

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055039	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/19/2026
NAME OF PROVIDER OR SUPPLIER Good Samaritan Rehab and Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1630 N. Edison Street Stockton, CA 95204	
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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observation, interview, and record review, the facility failed to ensure an environment free of accident hazards for 9 of 28 sampled residents (Residents 2, 27, 30, 34, 52, 65, 71, 81, and 90) when: Resident 2 did not have an updated smoking reassessment. Residents 27 and 81 smoked without supervision and had smoking paraphernalia (items used for smoking, such as cigarettes, lighters, and matches) with them instead of having it secured by staff. Residents 30 and 65 did not have updated smoking reassessments, smoked without supervision, and had smoking paraphernalia with them instead of having it secured by staff. Resident 34 smoked without supervision and did not have a smoking care plan. Resident 52 smoked without supervision, had smoking paraphernalia with them instead of having it secured by staff, and did not have a smoking care plan. Resident 71 smoked without supervision. Resident 90 did not have an initial smoking assessment completed, did not have a smoking care plan, smoked without supervision, and had smoking paraphernalia with them instead of having it secured by staff. These failures had the potential to place Residents 2, 27, 30, 34, 52, 65, 71, 81, and 90, as well as other residents in the facility, at risk for accidental burns, fire-related injuries, and other smoking-related accidents. Findings: 1. Review of Resident 2's admission RECORD, indicated Resident 2 was admitted to the facility with diagnoses including other specified respiratory disorders, fracture of the mandible (jaw), quadriplegia at the C1-C4 level (paralysis of all four limbs), unspecified psychosis (disconnection from reality), cognitive communication deficit, primary osteoarthritis of the hand, and schizophrenia (a mental illness that affects how a person thinks, feels, and behaves). Review of Resident 2's Brief Interview for Mental Status (BIMS, an assessment used to evaluate a resident's thinking and memory) dated 3/31/26, indicated Resident 2 had a BIMS score of 7, which indicated severely impaired cognition (13-15 = intact, 8-12 = moderate impairment, 0-7 = severe impairment). During a concurrent interview and record review on 6/18/26, at 12:42 PM, with the Director of Nursing (DON), Resident 2's Smoking Data Collection and Assessment, dated 1/5/25, and ASSESSMENT OF SAFE POSSESSION OF SMOKING PARAPHERNALIA, dated 1/5/25, were reviewed. The DON confirmed that Resident 2 did not have the quarterly assessments completed after 1/5/25 and stated that smoking reassessments were necessary to ensure Resident 2 could continue to smoke safely. 2a. Review of Resident 27's admission RECORD, indicated Resident 27 was admitted to the facility with diagnoses including chronic obstructive pulmonary disease (COPD, a lung disease that makes it hard to breathe), transient cerebral infarction (a temporary interruption of blood flow to the brain), lack of coordination (difficulty controlling body movements), hemiplegia and hemiparesis following cerebral infarction (weakness or paralysis on one side of the body after a stroke), bipolar disorder (a mental health condition that causes extreme changes in mood), paranoid schizophrenia (a mental illness that can affect a person's thoughts, judgment, and behavior), schizoaffective disorder (a mental illness with symptoms of schizophrenia and a mood disorder), and auditory and visual (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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	hallucinations (hearing or seeing things that are not actually present).Review of Resident 27's BIMS dated 6/9/26, indicated Resident 27 had a BIMS score of 15, which indicated intact cognition.During an interview on 6/16/26, at 1:34 PM, with Resident 27, Resident 27 stated that he kept his own lighter and smoked outside independently without staff supervision.During a concurrent interview and record review on 6/18/26, at 12:11 PM, with the DON, Resident 27's Smoking Data Collection and Assessment, dated 3/20/26, and ASSESSMENT OF SAFE POSSESSION OF SMOKING PARAPHERNALIA, dated 11/15/25, were reviewed. The Smoking Data Collection and Assessment, indicated Resident 27 could smoke independently but required staff to keep his lighter and matches secured at the nurses' station. The ASSESSMENT OF SAFE POSSESSION OF SMOKING PARAPHERNALIA, indicated Resident 27 had no clinical and physical limitations affecting his ability to smoke safely. The DON acknowledged that Resident 27 had physical limitations, including hemiplegia, hemiparesis, and lack of coordination, as well as mental health conditions and antipsychotic medication that could cause sleepiness, dizziness, and decreased alertness, limiting his ability to smoke safely without staff supervision and increasing the risk of burns or fire if he kept a lighter in his possession.2b. Review of Resident 81's admission RECORD, indicated Resident 81 was admitted to the facility with diagnoses including COPD, pneumonia, and acquired absence of the right leg below the knee (amputation of the lower right leg).Review of Resident 81's BIMS dated 6/15/26, indicated Resident 27 had a BIMS score of 14, which indicated intact cognition.During a concurrent observation and interview on 6/17/26, at 9:20 AM, with Resident 81 in the smoking area, Resident 81 was seated on a table alone smoking with no other staff present. Resident 81 stated that he kept his own cigarettes and lighter with him and smoked without supervision as he did not need supervision from staff. During a concurrent interview and record review on 6/18/26, at 12:11 PM, with the DON, Resident 81's Smoking Data Collection and Assessment, and ASSESSMENT OF SAFE POSSESSION OF SMOKING PARAPHERNALIA, both dated 3/6/26, were reviewed. The Smoking Data Collection and Assessment indicated Resident 81 could smoke independently but required staff to keep his lighter and matches secured at the nurses' station. The Assessment of Safe Possession of Smoking Paraphernalia indicated Resident 81 had no clinical conditions and physical limitations that would affect his ability to smoke safely. The DON acknowledged that Resident 81 had medical and clinical conditions that limited his ability to smoke safely without staff supervision, including COPD, heart failure and major depressive disorder. The DON stated Resident 27 was not safe to smoke without staff supervision or to keep his smoking paraphernalia in his possession. 3a. Review of Resident 30's admission RECORD, indicated Resident 30 was admitted to the facility with diagnoses including peripheral vascular disease, acquired absence of the right leg above the knee, transient ischemic attack, cerebral infarction (stroke), and a personal history of other mental and behavioral disorders.Review of Resident 30's BIMS dated 4/13/26, indicated Resident 30 had a BIMS score of 13, which indicated intact cognition.During a concurrent observation and interview on 6/18/26, at 10:20 AM, with the Minimum Data Set Coordinator (MDSC) in the hallway near the exit to the smoking area, Resident 30 entered the building from the smoking area while self-propelling her wheelchair. Resident 30 stated that she carried her lighter and cigarettes in her pouch and had just finished smoking without staff supervision. The MDSC confirmed Resident 30 smoked without staff supervision and kept her smoking paraphernalia in her possession.During a concurrent interview and record review on 6/18/26, at 10:33 AM, with the DON, Resident 30's Smoking Data Collection and Assessment, dated 4/14/25 and the undated ASSESSMENT OF SAFE POSSESSION OF SMOKING PARAPHERNALIA, were reviewed. The DON stated quarterly smoking assessments had not been completed after 4/14/25 and should have been completed as scheduled to determine whether (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	musculoskeletal system, muscle weakness, abnormalities of gait and mobility, acquired absence of right leg below knee, major depressive disorder, insomnia due to other mental disorder, and ischemic cardiomyopathy (a weakened heart caused by reduced blood flow). Review of Resident 90's BIMS dated 4/7/26, indicated Resident 90 had a BIMS score of 15, which indicated intact cognition. During a concurrent observation and interview on 6/17/26, at 9:17 AM, with the DON in Resident 90's room, the room was wide open, and Resident 90 was not present. Resident 90's lighter and a pack of cigarettes were on top of table, visible from the doorway and readily accessible to anyone entering the room. The DON stated it was not safe to leave the lighter in the room because anyone could take it and it could create a fire hazard. During an interview on 6/17/26, at 9:53 AM, with Resident 90, Resident 90 stated that he smoked without staff supervision and kept his lighter in his possession. During a concurrent interview and record review on 6/18/26, at 10:50 AM, with the DON, Resident 90's electronic health record (EHR - the resident's computerized medical record) and physical chart were reviewed. The DON stated Resident 90's initial smoking assessment had not been completed by the due date, which was a safety concern because Resident 90 had not been assessed to determine whether he could smoke safely while smoking independently and keeping his lighter in his possession. The DON further stated Resident 90 did not have a smoking care plan, which was a safety concern because nursing staff did not have resident-specific interventions to ensure he smoked safely. The DON stated Resident 90 was not safe to smoke without staff supervision or to keep smoking paraphernalia in his possession because he had not been assessed to determine whether he could do so safely. During a concurrent interview and review on 6/18/26, at 12:50 PM, with the DON, the facility's .RESIDENT SMOKING TIME SCHEDULE, was reviewed. The facility's smoking time indicated from 8 AM, 9 AM, 11 AM, 1 PM, 2 PM, 4 PM, 6:30 PM, and 8:30 PM, there was a list of staff designated to supervise residents who were smoking in the smoking area. The DON stated staff who were assigned were expected to be at the smoking area at that time to ensure residents who needed to smoke had supervision. The DON further stated if the assigned staff were not there, then no supervision to smokers would be provided and it was a safety risk, including a potential fire hazard. Review of the facility's undated policy and procedure titled, POLICY AND PROCEDURE ON SMOKING, indicated .In the case of any resident who is physically or mentally incapacitated, resident shall be permitted to smoke provided that smoking is done under close supervision of staff. Residents who are not capable of smoking safely including handling smoking paraphernalia safely may be placed on scheduled and/or supervised smoking. Review of the facility's undated policy and procedure titled, POLICY AND PROCEDURE ON SMOKING: SMOKING PARAPHERNALIA, indicated .The inter-disciplinary team shall assess residents who smoke, for safety awareness and self-handling of smoking paraphernalia. Assessment of residents shall include the following. Medical conditions or diagnoses that would limit or affect a resident's ability to smoke i.e. Parkinson's disease. Dementia. Huntington Chorea. Psychosis, others. Resident's physical ability to smoke, i.e. motor skills such as muscle coordination, grasp, and mobility. Resident's cognitive ability, i.e. alertness. Any periods of confusion. Behavioral problems. For residents who are incapable of keeping or possessing smoking paraphernalia. will be kept the licensed staff.		

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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 provide food storage and preparation in accordance with professional standards for food safety for the 74 residents who received facility prepared meals when: An opened and unlabeled food item was found in one of the freezers, and; Multiple temperature logs were found with missing documentation. These failures had the potential to place residents who ate the facility prepared meals at risk for foodborne illnesses. Findings: 1. During a concurrent observation and interview during the initial kitchen tour on 6/16/26, at 9:10 a.m., with the Dietary Supervisor (DS), the DS confirmed the stand-up freezer was found with one bag of opened whipped cream that was unlabeled. The DS stated the kitchen staff were supposed to have labeled food items upon opening and before putting them back in the freezer. During an interview on 6/18/26, at 3:37 p.m., with the Registered Dietician (RD), the RD stated it was her expectation for the kitchen staff to have labeled opened food items with both the open date and use by date. The RD further stated it was important for staff to properly label opened food items because it could be easily forgotten. The RD stated the risk of improper labeling of opened food items could be providing food to the residents that were not nutritionally complete or food could have developed decay or bacteria. A review of the facility's policy titled, Labeling and Dating of Foods, dated 1/21/26, indicated, .Policy: All food items in the storeroom, refrigerator and freezer will be labelled and dated. Procedures. Newly opened foods will be closed and labeled with an open date and use-by date. A review of the facility's undated policy titled, PROCEDURE FOR FREEZER STORAGE, indicated, .PROCEDURE.6. All frozen food should be labeled and dated. 2a. During a concurrent interview and record review on 6/16/26, at 9:05 a.m., with the DS, the Quaternary Ammonium (chemical sanitizer used to kill bacteria, viruses, and fungi on food- contact surfaces) Log was reviewed. The DS confirmed the log had missing documentation readings for AM (morning) shift for dates 6/13/26, 6/14/26, 6/15/26 and 6/16/26, and PM (afternoon) shift for 6/15/26. The DS stated the dietary aides or the cook scheduled to work could have checked and document the readings. The DS further stated it was her expectation for these checks to have been done in the morning and afternoon timeframes. During a concurrent interview and record review on 6/18/26, at 3:37 p.m., with the RD, the Quaternary Ammonium Log was reviewed. The RD stated the staff should have checked the temperatures when they made the sanitizing solution. The RD further stated the risk of not checking the sanitizing solution would have been the solution not being as effective in killing surface bacteria with the possibility of cross contamination. A review of the facility's undated policy titled, QUATERNARY AMMONIUM LOG POLICY, indicated, .POLICY: The concentration of the ammonium in the quaternary sanitizer will be tested to ensure the effectiveness of the solution. PROCEDURE. Food and Nutrition Services staff will record the readings twice a day, once in the AM and once in the PM, to document the process was completed. 2b. During a concurrent interview and record review on 6/16/26, at 8:48 a.m., with the DS, the Cold Storage Temperature logs for both the freezer and refrigerator were reviewed. The DS confirmed missing logged information or readings were found on both temperature logs for 6/15/26 for both AM and PM readings and AM reading for 6/16/26. The DS stated the cook was supposed to check the temperature before the breakfast and lunch meals were prepared. A review of the facility's undated policy titled, COLD STORAGE TEMPERATURE MONITORING AND RECORD KEEPING, indicated, .POLICY: Food & Nutrition staff shall review and record temperatures of all refrigerators and freezers to ensure they are at the correct temperature for food storage and handling. PROCEDURE.2. Food & Nutrition Services staff will record and initial the (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	temperatures.at the beginning of the AM and PM shifts. 2c. During a concurrent interview and record review on 6/16/26, at 9:20 a.m., with the Assistant Dietary Supervisor (ASD), the Dish Machine Temperature Log was reviewed. The ASD confirmed missing documentation or readings for dates 6/15/26 for breakfast, lunch and dinner timeframes and 6/16/26 for breakfast readings. The ASD stated the staff should have checked the temperatures readings were correct and to have ensured the sanitizer was working.During a concurrent interview and record review on 6/18/26, at 3:37 p.m., with the RD, the Cold Storage Temperature logs and Dish Machine Temperature logs were reviewed. The RD stated it was her expectation for the kitchen staff to have checked for the temperatures for the shifts indicated on the forms. The RD further stated the risk of not checking the temperatures would be for the temperature to have increased and any food contained could potentially have bacterial growth creating a food hazard for the residents.A review of the facility's undated policy titled, DISHWASHING, indicated, .PROCEDURE:.8. A temperature log (and chorine log for low-temperature machines) will be kept and maintained by the dishwasher to assure that the dish machine is working correctly. This log will be completed each meal prior to any dishwashing.		

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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. Based on observation, interview, and record review, the facility failed to implement appropriate infection prevention and control practices for 5 of 28 sampled residents (Resident 52, Resident 1, Resident 14, Resident 37, and Resident 81) when: Staff failed to perform hand hygiene (cleaning hands with soap and water or alcohol-based hand sanitizer to remove germs and prevent the spread of infection) between delivering meal trays to Resident 52 and Resident 1, and; Multiple urinals (portable, handheld containers designed for men with limited mobility to urinate while in bed or seated) used by Resident 14, Resident 37, and Resident 81 were not labeled. These failures had the potential to spread infection and cause adverse health outcomes for residents in the facility. Findings: 1. During a concurrent observation and interview on 6/16/26, at 12:30 PM, with Certified Nursing Assistant (CNA) 4 in the hallway outside Resident 1's and Resident 52's shared room, CNA 4 delivered a meal tray to Resident 52, placed the meal tray on Resident 52's over-bed table, and assisted Resident 52 with meal set-up (helped prepare the meal so the resident could eat). CNA 4 then exited the shared room without performing hand hygiene, opened the meal cart in the hallway, picked up the meal tray for Resident 1, returned to the shared room, placed the meal tray on Resident 1's over-bed table, and assisted Resident 1 with meal set-up. CNA 4 then exited the shared room without performing hand hygiene. CNA 4 stated she did not perform hand hygiene between delivering meal trays to Resident 52 and Resident 1 or after exiting the shared room. CNA 4 further stated that failure to perform hand hygiene between meal tray deliveries and after exiting residents' rooms was an infection control concern because germs on staff's hands could contaminate food and spread infection. During an interview on 6/18/26, at 11:51 AM, with the Director of Nursing (DON), the DON stated that staff were expected to perform hand hygiene between delivering meal trays to different residents and before entering and after exiting residents' rooms to prevent the spread of infection. Review of the facility's policy and procedure (P&P) titled, Handwashing/Hand Hygiene, dated 2001, indicated . This facility considers hand hygiene the primary means to prevent the spread of healthcare-associated infections. All personnel are expected to adhere to hand hygiene policies and practices to help prevent the spread of infections to other personnel, residents, and visitors. Hand hygiene is indicated. after touching the resident's environment . 2a. During a concurrent observation and interview on 6/16/26, at 9:51 AM, with Licensed Nurse (LN) 4, Resident 14's urinal was observed. LN 4 confirmed that Resident 14's urinal was dirty and not labeled with identifying information and should have been labeled. LN 4 stated that her expectation was for urinals to be labeled. LN 4 further stated that urinals should have been emptied right away and not have urine still in them. LN 4 stated that it was an infection control risk having urinals in active use without them being labeled. LN 4 further stated that urinals could get switched or mixed up and posed cross-contamination (the transfer of harmful bacteria, viruses, or allergens from one surface, object, or person to another) risks for the residents. (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2b. During a concurrent observation and interview on 6/16/26, at 9:52 AM, with LN 4, Resident 37's two urinals were observed. LN 4 confirmed that Resident 37's urinals were dirty and not labeled with identifying information and should have been labeled. 2c. During a concurrent observation and interview on 6/16/26, at 10:09 AM, with CNA 5, Resident 81's urinal was observed. CNA 5 confirmed that Resident 81's urinal was not labeled with identifying information and should have been labeled. CNA 5 stated that the urinals could get mixed up with other residents who have urinals and cause contamination. During an interview on 6/16/26, at 10:14 AM, with the Director of Staff Development (DSD), the DSD stated that urinals should have been cleaned or replaced if they were too dirty to be cleaned. The DSD further stated that the urinals should have been labeled with the residents' initials or room number. The DSD stated that infection control and cross-contamination could be a huge problem for the residents. During an interview on 6/18/26, at 9:25 AM, with the Infection Preventionist Assistant (IPA), the IPA stated that residents could get sick if the urinals were to be mixed up and potentially cause the residents to develop urinary tract infections (UTIs- are bacterial infections that affect any part of the urinary system, most commonly the bladder and urethra). The IPA further stated the urinals should have been labeled so that the staff would know which resident they belonged to. During an interview on 6/18/26, at 3:22 PM, with the DON, the DON stated that her expectation was for urinals to have been labeled for each individual resident. The DON further stated that if the urinals were not labeled, they could get commingled or mixed up. The DON stated that if urinals were labeled, it would be easy to identify who they belonged to. During a review of the facility's undated P&P titled, Policies and Procedures - Infection Prevention and Control, the P&P indicated, .maintain a safe, sanitary, and comfortable environment for personnel, residents, visitors, and the general public . During a review of the facility's undated P&P titled, POLICY AND PROCEDURE ON LABELING OF PERSONAL ITEMS/PERSONAL EFFECTS, the P&P indicated, .Residents shall have adequate supply of personal items/personal effects necessary to perform some aspect of daily living (i.e. personal hygiene).Residents identified to be in need of such items or materials shall be given appropriate assistance to ensure that adequate supply is secured.		

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures for flu and pneumonia vaccinations. Based on interview, and record review, the facility failed to provide education, offer, and document the influenza (commonly known as the flu, a contagious viral infection that attacks the respiratory system, including the nose, throat, and lungs) vaccinations and pneumococcal (a serious bacterial infection caused by Streptococcus pneumoniae. It spreads via respiratory droplets and can lead to severe illnesses like pneumonia, meningitis, and bloodstream infections) vaccinations for 4 of 5 sampled residents (Resident 27, Resident 81, Resident 37, and Resident 14) when: The influenza vaccine was not given, and education was not provided for Resident 27, Resident 81, and Resident 37, and; The pneumococcal vaccine was not given, and education was not provided for Resident 81, Resident 37, and Resident 14. This deficient practice placed Resident 27, Resident 81, Resident 37, and Resident 14 at higher risk of acquiring and transmitting complications from the influenza and pneumococcal diseases and violated the residents and/or responsible parties' rights to make an informed decision. Findings: 1a. During a concurrent interview and record review on 6/17/26, at 3:30 PM, with the Infection Preventionist Assistant (IPA), Resident 27's Electronic Health Record (EHR) and medical chart were reviewed. The IPA confirmed that there was no evidence of the influenza vaccine being offered during the flu season in late 2025/early 2026 or education being provided to Resident 27. 1b. During a concurrent interview and record review on 6/17/26, at 3:43 PM, with the IPA, Resident 81's EHR and medical chart were reviewed. The IPA confirmed that there was no evidence of the influenza vaccine being offered during the flu season in late 2025/early 2026 or education being provided to Resident 81. 1c. During a concurrent interview and record review on 6/17/26, at 3:46 PM, with the IPA, Resident 37's EHR and medical chart were reviewed. The IPA confirmed that there was no evidence of the influenza vaccine being offered during the flu season in late 2025/early 2026 or education being provided to Resident 37. During a review of the facility's undated policy and procedure (P&P) titled, Influenza Vaccine, the P&P indicated, .All residents and employees who have no medical contraindications to the vaccine will be offered the influenza vaccine annually to encourage and promote the benefits associated with vaccinations against influenza. The facility shall provide pertinent information about the significant risks and benefits of vaccines to staff and residents (or residents' legal representatives). Between October 1st and March 31st each year, the influenza vaccine shall be offered to residents. Prior to the vaccination, the resident (or resident's legal representative) or employee will be provided information and education regarding the benefits and potential side effects of the influenza vaccine. Provision of such education shall be documented in the resident's/employee's medical record. A resident's refusal of the vaccine shall be documented on the informed consent for influenza vaccine and placed in the resident's medical record. 2a. During a concurrent interview and record review on 6/17/26, at 3:43 PM, with the IPA, Resident 81's EHR and medical chart were reviewed. The IPA confirmed that there was no evidence of the pneumococcal vaccine being offered or education being provided to Resident 81. 2b. During a concurrent interview and record review on 6/17/26, at 3:46 PM, with the IPA, Resident 37's EHR and medical chart were reviewed. The IPA confirmed that there was no evidence of the pneumococcal vaccine being offered or education being provided to Resident 37. 2c. During a concurrent interview and record review on 6/17/26, at 3:48 PM, with the IPA, Resident 14's EHR and medical chart were reviewed. The IPA confirmed that there was no evidence of the pneumococcal vaccine being offered or education being provided to Resident 14. During an interview on 6/18/26, at 9:41 AM, with the IPA, the IPA stated that it was her expectation for the influenza and pneumococcal vaccines to be offered and education given upon the residents' admission to the facility. The IPA further stated that the residents should have (continued on next page)		

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	been provided with education on the vaccines so they could make the best decisions for their health. The IPA stated that influenza vaccines were important to prevent the development of the flu. During an interview on 6/18/26, at 9:50 AM, with the Admissions Coordinator (AC), the AC stated that immunizations were not offered as part of the initial admission packet when residents were admitted to the facility. During an interview on 6/18/26, at 3:22 PM, with the Director of Nursing (DON), the DON stated that it was important for the residents at the facility to receive the influenza and pneumococcal vaccinations to help prevent the diseases. The DON further stated that it was important to educate the residents on the risks and benefits so they could make informed decisions to receive the vaccines or not. The DON stated that the staff should have documented the education being provided for the residents on their EHR or medical chart. During a review of the facility's undated P&P titled, Pneumococcal Vaccine, the P&P indicated, .All residents are offered pneumococcal vaccines to aid in preventing pneumonia/pneumococcal infections. Prior to or upon admission, residents are assessed for eligibility to receive the pneumococcal vaccine series, and when indicated, are offered the vaccine series within thirty (30) days of admission to the facility unless medically contraindicated or the resident has completed the current recommended vaccine series. Assessments of pneumococcal vaccination status are conducted within five (5) working days of the resident's admission if not conducted prior to admission. Before receiving a pneumococcal vaccine, the resident or legal representative receives information and education regarding the benefits and potential side effects of the pneumococcal vaccine. Provision of such education is documented in the resident's medical record. Residents/representatives have the right to refuse vaccination. If refused, appropriate information is documented in the resident's medical record indicating the date of the refusal of the pneumococcal vaccination.		

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. Based on interview, and record review, the facility failed to provide education, offer, and document Covid-19 (Coronavirus Disease 2019, a respiratory viral infection that affects primarily the lungs and results in coughing and difficulty breathing) vaccinations for four (4) of five (5) sampled residents (Resident 27, Resident 81, Resident 37, and Resident 14). This deficient practice placed the residents and staff at risk for possible Covid-19 infection due to missed vaccination dosage and violated the residents and/or responsible parties' rights to make an informed decision. Findings: a. During a concurrent interview and record review on 6/17/26, at 3:30 PM, with the Infection Preventionist Assistant (IPA), Resident 27's Electronic Health Record (EHR) and medical chart were reviewed. The IPA confirmed that there was no evidence of the Covid-19 vaccine being offered or education being provided to Resident 27. b. During a concurrent interview and record review on 6/17/26, at 3:43 PM, with the IPA, Resident 81's EHR and medical chart were reviewed. The IPA confirmed that there was no evidence of the Covid-19 vaccine being offered or education being provided to Resident 81. c. During a concurrent interview and record review on 6/17/26, at 3:46 PM, with the IPA, Resident 37's EHR and medical chart were reviewed. The IPA confirmed that there was no evidence of the Covid-19 vaccine being offered or education being provided to Resident 37. d. During a concurrent interview and record review on 6/17/26, at 3:48 PM, with the IPA, Resident 14's EHR and medical chart were reviewed. The IPA confirmed that there was no evidence of the Covid-19 vaccine being offered or education being provided to Resident 14. During an interview on 6/18/26, at 9:45 AM, with the IPA, the IPA stated that it was her expectation for the Covid-19 vaccine to be offered and education given upon the residents' admission to the facility. The IPA further stated that residents should have been provided with education on Covid-19 so they could make the best decisions for their health. During an interview on 6/18/26, at 9:50 AM, with the Admissions Coordinator (AC), the AC stated that immunizations were not offered as part of the initial admission packet when residents were admitted into the facility. During an interview on 6/18/26, at 3:22 PM, with the Director of Nursing (DON), the DON stated that it was important for the residents at the facility to receive the Covid-19 vaccine to help prevent against the disease. The DON further stated that it was important to educate the residents on the risks and benefits so they could make informed decisions to receive the vaccine or not. The DON stated that staff should have documented the education being provided for the residents on their EHR or medical chart. During a review of the facility's policy and procedure (P&P) titled, Coronavirus Disease (COVID-19) - Vaccination of Residents, revised 5/23, the P&P indicated, .Each resident is offered the COVID-19 vaccine unless the immunization is medically contraindicated or the resident is fully vaccinated .COVID-19 vaccine education, documentation and reporting are overseen by the infection preventionist and coordinated by his or her designee. Before the COVID-19 vaccine is offered, the resident is provided with education regarding the benefits, risks, and potential side effects associated with the vaccine. The resident's medical record includes documentation that indicates, at a minimum, the following: .That the resident or resident representative was provided education regarding the benefits and potential risks associated with COVID-19 vaccine. If the resident did not receive the COVID-19 vaccine due to medical contraindications, prior vaccination or refusal, appropriate documentation is made in the resident's record.		

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observation, interview, and record review, the facility failed to ensure residents were treated with dignity and respect for 3 of 28 sampled residents (Residents 24, 70, and 84) when: Resident 24 was observed lying in bed without lower body clothing or a covering and was visible from the hallway and through the room window while wearing only a fully soaked incontinent brief (a disposable undergarment designed to absorb urine and stool). Certified Nursing Assistant (CNA) 4 stood over Resident 70 and CNA 3 stood over Resident 84 while assisting with meals and did not position themselves at the residents' eye level. These failures had the potential to negatively affect the residents' dignity, privacy, psychosocial well-being (emotional and social functioning), and quality of life. Findings: 1. Review of Resident 24's 'admission RECORD' indicated Resident 24 was admitted to the facility with diagnoses of dementia (a condition that affects memory, thinking, and decision-making), pseudobulbar affect (a condition that causes sudden, uncontrollable episodes of laughing or crying), conduct disorder (a condition characterized by behavioral problems), and other symptoms and signs involving appearance and behavior. Review of Resident 24's Brief Interview for Mental Status (BIMS-to assess a resident's thinking and memory) dated 6/17/26 indicated Resident 24 had a BIMS score of 10, which showed Resident 24 had moderately impaired cognition (the ability to think, understand, remember, and make decisions; 13-15 = Intact, 8-12 = Moderate, 0-7 = Severe). Review of Resident 24's Task: B&B - Bladder Elimination (urination and bladder control), dated 6/1/26 through 6/18/26 indicated Resident 24 was incontinent of bladder most of the time, with three episodes of continence (able to control bladder function). Review of Resident 24's Task: ADL (Activities of Daily Living - routine self-care activities) - Toilet Use dated 6/1/26 through 6/18/26 indicated Resident 24 was totally dependent (required full staff assistance) for cleaning after elimination, changing pads, and adjusting clothing most of the time, with five episodes requiring limited assistance (resident performed most of the activity with some staff assistance). During a concurrent observation and interview on 6/17/26 at 9:14 AM with Licensed Nurse (LN) 1 in the hallway outside Resident 24's room, Resident 24 was visible from the hallway while lying in bed without lower body clothing or a covering, exposing the incontinent brief that Resident 24 was wearing. Resident 24's bed was positioned next to a large glass window, allowing Resident 24 to be visible from the parking lot outside the facility while wearing only an incontinent brief. LN 1 stated that Resident 24 should not be left uncovered because it was a dignity issue, as individuals in the hallway and outside the facility could see Resident 24 wearing an incontinent brief. Resident 24 stated that he needed his brief changed and had last been assisted with incontinent care at 4 AM, approximately five hours before the observation. LN 1 confirmed that Resident 24's incontinent brief was fully soaked and stated that it needed to be changed to prevent skin breakdown (damage to the skin caused by prolonged exposure to moisture). During a concurrent observation and interview on 6/17/26 at 4:09 PM with Certified Nursing Assistant (CNA) 2 in the hallway outside Resident 24's room, Resident 24 was sleeping in bed without lower body clothing or a covering and was visible from both the hallway through the entrance door and outside through the large window. CNA 2 stated that Resident 24 should be covered and not exposed while wearing an incontinent brief to maintain privacy and dignity. During an interview on 6/18/26 at 8:23 AM with Certified Nursing Assistant (CNA) 3, CNA 3 stated that she was assigned to Resident 24 during the AM shift on 6/17/26. CNA 3 stated that she did not change Resident 24's incontinent brief before 9 AM on 6/17/26 because Resident 24 did not ask to be changed. CNA 3 further stated that she was not aware of the last time Resident 24 had been (continued on next page)		

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	changed before the AM shift on 6/17/26. During an interview on 6/18/26 at 9:03 AM with the Director of Nursing (DON), the DON stated that staff were expected to check on residents every two hours, or more frequently as needed, including determining whether residents required incontinent care. The DON stated that leaving residents wet or soiled in an incontinent briefs and exposing them to view by others while wearing those briefs was a dignity issue and increased the risk for skin breakdown and urinary tract infections (UTIs - infections involving the bladder, kidneys, or urinary system). The DON further stated that staff were expected to maintain residents' privacy and dignity by ensuring residents were appropriately covered. Review of the facility's undated policy and procedure titled, POLICY AND PROCEDURE ON PROVIDING ASSISTANCE WITH ADL CARE, indicated, 'Always check with the resident if he or she is doing all right in his or her ADL care. Provide privacy at all times. Review of the facility's undated policy and procedure titled, DIGNITY AND RESPECT, indicated 'Privacy of a resident body shall be maintained. 2. Review of Resident 70's 'admission RECORD' indicated Resident 70 was admitted to the facility with diagnoses of seizures, stimulant dependence (physical or psychological reliance on stimulant drugs), schizoaffective disorder (a mental health disorder characterized by symptoms of schizophrenia, such as hallucinations or delusions, along with mood disorder symptoms), cerebral infarction (stroke), and major depressive disorder. Review of Resident 70's Brief Interview for Mental Status (BIMS-to assess a resident's thinking and memory) dated 5/22/26 indicated Resident 70 had a BIMS score of 7, which showed Resident 70 had severe cognitive impairment. Review of Resident 70's Task: ADL (Activities of Daily Living - routine self-care activities) - Eating dated 6/1/26 through 6/18/26 indicated Resident 70 was totally dependent (required full staff assistance) for eating. During a concurrent observation and interview on 6/16/26 at 12:40 PM with LN 2 in the hallway outside Resident 70's room, Resident 70 was lying in bed with the head of the bed elevated while CNA 4 assisted Resident 70 with meals while standing over Resident 70 at the side of the bed. LN 2 stated CNA 4 was not at eye level while assisting Resident 70 with meals. LN 2 further stated staff should position themselves at eye level when assisting residents with meals to promote dignity because standing over residents may cause them to feel intimidated, disrespected, or belittled. Review of Resident 84's 'admission RECORD' indicated Resident 84 was admitted to the facility with hemiplegia and hemiparesis following cerebral infarction (paralysis and weakness on one side of the body following a stroke), moderate protein-calorie malnutrition (inadequate intake of protein and calories resulting in poor nutritional status), dysphagia (difficulty swallowing), other symptoms and signs involving the musculoskeletal system (problems affecting the muscles, bones, or movement), type 2 diabetes mellitus, and cerebral insufficiency (reduced blood flow to the brain). Review of Resident 84's Brief Interview for Mental Status (BIMS-to assess a resident's thinking and memory) dated 3/30/26 indicated Resident 84 had a BIMS score of 7, which showed Resident 84 had severe cognitive impairment. Review of Resident 84's Task: ADL (Activities of Daily Living - routine self-care activities) - Eating dated 6/1/26 through 6/17/26 indicated Resident 84 was totally dependent (required full staff assistance) for eating. During a concurrent observation and interview on 6/18/26 at 8:19 AM with the Director of Staff Development (DSD) in the hallway outside Resident 84's room, Resident 84 was lying in bed with the head of the bed elevated while CNA 3 assisted Resident 84 with the meal. CNA 3 was standing over Resident 84 and was not at eye level while assisting at the bedside. The DSD stated CNA 3 should have been seated on a stool at eye level with Resident 84 to promote engagement, prevent Resident 84 from feeling rushed, and promote dignity. During an interview on 6/18/26 at 8:23 AM with CNA 3, CNA 3 acknowledged that she stood over Resident 84 while assisting Resident 84 with the meal which was a dignity issue. During an interview on 6/18/26 at 12:03 PM with the DON, the DON stated staff were (continued on next page)		

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	expected to be at eye level with residents when assisting with feeding to promote safety, encourage engagement, and maintain resident dignity, and avoid appearing authoritative. Review of the facility's undated policy and procedure titled, DIGNITY AND RESPECT, indicated .It is the policy of this facility that all residents be treated with kindness, dignity and respect .The staff shall display respect for residents when caring for as constant affirmation of their individuality and dignity as human beings.		

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. Based on interview, and record review, the facility failed to ensure a resident was properly informed of and consented to the use of psychotherapeutic medications (medications used to control behavior or treat thought disorders) for 1 of 28 sampled residents (Resident 52), when Resident 52's informed consent for olanzapine (an antipsychotic medication used to treat mental health conditions that affect a person's thinking, mood, behavior, or perception of reality), signed on 1/22/25, was not renewed within the required timeframe while Resident 52 continued to receive the medication. This failure had the potential to violate Resident 52's right to make informed decisions regarding psychotherapeutic medication use, including understanding the benefits of medication, risks, side effects, and alternative treatment options. Findings: Review of Resident 52's admission RECORD, indicated Resident 52 was admitted to the facility with diagnoses including unspecified psychosis, schizophrenia (a mental health disorder characterized by disturbances in thinking, perception, and behavior), bipolar disorder (a mental health disorder characterized by episodes of mood changes ranging from depression to elevated mood), cerebral infarction (brain damage caused by interrupted blood flow to the brain, also known as a stroke), lack of coordination, and other symptoms and signs involving the musculoskeletal system. Review of Resident 52's Brief Interview for Mental Status (BIMS-to assess a resident's thinking and memory) dated 4/13/26, indicated Resident 52 had a BIMS score of 15, which showed Resident 52 had intact cognition (13-15 = Intact, 8-12 = Moderate, 0-7 = Severe). Review of Resident 52's Medication Administration Record (MAR, a document that indicates what medications have been ordered, given, or held), dated 6/1/26 through 6/17/26, indicated Resident 52 received olanzapine 2.5 milligram (mg - unit measure) at 9 PM daily from 6/1/26 through 6/17/26. During a concurrent interview and record review on 6/18/26, at 10:12 AM, with the Director of Nursing (DON), Resident 52's FACILITY VERIFICATION OF RESIDENT INFORMED CONSENT TO PSYCHOTROPIC MEDICATIONS [Informed Consent], for olanzapine dated 1/22/25 was reviewed. The DON stated that 1/22/25 was the last date informed consent for olanzapine was obtained from Resident 52. The DON acknowledged that the informed consent for the psychotherapeutic medication olanzapine was not renewed as required despite Resident 52's continued use of the medication. The DON further acknowledged that antipsychotic medications such as olanzapine could cause adverse reactions, especially in elderly residents. The DON acknowledged that renewing informed consents ensured residents were informed of the medication's risks and benefits and could make informed decisions about continued treatment. The DON stated she was not aware of the requirement to renew the informed consent for the psychotherapeutic medication olanzapine every six months. Review of the facility's undated policy and procedure titled, POLICY AND PROCEDURE ON CONSENT, indicated, .In accordance with state and federal regulations, and in adherence with patient's bill of rights, facility shall obtain consent, whereby applicable and indicated, from resident. for administration of treatment.		

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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 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 accommodate the needs of 1 of 28 sampled residents (Resident 1) when Resident 1 had a call light (device used to contact staff for assistance) that was not within Resident 1's reach. This deficient practice placed Resident 1 at increased risk for unmet care needs, delayed staff response, falls, and potential injury. Findings: Review of Resident 1's 'admission RECORD' indicated Resident 1 was admitted to the facility with diagnoses including chronic obstructive pulmonary disease (a long term lung disease that causes ongoing breathing problems), asthma (a lung condition that causes episodes of breathing difficulty when the airways narrow), muscle weakness, cerebral infarction (stroke caused by interrupted blood flow to the brain), schizophrenia (a mental health disorder that affects thinking and perception), bipolar disorder (a mental health condition causing extreme mood changes), major depressive disorder (persistent feelings of sadness and loss of interest), anxiety disorder (excessive worry or fear), insomnia (difficulty sleeping), hemiplegia and hemiparesis (paralysis or weakness on one side of the body), and low back pain. Review of Resident 1's Brief Interview for Mental Status (BIMS-to check a resident's thinking and memory) dated 6/12/26, Resident 1 BIMS score was 15 which showed that Resident 1 had intact cognition (13-15 = Intact, 8-12 = Moderate impairment, 0-7 = Severe impairment). During a concurrent observation and interview on 6/16/26 at 11:11 AM with Resident 1 in Resident 1's room, Resident 1 was lying in bed. Resident 1's call light was wrapped around the right half bedside rail, hanging toward the floor, and was not within Resident 1's reach. Resident 1 stated that she could not find her call light and that there were other times when she was unable to reach it. During a concurrent observation and interview on 6/16/26 at 11:19 AM with Certified Nursing Assistant (CNA) 1 in Resident 1's room, Resident 1's call light remained wrapped around the right half bed side rail and hanging toward the floor. CNA 1 stated that Resident 1's call light was not within Resident 1's reach and that could result in delayed staff assistance, unmet needs, and an increased risk for falls if Resident 1 attempted to get out of bed without assistance. During an interview on 6/16/26 at 4:17 PM with the Director of Nursing (DON), the DON stated that residents' call lights should always be within residents' reach. The DON further stated that residents being unable to reach their call lights posed a safety risk and increased the risk of falls. Review of undated facility's policy and procedure (P&P), titled POLICY AND PROCEDURE ON CALL LIGHT, indicated .Keep call light within easy reach of the resident.		

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Encode each resident's assessment data and transmit these data to the State within 7 days of assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a Minimum Data Set (MDS - a standardized assessment used to evaluate a resident's physical, mental, and functional status and identify care needs) discharge assessment was completed, encoded (entered into the facility's MDS software), and transmitted (electronically submitted and accepted into the federal MDS system) within the required timeframe for 1 of 28 sampled residents (Resident 41), when Resident 41 was discharged from the facility on 3/6/26. This failure had the potential to result in incomplete resident assessment information and inaccurate information regarding the resident's discharge status being reported to the Centers for Medicare and Medicaid Services (CMS). Findings: Review of Resident 41's admission RECORD indicated Resident 41 was admitted to the facility with diagnoses of orthopedic after care following surgical amputation (care provided after surgical removal of a body part), acute osteomyelitis right ankle and foot (a bone infection of the right ankle and foot), and type 2 diabetes mellitus (a condition in which the body does not properly regulate blood sugar levels) and was discharged on 3/6/26. During a concurrent interview and record review on 6/18/26 at 4:21 PM with the Minimum Data Set Coordinator Nurse (MDSC - a nurse responsible for completing resident assessments for care planning and reporting), Resident 41's MDS tracking (a record used to monitor the completion and submission status of MDS assessments) was reviewed. Resident 41's MDS tracking indicated that the last MDS assessment completed was an admission assessment dated [DATE], which was transmitted and accepted by CMS, and there were no further MDS assessments documented after the admission assessment. The MDSC confirmed that no additional MDS assessments were completed after 1/13/26 and that Resident 41 was discharged from the facility on 3/6/26. The MDSC stated that an MDS discharge assessment was not completed upon Resident 41's discharge, resulting in the facility being unable to encode and transmit the required discharge assessment to CMS. The MDSC further stated that failure to complete an MDS assessment could result in inaccurate information regarding the resident's status being reported to CMS. During an interview on 6/19/26 at 9:39 AM with the Director of Nursing (DON), the DON stated that the facility was expected to complete MDS assessments, including MDS discharge assessments, and transmit them to CMS by the required due date. The DON further stated that failure to complete MDS discharge assessments and transmit them to CMS could result in inaccurate resident assessments, inaccurate data being reported to CMS, and could affect billing. Review of the facility's undated policy and procedure titled, Minimum Data Set (MDS) Completion, Tracking, and Transmission Policy indicated .It is the policy of this Skilled Nursing Facility (SBF) to ensure the timely, accurate, complete, and compliant completion, tracking, submission, correction, and transmission of all Minimum Data Set (MDS) assessments in accordance with Centers for Medicare & Medicaid Services (CMS), state regulations.		

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. Based on observation, interview and record review, the facility failed to ensure a Preadmission Screening and Resident Review (PASRR - a required screening process used to identify residents with serious mental illness or intellectual disabilities and determine whether they need specialized services) was completed for 1 of 28 sampled residents (Resident 17) when Resident 17's PASRR completed on 9/25/23 determined Resident 17 did not require a PASRR Level II evaluation (an in-depth evaluation to determine the need for specialized mental health services), but Resident 17 was later prescribed risperidone (an antipsychotic medication used to treat certain mental health conditions) on 9/30/25 due to increased behavioral symptoms and was not referred for PASRR review. This failure had the potential for Resident 17 not to be properly evaluated for specialized mental health services and not to receive the care and services appropriate to the resident's needs. Findings: Review of Resident 17's admission RECORD, indicated Resident 17 was admitted to the facility with diagnosis including schizophrenia (a mental health disorder characterized by disturbances in thinking, perception, and behavior) and cerebral infarction (brain damage by interrupted blood flow to the brain, also known as a stroke). Review of Resident 17's Brief Interview for Mental Status (BIMS-to assess a resident's thinking and memory) dated 5/29/26 indicated Resident 17 had a BIMS score of 9, which showed Resident 17 had moderately impaired cognition (13-15 = Intact, 8-12 = Moderate, 0-7 = Severe). Review of Resident 17's UNABLE TO COMPLETE LEVEL II EVALUATION Letter dated 9/15/23 indicated that Resident 17 did not require a PASRR Level II evaluation because Resident 17 did not have a serious mental illness. Review of Resident 17's Medication Administration Record (MAR) for 6/1/26 through 6/17/26, Resident 17 received risperidone 1 milligram (MG - unit measure) daily at 9 PM from 6/1/26 through 6/17/26 for schizophrenia manifested by paranoia and thoughts that food and medications were poisoned, with a start date of 9/30/25. Review of Resident 17's Care Plan, initiated on 11/10/25, in the section titled Focus, indicated .[Resident 17] The resident has potential to be verbally aggressive and has angry outburst as manifested by yelling at her husband. Mood swings, purposeless screaming, exaggerated range no reasons. During a concurrent interview and record review on 6/17/26 at 4:48 PM with the Director of Nursing (DON), Resident 17's PASRR Level I Screening dated 9/14/23 was reviewed. Resident 17's PASRR Level I Screening (an initial screening to determine if further evaluation is needed), in the section titled Section III - Serious Mental Illness - Definition, indicated that risperidone was not documented as a prescribed psychotropic medication. The DON stated risperidone was not documented because the PASRR evaluation was completed before Resident 17 exhibited new behaviors, including paranoia and angry outbursts, and before risperidone was prescribed on 9/30/25, approximately two years after the PASRR evaluation dated 9/15/23. The DON acknowledged the facility failed to complete a PASRR review following Resident 17's increase in behaviors and stated this was a safety risk because Resident 17 was not evaluated to determine whether the facility could safely manage Resident 17's behavioral and mental health needs, and no recommendations were obtained regarding specialized mental health services and interventions to address Resident 17's increased behaviors. Review of the facility's policy and procedure dated titled, Pre-admission SCREENING RESIDENT REVIEW (PASRR) dated 8/2000, indicated .Change in Health Status.resident experiences a significant change in health status.or physical status.must complete a new PASRR form.refer immediately for a Level II determination. This applies as well to the NF [Nursing Facility] resident whose initial Level I did not require a referral for Level II determination, but who has (continued on next page)		

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	experienced a significant change in health status that raises a question of possible change in the resident's MI/MR [Mental Illness/Mental Retardation] status.		

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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. Based on observation, interview, and record review, the facility failed to update the care plan with appropriate, resident-specific fall interventions for 1 of 28 sampled residents (Resident 75) following a fall on 5/12/26 when the Interdisciplinary Team (IDT - a group of healthcare professionals from different disciplines who collaborate to provide resident care) did not complete a root cause analysis or identify recommendations related to the cause of the fall, and nursing staff did not complete post-fall monitoring to identify risks and develop resident-specific interventions to prevent future falls. These failures had the potential to place Resident 75 at risk for recurrent falls and injury. Findings: Review of Resident 75's admission RECORD indicated Resident 75 was admitted to the facility with diagnoses including muscle weakness, other symptoms and signs involving the musculoskeletal system, type 2 diabetes mellitus, major depressive disorder, hemiplegia and hemiparesis following cerebral infarction (partial or complete weakness or paralysis on one side of the body following a stroke), transient alteration of awareness (temporary episodes of confusion or changes in alertness), dementia (a condition that affects memory, thinking, and decision-making), parkinsonism (a condition that causes movement problems such as tremors, stiffness, and slow movements), and gout (a painful type of arthritis caused by a buildup of uric acid crystals in the joints). Review of Resident 75's Brief Interview for Mental Status (BIMS, an assessment used to evaluate a resident's thinking and memory) dated 6/17/26 indicated Resident 75 had a BIMS score of 10, which indicated moderately impaired cognition (13-15 = intact, 8-12 = moderate impairment, 0-7 = severe impairment). Review of Resident 75's FALL RISK ASSESSMENT (an assessment used to identify a resident's risk for falling) dated 6/1/26 indicated Resident 75 had a total score of 13. The assessment indicated that a score greater than 10 represented a high risk for falls. Resident 75 was considered at high risk for falls. Review of Resident 75's progress notes dated 5/12/26 at 3:54 PM indicated that on 5/12/26, at approximately 2:20 PM, staff heard yelling for help in the therapy room and found Resident 75 on the floor. Resident 75 stated that he wanted to climb the stairs but lost his balance when he attempted to get up from his wheelchair. During an observation on 6/17/26 at 10:00 AM in the therapy room, the therapy room was accessible through an unlocked door with a standard doorknob. Upon entering the therapy room, offices were located near the entrance. Therapy equipment used for exercises was located further inside the room. During a concurrent observation and interview on 6/16/26 at 12:16 PM with Certified Nursing Assistant (CNA) 7 in Resident 75's room, Resident 75 was lying in bed without water readily accessible for drinking. CNA 7 confirmed the water was not within Resident 75's reach and stated that if Resident 75 attempted to get out of bed to obtain water, he could fall because Resident 75 required assistance to get out of bed. During a concurrent interview and record review on 6/19/26 at 9:39 AM with the Director of Nursing (DON), Resident 75's IDT Post Fall note dated 5/13/26 was reviewed. The IDT Post Fall note was signed by IDT members but did not include a root cause analysis or recommendations specific to the cause of Resident 75's fall on 5/12/26. The DON confirmed the IDT Post Fall note did not identify interventions to prevent Resident 75 from independently accessing the therapy room without supervision. Resident 75's post-fall monitoring progress notes dated 5/12/26 through 5/14/26 were also reviewed with the DON. The DON confirmed post-fall monitoring documentation was missing for the 5/12/26 PM and night shifts, 5/13/26 PM shift, and 5/14/26 PM shift. The DON stated nursing staff were expected to monitor residents who experience a fall every shift for three days, with the monitoring documented in the progress notes, and acknowledged that incomplete monitoring could result in missed injuries or (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	changes in condition. Resident 75's care plan was also reviewed with the DON. The DON confirmed Resident 75 did not have a care plan specific to the 5/12/26 fall and that the care plan was not updated to include resident-specific interventions to prevent future falls. The DON acknowledged that completing a root cause analysis and post-fall monitoring was essential to identify risks and develop a care plan with resident-specific interventions to prevent future falls. Review of the facility's undated policy and procedure titled, Fall Policy and Procedure indicated .The Interdisciplinary Team (IDT) shall investigate all falls. A root cause analysis shall be completed for. Significant incidents. Following each fall. The interdisciplinary team shall. Review the resident's risk factors. Update the care plan. Implement additional interventions as indicated. Care plan revisions shall be documented. Monitoring After a Fall. Residents shall be monitored for. Pain. Changes in mobility. Changes in cognition. Delayed signs of injury. Neurological changes. Nursing staff. Assess and monitor residents. Document findings. Implement interventions. Review of the facility's undated policy and procedure titled, POLICY AND PROCEDURE ON FALL PREVENTION AND REDUCTION indicated .Residents identified to be at risk for falls or further falls shall have plans of care developed to minimize or reduce risk factors for falls or further falls. Plans of care shall include interventions on the following. Provision of monitoring and supervision to resident to prevent fall incident. Plans of care shall be revised and updated for. Whenever resident experiences actual fall. Whenever there are changes in interventions to prevent and/or reduce fall.		

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. Based on observation, interview, and record review, the facility failed to ensure 1 of 28 sampled residents (Resident 75) had their hydration needs addressed when Resident 75, who preferred to have water readily available at the bedside and within his reach, did not have water available to drink at the bedside. This failure had the potential to place Resident 75 at risk for dehydration (when the body does not get enough fluids to function properly), and overall decline in health. Findings: Review of Resident 75's admission RECORD, indicated Resident 75 was admitted to the facility with diagnoses including muscle weakness, other symptoms and signs involving the musculoskeletal system, type 2 diabetes mellitus (a disease that causes uncontrolled blood sugar), chronic kidney disease (long-term damage to the kidneys that affects their ability to function properly), secondary polycythemia (a condition in which the body produces too many red blood cells), major depressive disorder, hemiplegia and hemiparesis following cerebral infarction (partial or complete weakness or paralysis on one side of the body following a stroke), transient alteration of awareness (temporary episodes of confusion or changes in alertness), dementia (a condition that affects memory, thinking, and decision-making), parkinsonism (a condition that causes movement problems such as tremors, stiffness, and slow movements), and gout (a painful type of arthritis caused by a buildup of uric acid crystals in the joints). Review of Resident 75's Brief Interview for Mental Status (BIMS-to assess a resident's thinking and memory) dated 6/17/26, indicated Resident 75 had a BIMS score of 10, which showed Resident 75 had moderately impaired cognition (13-15 = Intact, 8-12 = Moderate, 0-7 = Severe). During a concurrent observation and interview on 6/16/26, at 12:03 PM, with Resident 75 in Resident 75's room, Resident 75 was lying in bed without water or other fluids within reach. Resident 75 stated he wanted water readily available at bedside and that it had not always been available when needed. During a concurrent observation and interview on 6/16/26, at 12:16 PM, with Certified Nursing Assistant (CNA) 7, in Resident 75's room, Resident 75 remained lying in bed without water readily accessible for drinking. Resident 75's water pitcher was placed on a table across from the bed and was not within Resident 75's reach. CNA 7 confirmed the water was not within Resident 75's reach and stated that if Resident 75 attempted to get out of bed to obtain water, he could fall because he required assistance to get out of bed. Resident 75 stated he wanted his water kept at bedside so he could drink whenever needed. CNA 7 stated that not having water readily available placed Resident 75 at risk for dehydration. During an interview on 6/18/26, at 11:28 PM, with the Director of Nursing (DON), the DON stated that staff were expected to ensure fluids were within residents' reach. The DON further stated if fluids were not readily accessible to residents, residents were at risk for dehydration and falls. Review of the facility's undated policy and procedure titled, POLICY AND PROCEDURES ON HYDRATION, indicated .It is the policy of this facility to maintain a resident's hydration by encouraging adequate fluid intake. As part of facility's hydration program, Certified Nursing Assistants shall ensure provision of water pitcher by the resident's bedside.		

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the medication error rate was less than 5% (% or percentage is a fraction of a number out of 100) during medication administration for a census of 78. The facility had a total of four errors out of 55 opportunities which resulted in a facility wide medication error rate of 7.27%. Medication observations were conducted over multiple days, at varied times, in random locations throughout the facility. The four medication errors were identified in three residents (Resident 72, Resident 12, Resident 15) out of 8 residents observed for medication administration observation as follows: Resident 15 was given 1000 mg (mg -is a milligram a unit of measurement) of Fish Oil (a dietary fat removed from fish) with 300 mg of omega 3 (three essential polyunsaturated [healthy Fats]) instead of the ordered 1000 mg of omega 3. Resident 12 was given [NAME]-Vite (an all-purpose multivitamin) instead of [NAME]-Vite Oral Tablet (B-complex [a group of 8 essential B vitamins] w/ C & Folic Acid [W-with, C-Vitamin C, &-and]). The directions of administration were not followed for Resident 72's esomeprazole (a medication to reduce stomach acid), and the medication was administered with 5 ml (a unit of liquid measurement) instead of the ordered 50 ml of water ordered. LN 5 did not flush Resident 72's Gastronomy Tube (G-Tube- a tube that enters directly into the stomach) in between medication administration. These failures could contribute to unsafe medication use and inadequate treatment in the facility and have the potential to impact the health and well- being of the residents including Resident 15, Resident 12, and Resident 72. Findings: 1. During a medication administration observation on 6/17/26, at 8:49 AM, with Licensed Nurse (LN) 3, LN 3 obtained a small cup to place the medication that will be used to administer medication to Resident 15. While preparing the medications LN 2 used the Medication Administration Record (MAR- A place where medication and treatment orders are placed for staff to view and administer as indicated). LN 3 removed one capsule from a bottle titled, Fish Oil 1000mg Omega -3 300mg and placed the capsule in the small cup with the rest of Resident 15's medication that was added according to the MAR. LN 3 then poured a cup of water and administered the medication to Resident 15. A review of Resident 15's electronic medical record titled, Medication Administration Record, dated 6/2026, indicated an order as follows: .Omega-3 Oral Capsule 1000 MG; Give 1 capsule by mouth one time a day for SUPPLEMENT. During a concurrent interview and record review on 6/19/26, at 1:08 PM, with LN 3, LN 3 confirmed the doctors order for Omega- 3 Oral Capsule 1000 MG for Resident 15 was not the medication administered. LN 3 further confirmed Resident 15 was administered fish oil which was not ordered and 300mg of the ordered 1,000 mg of omega-3. LN 3 explained that the medication was important for heart health. LN 3 stated the dose she administered placed the Resident 15 at risk of not receiving the full benefit of the medication. 2 During a medication observation on 6/17/26, at 9:30 AM, with LN 4, LN 4 obtained a small cup to place the medication that will be used to administer the medications to Resident 12. While preparing the medications LN 4 used the MAR. LN 4 removed one tablet from a bottle titled, [NAME]-Vite Tablets Dietary Supplement., and placed that tablet in the small cup with the rest of Resident 12's medication that was added according to the MAR. LN 4 then poured a cup of water and administered the medication to Resident 12. During a record review of Resident 12's electronic medical record titled, .Medication Administration Record., dated 6/2026, indicated an order as follows: .[NAME]-Vite Oral Tablet (B-complex w/ C & Folic Acid) Give 1 tablet by mouth one time a day for supplement. During a concurrent interview and record review on 6/19/26, at 9:29 AM, with LN 4, Resident 12's MAR, dated 6/2026 was reviewed. LN 4 confirmed the doctors order for Resident 12 indicated, .[NAME]-Vite Oral Tablet (B-Complex w/ C & Folic Acid) (continued on next page)		

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give 1 tablet by mouth one time a day for supplement. LN 4 then opened his medication cart and obtained the bottle of Rena Vite and confirmed the bottle used to administer Resident 12's medication did not match the doctors order. LN 4 stated this error placed Resident 12 at risk for of not receiving all of the vitamins as ordered. LN 4 further stated the medication given may have unknown components given to Resident 12.3. During a medication observation on 6/18/26, at 8:16 AM, with LN 5, LN 5 obtained multiple small cups to place each of the medications that were to be used to administer the medications to Resident 72. While preparing the medications LN 5 used the MAR. LN 5 removed one capsule from the bubble pack titled, ESOMEPRAZOLE MAG [magnesium] DR [delayed release] 40 MG., with the directions of, GIVE 1 CAPSULE VIA PEG TUBE [percutaneous endoscopic gastrostomy- a flexible feeding tube] ONCE EVERY DAY: OPEN CAPSULES AND PLACE GRANULES INTO 60ML SYRUNGE; MIX WITH 50ML OF WATER; SHAKE. LN 5 opened the capsule and added 5 ML of water to the small cup and mixed it. LN 5 then placed the small cups with the medication on it, on a tray to administer it to Resident 72. LN 5 flushed the G-Tube with 15 ML of water then administered each medication one after the other. LN 5 administered the esomeprazole mag dr 40mg mixed in 5ML of water. After administering all the medications LN 5 then flushed the tube with 15 ML of water. During a record review of Resident 72's electronic medical record titled, .Medication Administration Record., dated 6/2026, indicated an order as follows: .Esomeprazole Magnesium Oral Capsule Delayed Release 40 MG. Give 1 capsule via PEG-Tube one time a day for GERD with 50 ml of water.4. During a medication observation on 6/18/26, at 8:16 AM, LN 5 was observed giving six different medications to Resident 72 via the G-Tube (Gastric Tube). LN 5 was observed flushing the G-tube with 15ml of water prior to medication administration. LN 5 did not flush the G-tube in between the 6 medications she administered. LN 5 flushed the G-tube line with 15 ML at the end of last medication she administered. During an interview on 6/19/26, at 9:39 AM, with LN 5, LN 5 acknowledged that she administered Resident 72's morning medications via G-Tube without a flush in between. LN 5 stated she believed that the flush should only be before and after the medications were administered. LN 5 further stated Resident 72's G-tube line could have gotten clogged without adequate flushing in-between medications and Resident 72 could become dehydrated. During an interview on 6/19/26, at 8:29 AM, with the Director of Nursing (DON), the DON stated she expect her nurses to follow the proper guidelines to administer medication. The DON stated she expect the licensed nurses to administer the medication as ordered by the doctor. The DON further stated it was the facility's policy that when multiple g-tube medications were being administered, 30 ml of water should be given before and after administration of the medications. The DON stated the nurses needed to flush the g-tube with 15 ml in between each medication administered. The DON further stated this helped with proper absorption of the medications. The DON stated giving the wrong or missing a medication placed the resident at risk for not receiving the intended treatment. A review of the facility's policy and procedure titled, .MEDICATION ADMINISTRATION-GENERRAL GUIDELINES., dated 8/1/19, indicated, .Policy Medications re-administered as prescribed in accordance with good nursing principles and practices and only by persons legally authorized to do so.FIVE RIGHTS- Right resident, right drug, right dose, right route and right time, are applied for each medication being administered. A triple check of these 5 Rights is recommended at three steps in the process of preparation of a medication of administration. Check #3: Complete the preparation of the dose and re-verify the label against the MAR by reviewing the 5 rights. A review of the facility's policy and procedure titled, .GENERAL GUIDELINES FOR ADMINISTERING MEDICATIAONS VIA ENTERAL TUBE., dated 8/1/19, indicated, .The facility assures the safe effective administration of enteral formulas and medication via enteral tubes. Enteral tubes are flushed with at least 15 ML of purified or sterile (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055039	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/19/2026
NAME OF PROVIDER OR SUPPLIER Good Samaritan Rehab and Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1630 N. Edison Street Stockton, CA 95204	
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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	water before administering, between each medication, and after all medications have been administered. Tablets, powders and beads (never crushed) from opened capsules, are mixed with 15-30ml of water prior to administration via the tube.		

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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 use and storage of medication and labeling practices for a census of 78 when:1. A carton of an opened and unlabeled nutritional supplement was found on a medication cart.2. Personal items and cleaning chemicals were found stored in one of the cabinets.3. The facility did not monitor the temperatures of both medication rooms, and,4. Unauthorized personnel had access to the medication room.These failures could contribute to the risk of using contaminated products on residents, contribute to unsafe medication use, lack of accountability and risk of drug diversion (the illegal distribution or abuse of prescription drugs or their use for purposes not intended by the prescriber).Findings:1. During a concurrent observation and interview on 6/17/26, at 10:20 a.m., with Licensed Nurse (LN) 2, the medication room at Nursing Station 3 was observed. LN 2 stated every morning the Central Supply staff would have checked and delivered nutritional supplies to the nursing station medication rooms. LN 2 further stated the nutritional supplements were opened daily and then kept at the medication carts. LN 2 stated the morning shift nurse would have opened a new nutritional supplement carton at the beginning of the shift and would usually be emptied by the end of the shift. LN 2 confirmed the medication room had various cartons of nutritional supplements. During a concurrent observation and interview on 6/17/26, at 10:41 a.m., with LN 2, the medication room at the Nursing Station 1&2 was observed. LN 2 confirmed the medication room contained cartons of nutritional supplements. During a concurrent observation and interview on 6/17/26, at 10:46 a.m., with LN 2, a medication cart was observed with two cartons of nutritional supplement at the nursing station. LN 2 confirmed one carton of ReadyCare 2.0 (a high calorie protein nutritional drink) was opened and in use and was not labeled by staff. LN 2 stated the nurse who opened the nutritional supplement carton should have labeled with an open date to ensure it was not reused and was safe to be given to the residents.During an interview on 6/17/26, at 11:01 a.m., with LN 3, LN 3 stated the nurse would have opened a new nutritional supplement carton at the start of the shift and labeled with an open date. LN 3 further stated it was important to have labeled the nutritional supplement upon opening so the nurses would know when to throw it away and to ensure it was not spoiled for the residents.During an interview on 6/18/26, at 3:37 p.m., with the Registered Dietician (RD), the RD stated the nursing staff were in charge of labeling opened supplemental feeding cartons. The RD further stated it was important to have ensured open dates and schedules were being followed by the staff. The RD stated that any food item over time could have begun the process of decay and development of bacteria.During an interview on 6/19/26, at 11:01 a.m., with the Director of Nursing (DON), the DON stated it was her expectation for the staff to have labeled nutritional supplements with open dates and daily changes. The DON further stated the staff should have monitored when the nutritional supplements were opened for the staff to know when they need to be thrown out so they were not reused.A review of the facility's undated policy titled, Policy and Procedure: Nutritional Supplements, indicated, .Purpose.To ensure that nutritional supplements are ordered, stored, administered, monitored, and documented appropriately to meet resident's nutritional needs, promote optimal health, prevent malnutrition, and comply with federal, state, and facility regulations.Procedures.B. Storage and Handling.6. Opened supplements shall be labelled with: Resident name, Date opened, time opened.A review of the facility's undated policy titled, Policy: Ready Care Supplement Storage and Temperature (continued on next page)		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Control, indicated, .Purpose.To ensure the safety, quality, nutritional integrity, and proper handling of Ready care nutritional supplements and enteral feeding formulas adherence to temperature control, storage, monitoring, and administration guidelines.Procedures.4. Handling Ordered Supplements.Opened supplements shall be labelled with: Date opened, Time opened, staff initials. 2. During a concurrent observation and interview on 6/16/26, at 9 AM, with the DON, in medication room [ROOM NUMBER], one of the cabinets was found to have a staff member's purse, clothing cleaning chemicals, and personal air fresheners. The DON acknowledged the items and stated that the cabinet was for the staff to place their personal items.During an interview with on 6/19/26, at 9:10 AM, with the DON, the DON stated staff should not have placed personal items in the medication room. The DON further stated the personal items placed a risk for drug diversion. The DON stated the medication room should never had chemicals stored inside of it and the risk was for the medications coming in contact with the chemicals. The DON further stated the personal items in the medication room and the chemicals being stored in the medication room did not meet her expectations and was not the facility's process.3. During a concurrent observation and interview on 6/16/26, at 10:27 AM, with LN 2, the station 3 medication room was observed. LN 2 confirmed that there was no temperature log. LN 2 stated the temperature log should have been available in the medication room because medications and supplements were stored inside. LN 2 stated the risk of not checking the temperature and having a log to record the temperatures was that the facility would be unable to monitor the temperature which could affect the nutritional supplements and the possibility of spoilage if the temperature increased too much.During a follow-up concurrent observation and interview on 6/16/26, at 10:41 AM, with LN 2, the station 1 and station 2 medication room was observed. LN 2 confirmed the absence of a temperature log.During an interview on 6/19/26, at 8:39 AM, with the DON, the DON confirmed that she was aware that the medication room temperatures were not being monitored or logged. The DON stated the Maintenance Director (MD) was responsible for checking the temperatures and log them. The DON stated the facility's policy was to log the temperature of the medication rooms daily. 4. During a concurrent observation and interview on 6/16/26, at 10:27 AM, with LN 2, the station 3 medication room was observed. LN 2 confirmed that there was not a temperature log and stated the MD was the one who checked the temperatures and not the nursing staff.During an interview on 6/19/26, at 8:39 AM, with the DON, the DON confirmed the MD has had access to the medication room and obtained his own key. The DON stated the MD should not have access to the medication rooms because he was not an authorized person. The DON further stated the risk of the MD having access to the medication room was drug diversion.During a review of the facility's policy and procedures titled, MEDICATION STORAGE IN THE FACILITY, dated 8/1/19, indicated, .Medications and biologicals are stored safely, securely, and properly, following manufactures recommendations or those of the supplier. The medication supply is accessible only to licensed nursing personnel .Potentially harmful substances [Such as urine test reagent tablets, household poisons, cleaning supplies, disinfectants] are clearly identified and stored in a locked area separately from medications .All medications are maintained within the temperature ranges noted in the United States Pharmacopeia . Controlled Room Temperature .with a thermometer to allow temperature monitoring .The facility should maintain a temperature log in the storage area to record temperatures at least once a day .		

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. Based on observation, interview, and record review, the facility failed to accommodate resident meal preferences and food allergies for 1 of 28 sampled residents (Resident 54) when Resident 54 was served a bread roll on the 6/16/26 lunch meal service. This failure placed Resident 54 at risk for an allergic reaction due to her food allergies to wheat products. Findings: Review of Resident 54's admission RECORD, indicated that Resident 54 had diagnoses that included, but were not limited to, systemic lupus erythematosus (a chronic, systemic autoimmune disease where the body's immune system mistakenly attacks healthy tissues and organs), and psoriasis (a chronic, noncontagious immune-mediated disease causing skin cells to multiply up to 10 times faster than normal). Further review of the record indicated that Resident 54 had allergies to cornstarch (a fine, white, flavorless powder made from the starchy part [endosperm] of the corn kernel), cranberry, high fructose corn syrup (a liquid sweetener made from cornstarch, commonly used in processed foods and beverages like sodas, baked goods, cereals, condiments [ketchup, BBQ sauce], and canned fruits), kiwi fruit, mango, peanut, and wheat. During an interview on 6/16/26, at 9:26 AM, with Resident 54, Resident 54 stated that she had multiple food allergies including bread and high fructose corn syrup. Resident 54 further stated that she had talked to the Registered Dietician (RD) about her food allergies and food dislikes in the past. During a concurrent observation and interview on 6/16/26, at 12:51 PM, with Resident 54, Resident 54's lunch meal plate and meal ticket were observed. Resident 54 confirmed that she received a bread roll and had placed it onto the side of her meal plate. Resident 54 further confirmed that her meal ticket also stated that she food allergies and food dislikes to wheat products and was still served a bread roll. Resident 54 stated that she did not want to be loaded up on bread products. During a concurrent interview and record review on 6/16/26, at 2:49 PM, with Licensed Nurse (LN) 7, a picture of Resident 54's lunch meal plate and meal ticket were reviewed. LN 7 confirmed that Resident 54 was served a bread roll on the 6/16/26 lunch meal. LN 7 stated that the LN's were responsible for ensuring the tray carts were providing accurate food items to the residents to ensure resident safety. LN 7 further stated that it was his expectation for residents not to receive food items that they were allergic to or disliked. LN 7 stated that residents could have unwanted reactions if they were to eat food items that they were allergic to. During a concurrent interview and record review on 6/16/26, at 2:41 PM, with the RD, a picture of Resident 54's lunch meal plate and meal ticket were reviewed. The RD confirmed that Resident 54 was served a bread roll on the 6/16/26 lunch meal. The RD stated that her expectation was for residents not to receive food items that they were allergic to. The RD further stated that resident food wishes should be honored as much as possible and that adjustments should be made. The RD stated that unwanted food reactions and problems with food intake could occur if Resident 54 were to eat food products that she was allergic to. During an interview on 6/18/26, at 3:22 PM, with the Director of Nursing (DON), the DON stated that her expectation was for the LN's to check the meal carts before the residents were served their meals. The DON further stated that the LN's were the last line of defense to check the meal carts. The DON stated that it could be dangerous for the residents to receive food products that they were allergic to. During a review of the facility's undated policy and procedure (P&P) titled, FOOD PREFERENCES, the P&P indicated, .Resident's food preferences will be adhered to within reason. Substitutes for all foods disliked will be given from the appropriate food group. During a review of the facility's undated P&P titled, FOOD ALLERGIES, the P&P indicated, .Allergies will be noted in the medical record. Appropriate food substitutions will be offered for foods the resident cannot (continued on next page)		

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	eat.Allergies will be noted on the tray card, the resident diet profile, and posted in the kitchen and nursing station.		