Backflow Prevention, Air Gap. During periods of extraordinary demand, drinking water systems may develop negative pressure (when water flows in the opposite direction) in portions of the system. If a connection exists between the system and a source of contaminated (dirty) water during times of negative pressure, contaminated water may be drawn into and foul (to make dirty) the entire system. Standing water in sinks . and other equipment may become contaminated with cleaning chemicals or food residue . 2.During an observation and interview on 8/4/25 at 7:44 a.m. in the kitchen, an undated opened bag of sausages was on the top shelf of the freezer. The Dietary Chef (DC) 2 stated the bag should have had a label with an open date and a delivered date. During an observation and interview on 8/4/25 at 7:55 a.m. in the storage pantry a dried macaroni pasta bin was not labeled. DC 2 stated the bin was missing a label to indicate opened date and received by date. DC 2 stated Everything in here should have been labeled with an opened date and received date. DC 2 stated It is important to make sure it's not expired. DC 2 stated kitchen staff were responsible for labeling the items in the storage pantry. DC 2 stated dating the items would prevent the kitchen staff from serving expired food to residents. DC 2 stated expired food could cause foodborne illness and gotten residents sick.During an observation and interview on 8/4/25 at 8:29 a.m. in the kitchen with DC 2, a bowl of fruit salad with clear plastic wrapped on top did not have a label with the dates the food was prepared on or when it should be used by. DC 2 stated it should have been labeled with the prepared date and used by date. During an observation and interview on 8/4/25 at 8:40 a.m. in the kitchen with DC 1, an opened bag of tortillas was not labeled with an open date and a used by date. DC 1 stated she was not able to find the label containing the opened date and used by date. DC 1 stated the opened tortilla bag should be labeled to keep track of the expiration date. DC 1 stated the tortillas could have expired and caused residents to get sick. During an interview on 8/6/2025 at 12:27 p.m. with the DSM, the DSM stated the macaroni pasta bin should have been labeled with a received and used by date. The DSM stated it should have been labeled once it was removed from the original package and put side the bin. The DMS stated the kitchen staff were responsible for labeling the bin. The DSM stated using items beyond their used by date could have altered the taste of the food, it could lose its flavor and nutrition value. The DSM stated using items beyond their used by date could cause residents to have foodborne illness. The DSM stated we did not follow the facility policy.During an interview on 8/7/25 at 9:12 a.m. with the RD, the RD stated prepared food should have been labeled before putting the items in the refrigerator. The RD stated kitchen staff should have labeled the fruit salad with the date it was made and the used by date before putting it inside the

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Dispose of garbage and refuse properly. Based on observation, interview and record review, the facility failed to follow their Waste Disposal policy when two of four garbage bins had their lids open.This failure had the potential to attract insects and rodents which could transmit disease and infection to the residents in the facility. FindingsDuring an observation and interview on 8/5/25 at 2:46 p.m. with the Housekeeping Supervisor (HSK), outside the facility, two trash bins were observed with their lids open. The HSK stated that the trash bins should always be covered to prevent rodents and insects from getting into the trash and then coming into the facility which could make the residents sick. During an interview on 8/5/25 at 3:45 p.m. with the Maintenance Supervisor (MAINT), the MAINT stated all trash inside and outside of the facility should always be covered to prevent insects, and rodents from getting into the trash and bringing disease into the facility that could infect the residents.During a review of the facility's policy and procedure (PNP), titled, Garbage and Rubbish Disposal dated 2000, indicated, the PNP indicated, .Food Related Garbage and Refuse Disposal indicated . All garbage or rubbish is to be put into waste containers which are emptied as often as necessary to prevent over filling . all containers will be provided with tight-fitting lids or covers, and will be leak proof and water proof . as to be inaccessible to vermin .

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F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the quality assessment assurance (QAA) committee consisted of the minimum required members when the Medical Director did not attend QAA committee meetings for three consecutive quarters (1/9/25, 4/18/25, and 7/16/25). This failure had the potential to affect the overall medical care provided to all the residents in the facility because the Medical Director was not informed and did not participate in oversite activities that included identifying, analyzing and correcting problems in resident care policies and resident care areas in the facility.Findings: During a concurrent interview and record review on 8/8/25 at 12:11 p.m. with the Administrator (ADM) the Quality Assurance Performance Improvement (QAPI) reports, dated 2025 were reviewed. The administrator stated the QAPI committee met every second Tuesday of the month, and the Continuous Quality Improvement (CQI) committee met every quarter. The ADM stated the CQI committee was the same as the QAA committee. The ADM stated the Medical Director (MD), and Pharmacist Consultant (PC) were not always present during the monthly QAPI committee meetings. The sign-in sheets were reviewed for the CQI committee meetings for 1/9/25, 4/18/25, and 7/16/25, which indicated no MD, and no MD designee was listed on each sheet. The sign-in sheets for the QAPI committee meetings dated 1/25, 6/25 and 7/25 were reviewed with the ADM, which indicated no MD or MD designee was listed on each sheet. The ADM stated the MD did not always attend the CQI quarterly meetings. The ADM stated the MD should have attended the CQI meetings. The ADM stated the Performance Improvement Projects (PIP)s were prioritized by ongoing issues affecting multiple departments, or if the issues affected resident care. The ADM stated some of the PIPs the facility was working on were resident falls and resident urinary tract infections (UTI - an infection in the bladder/urinary tract). The ADM stated if the MD did not regularly attend the CQI meetings, things could have been missed, and the MD would not have known what the issues in the facility were. The ADM stated it was important the MD knew what the PIPs were so he would know what projects were being addressed. The ADM stated the MD was responsible for the physicians working in the facility and how the facility was managed for resident care. During a review of the facility's document titled, QA&A Committee Info:, undated, indicated, . the QA&A Committee meets monthly and quarterly . members: Dr. [name], Medical Director . During a review of the facility document titled QAA/QAPI Meeting Agenda Guide, undated, the document indicated, . the facility is required to have a QAA committee . that meets at least quarterly - and as needed - to coordinate and evaluate activities under the QAPI program . attending . the following members are required to be on the QAA committee . Medical Director .