STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055084	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/23/2026
NAME OF PROVIDER OR SUPPLIER Riverbank Post-Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 2649 Topeka Street Riverbank, CA 95367	

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 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide medically-related social services to help each resident achieve the highest possible quality of life. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide medically related social service needs for three of seven sampled residents (Residents 1, 2, and 3) when the Social Services Director (SSD) did not schedule physician ordered consultations and diagnostic testing from outside entities and failed to document any attempts to schedule the appointments or contact with the responsible parties (RP) in the electronic medical record (EMR). These failures caused a delay in care and had the potential for the residents' needs to go unmet. (cross reference F842)During a review of Resident 1's admission Record, undated, indicated Resident 1 was admitted to the facility on [DATE] with diagnoses that included hemiplegia (severe paralysis affecting one side of the body) and hemiparesis (weakness, numbness or reduced movement on one side of the body) following cerebral infarction (type of stroke caused by a blockage in the blood vessels sullying the brain resulting in tissue death), dysphagia (difficulty swallowing), aphasia (communication disorder caused by brain damage impairing a person's ability to process, speak, write or understand language), and gastrostomy (G-tube- medical device inserted through the abdomen directly into the stomach to deliver nutrition).During an observation on 3/23/26 at 11:15 a.m. with Resident 3, Resident 3 was lying in bed. Resident 3 had an enteral feeding pump (medical device that delivers liquid nutrition directly into the patient's stomach) at bedside not hooked up to his gastrostomy tube. Resident 3 was verbally nonresponsive.During a review of Resident 3's admission Record, undated, the admission record indicated, Resident 3 was admitted to the facility on [DATE] with diagnoses that included seizures (sudden, uncontrolled electrical disturbance in the brain which can cause uncontrolled jerking, blank states and loss of consciousness), dystonia (movement disorder that causes the muscles to contract), history of traumatic brain injury (form of acquired brain damage caused by a sudden external force) and gastrostomy.During a concurrent observation and interview on 3/23/26 at 11:18 a.m. with Resident 2, Resident 2 was groomed, dressed and lying in bed. Resident 2 stated he was unsure if he had any outside testing or consultations ordered.During a review of Resident 2's admission Record, undated, the admission record indicated, Resident 2 was admitted to the facility on [DATE] with diagnoses that included chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing), dysphagia, and altered mental status.During an interview on 3/23/26 at 11:26 a.m. with Certified Nursing Assistant (CNA) 1, CNA 1 stated she was assigned to Residents 2 and 3. CNA 1 stated Resident 2 was receiving a modified diet (altered food consistency to assist with swallowing difficulties), mechanical soft (foods that are soft, moist, chopped, ground or pureed to require minimal chewing) with nectar thick liquids (mildly thick liquids designed for residents with difficulty swallowing). CNA 2 stated Resident 3 had a G-tube feeding and he did not eat orally for as long as she had known him.During a concurrent interview and record review on 2/23/26 at 12:28 p.m. with Licensed Vocational Nurse (LVN) 1, LVN 1 stated she was assigned to Residents 2 and 3. Resident 2's physician's order dated 10/9/26, was reviewed. The order indicated, . 10/9/3025. Modified Barium Swallow [MBS- real-time X-ray procedure used to evaluate swallowing function, identify aspiration (food/liquid entering the lungs), and determine safe food textures] to R/O [rule out] Silent (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055084	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/23/2026
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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Aspiration. Resident 2's Nurses Notes, dated 10/9/25, indicated, . [name of physician] made rounds and examined resident with new order for Modified Barium Swallow to R/o Silent Aspiration [name of SSD] Social Service notified. LVN 1 stated it was important to schedule Resident 2's MBS to rule out swallowing issues because he had a high risk of choking on food and drink and could aspirate. LVN 1 stated the staff were aware Resident 2 was at high risk of aspiration and would watch him carefully while he ate and made sure his liquids were the correct thickened consistency. LVN 1 stated the note indicated the SSD was notified and should have scheduled the MBS according to the physician's order. Resident 3's physician's order dated 7/22/25, indicated, . for Barium Swallow Consult. Resident 3's Nurses Notes, dated 7/22/25, indicated, . [name of physician] made rounds examined resident with New order for Barium Swallow Consult [name of Social Services Assistant (SSA)] Social Worker notified. LVN 1 stated Resident 3 had swallowing issues so he had the G-tube for nutrition and medication because he was not safe to eat or drink by mouth. LVN 1 stated the SSA or SSD should have scheduled the appointment and documented any follow-up in the residents EMR. Resident 1's physician's orders, dated 12/10/25 was reviewed and indicated, . EENT [Ear, Nose and Throat] Consult to assist Vocal Cord Mobility [normal movement of the vocal cords required for breathing, swallowing, and producing sound]. Modified Barium Swallow to r/o Silent aspiration to help determine if PO [by mouth] diet placement is possible. LVN 1 stated Resident 1 was her resident while he was at the facility but had been discharged . LVN 1 stated Resident 1 had a G-tube when he was admitted to the facility and had graduated to an oral diet while admitted . LVN 1 stated the MBS was ordered to see if he could tolerate oral food and drink safely. LVN 1 stated it was important for Resident 1 to have the test done to rule out choking or aspiration with oral intake. LVN 1 was unable to locate documentation the SSD had scheduled appointment or followed up. LVN 1 stated the process for scheduling consultations and outside appointments such as the MBS was for the physician to enter the order, then the nurse would document in the nurse's note they received the order and then send it to the SSD who would schedule the appointments. LVN 1 stated she would print the order and give a copy to the SSD for follow up. LVN 1 stated after the SSD has the order, the nurses do not normally follow up because the SSD was responsible for scheduling the appointments.During a concurrent interview and record review on 3/23/26 at 1:57 p.m. with the Speech Therapist (ST), the ST stated Residents 1, 2, and 3 had MBS' ordered and the SSD did not schedule the appointments. The ST stated she was treating Resident 1 while he was in the facility, the resident was dependent on a G-tube feeding and needed an MBS to be sure he could tolerate an oral diet without aspirating. The ST stated Resident 1 was also supposed to have an ENT consultation for his vocal cords to help with his communication. The ST stated Resident 2 needed an MBS to rule out if he was aspirating while eating to prevent any respiratory infections and to assess if he could tolerate advancing his diet. The ST stated Resident 3 was dependent on a G-tube feeding and had an order for an MBS on 7/22/25 to assess if he would be able to tolerate an oral diet. The ST stated she would discuss needed consultations with the SSD after the physician placed an order and the resident or responsible party had agreed to the testing and/or consultation. The ST stated she had been told by the SSD that it would take three months for the tests and consultations to be scheduled. The ST stated she had discussed Resident 3's MBS and had followed up with the SSD three months later and was told the SSD was still working on scheduling the test. The ST stated the SSD stated Resident 2 had refused the MBS, but she had already discussed the test with Resident 2 and his RP and they agreed with the testing. The ST stated the process if she determined a resident needed a consultation or MBS was to discuss it with the patient and RP, if okay request an order from the physician either directly or through the charge nurse, then the order was to be sent by nursing to the SSD for scheduling.During a concurrent interview and record review on 3/23/26 at 3:00 p.m., with the SSD, the SSD stated the referral process for consultations or outside testing was for a physician order to be placed, then nursing would send her a copy of the order. The SSD stated if she was not at the facility, the nursing staff would place the order under the door of her office. The SSD stated she (continued on next page)

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	would then start the process for scheduling the appointments. The SSD stated she did not document attempts to schedule appointments or follow-up notes in the EMR but kept papers in a folder with the orders and her notes on them. The SSD declined to answer if her folder was part of the Resident's medical record. The SSD stated that when she scheduled appointments, she would place a communication note in the facility's EMR program, but those notes were deleted after a set amount of time, it was not a part of the resident's medical record. Resident 3's order for an MBS on 7/22/25 was reviewed, the SSD stated she had contacted Resident 3's sister when she had called to schedule the appointment and the hospital indicated an RP needed to attend Resident 3's appointment to sign consents. The SSD stated she called the RP several times but did not document any of the attempts to schedule the MBS or contact the sister in the EMR. The SSD stated if something was not documented it was considered not done. The SSD stated she did not follow up with the ST after she was unable to schedule the test. The SSD stated Resident 2 had refused to have the MBS, so she had contacted his RP. The SSD stated she did not document a note in the resident's medical record that the resident and RP refused the appointment. Resident 1's order for the MBS and ENT consultation from 12/20/25 was reviewed and the SSD stated Resident 1 had been scheduled for an in-house ENT consultation on 2/23/26 but had discharged prior to the appointment. The SSD stated she did not document the appointment in the EMR. The SSD stated Resident 1's MBS had not been scheduled because they were waiting for the ENT consultation. The SSD stated she was working with Resident 1's insurance to have the MBS approved but had not received authorization prior to the residents' discharge. The SSD was unable to state if the ST or primary physician had been notified of the delay in the MBS appointment and had not documented any notification or follow up in the EMR. The SSD stated the ST usually notified her of recommended tests and consultations, but the SSD did not follow up unless she received the physician order. The SSD was unable to answer if the residents' needs had been met without the ordered tests and follow-up. The SSD stated she should have documented in the EMR so her attempts to schedule the appointments and follow-up phone calls were a part of the medical record.During an interview on 3/23/26 at 3:55 p.m. with the Director of Nursing, the DON stated the process for consultations and outpatient diagnostic testing were for the Interdisciplinary team (IDT- team from different healthcare disciplines who work together to provide comprehensive patient care) to review new orders during their daily meeting. The DON stated the IDT would discuss the orders as a group, where to schedule the appointments and then the SSD was responsible for scheduling the appointments. The DON stated the facility did not have a good system in place to verify appointments were made and followed up on and they were in the process of putting a new system in place. The DON stated she was unaware of Resident 1, 2, and 3's appointments were never completed. The DON stated she was not aware the SSD was keeping paper notes and stated it was not a wise choice. The DON stated the information needed to be documented in the Resident's EMR so everyone could track the appointment and follow up as needed. The DON stated the SSD should document all follow up phone calls in a progress note in the EMR. The DON stated it was important for the physician ordered ENT consultations and MBS' to be scheduled as ordered for quality and continuity of care.During a telephone interview on 3/24/26 at 4:16 p.m. with the Administrator (ADM), the ADM stated the IDT was made aware of the referral issues recently. The ADM stated his expectations were for the physician's orders to be followed and for the SSD to schedule the appointments as ordered. The ADM stated the SSD told him she was documenting on paper which was kept in her office and was not part of the EMR. The ADM stated he instructed the SSD her work needed to be documented in the Residents medical records because papers could be lost. The ADM stated the SSD notified him the hospital required the RP to be present at the MBS appointment which was an issue. The ADM stated they were working with the RPs to have them attend an appointment. The ADM stated advancing diet was in the ST's scope of practice and it sounds doubtful they [the MBS'] are necessary. But I'm not a clinician. The ADM stated the facility was responsible for carrying out the physician orders. The ADM stated he was the SSDs direct supervisor, but he was not aware (continued on next page)

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	she had not scheduled the appointments or documented in the EMR. The ADM stated the appointment scheduling and follow-up notes needed to be a part of the medical record. The ADM stated he reviewed the EMR with the SSD and she showed him where she was entering appointments after they were made in the communication section of the EMR program. The ADM stated the communication board was automatically cleared within 3 days and was not part of the permanent medical record. During a review of the facility's Job Description: Director of Social Service, undated, the job description indicated, . primary purpose of your job position is to assist in planning, developing, organizing, implementing evaluating, and directing social service programs in accordance with current federal, state, and local standards, guidelines, and facility policies and procedures [P&P], to assure that the medically related emotional and social needs of the resident are met/maintained on an individual basis. As Social Services Director you are delegated the administrative authority, responsibility and accountability necessary for carrying out your assigned duties. Record and maintain regular Social Service progress notes indicating response to the treatment plan and/or adjustment to institutional life. Perform other charting duties as necessary. Assist in making appointments for the resident/family as requested or appropriate. Assist in arranging transportation. Assist in obtaining resources from community social, health and welfare agencies to meet the needs of the resident.During a review of the facility's policy and procedure (P&P) titled Referrals, Social Services, dated 12/2008, the P&P indicated, . Social Services personnel shall coordinate most resident referrals with outside agencies. Referrals for medical services must be based on physician evaluation of resident need. Social services will collaborate with the nursing staff or other pertinent disciplines to arrange for services that have been ordered by the physician. Social Services will document the referral in the resident's medical record.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Administer the facility in a manner that enables it to use its resources effectively and efficiently. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility's Administrator (ADM) failed to provide effective oversight and necessary resources to ensure resident care services were met to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident for four of seven sampled residents (Residents 1, 2, and 3) when the Administrator did not provide oversight and supervision of the Social Services Director (SSD) and Residents 1, 2, and 3's physician ordered consultations and testing as outside entities were not scheduled timely and there was no documentation of a follow up or reason in the electronic medical record (EMR). This failure had the potential for residents' needs to go unmet. (cross reference F745 and F842)During a review of Resident 1's admission Record, undated, indicated Resident 1 was admitted to the facility on [DATE] with diagnoses that included hemiplegia (severe paralysis affecting one side of the body) and hemiparesis (weakness, numbness or reduced movement on one side of the body) following cerebral infarction (type of stroke caused by a blockage in the blood vessels sullying the brain resulting in tissue death), dysphagia (difficulty swallowing), aphasia (communication disorder caused by brain damage impairing a person's ability to process, speak, write or understand language), and gastrostomy (G-tube- medical device inserted through the abdomen directly into the stomach to deliver nutrition).During an observation on 3/23/26 at 11:15 a.m. with Resident 3, Resident 3 was lying in bed. Resident 3 had an enteral feeding pump (medical device that delivers liquid nutrition directly into the patient's stomach) at bedside not hooked up to his gastrostomy tube. Resident 3 was verbally nonresponsive.During a review of Resident 3's admission Record, undated, the admission record indicated, Resident 3 was admitted to the facility on [DATE] with diagnoses that included seizures (sudden, uncontrolled electrical disturbance in the brain which can cause uncontrolled jerking, blank states and loss of consciousness), dystonia (movement disorder that causes the muscles to contract), history of traumatic brain injury (form of acquired brain damage caused by a sudden external force) and gastrostomy.During a concurrent observation and interview on 3/23/26 at 11:18 a.m. with Resident 2, Resident 2 was groomed, dressed and lying in bed. Resident 2 stated he was unsure if he had any outside testing or consultations ordered.During a review of Resident 2's admission Record, undated, the admission record indicated, Resident 2 was admitted to the facility on [DATE] with diagnoses that included chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing), dysphagia, and altered mental status.During a concurrent interview and record review on 2/23/26 at 12:28 p.m. with Licensed Vocational Nurse (LVN) 1, Resident 2's physician's order dated 10/9/26, was reviewed. The order indicated, . 10/9/3025. Modified Barium Swallow [MBS- real-time X-ray procedure used to evaluate swallowing function, identify aspiration (food/liquid entering the lungs), and determine safe food textures] to R/O [rule out] Silent Aspiration. Resident 2's Nurses Notes, dated 10/9/25, indicated, . [name of physician] made rounds and examined resident with new order for Modified Barium Swallow to R/o Silent Aspiration [name of SSD] Social Service notified. LVN 1 stated the note indicated the SSD was notified and should have scheduled the MBS according to the physician's order. Resident 3's physician's order dated 7/22/25, indicated, . for Barium Swallow Consult. Resident 3's Nurses Notes, dated 7/22/25, indicated, . [name of physician] made rounds examined resident with New order for Barium Swallow Consult [name of Social Services Assistant (SSA)] Social Worker notified. LVN 1 stated the SSA or SSD should have scheduled the appointment and documented any follow-up in the residents EMR. Resident 1's physician's orders, dated 12/10/25 was reviewed and indicated, . EENT [Ear, Nose and Throat] Consult to assist Vocal Cord Mobility [normal movement of the vocal cords required for breathing, swallowing, and producing sound]. Modified Barium Swallow to r/o Silent aspiration to help determine if PO [by mouth] diet placement is possible. LVN 1 stated the MBS was ordered to see if he could tolerate oral food and drink safely. LVN 1 was unable to locate documentation the SSD had scheduled appointment or followed up. LVN 1 (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	stated the process for scheduling consultations and outside appointments such as the MBS was for the physician to enter the order, then the nurse would document in the nurse's note they received the order and then send it to the SSD who would schedule the appointments.During a concurrent interview and record review on 3/23/26 at 3:00 p.m., with the SSD, the SSD stated the referral process for consultations or outside testing was for a physician order to be placed, then nursing would send her a copy of the order. The SSD stated if she was not at the facility, the nursing staff would place the order under the door of her office. The SSD stated she would then start the process for scheduling the appointments. The SSD stated she did not document attempts to schedule appointments or follow-up notes in the EMR but kept papers in a folder with the orders and her notes on them. The SSD declined to answer if her folder was part of the Resident's medical record. The SSD stated she was told by the ST she was going to have a physician order placed, but she did not receive an order and did not follow up. The SSD stated that when she scheduled appointments, she would place a communication note in the facility's EMR program, but those notes were deleted after a set amount of time, it was not a part of the resident's medical record. Resident 3's order for an MBS on 7/22/25 was reviewed, the SSD stated she had contacted Resident 3's sister when she had called to schedule the appointment and the hospital indicated an RP needed to attend Resident 3's appointment to sign consents. The SSD stated she called the RP several times but did not document any of the attempts to schedule the MBS or contact the sister in the EMR. The SSD stated if something was not documented it was considered not done. The SSD stated she did not follow up with the ST after she was unable to schedule the test. The SSD stated Resident 2 had refused to have the MBS, so she had contacted his RP. The SSD stated she did not document a note in the resident's medical record that the resident and RP refused the appointment. Resident 1's order for the MBS and ENT consultation from 12/20/25 was reviewed and the SSD stated Resident 1 had been scheduled for an in-house ENT consultation on 2/23/26 but had discharged prior to the appointment. The SSD stated she did not document the appointment in the EMR. The SSD stated Resident 1's MBS had not been scheduled because they were waiting for the ENT consultation. The SSD stated she was working with Resident 1's insurance to have the MBS approved but had not received authorization prior to the residents' discharge. The SSD was unable to state if the ST or primary physician had been notified of the delay in the MBS appointment and had not documented any notification or follow up in the EMR. The SSD stated the ST usually notified her of recommended tests and consultations, but the SSD did not follow up unless she received the physician order. The SSD was unable to answer if the residents' needs had been met without the ordered tests and follow-up. The SSD stated she should have documented in the EMR so her attempts to schedule the appointments and follow-up phone calls were a part of the medical record.During a telephone interview on 3/24/26 at 4:16 p.m. with the Administrator (ADM), the ADM stated the IDT was made aware of the referral issues recently. The ADM stated his expectations were for the physician's orders to be followed and for the SSD to schedule the appointments as ordered. The ADM stated the SSD told him she was documenting on paper which was kept in her office and was not part of the EMR. The ADM stated he instructed the SSD her work needed to be documented in the Residents medical records because papers could be lost. The ADM stated the SSD notified him the hospital required the RP to be present at the MBS appointment which was an issue. The ADM stated they were working with the RPs to have them attend an appointment. The ADM stated advancing diet was in the ST's scope of practice and it sounds doubtful they [the MBS'] are necessary. But I'm not a clinician. The ADM stated the facility was responsible for carrying out the physician orders. The ADM stated he was the SSDs direct supervisor, but he was not aware she had not scheduled the appointments or documented in the EMR. The ADM stated the appointment scheduling and follow-up notes needed to be a part of the medical record. The ADM stated he reviewed the EMR with the SSD and she showed him where she was entering appointments after they were made in the communication section of the EMR program. The ADM stated the communication board was automatically cleared within 3 days and was not part of the permanent medical record.During a review (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on interview and record review, the facility failed to ensure a complete and accurately documented medical record in accordance with acceptable professional standards of practice and the facility policy and procedure for three of seven sampled residents (Residents 1, 2, and 3) when the Social Services Director (SSD) did not document her attempts to schedule physician ordered consultations and diagnostic testing or contact and follow up with the responsible parties (RP) in the residents' electronic medical record (EMR). These failures had potential for Residents 1, 2, and 3 care needs to go unmet due to inaccurate documentation. (cross reference F745)During a concurrent interview and record review on 2/23/26 at 12:28 p.m. with Licensed Vocational Nurse (LVN) 1, Resident 2's physician's order dated 10/9/26, was reviewed. The order indicated, . 10/9/3025. Modified Barium Swallow to R/O [rule out] Silent Aspiration. Resident 2's Nurses Notes, dated 10/9/25, indicated, . [name of physician] made rounds and examined resident with new order for Modified Barium Swallow to R/o Silent Aspiration [name of SSD] Social Service notified. LVN 1 stated it was important to schedule Resident 2's MBS to rule out swallowing issues and have a high risk of choking on food and drink and could aspirate. LVN 1 stated the note indicated the SSD was notified and should have scheduled the MBS according to the physician's order and documented in the EMR. Resident 3's physician's order dated 7/22/25, indicated, . for Barium Swallow Consult. Resident 3's Nurses notes, dated 7/22/25, indicated, . [name of physician] made rounds examined resident with New order for Barium Swallow Consult [name of Social Services Assistant (SSA)] Social Worker notified. LVN 1 stated Resident 3 had swallowing issues so he had the G-tube and an order for nothing by mouth. LVN 1 stated the SSA or SSD should have scheduled the appointment and documented follow-up in the residents EMR. Resident 1's physician's orders, dated 12/10/25 was reviewed and indicated, . EENT Consult to assist Vocal Cord Mobility. Modified Barium Swallow to r/o Silent aspiration to help determine if PO [by mouth] diet placement is possible. LVN stated Resident 1 was her resident while at the facility but had been discharged . LVN 1 stated Resident 1 had a G-tube when he was admitted to the facility and had graduated to an oral diet while admitted . LVN 1 stated the MDS was ordered to see if he could tolerate oral food and drink safely. LVN 1 stated it was important for Resident 1 to have the test done to rule out choking or aspiration with oral intake. LVN 1 was unable to locate documentation the SSD had scheduled appointment or followed up. LVN 1 stated the SSD was responsible for scheduling the appointments and documenting follow-up.During a concurrent interview and record review on 3/23/26 at 3:00 p.m., with the SSD, the SSD stated the referral process for consultations or outside testing was for a physician order to be placed, then nursing would send her a copy of the order. The SSD stated she would then start the process for scheduling the appointments. The SSD stated she did not document attempts to schedule appointments or follow-up notes in the EMR but kept papers in a folder with the orders and her notes on them. The SSD declined to answer if her folder was part of the Resident's medical record. The SSD stated that when she scheduled appointments, she would place a communication note in the facility's EMR program, but those notes were deleted after a set amount of time, it was not a part of the resident's medical record. Resident 3's order for an MBS on 7/22/25 was reviewed, the SSD stated she had contacted Resident 3's sister when she had called to schedule the appointment and the hospital indicated an RP needed to attend Resident 3's appointment to sign consents. The SSD stated she called the RP several times but did not document any of the attempts to schedule the MBS or contact the sister in the EMR. The SSD stated if something was not documented it was considered not done. The SSD stated Resident 2 had refused to have the MBS, so she had contacted his RP. The SSD stated she did not document a note in the resident's medical record that the resident and RP refused the appointment. The SSD stated Resident 1 had been scheduled for an inhouse ENT consultation on 2/23/26 but had been discharged prior to the appointment. The SSD stated she did (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	not document the appointment in the EMR. The SSD stated she did not document any information in Resident 1's medical record regarding the appointments or follow-up phone calls. The SSD declined to answer if the Resident's medical records were accurate without her documentation and stated she kept notes in a folder in her office. The SSD stated she should have documented in the EMR so her attempts to schedule the appointments and follow-up phone calls were a part of the medical record.During an interview on 3/23/26 at 3:55 p.m. with the Director of Nursing, the DON stated the process for consultations and outpatient diagnostic testing were for the Interdisciplinary team (IDT- team from different healthcare disciplines who work together to provide comprehensive patient care) to review new orders during their daily meeting. The DON stated the IDT would discuss the orders as a group, where to schedule the appointments and then the SSD was responsible for scheduling the appointments. The DON stated the facility did not have a good system in place to verify appointments were made and followed up on and they were in the process of putting a new system in place. The DON stated she was unaware of Resident 1, 2, and 3's appointments were never completed. The DON stated she was not aware the SSD was keeping paper notes and stated it was not a wise choice. The DON stated the information needed to be documented in the Resident's EMR so everyone could track the appointment and follow up as needed. The DON stated the SSD should document all follow up phone calls in a progress note in the EMR. During a telephone interview on 3/24/26 at 4:16 p.m. with the Administrator, the ADM stated the IDT was made aware of the referral issues recently. The ADM stated his expectations were for the physician's orders to be followed and for the SSD to schedule the appointments as ordered. The ADM stated the SSD told him she was documenting on paper which was kept in her office and was not part of the EMR. The ADM stated he instructed the SSD her work needed to be documented in the Residents medical records because papers could be lost. The ADM stated the SSD notified him the MBS required the RP to be present at the appointment which was an issue. The ADM stated they were working with the RPs to have them attend an appointment. The ADM stated the facility was responsible for carrying out the physician orders. The ADM stated he was the SSDs direct supervisor, but he was not aware she was not documenting in the EMR. The SSD stated the notes needed to be a part of the medical record. The ADM stated he reviewed the EMR with the SSD and she showed him where she was entering appointments after they were made in the communication section of the EMR program. The ADM stated the communication board was automatically cleared within 3 days and was not part of the permanent medical record.During a review of the facility's P&P titled Charting and Documentation, July 2017, the P&P indicated, . All services provided to the resident, progress toward the care plan goals, or changes in the resident's medical, physical, functional or psychosocial condition, shall be documented in the resident's medical record. Documentation of procedures and treatments will include care-specific details, including. notification of family, physician or other staff.During a review of the facility's P&P titled Referrals, Social Services, dated 12/2008, . Social services personnel shall coordinate most resident referrals with outside agencies. Social services shall coordinate most resident referrals. Social services will collaborate with the nursing staff or other pertinent disciplines to arrange for services that have been ordered by the physician. Social services will document the referral in the resident's medical record.During a review of the facility's Job Description: Director of Social Service, undated, the job description indicated, . primary purpose of your job position is to assist in planning, developing, organizing, implementing evaluating, and directing social service programs in accordance with current federal, state, and local standards, guidelines, and facility policies and procedures [P&P], to assure that the medically related emotional and social needs of the resident are met/maintained on an individual basis. As Social Services Director you are delegated the administrative authority, responsibility and accountability necessary for carrying out your assigned duties. Record and maintain regular Social Service progress notes indicating response to the treatment plan and/or adjustment to institutional life. Perform other charting duties as necessary. Assist in making appointments for the resident/family as requested or appropriate. Assist in arranging transportation. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Assist in obtaining resources from community social, health and welfare agencies to meet the needs of the resident.

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Keep all essential equipment working safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure the ice machine was in safe operating condition when the ice machine malfunctioned and the facility did not provide the residents with ice for two days, 3/21/26 and 3/22/26.This failure had the potential for the residents to decrease the amount of fluid they consumed risking dehydration (condition when body loses more fluids than it takes in) and urinary tract infections (UTI-infection caused by bacteria entering the urinary system [bladder, urethra, or kidneys] leading to painful urination).During a concurrent observation and interview on 3/23/26 at 10:51 a.m. with Resident 6, Resident 6 was lying in bed, there was an indwelling catheter bag hanging at her bedside. Resident 6 pointed to her cup on the overbed table and stated she had not received any ice since Friday 3/20/26. Resident 6's cup was empty and she stated she preferred her drinks to be ice cold and did not consume as much fluid as she normally would because there was no ice available. Resident 6 stated she was at high risk for UTIs because she had an indwelling catheter (thin flexible tube inserted into the bladder to drain urine).During a review of Resident 1's admission Record, undated, the admission record indicated, Resident 1 was admitted to the facility on [DATE] with diagnoses which included neuromuscular dysfunction of bladder (condition where the nerves to hold urine are damaged causing the bladder and muscles to work poorly), pressure ulcer left hip (skin wound or injury caused by long-lasting pressure on the skin over bony areas), protein-calorie malnutrition (state of inadequate intake of food) and paraplegia (form of paralysis [loss of ability to move one or more muscles in the body] that affects the lower half of the body).During a review of Residents 6's Minimum Data Set (MDS- a resident assessment tool used to identify resident cognitive and physical function) assessment dated [DATE], indicated Resident 6's Brief Interview of Mental status assessment (BIMS - assessment of cognitive status for memory and judgement) scored 15 of 15 (a score of 13-15 indicates cognitively intact, 08-12 indicates moderately impaired, and 00-07 indicates severe impairment). The BIMS assessment indicated Resident 6 was not cognitively impaired.During a concurrent observation and interview on 3/23/26 at 10:59 a.m. with Resident 5, Resident 6's roommate, Resident 5 stated there was no ice to drink over the weekend. A Certified Nursing Assistant (CNA) entered the residents' room with a pitcher of ice and added ice to Resident 5's and 6's cups. The CNA stated the facility's ice machine stopped working on Friday. The CNA stated but the kitchen brought some ice to the floor this morning, so she was delivering ice to her residents. Resident 5 stated she had a urinary tract infection recently and needed to drink fluids to help prevent another infection. Resident 5 stated she preferred to have ice in her drinks and asked the CNA to bring her a soda with ice. During a review of Resident 5's admission Record, undated, the admission record indicated, Resident 5 was admitted to the facility on [DATE] with diagnoses that included cerebral palsy (a group of conditions that affect movement and posture caused by brain damage that occurs most often before birth), malignant neoplasm of the breast (breast cancer) and bipolar disorder mental health condition that causes extreme mood swings).During a review of Residents 5's Minimum Data Set (MDS- a resident assessment tool used to identify resident cognitive and physical function) assessment dated [DATE], indicated Resident 5's Brief Interview of Mental status assessment (BIMS - assessment of cognitive status for memory and judgement) scored 14 of 15 (a score of 13-15 indicates cognitively intact, 08-12 indicates moderately impaired, and 00-07 indicates severe impairment). The BIMS assessment indicated Resident 5 was not cognitively impaired.During an interview on 3/23/26 at 11:26 a.m. with CNA 1, CNA 1 stated there was no ice available over the weekend. CNA 1 stated the kitchen staff brought ice late this morning for the residents. CNA 1 stated the facility's process was to bring out ice chests with ice to keep at the nurses' station and change it for clean ice once a shift. CNA 1 stated it was important to have ice available to provide ice water for the residents. CNA 1 stated it was important to have ice to make sure the residents drink enough water and fluids to stay hydrated because some (continued on next page)

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	residents did not like to drink water at room temperature water.During an interview on 3/23/26 at 12:13 p.m. with CNA 2, CNA 2 stated she had worked on 3/22/26 and the residents were complaining about not having ice for water or drinks. CNA 2 stated ice was important because some residents preferred to have ice in their drinks which improved the amount of fluid they drank.During an interview on 3/23/26 at 12:28 p.m. with Licensed Vocational Nurse (LVN) 1, LVN 1 stated the ice machine has broken down on occasion in the past. LVN 1 stated there was no ice on Saturday 3/21/26 when she passed medications. LVN 1 stated it was important to have ice available because some residents would not drink as much fluid if it were not cold.During a concurrent observation and interview on 3/23/26 at 1:16 p.m. with the Certified Dietary Manager (CDM), in the kitchen, the CDM stated she arrived at work and the ice chests which were normally out on the floor were sitting empty in the room next to the kitchen. The CDM stated she checked the ice machine, and the plastic dispenser was broken so the machine was not dispensing ice. The CDM stated she checked freezers for ice and realized there was no ice in the kitchen. The CDM stated she notified the Director of Maintenance (DOM) that the ice machine was not working, and he was able to fix it midmorning. The CDM stated it was an issue for the residents not to have ice because it would place them at risk for dehydration if they did not drink enough water. The CDM stated she did not receive any phone calls over the weekend notifying her the ice machine was not working.During a concurrent interview on 3/23/26 at 1:22 p.m. with [NAME] (CK) 1 and CK 2, CK 1 stated she had worked over the weekend and there was no ice available because the ice machine was not working. CK 2 stated she had worked on Saturday evening and the nursing supervisor was aware there was no ice and they were still waiting on ice when she left Saturday night. CK 2 stated she was told the administrator (ADM) had been notified there was no ice at the facility.During an interview on 3/23/26 at 1:44 p.m. with the DOM, the DOM stated on Thursday 3/19/26 he was notified by the CDM that the ice machine not working correctly so he checked it and found that the dispenser was misaligned and he was able to fix it on Thursday. The DOM stated he received a text message on Friday 3/20/26 that the ice machine was not working again. The DOM stated he was off work and did not hear any further communication, so he had thought the matter had been resolved. The DOM stated the dispenser gets off track if it is pushed too hard or too aggressively and will not dispense the ice. The DOM stated he came in to work earlier today and was told there was no ice over the weekend because the machine had not been dispensing the ice. The DOM stated when he checked the machine the plastic part was off track and hanging there. The DOM stated the ice machine was an old piece of equipment and has acted up off and on. The DOM stated he had not been called over the weekend, so he assumed the ice machine was working. During an interview on 3/23/26 at 2:49 p.m. with the Administrator (ADM), the ADM stated he had not been notified over the weekend that the ice machine was not working, and the residents did not have ice. The ADM stated he was disappointed there was no follow up because the staff could have bought ice to get through the weekend. The ADM stated if residents preferred ice cold drinks they may not drink as much if that was their preference. The ADM stated the department heads rotated working on the weekend, and the Minimum Data Set Coordinator (MDSC) was in the facility on Saturday and Payroll (PAY) was in the facility on Sunday.During an interview on 3/23/26 at 2:55 p.m. with the PAY, the PAY stated she was at the facility for most of the day on Sunday and she was not notified there was no ice for the residents.During an interview on 3/23/26 at 3:55 p.m. with the Director of Nursing (DON), the DON stated she was not notified the ice machine was not working over the weekend. The DON stated her expectation would be for the weekend staff to notify the DOM and ADM. The DON stated the residents not having ice available had the potential risk for dehydration and UTIs from not intaking enough fluid.During a telephone interview on 3/24/26 at 11:30 a.m. with the MDSC, the MDSC stated she was the department head on call and came to the facility on Saturday 3/21/26 from 8:00 am to 4:30 p.m. The MDSC stated she was not notified there was no ice until around 2:30 or 3:00 p.m. The MDSC stated a charge nurse notified her there was no ice and she asked the nurse if she notified other staff members. The MDSC stated the charge nurse sent it in a group (continued on next page)

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	chat which included the ADM, DON, herself and other department heads. The MDSC stated she checked the chat and had received the message. The MDSC stated she did not follow up further because the message was also sent to the ADM and she figured there was no further follow up needed from her. The MDSC stated if residents preferred ice in their drinks and did not have it available, they may not drink enough water which had the potential for dehydration.During a review of the facility's document titled Instructions, dated 3/23/2026, the document indicated, . Ice Machines. 3/19[2026] . Ice chute had fallen off track, likely due to pushing too hard on lever.During a review of the ice machine manufacturer guidelines titled Installation, Operation and Maintenance Manual, dated 3/9/23, the guidelines indicated, . Safety Notices. Proper installation, care and maintenance are essential for maximum performance and trouble-free operation of your equipment. Do not operate equipment that has been misused, abused, neglected, damaged. from that of original manufactured specifications. Ice Delivery. ice falls from the paddle wheel to the ice chute opening of the dispenser bin.During a review of the facility's policy and procedure titled Ice Machines and Ice Storage Chests, dated 1/2012, . Ice machines and ice storage/distribution containers will be used and maintained to assure a safe and sanitary supply of ice.