STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055141	A. Building B. Wing	07/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Madera Post Acute Center	11900 Ramona Boulevard El Monte, CA 91732

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to promote and treat four of four sampled residents (Residents 10, 34, 61 and 102) with respect, privacy and dignity by failing to ensure:a. The Director of Staff and Development (DSD) close the privacy curtain while checking Resident 102's Gastrostomy tube (G-tube, feeding tube that is surgically placed through an opening into the stomach from the abdominal wall) site. b. Resident 34's nephrostomy (a thin catheter that drains urine from kidney into a bag) drain was covered and provided Resident 34 with privacy. c. Certified Nursing Assistant 8 (CNA 8) and Restorative Nursing Assistant 2 (RNA 2) closed the privacy curtain completely while providing care to Resident 61.d. Resident 10 was offered to get up to go to the bathroom between 7:30 am and 11:02 am on 7/9/2025. As a result, Resident 10 was sitting in Resident 10's urine-soaked brief from 8:13 am to 11:02 am. Resident 10 felt sore, mad, and angry that facility staff did not offer Resident 10 to get up to use the restroom.These deficient practices had the potential to cause a psychosocial (mental and emotional well-being) decline and lowered self-esteem and self-worth for Residents 10, 34, 61 and 102. Findings: a. During a review of Resident 102's admission Record (AR), the AR indicated Resident 102 was admitted to the facility on [DATE], with diagnoses that included encounter for attention to gastrostomy (creation of an artificial external opening into the stomach), dysphagia (difficulty swallowing) and dementia (long term and often gradual decrease in the ability to think and remember severe enough to affect a person's daily functioning). During a review of Resident 102's untitled Care Plan (CP) dated 4/8/2025, the CP indicated Resident 102’s had Activities of Daily Living (ADL) deficit related to dementia. Resident 102’s CP indicated for staff to promote dignity by ensuring privacy to the resident. During a review of Resident 102's Minimum Data Set (MDS - a federally mandated resident assessment tool) dated 4/14/2025, the MDS indicated Resident 30 had severely impaired cognition (mental action or process of acquiring knowledge and understanding) for daily decision making. The MDS indicated Resident 102 was dependent (helper does all of the effort) on staff for toileting, showering/bathing self, lower body dressing, putting on/taking off footwear, and personal hygiene. The MDS indicated Resident 102 needed maximum assistance (helper does more than half the effort) on staff for upper body dressing. (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 102's Physician Order (PO) dated 4/29/2025, the PO indicated for staff to administer Jevity 1.5 (liquid formula used for G-tube feeding) at 70 cubic centimeters per hour (cc/hr- unit of measurement) for 20 hours to provide 1,400 cc per 2,100 kilo calories (kcal, unit of energy) in 24 hours via enteral feeding; pump on at 1 pm and pump off at 9 am or until desired volume is reached. During an observation on 7/7/2025 at 9:20 am with the DSD, in Resident 102's room. Resident 102 was awake, lying in bed. The DSD pulled up Resident 102's gown and checked Resident 102's G-tube site. The DSD did not close Resident 102's privacy curtain to provide Resident 102 privacy, exposing Resident 102's abdominal area to the resident’s roommate and the hallway. During an interview on 7/7/2025 at 9:22 am with the DSD, the DSD stated she pulled up Resident 102's gown to check Resident 102's G-tube site and did not close the privacy curtain to provide Resident 102 privacy, exposing Resident 102's abdomen. The DSD stated privacy curtain needed to be closed prior to providing care and treatment to the residents to provide privacy. During a concurrent interview on 7/9/2025 at 12:36 pm with the facility’s Director of Nursing (DON), the DON stated, privacy curtains needed to be closed to provide privacy and dignity to the residents while providing care. The DON stated residents’ body parts should not be exposed during care and treatment. During a review of the facility's Policy and procedure (P&P) titled, Dignity and Respect, reviewed 1/2025, the P&P indicated, residents shall be examined and treated in a manner that maintains privacy of their body. The P&P indicated a closed door or drawn curtain shields the Resident from passers-by. b. During a review of Resident 34's AR, the AR indicated Resident 34 was initially admitted to the facility on [DATE] and readmitted on [DATE], with diagnoses that included Urinary tract infection (UTI- infection that affects part of the urinary tract), and Acute Kidney Injury (AKI - kidneys suddenly stop functioning). During a review of Resident 34's MDS dated [DATE], the MDS indicated Resident 34 had intact cognition for daily decision making. The MDS indicated Resident 34 was dependent on staff for toileting hygiene, showering/bathing self, lower body dressing and putting on/taking off footwear. During a review of Resident 34's PO dated 7/4/2025, the PO indicated for staff to cleanse Resident 34’s left lower back nephrostomy site with normal saline, pat dry then cover with border gauze dressing every shift. During a review of Resident 34's PO dated 7/4/2025, the PO indicated for staff to cleanse Resident 34’s right lower back nephrostomy site with normal saline, pat dry then cover with border gauze dressing every shift. During a concurrent observation and interview on 7/7/2025 at 9:06 am with the DSD, in Resident 34's room, Resident 34 was awake, lying in bed with bilateral nephrostomy bag hanging on the bed frame uncovered without a dignity bag (privacy cover) exposing light yellow colored fluid inside the bag. The DSD stated Resident 34’s nephrostomy drain bag needed to have a privacy bag to cover the drain to provide privacy to Resident 34. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview on 7/7/2025 at 6:43 pm with the DON and record review of the facility’s P&P titled, Indwelling Urinary Catheter Care, revised 1/2025, the P&P indicated to cover the drainage bag with a privacy bag to maintain dignity. The DON stated the P&P was applicable to Resident 34 with nephrostomy bag. The DON stated for all body fluid collection devices such as nephrostomy bag, the device needed to be covered with dignity bag to provide privacy to the resident. c. During a review of Resident 61’s admission Record (AR), the AR indicated the facility admitted Resident 61 on 4/24/2024, with diagnoses that included morbid obesity (which is defined as having a BMI of 40 or greater or weighing in excess of 100 pounds of one’s ideal weight), and urinary tract infection (UTI - common infections that happen when bacteria, often from the skin or rectum, enter the urethra and infect the urinary tract). During a review of Resident 61’s Minimum Data Set (MDS – a federally mandated resident assessment tool) dated 4/25/2025, the MDS indicated Resident 61 had intact cognition. The MDS indicated Resident 61 was dependent in toileting hygiene and required maximal assistance (helper does more than half the effort. Helper lifts or holds trunk or limbs and provides more than half the effort) with toilet transfers, sit to stand, chair/bed-to-chair transfer). During an observation on 7/9/2025 at 8:32 AM, Certified Nursing Assistant 8 and Restorative Nursing Assistant 2 were preparing to go inside Resident 61’s room by donning personal protective equipment (PPE - clothing and equipment that is worn or used to provide protection against hazardous substances and/or environments). RNA 2 closed the door and then closed the curtain, the curtain could not be closed completely. CNA 8 moved Resident 61’s gown upward to expose the lower part of the body. CNA 8 cleaned the abdominal fold with a moistened towel and then proceeded to wipe the front of the perineal area then the groin area. During an interview on 7/9/2025 at 9 AM, RNA 2 stated the privacy curtain could not be closed completely because a few inches of the curtain was folded inward. When someone would open the door, Resident 61 would be exposed. During an interview on 7/9/2025 at 10:29 am, the Maintenance Supervisor stated the curtain was folded inward because there were 3-4 curtain hooks missing. The MS stated MS needed to add 3-4 curtain hooks so the curtain could be fully installed, and the curtain could be closed completely. The curtain needed to be closed completely to provide privacy during care. During a review of the facility’s Policy and Procedure (P&P) titled “Resident Rights” dated 1/2025, the P&P indicated privacy of a resident’s body shall be maintained during toileting, bathing and other activities of personal hygiene, except when staff assistance is needed for the Resident’s safety. d. During a review of Resident 10’s admission Record (AR), the AR indicated the facility admitted Resident 10 on 3/22/2023, and was readmitted on [DATE] with diagnoses that included abnormalities of gait and other mobility (inability to walk normally due to injuries or underlying conditions), need for assistance with personal care, and urinary tract infection (UTI- infection that happen when bacteria enter the urethra, and infect the urinary tract). (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 10’s untitled Care Plan Report (CP), the CP indicated Resident 10 had activities of daily living (ADL- the tasks of everyday life fundamental to caring for oneself) self-care performance deficit related to chronic obstructive pulmonary disease (COPD- lung disease causing restricted airflow and chronic breathing problems), diabetes mellitus (a condition that happens because of a problem in the way the body regulates and uses sugar as fuel)… initiated 4/21/2025 and revised 6/26/2025. The CP goals indicated Resident 10 would safely perform…toilet use through the review date. The CP interventions included toilet use (toilet transfers and toilet hygiene. The CP interventions indicated toilet use required staff participation to use toilet. During a review of Resident 10’s Minimum Data Set (MDS- a resident assessment tool) dated 6/18/2025, the MDS indicated Resident 10 had intact cognition (ability think, remember, and reason). The MDS indicated Resident 10 required substantial/maximal assistance (helper does more than half the effort. Helper lifts or holds trunk or limbs and provides more than half effort) with toileting hygiene. The MDS indicated Resident 10 required partial/moderate assistance (helper does less than half the effort and lifts or holds trunk or limbs but provides less than half the effort) with walking 50 feet (ft- unit of measurement). During an interview on 7/72025 at 3:10 pm with Resident 10, while inside Resident 10’s room, Resident 10 pointed towards Resident’s 10’s bathroom and stated, “I want to go…they tell me I have a diaper (brief) on.” Resident 10 stated it made Resident 10 feel sore to go to the bathroom in Resident 10’s brief. During multiple observations on 7/9/2025, timed at 8:13 am, 9:24 am, 9:28 am, 9:32 am, 10:18 am, and 10:30 am, while in Resident 10’s room, certified nurse assistant (CNA) 9 was observed. CNA 9 was not observed offering Resident 10 an opportunity to get up to go to the bathroom. CNA 9 was not observed, asking Resident 10 if Resident 10 needed to be changed. During a concurrent observation and interview on 7/9/2025 at 10:51 am, with Resident 10 and Physical Therapist (PT) 1, while inside Resident 10’s room, Resident 10 was observed. Resident 10 appeared agitated but was redirected by PT 1. Resident 10 stated, “I need to go to the bathroom.” PT 1 stated Resident 10 smelled of urine and Resident 10’s brief looked full. PT 1 stated Resident 10 was able to tell staff when Resident 10 needed to use the restroom. PT 1 assisted Resident 10 to the bathroom. Resident 10 was able to sit on the toilet. PT 1 stated Resident 10 was able to get up with assistance. PT 1 stated (while on the toilet) Resident 10 was able to void and have a bowel movement. During a concurrent observation and interview on 7/9/2025 at 11:02 am, with Restorative Nurse Assistant (RNA) 2, while inside Resident 10’s room, Resident 10 was observed. RNA 2 stated Resident 10 had days when Resident 10 was able to hold Resident 10’s urine and bowel movement and days when Resident 10 was unable to. RNA 2 stated Resident 10 was not always incontinent (inability to control the bladder and bowels partially or entirely) of bowel and bladder. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 7/9/2025 at 11:43 am, with CNA 9, CNA 9 stated CNA 9 checked Resident 10’s brief between 7:30 am and 8 am on the day of the interview. CNA 9 stated CNA 9 checked Resident 10’s brief between 9:30 am and 10 am, but it was not soiled. CNA 9 stated CNA 9 asked Resident 10 if Resident 10 wanted to be changed at 10:30 am, but stated Resident 10 told CNA 9, “No.” CNA 9 stated CNA 9 did not ask Resident 10 if Resident 10 wanted to get up to go to the bathroom. CNA 9 stated Resident 10 was not always incontinent of bowel and bladder function. CNA 9 stated Resident 10 had times when Resident 10 could hold “it, and times when Resident 10 could not. CNA 9 stated Resident 10 was able to tell CNA 9 if Resident 10 needed to go to the bathroom. CNA 9 stated when Resident 10 needed to go to the bathroom and had not been taken, Resident 10 could get a little mad. During an interview on 7/10/2025 at 8:39 am, with CNA 10, CNA 10 stated (in general) if a resident was wearing a brief, it did not mean they were incontinent. CNA 10 stated, “Sometimes it’s easier for them (resident) to go to the bathroom in the brief so they don’t have to wait for help to the toilet or have to come back to their room to go to the bathroom.” CNA 10 stated Resident 10 could tell CNA 10 when Resident 10 needed to use the restroom and was not always incontinent. CNA 10 stated Resident 10 sometimes got aggressive or agitated when Resident 10 needed to use the restroom. CNA 10 stated it was important to ensure residents were changed as needed, checked frequently, and/or asked if they needed to go to the restroom, so they were not sitting in soiled briefs, so they did not get infections, rashes, or redness on their bottoms. During an interview on 7/10/2025 at 9:18 am, with the Director of Nursing (DON), the DON stated (in general), even if a resident was wearing a brief, staff needed to ask residents if they needed to use the restroom and offer to assist residents up to the restroom, if they required assistance. The DON stated it was the residents’ right to get up to go to the bathroom if they wanted. The DON stated it was a dignity issue for a resident to be left soiled in their brief and could make them feel ashamed or angry. During a review of the facility’s P&P titled, “Resident Rights and Responsibilities, Notice of, ” the P&P indicated residents had the right to a dignified existence, self-determination, and communication with and access to persons and service inside and outside the facility. The P&P indicated residents had the right to be treated with respect and dignity, including the right to reside and receive services in the facility with reasonable accommodation of residents’ needs and preferences.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure one of one sampled resident (Resident 109) had a bedroom wall that was not missing part of the baseboard.This failure had the potential to result in the exposure of Resident 109 and Resident 109's visitors to dust and other unknown contaminants and failed to provide a safe, clean, comfortable, and homelike environment.Findings:During a review of Resident 109's admission Record (AR), the AR indicated Resident 109 was admitted to the facility on [DATE] with diagnoses including sepsis (a life-threatening blood infection), lack of coordination, and dysphagia (difficulty swallowing). During a review of Resident 109's History & Physical (H&P), dated 6/7/2025, the H&P indicated the resident had the capacity to understand and make decisions. During a review of Resident 109's Minimum Data Set (MDS, a resident assessment tool), dated 6/17/2025, the MDS indicated Resident 109 had moderately impaired cognition (ability to understand), used a walker and needed setup or clean-up assistance (helper sets up or cleans up, residents' complete activity. Helper assists only prior to or following the activity) with toileting hygiene.During an observation on 7/8/2025 at 9:15 am, in Resident 109's room, the baseboard behind the resident's bed was missing, exposing the drywall and peeling paint.During a concurrent observation and interview on 7/8/2025 at 9:19 am with the Director of Nursing (DON) in Resident 109's room, the baseboard behind the resident's bed was missing. The DON stated room maintenance was overseen by the maintenance and housekeeping supervisors. The DON stated the wall was broken and the bare wall should be covered and fixed to make it more homelike for Resident 109. During an interview on 7/8/2025 at 9:27 am with the Maintenance Supervisor (MS), the MS stated the bottom of Resident 109's wall was bare and should not be in that condition, as it could expose the resident to dust.During a review of the facility's policy and procedure (P&P) titled, Housekeeping: Rooms, Cleaning Residents, last revised 2001, the P&P indicated the facility would provide a clean, comfortable, homelike and sanitary living area.During a review of the facility's policy and procedure (P&P) titled, Environmental: Maintenance Policy, dated 1/2025, the P&P indicated the maintenance policy ensured the building, equipment, and overall environment remain safe, clean, and functional for residents, staff, and visitors.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to promote continence (ability to control the bladder and bowels) for one of two sampled residents (Resident 10), according to the facility's policies and procedures (P&P) titled, Bowel and Bladder Assessment, and Resident Assessment and Associated Processes, by failing to:1. Ensure Resident 10 was placed on a scheduled toileting program (taking resident on a planned schedule to the toilet) after Resident 10 was assessed to not be a candidate for bowel and bladder retraining on 4/18/2025 and 6/18/2025. 2. Ensure Resident 10's bowel and bladder assessments (BBA) dated 6/18/2025 and Minimum Data Set (MDS- a resident assessment too) dated 6/18/2025 provided an accurate assessment of Resident 10's continence level based off the facility staff's observations. Licensed nurses assessed Resident 10 as always incontinent of bowel and bladder.As a result of these failures, Resident 10 was not placed on a scheduled toileting program on 4/18/2025 and 6/18/2025. Consequently, the facility staff were not appropriately assessing Resident 10's bowel and bladder function. These failures had the potential to result in Resident 10 becoming permanently incontinent (inability to control the bladder and bowels). Findings:During a review of Resident 10's admission Record (AR), the AR indicated the facility admitted Resident 10 on 3/22/2023, and was readmitted on [DATE] with diagnoses that included abnormalities of gait and other mobility (inability to walk normally due to injuries or underlying conditions), need for assistance with personal care, and urinary tract infection (UTI- infection that happen when bacteria enter the urethra, and infect the urinary tract).During a review of Resident 10's admission Assessment (AA) dated 4/18/2025, timed at 9:57 pm, the AA indicated Resident 10 was incontinent of bowel and bladder. The AA indicated Resident 10 had inadequate control, incontinent episodes occurring multiple times per day). The AA indicated Resident 10 was not using a toilet, bedside commode (portable toilet at bedside), urinal, bedpan, pads/briefs, or inappropriate receptacles as toileting locations.During a review of Resident 10's BBA dated 4/18/2025, timed at 11:39 pm, the BBA indicated Resident 10 was always incontinent of bowel and bladder. The BBA indicated Resident 10 was indifferent for bowel and bladder retraining and was not a candidate for bowel and bladder retraining.During a review of Resident 10's BBA dated 6/18/2025, timed at 5:17 pm, the BBA indicated Resident 10 was always incontinent of bowel and bladder. The BBA indicated Resident 10 showed willingness for bowel and bladder retraining but was an unlikely candidate.During a review of Resident 10's MDS dated [DATE], the MDS indicated Resident 10 had intact cognition (ability to think, remember, and reason). The MDS indicated Resident 10 required substantial/maximal assistance (helper does more than half the effort. Helper lifts or holds trunk or limbs and provides more than half effort) with toileting hygiene. The MDS indicated Resident 10 required partial/moderate assistance (helper does less than half the effort and lifts or holds trunk or limbs but provides less than half the effort) with walking 50 feet (ft- unit of measurement). The MDS indicated Resident 10 was always incontinent of bowel and bladder. The MDS indicated Resident 10 had not had a trial of toileting program (scheduled toileting, prompted voiding, or bladder training), and was not currently using a toileting program to manage Resident 10's bowel continence.During an interview on 7/72025 at 3:10 pm with Resident 10, while inside Resident 10's room, Resident 10 pointed towards Resident's 10's bathroom and stated, I want to go.they tell me I have a diaper (brief) on. During a concurrent observation and interview on 7/9/2025 at 10:51 a.m., with Resident 10 and Physical Therapist (PT) 1, while inside Resident 10's room, Resident 10 was observed. Resident 10 appeared agitated but was redirected by PT 1. Resident 10 stated, I need to go to the bathroom. PT 1 stated Resident 10 smelled of urine and Resident 10's brief looked full. PT 1 stated Resident 10 was able to tell staff when Resident 10 needed to use the restroom. PT 1 assisted Resident 10 to the bathroom. Resident 10 was able to sit on the toilet. PT 1 stated Resident 10 was able to get up with assistance. PT 1 stated (while on the toilet) Resident 10 was able to void and have a bowel movement.During a concurrent observation and interview on 7/9/2025 at 11:02 am, with Restorative Nurse Assistant (RNA) 2, while inside Resident 10's room, Resident 10 was observed. RNA 2 stated Resident 10 had days when Resident 10 was able to hold Resident 10's urine and bowel movement and days when Resident 10 was unable to. RNA 2 stated Resident 10 was not always incontinent (inability to control the bladder and bowels partially or entirely) of bowel and bladder.During an interview on 7/9/2025 at 11:43 am, with CNA 9, CNA 9 stated CNA 9 did not ask Resident 10 if Resident 10 wanted to get up to go to the bathroom. CNA 9 stated Resident 10 was not always incontinent of bowel and bladder function. CNA 9 stated Resident 10 had times with Resident 10 could hold

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to develop and implement a comprehensive care plan (CP) for four of four sampled residents (Residents 4, 335, 61 and 44).a. Resident 4's CP was not initiated and implemented for the use of Buspirone (anxiolytic - medication used to treat anxiety disorders).b. Resident 335's CP was not initiated and implemented to address chronic abdominal pain.c. Resident 61 CP was not initiated and implemented to address recurrent Urinary Tract Infection (UTI - common infections that happen when bacteria, often from the skin or rectum, enter the urethra and infect the urinary tract).d. Resident 44's CP was not initiated and implemented for the use of Hydrocodone (narcotic pain medication). These deficient practices had the potential to not provide adequate care and services to address specific needs of Residents 4, 335, 61 and 44.Findings: a. During a review of Resident 4’s admission Record (AR), the AR indicated Resident 96 was admitted to the facility on [DATE] with diagnoses that included anxiety disorder and insomnia (trouble with sleeping.) During a review of Resident 4's Order Summary Report (OSR), dated 5/1/2025, the OSR indicated for licensed staff to administer Buspirone Hydrochloride (HCL) tablet 10 milligrams (mg) one tablet by mouth two (2) times a day manifested by verbalization of feeling anxious causing hyperventilation related to Anxiety disorder, hold if resident is sedated. During a review of Resident 4’s Minimum Data Set (MDS – a federally mandated resident assessment tool) dated 6/25/2025, the MDS indicated Resident 4 had intact cognition (mental action or process of acquiring knowledge and understanding) for daily decision making. The MDS indicated Resident 4 was dependent (helper did all the effort and lifted or held trunk or limbs) to staff for putting on/taking off footwear. The MDS indicated Resident 4 needed maximum assistance (helper did more than half the effort and lifted or held trunk or limbs) to staff for shower and lower body dressing. During an interview and concurrent record review on 7/8/2025 at 10:16 am, with the Treatment Nurse (TN) of Resident 4’s medical records (PointClickCare - PCC, a cloud-based software), the TN stated the there was no clinical documentation that a care plan (CP) was initiated and implemented for the management of Buspirone use. The TN stated the purpose of the CP was to ensure Resident 4 received proper and effective interventions while receiving Buspirone. During a concurrent interview and record review of Resident 4’s PCC on 7/8/2024 at 2:17 pm with the facility’s Director of Nursing (DON), the DON stated a comprehensive care plan regarding Buspirone use should be developed and implemented to guide staff on how to provide necessary care and treatment to Resident 4. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's Policy and Procedure (P&P) titled, “Comprehensive Person – Centered Care Planning,” revised 1/2025, the P&P indicated the facility’s interdisciplinary team (IDT) shall develop a comprehensive p[person centered care plan for each resident that includes measurable objectives and timeframes to meet a resident’s medical, nursing, mental and psychosocial needs that are identified in the comprehensive assessment. The P&P indicated the facility will develop and implement a comprehensive person-centered care plan for each resident within seven (7) days of completion of the Resident Minimum Data Set (MDS) and will include residents needs identified in the comprehensive assessment. b. During a review of Resident 335’s admission Record (AR), the AR indicated the facility admitted the resident on 5/1/2025, with diagnoses that included enterocolitis due to clostridium difficile (an inflammation of the intestines that is predominantly associated with antibiotic use), irritable bowel syndrome (a condition that causes abdominal discomfort and altered bowel movements). During a review of Resident 335’s MDS dated [DATE], the MDS indicated Resident 335 had intact cognition. The MDS indicated Resident 335 was dependent in toileting hygiene and bed mobility; rolling left and right, sitting to lying, lying to sitting on the side of the bed, chair/bed-to-chair transfer. During a concurrent observation and interview on 7/7/2025 at 10:54 AM, Resident 335 was lying in bed, awake. Resident 335 stated “My stomach hurts.” Resident 335 described a pain level of 10/10 (A score of 0 means no pain, and 10 means the worst pain you have ever known). During an observation on 7/7/2025 at 10:56 AM, Resident 335 pressed the call light asking for pain medication. Certified Nursing Assistant 9 stated CNA 9 would inform the assigned charge nurse. During a review of Resident 335’s Order Summary Report (OSR), with active orders as of 7/10/2025, the OSR indicated an order for oxycodone hydrochloride (pain medication), to administer one tablet by mouth every eight hours as needed for severe pain (7/10) for 14 days with an order start date of 7/3/2025. During a review of Resident 335’s Medication Administration Record (MAR) dated July 2025, the MAR indicated oxycodone was administered on 7/3/2025, 7/5/2025, 7/7/2025 at 11:06 AM, 7/8/2025 and 7/9/2025. The MAR did not indicate the location of the pain. A review of Resident 335’s Progress Notes was done on the following dates: On 7/3/2025, the Progress Notes indicated Resident 335 complained of pain in the right lower leg On 7/5/2025, the Progress Notes indicated Resident 335 complained of pain located in the abdomen. On 7/7/2025, the Progress Notes did not indicate the location of Resident 335’s pain. On 7/8/2025, the Progress Notes did not indicate the location of Resident 335’s pain On 7/9/2025, the Progress Notes did not indicate the location of Resident 335’s pain. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 335’s care plans, in the presence of and with the Assistant Director of Nursing, there was no plan of care developed for Resident 335’s abdominal pain on 7/9/2025 at 6:04 PM. The ADON stated that when a resident has abdominal pain, a care plan would help provide specific interventions to address abdominal pain. During an interview on 7/9/25 at 6:46 PM, Licensed Vocational Nurse 4 (LVN 4) stated that during hand-off report, LVN 4 received a report that Resident 335 had been having abdominal pain and had a poor appetite. During a review of Resident 335’s care plan for being at risk for acute/chronic pain on 7/9/2025, the care plan indicated the interventions were initiated on 7/9/2025. The interventions did not address abdominal pain. The intervention initiated on 7/9/2025 indicated to report occurrences to the physician. During a review of Resident 335’s care plan for Clostridium Difficile, the care plan did not indicate to monitor symptoms of stomach tenderness or pain. During a review of the Center for Disease Control and Prevention (CDC) topic titled “Clostridium Difficile” (C Diff – is a germ that causes diarrhea and colitis {inflammation of the colon}) which can be life-threatening. The CDC indicated to watch for symptoms of diarrhea, fever, loss of appetite, nausea, and stomach tenderness or pain. c. During a review of Resident 61’s admission Record (AR), the AR indicated the facility originally admitted Resident 61 on 3/12/2024, and readmitted Resident 61 on 5/10/2025, with diagnoses that included morbid obesity (which is defined as having a BMI of 40 or greater or weighing in excess of 100 pounds of one’s ideal weight), and urinary tract infection (UTI - common infections that happen when bacteria, often from the skin or rectum enter the urethra and infect the urinary tract). During a review of Resident 61’s Minimum Data Set (MDS – a federally mandated resident assessment tool) dated 3/28/2025, the MDS indicated an active diagnosis of UTI in the last 30 days. During a review of Resident 61’s MDS dated [DATE], the MDS indicated Resident 61 had intact cognition. The MDS indicated Resident 61 was dependent with toileting hygiene and required maximal assistance (helper does more than half the effort. Helper lifts or holds trunk or limbs and provides more than half the effort) with toilet transfers, sit to stand, and chair/bed-to-chair transfer). The MDS indicated Resident 61 had an active diagnosis of UTI in the last 30 days. During a review of the Resident 61’s MDS dated [DATE], the MDS indicated Resident 61 had an active diagnosis of UTI in the last 30 days. During an interview on 07/07/25 at 10:11 AM with Resident 61, Resident 61 stated Resident 61 had multiple hospitalizations for UTI’s. Resident 61 stated “I was not myself. I was told I had a UTI”. Resident 61 had a Foley catheter with clear, yellow urine. During a review of Resident 61’s MDS, the MDS indicated Resident 61 was discharged to the general acute hospital (GACH) on the following dates: (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	6/26/2025 5/6/2025 3/28/2025 3/12/2025 During a review of Resident 61’s Change of Condition Note for the following dates, indicated the following: On 3/12/2025, Resident 61 had an altered level of consciousness. On 3/27/2025, Resident 61 was yelling for no reason On 5/6/2025, Resident 61 was lethargic and had an altered level of consciousness. During an interview on 7/9/2025 at 3:23 PM, the Minimum Data Set Nurse (MDS Nurse) and the MDS Coordinator stated they could not find a care plan to address Resident 61’s recurrent UTI’s. They could only find the short-term care plan when Resident 61 came back from hospitalizations dated 4/4/2025, revised on 6/9/2025. The MDS Nurse stated interventions that could be implemented for Resident 61’s recurrent UTI would include: 1) Ensure adequate fluid intake, 2). Consult with the physician to discuss the problem with the recurrent UTI, 3). Provide good peri-care at least every two hours and as needed. The When asked if improper peri care could contribute to a UTI, the MDS Nurse stated “Yes. ” During a concurrent interview and review of Resident 61’s care plan for UTI dated 4/4/2024, with the MDS Nurse, when asked if this was a comprehensive plan of care for UTI, the MDS Coordinator stated “No.” When asked if the care plan included interventions to prevent further UTI’s, the MDS Nurse and the MDS Coordinator stated “No.” During a review of the facility’s Policy and Procedure (P&P) titled “Comprehensive Person-Centered Care Planning” dated 4/2025. The P&P indicated It is the policy of this facility that the interdisciplinary team (IDT) shall develop a comprehensive person-centered care plan for each resident that includes measurable objectives and timeframes to meet a resident's medical, nursing, mental and psychosocial needs that are identified in the comprehensive assessment. The resident's comprehensive plan of care will be reviewed and/or revised by the IDT after each assessment, including both the comprehensive and quarterly review assessments. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility’s P&P titled “Change in Condition” dated 4/2024, the P&P indicated if at any time it is recognized by any of the team members that the condition or care needs of the resident have changed, the Licensed Nurse or Nurse Supervisor should be made aware. Examples would be the following but not limited to…new complaints of pain or worsening pain, any signs or symptoms of infection. The nurse will transcribe the treatment and plan of care relative to the change of condition on the resident Electronic Medical Record (EMR). The P&P indicated The interdisciplinary team (IDT) shall collaborate with the attending physician, resident, and/or resident representative to review risk indicators and the plan of care. The IDT will document this collaboration in the EMR in the next scheduled Comprehensive Care Plan Meeting or sooner if deemed necessary by the IDT. d. During a review of Resident 44’s admission Record (AR), the AR indicated Resident 44 was admitted to the facility on [DATE] with diagnoses including multiple right-sided rib fractures, dementia (a progressive state of decline in mental abilities), and Parkinson’s disease (a progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movements). During a review of Resident 44’s History & Physical (H&P), dated 4/10/2025, the H&P indicated the resident had the capacity to understand and make decisions. During a review of Resident 44’s Minimum Data Set (MDS, a resident assessment tool), dated 6/24/2025, the MDS indicated Resident 44 had moderately impaired cognition (ability to understand) and had experienced pain or hurting frequently. During a review of Resident 44’s Order Summary Report, dated 7/9/2025, the Order Summary indicated Resident 44 had an active order for Hydrocodone-Acetaminophen (a controlled drug used to treat moderate to severe pain with a moderate to low potential for physical and psychological dependence) Oral Tablet 5-325 milligrams (mg) to be given by mouth every four hours as needed for severe pain (7-10), ordered on 4/8/2025. During a review of Resident 44’s Medication Administration Records (MAR) dated 7/1/2025 to 7/31/2025, the MAR indicated Resident 44 received Hydrocodone-Acetaminophen Oral Tablet 5-325 mg on 7/1/2025 at 5:06 pm and on 7/3/2025 at 7:07 pm. During a concurrent interview and record review on 7/9/2025 at 10:34 am with Registered Nurse Supervisor 1 (RN 1), Resident 44’s all care plans were reviewed. The CP indicated a lack of documentation to address Hydrocodone-Acetaminophen usage. RN 1 stated, Hydrocodone-Acetaminophen had a black box warning (a serious warning given by the Food and Drug Administration for drugs or drug classes that may cause serious harm or death), which meant the nurses needed to watch for serious adverse effects from the medication. RN 1 stated, licensed nurses created resident care plans with the purpose of benefitting the residents with interventions and goals for their issues. RN 1 stated there was no CP in place for Resident 44 and this use of Hydrocodone-Acetaminophen. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 7/9/2025 at 4:30 pm with the Director of Nursing (DON), the DON stated Resident 44 received Hydrocodone-Acetaminophen 5-325 mg for his pain, which was an opioid (class of drugs used to reduce pain) with a black box warning that could cause central nervous system depression (slowed breathing, drowsiness, confusion, lethargy, seizures) and drug dependence. The DON stated care planning was done to evaluate what interventions were beneficial and worked for the resident, ensuring the resident had goals and a person-centered CP. The DON stated Resident 44 should have had a CP in place for Hydrocodone-Acetaminophen to allow them to be aware of the drug’s side effects and monitor its effectiveness. During a review of the facility’s policy and procedure (P&P) titled, “Comprehensive Person-Centered Care Planning,” last revised 4/2025, the P&P indicated to develop a comprehensive person-centered care plan for each resident that included measurable objectives and timeframes to meet a resident's medical, nursing, mental and psychosocial needs that were identified in the comprehensive assessment. The P&P indicated the CP included minimum healthcare information necessary to properly care for each resident and instructions needed to provide effective and person-centered care that met professional standards of quality care, which included physician’s orders.

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure a change of condition was developed and the physician was notified for one of one resident (Resident 335) who had an alert notification for no bowel movement for three days.This deficient practice had the potential to lead to a bowel obstruction, bowel rupture and/or death.Findings:During a review of Resident 335's admission Record (AR), the AR indicated the facility admitted the resident on 5/1/2025, with diagnoses that included enterocolitis due to clostridium difficile (is an inflammation of the intestines that is predominantly associated with antibiotic use), irritable bowel syndrome (a condition that causes abdominal discomfort and altered bowel movements).During a review of Resident 335's MDS dated [DATE], the MDS indicated Resident 335 had intact cognition. The MDS indicated Resident 335 was dependent in toileting hygiene, bed mobility; rolling left and right, sit to lying, lying to sitting on the side of the bed, chair/bed-to-chair transfer.During a concurrent observation and interview on 7/7/2025 at 10:54 AM, Resident 335 was lying in bed, awake. Resident 335 stated My stomach hurts and described pain as a level 10/10.During a review of Resident 335's bowel movement task documentation for the month of July, the BM task documentation indicated no BM on 7/6/2025, 7/7/2025, 7/8/2025 and 7/9/2025.During a concurrent record review of Resident 335's bowel movement and interview on 7/9/2025 at 6:34 PM, Resident 335's last bowel movement was on 7/5/2025. The Assistant Director of Nursing (ADON) stated Resident 335 had no BM since 7/6/2025 for a total of four days. The ADON showed the clinical alert for Resident 335's change of condition dated 7/8/2025.During a concurrent record review of Resident 335's change of condition and progress notes on 7/9/2025 at 6:35 PM, the ADON stated there was no change of condition and there were notes to indicate notification of the physician from 7/8/2025 to 7/9/2025. The ADON stated if Resident 335 had no BM for more than three (3) days or more this would be considered a change of condition; Therefore, we needed to make a change of condition and notify the physician, so the problem could be addressed.During an interview on 7/9/2025 at 6:46 PM, with Licensed Vocational Nurse 4 (LVN 4), when asked regarding clinical alerts stated the only clinical alert communication LVN 4 would check, would be the hand-off communication. LVN 4 stated during hand-off report, LVN 4 received report that Resident 335 had poor intake and abdominal pain.During an interview on 7/9/2025 at 7:09 PM, LVN 5 stated LVN 5 did not see any Stop and Watch report from the certified nursing assistant. LVN 5 stated a Stop and Watch is a form that the CNA will fill out if there was an important concern they wanted to communicate to the licensed nurses, such as changes in skin condition or any other resident issues.During a review of the facility's Policy and Procedure (P&P) titled Change in Condition dated 4/2025, the P&P indicated if, at any time, it is recognized by any one of the team members that the condition or care needs of the resident have changed, the Licensed Nurse or Nurse Supervisor should be made aware. Examples would be the following: Change in output (bowel or bladder) including amount, color, consistency, odor, or frequency.The P&P indicated the nurse will perform and document an assessment of the resident and identify the need for additional interventions, considering implementation of existing orders or nursing interventions or through communication with the resident's provider using SBAR or similar process to obtain new orders or interventions.

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure three of seven sampled residents (Residents 48, 50, and 64) who required supervision while smoking (breathing in smoke from cigarettes [tobacco wrapped in paper]) had an environment free of accident hazards (risk) by failing to:1. Implement the facility's Policy and Procedure (P&P) titled, Smoking Policy, which indicated no lighting materials (e.g. matches, lighters), tobacco products, or smoking devices (e.g. tobacco cigarettes, cigars) will be allowed to be kept in the possession of the residents, either on their person or in the facility. 2. Ensure Residents 48, 50, and 64 were not in possession of smoking materials (cigarettes and lighters). 3. Implement Resident 48, 50 and 64's Care Plans (CPs) interventions to keep Resident 48, 50 and 64's smoking materials at the Nurses' Station and ensure for staff to observe Resident 64 while smoking in designated areas (smoking patio).These deficient practices had the potential for Residents 48, 50, and 64 to turn on their lighters, smoke cigarettes unsupervised inside the facility, cause fire that could affect the health, safety, and wellbeing of all 135 residents in the facility, staff, visitors and result in serious harm, injury, hospitalization and or death.On 7/7/2025 at 5:33 pm, while onsite at the facility, the State Survey Agency (SSA) called an Immediate Jeopardy (IJ, a situation in which the facility's non-compliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident). The IJ was called in the presence of the facility's Administrator (ADM) and the Director of Nursing (DON) due to the facility failing to safely secure/store lighters and cigarettes for Residents 48, 50 and 64 to prevent accident hazards such as fire in accordance with the facility's Smoking Policy.On 7/8/2025 at 2:43 pm, the facility submitted an acceptable IJ Removal Plan (IJRP, a detailed plan with interventions to immediately correct the deficient practices in the IJ). While onsite at the facility, the SSA verified and confirmed the facility's implementation of the IJRP through observation, interview, record review, and determined the IJ situation of fire hazard was no longer present. The SSA removed the IJ situation on 7/8/2025 at 6:45 pm in the presence of the ADM and the DON.The facility provided an acceptable IJRP as follows:A. Immediate Corrective Actions:1. On 7/7/2025, lighters and cigarettes were immediately confiscated (removed) by the ADM and the DON from Residents 48, 50 and 64. The confiscated lighters were safely secured in a locked box, located in Station 1 Nurse's Station.2. On 7/7/2025, the ADM met with Residents 48, 50, and 64 to review the facility's smoking policy. During this meeting, it was reinforced that residents (all residents in the facility) were not permitted to keep any lighting materials such as matches or lighters, tobacco products, or smoking devices in their possession or anywhere within the facility. Residents 48, 50, and 64 were reminded that all lighters and smoking paraphernalia (lighters and cigarettes) must be stored in the locked box located at Station 1 Nurse's Station.3. On 7/7/2025, the Assistant Director of Nursing (ADON) immediately completed a change of condition evaluation for Residents 48, 50, and 64. This evaluation assessed any acute injuries or changes in condition of Residents 48, 50 and 64. The ADON also re-educated Residents 48, 50 and 64 regarding the facility's smoking policy and confirmed Residents 48, 50 and 64's understanding of fire safety risks.4. On 7/7/2025, the ADON completed smoking evaluations for Residents 48, 50 and 64. Each resident's care plan was reviewed and updated. These updates reflected the need for increased supervision regarding smoking materials and to ensure adherence to the facility's policy on the proper storage of lighters and other smoking-related items.B. Identification of Other Residents Having the Potential to be Affected:1. All residents in the facility were potentially at risk of being affected.2. On 7/7/2025 at 6 pm, the ADON completed the Smoking Evaluation Assessment of the other four residents (Residents 32, 61, 91 and 123) who smoked cigarettes. These residents did not have the same findings (no lighters or cigarettes were found in Residents 32, 61, 91 and 123's possessions).3. On 7/7/2025, the facility's Department Heads conducted a comprehensive facility wide room rounds for all 135 residents who are residing in the facility. All 135 residents' rooms and bedside areas were thoroughly assessed, and no lighters or smoking materials were found in 135 residents' possessions or stored at the bedside.4. On 7/8/2025, the facility completed the Smoking Assessment Evaluations for all 128 residents, excluding the 7 known smokers (individual who inhales smoke from cigarettes/Residents 32, 48, 50, 61, 64, 91 and 123) who had already been evaluated.5. On 7/8/2025, the facility's Interdisciplinary Team (IDT- group of health care workers who worked together to share information and collaborate the plan of care for the residents) and designees completed rounds to meet with all 135 residents. During these rounds, the facility's smoking policy was discussed with all 135

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	a. During a review of Resident 48’s admission Record (AR), the AR indicated the facility admitted Resident 48 on 3/12/2025 with diagnoses that included anxiety (intense, excessive, and persistent worry and fear about everyday situations), bipolar disorder (a mental illness characterized by extreme shifts in mood, energy, and activity levels, alternating between periods of elevated mood [a state of abnormally elevated mood, energy, and activity] and periods of depression [persistent sadness, loss of interest, and a range of other symptoms that can significantly impair a person's ability to function in everyday life]). During a review of Resident 48’s Smoking Evaluation (SE) dated 6/17/2025, the SE indicated Resident 48 was a smoker. The SE indicated Resident 48 smoked three (3) to four (4) times a day (morning, afternoon, evening and night). The SE indicated for Resident 48’s safety, Resident 48 needed to use adaptive clothing (bibs and aprons are made from flame-retardant materials to prevent burns to clothing and skin)/device/assistance while smoking and required supervised smoking. During a review of Resident 48’s untitled CP, dated 6/17/2025, the CP indicated Resident 48 had a potential for injury related to smoking. The CP interventions included for facility ‘s staff to maintain smoking materials at the nurse’s station or other designated areas and to monitor to assess compliance with the facility’s smoking policy. During a concurrent observation inside Resident 48’s room and interview with Resident 48 and Certified Nurse Assistant 1 (CNA 1) on 7/7/2025 at 11:30 am, Resident 48 was lying in bed. Resident 48’s room was located next to Resident 15. Resident 15 had chronic obstructive pulmonary disease (COPD, lung disease characterized by long-term poor airflow) and was on continuous oxygen use at 2 liters (L, unit of measuring volume of a liquid or gas) via (through) nasal cannula (NC, tube which on one end splits into two prongs which are placed in the nostrils [opening of the nose] to deliver oxygen [colorless/odorless gas]). Resident 48 stated Resident 48 had been smoking for many years. Resident 48 stated Resident 48 kept cigarettes and lighter in Resident 48’s possession. Resident 48 stated Resident 48’s family member brought cigarettes and lighter to Resident 48 during visitation. Resident 48 stated Resident 48 would smoke anytime Resident 48 wanted to smoke. CNA 1 stated CNA 1 did not know Resident 48 had cigarettes and lighter in Resident 48’s possession. During a concurrent observation at Station 1 Nurse’s Station and interview on 7/7/2025 at 11:40 am with Licensed Vocational Nurse 1 (LVN 1), a blue box was seen on the top shelf inside Station 1 Nurse’s Station. The blue box was locked with residents’ smoking materials. LVN 1 stated Resident 48 did not have cigarettes and lighter locked up inside the blue box. During an interview on 7/7/2025 at 11:57 am with the AD, the AD stated Resident 48 was a smoker and Resident 48 needed supervision while smoking. The AD did not know Resident 48 kept cigarettes and lighter in Resident 48’s possession. The AD stated all residents’ cigarettes and lighters should be kept and locked in a box at Station 1 Nurse’s Station for the safety of the residents and prevent potential fire hazard. During an interview on 7/7/2025 at 12:21 pm with the facility’s DON, the DON stated Resident 48 “admitted (confess to be true, typically with reluctance)” that Resident 48 currently had cigarettes and lighter in Resident 48’s possession. The DON stated the DON did not know how Resident 48 had cigarettes and lighter in Resident 48’s possession. The DON stated all residents who smoke were not allowed to keep cigarettes and lighters inside the residents’ room because of fire risks and to ensure the safety of all 135 residents in the facility from fire. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 7/7/2025 at 12:54 pm with the ADM, the ADM stated the ADM retrieved one (1) functional white lighter and 1 pack of cigarettes (20 sticks) from Resident 48. The ADM stated the ADM did not know Resident 48 had cigarettes and lighter in Resident 48’s possession and did not know how Resident 48 obtained the cigarettes and lighter. The ADM stated that all smokers were not allowed to keep cigarettes and lighters in their possessions inside their rooms to prevent them from lighting the cigarettes up for the safety of all 135 residents in the facility. b. During a review of Resident 50’s AR, the AR indicated the facility admitted Resident 50 on 2/9/2023 and readmitted on [DATE] with diagnoses that included heart failure (condition when the heart is unable to pump sufficiently to maintain blood flow to meet the body's needs) and a pacemaker (a medical device that helps the heartbeat regularly). During a review of Resident 50’s untitled CP, revised 4/25/2025, the CP indicated Resident 50 had the potential for injury related to smoking. The CP interventions included explaining the smoking policy to Resident 50, maintaining smoking materials at the nurses’ station, and monitoring Resident 50 to assess compliance with the facility’s smoking policy and individual plan. The CP goal indicated for Resident 50 to be compliant with smoking protocols, individual smoking plan, and follow the smoking policy. During a review of Resident 50’s SE dated 5/15/2025, the SE indicated, for Resident 50’s safety, Resident 50 needed to use adaptive clothing/device/ assistance while smoking and required supervised smoking. During an interview on 7/7/2025 at 12:13 pm with Resident 50, Resident 50 stated Resident 50 kept Resident 50’s cigarettes and lighter in Resident 50’s possession and smoked in the patio. Resident 50 shouted and refused to answer how long Resident 50 had cigarettes and lighter in Resident 50’s possession. During an interview on 7/7/2025 at 12:58 pm with the facility’s DON, the DON stated the DON was not aware Resident 50 had kept Resident 50’s cigarettes and lighter at Resident 50’s bedside. The DON stated Resident 50 could only smoke with supervision and no residents were allowed to keep cigarettes in their possession according to the facility’s policy on smoking. The DON stated all cigarettes and lighters needed to be kept locked at Station 1 Nurse’s Station. The DON stated residents who smoke (Residents 32, 48, 50, 61, 64, 91 and 123) were not allowed to keep lighters at their bedside for safety. The DON stated, due to oxygen being flammable (easily catch fire), there was a potential risk the whole facility could catch fire when smokers had lighters and cigarettes in their possession. During a concurrent observation in the hallway and interview on 7/7/2025 at 1:25 pm with the ADM, one box of cigarettes and one yellow lighter were in a clear bag with Resident 50’s name on the bag. The ADM stated the items were taken from Resident 50 on 7/7/2025 and the lighter in Resident 50’s possession was functioning (working). c. During a review of Resident 64’s AR, the AR indicated the facility admitted Resident 64 on 5/9/2022 and readmitted on [DATE], with diagnoses that included anxiety disorder (group of mental disorders characterized by feelings of anxiety [an unpleasant state of inner turmoil] and fear) and palliative care (specialized medical care for people living with a serious illness focused on providing relief from the symptoms of the illness). (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During a review of Resident 64 untitled CP revised 2/21/2025, the CP indicated Resident 64 had the potential for injury related to smoking. The CP goal indicated for Resident 64 to be compliant with the facility’s smoking protocol and individual smoking plan. The CP interventions included maintaining Resident 64’s smoking materials at the nurse’s station or other designated area and monitoring Resident 64 to assess compliance with facility smoking policy/individual plan. The CP interventions also indicated for staff to observe Resident 64 while smoking in designated areas. During a review of Resident 64’s SE dated 2/21/2025, the SE indicated Resident 64 smoked 4 to 5 times per day. The SE indicated for Resident 64’s safety, Resident 64 needed to use adaptive clothing/devices/assistance while smoking and required supervised smoking. During a review of Resident 64’s Minimum Date Set (MDS, a resident assessment tool) dated 5/21/2025, the MDS indicated Resident 64 had short term memory (memory that helps you remember for a short time) problem. During a review of Resident 64’s Interdisciplinary Team (IDT) Brief Interview for Mental Status (BIMS, a screening tool used to assess cognitive function, particularly in long-term care settings) assessment dated [DATE], the IDT BIMS Assessment indicated Resident 64 had severely impaired cognition status (ability to think and process information). During an interview on 7/7/2025 at 12:15 pm with Resident 64, Resident 64 stated Resident 64 had a lighter and cigarettes inside Resident 64’s pocket. During an interview on 7/7/2025 at 12:16 pm with the AD, the AD stated Resident 64 should not have lighters because it would not be safe for Resident 64 to smoke inside Resident 64’s rooms due to fire hazard. The AD stated the only location for smoking would be the facility’s smoking patio. The AD stated no residents could keep cigarettes and lighters at the bedside. During an interview on 7/7/2025 at 1:23 pm with the ADM, the ADM stated there were 40 sticks of cigarettes and a blue lighter retrieved by the ADM from Resident 64’s pocket. The ADM stated Resident 64 could have bought the cigarettes when Resident 64 went out on pass. During an interview on 7/7/2025 at 1:29 pm with Resident 64, Resident 64 stated Resident 64 found the lighter last night (7/6/2025) inside the pocket of Resident 64’s jacket. Resident 64 stated Resident 64 bought the cigarettes when Resident 64 went outside of the facility during an out on pass. During an interview on 7/7/2025 at 2:23 pm, CNA 7 stated Resident 64 was independent and would go anytime to the smoking patio because Resident 64 had access to the pin code (a passcode used in the process of authenticating a user accessing a system or a door) to the smoking patio. CNA 7 stated Resident 64 would go to the smoking patio even if it was not the scheduled smoking time because Resident 64 had access to the pin code to the smoking patio. CNA 7 stated, if Resident 64 would come and go to the smoking patio anytime, facility staff (in general) would not be able to monitor Resident 64 while smoking. During an interview on 7/7/2025 at 5:15 pm, with the facility’s DON and ADM, the DON and ADM stated Resident 64 needed to be monitored and supervised when smoking. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 7/8/2025 at 4:00 pm, with the ADON, the ADON stated only a designated person (assigned staff) should know the access pin code to the smoking patio to ensure residents who smoke would be supervised when smoking. The ADON stated the residents who smoke should not have the access pin code to the smoking patio. During a review of the facility’s P&P titled, “Smoking Policy,” revised 4/2024, the P&P indicated, “Designated smoking areas outside the building are available for this purpose based on the facility smoking schedule with assigned staff to supervise. No lighting materials (e.g. matches, lighters), tobacco products, or smoking devices will be allowed to be kept in the possession of the residents, either on their person or in the facility. If it is determined that a resident is a safe smoker (someone who smokes in a way that reduces risk to others) all smoking materials will still be retained by nursing staff.”

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure a physician order and an informed consent (voluntary agreement to accept treatment and/or procedures after receiving education regarding the risks, benefits, and alternatives offered) were obtained before the installation of side rails for one of two sampled residents (Resident 83).This failure placed Resident 83 at risk for entrapment (an event in which residents were caught, trapped, or entangled in a tight space around the bed) and injury from use of side rails.Findings:During a review of Resident 83's admission Record (AR), the AR indicated Resident 83 was admitted to the facility on [DATE] with diagnoses that included hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body), hemiparesis (weakness on one side of the body) and dysarthria (a speech disorder that results in slurred, slow, or imprecise speech).During a review of Resident 83's Minimum Data Set (MDS, a resident assessment tool), dated 5/6/2025, the MDS indicated Resident 83 had an intact cognition (ability to understand and process information). The MDS indicated Resident 83 was dependent (helper did all the effort, resident did none of the effort to complete the activity) with oral hygiene, toileting, upper and lower body dressing. During a concurrent observation while inside Resident 83's room and during an interview on 7/8/2025 at 2:55 pm with Licensed Vocational Nurse 1 (LVN 1), Resident 83 was lying in bed and on Resident 83's back with upper side rails up on both sides of the bed. LVN 1 stated Resident 83 had right-sided paralysis.During a concurrent interview and record review on 7/8/2025 at 3:04 pm with the Director of Nursing (DON), Resident 83's medical record (chart) and electronic medical record (EMR) were reviewed. The DON stated Resident 83 did not have a documented record in Resident 83's chart and /or EMR that a physician order and an informed consent for the use of bilateral upper side rails were obtained and signed before the installation of bilateral upper side rails. The DON stated a physician order, and an informed consent needed to be obtained from Resident 83 or Resident 83's responsible party (RP) and a copy retained in the chart to make sure Resident 83 and/or RP understood and were educated on the risks and benefits of using side rails/bed rails for the safety of the resident.During a review of the facility's policy and procedures (P&P) titled, Bedrails, revised 4/2025, the P&P indicated, After the facility has attempted alternatives to bed rails and determines that these alternatives failed to meet the resident's assessed needs, the facility interdisciplinary team (IDT) will assess the resident for risk of entrapment. The risks and benefits regarding the use of bed rails will be considered for each resident. If the use of bed rails is recommended by the IDT, the facility must obtain informed consent from the resident, or if applicable, the resident representative for the use of bed rails prior to installation or use.

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Some	Post nurse staffing information every day. Based on observation, interview and record review, the facility failed to post nursing hours in a prominent place readily accessible to residents and visitors.This failure had the potential to result in the residents and visitors not knowing whether there was sufficient staff to provide quality care for the residents and resulted in nurse staffing information being inaccessible to visitors.Findings:During observations on 7/8/2025 at 3:08 pm and 7/9/2025 at 3:06 pm, the staffing sheet was posted on the consumer board in the hallway with no other postings at the facility entrance or nursing stations one through four.During an interview on 7/9/2025 at 5:34 pm with the Director of Staff Development (DSD), the DSD stated she was responsible for the nurse staffing posting and it was displayed in the hallway on the consumer board.During a concurrent observation and interview on 7/10/2025 at 9:30 am with the DSD, the staffing posting was observed on the consumer board in the hallway. The DSD stated it was only posted on the consumer board and was not at any other location. The DSD stated the facility was large and other residents, especially those utilizing wheelchairs, could not view it. The DSD stated the posting should be accessible to residents and visitors to allow them to know how much staffing was available and allow transparency between them and the facility.During a review of the facility Shift Hours Form (SHF), undated, the SHF indicated posted nurse staffing information was posted daily in a prominent place at the beginning of each shift and was accessible to residents and visitors.

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F 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide special eating equipment and utensils for residents who need them and appropriate assistance. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide a resident with a physician order to have a plate guard (a dining aid that can help people with limited control, grip, or dexterity eat with one hand and reduce the risk of spills) during meals for one of one sampled resident (Resident 83).This failure had the potential to result in Resident 83's decline in nutritional status and inability to maintain independence during mealtimes.Findings:During a review of Resident 83's admission Record (AR), the AR indicated Resident 83 was admitted to the facility on [DATE], with diagnoses that included hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body), hemiparesis (weakness on one side of the body), dysarthria (a speech disorder that results in slurred, slow, or imprecise speech) and adult failure to thrive (a decline caused by chronic diseases and functional impairments which can cause weight loss, decreased appetite, poor nutrition, and inactivity).During a review of Resident 83's Minimum Data Set (MDS, a resident assessment tool), dated 5/6/2025, the MDS indicated Resident 83 had an intact cognition (ability to understand and process information). The MDS indicated Resident 83 was dependent (helper did all the effort, resident did none of the effort to complete the activity) with oral hygiene, toileting, upper and lower body dressing. During a review of Resident 83's Order Summary Report (OSR), dated 6/1/2025, the OSR indicated Resident 83 had an order to use a plate guard for all meals to prevent spillage and assist with scooping food.During a concurrent observation while inside Resident 83's room and interview on 7/8/2025 at 6:38 pm with Licensed Vocational Nurse 2 (LVN 2), Resident 83 was in bed, eating dinner with the head of bed elevated. Resident 83 was eating using Resident 83's left hand and food was spilling on Resident 83's blanket and clothes. Resident 83 did not have a plate guard. LVN 2 stated Resident 83 was picking up spilled food from Resident 83's blanket and clothes. LVN 2 stated Resident 83 had an order to use a plate guard for all meals. LVN 2 stated Resident 83's food should be served on a plate guard for Resident 83 to scoop food better and prevent spilling of food on Resident 83's blanket or clothes.During an interview on 7/9/2025 at 10:56 am with the Director of Nursing (DON), the DON stated Resident 83's food should have been served on a plate guard as ordered by the physician to scoop food better and minimize spilling of food on the blanket and clothes, and to maintain the resident's independence during mealtime.During a review of the facility's policy and procedure (P&P) titled, Adaptive Equipment-Plate Guard, revised 5/2007, the P&P indicated, Residents who are recommended to use a plate guard as part of their care plan will have it available and in place during meals to promote independence, safety, and dignity during dining.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview and record review, the facility failed to ensure 20 cups of milk were maintained at temperature of 41 degrees Fahrenheit (41 F) during the meal service (Food Service- Meal service may include, but is not limited to, the steam table where hot prepared foods are held and served, and the chilled area where cold foods are held and served.This deficient practice had the potential to affect microbial (germs) growth that could lead to food poisoning (Food poisoning can happen to anyone who swallows food or water that's contaminated by ‘germs).Findings:During a kitchen observation on 7/7/2025 at 7:59 AM, of the meal service which had already started, there were 20 cups of thickened milk and boxed milk placed on top of the plastic trays at room temperature. The temperature of the thickened milk of a cup was 57. F and the temperature of the boxed milk was 47.8 F.During an interview on 7/7/2025 at 8:01 AM, the Dietary Services Supervisor (DSS) stated the DSS would put the milk cups and boxed milk on ice now during the meal service.During an interview on 7/7/2025 at 8:48 AM, the Kitchen Staff (KS) stated the KS took out the cups of milk and boxed milk from the chiller at 7 AM when the meal service for breakfast would usually start and placed the milk on the plastic tray. The KS stated the KS would not put the milk on ice during the meal service for breakfast because it was not as hot inside the kitchen during breakfast.During an observation on 7/7/2025 at 9 AM, the temperature inside the kitchen was 81.5 degrees Fahrenheit.During a review of the facility's Policy and Procedure (P&P) titled Meal Service the P&P indicated the Food and Nutrition Services staff member will take the food temperatures prior to service of the meal with a thermometer. The temperature of the foods should be periodically monitored throughout the meal service to ensure proper hot or cold holding temperature. Cold foods will be placed on the trays as close to serving time as possible to ensure the temperature was below 41F. To accomplish this, all cold foods will be pre-poured and kept in the refrigerator or freezer and pulled out in small quantities at a time. The cold beverages can be stored up to 1-2 hours prior to service in a freezer and pulled out in quantities sufficient to maintain proper temperature.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure policies and procedures (P&P) on Infection Prevention and Control were implemented for five of five sampled residents (Residents 105, 122, 61, 53, and 34) by failing to:a. Ensure Resident 105's urinal was stored appropriately and labeled with a resident identifier.b. Ensure staff wore proper personal protective equipment (PPE - clothing and equipment that is worn or used to provide protection against hazardous substances and/or environments) for Enhanced Barrier Precautions (EBP- an infection control intervention designed to reduce transmission of multidrug-resistant organisms [MDROs] that employs targeted gown and glove use during high contact resident care activities and were indicated for residents with infections, wounds, and indwelling medical devices) while providing range of motion (ROM) exercises to Resident 122.c. Ensure staff changed PPE in between Resident 61 and Resident 53's care.d. Ensure staff placed EBP signage and PPE equipment/cart outside of Resident 34's door who had a nephrostomy (artificial opening created between the kidney and the skin which allows for urine drainage).These failures had the potential to transmit infectious microorganisms (pathogens [bacteria, algae, protozoa, fungi] may include viruses that can cause disease in other living organisms) and increase the risk of infection for the residents potentially causing sepsis (a life-threatening emergency that happens when the body has an extreme response to an infection that damages vital organs and can be fatal) and death.Findings: a. During a review of Resident 105’s admission Record (AR), the AR indicated Resident 105 was admitted to the facility on [DATE] with diagnoses including dementia (a progressive state of decline in mental abilities) and osteoarthritis (a progressive disorder of the joints, caused by a gradual loss of cartilage) of the hip. During a review of Resident 105’s Care Plan (CP), revised 8/22/2024, the CP indicated Resident 105 was at risk for decline in bowel and bladder continence related to dementia, disease process, medication side effects and physical limitations. During a review of Resident 105’s History & Physical (H&P), dated 11/1/2024, the H&P indicated the resident had a fluctuating capacity to understand and make decisions. During a review of Resident 105’s Minimum Data Set (MDS, a resident assessment tool), dated 5/28/2025, the MDS indicated Resident 105 used a walker and needed setup or clean-up assistance (helper sets up or cleans up; residents completes activity. Helper assists only prior to or following the activity) with toileting hygiene. During a concurrent observation and interview on 7/7/2025 at 8:55 am with Licensed Vocational Nurse 3 (LVN 3) in Resident 105’s room, Resident 105’s urinal was hanging on the garbage can next to the resident’s bed, unlabeled and filled with urine. LVN 3 stated urinals should be labeled with the room number, patient name and placed at the bedside in a basket to prevent them from being mistaken for another resident’s urinal. LVN 3 stated Resident 105’s urinal was not labeled and it should have been. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 7/9/2025 at 11:18 am with Registered Nurse Supervisor (RN) RN 1 stated each patient should have their urinal labeled with their room number to prevent cross-contamination. RN 1 stated it was important for infection control, and to prevent the spread of infection from resident-to-resident. RN 1 stated nursing assistants and licensed nurses were responsible for labeling urinals, and they should be stored in the urinal basket that was attached to the bedframe. RN 1 further stated everyone knew that urinals should be labeled. During an interview on 7/9/2025 at 4:37 pm with the Director of Nursing (DON), the DON stated urinals should be labeled for infection control and because they were part of the resident’s personal belongings. The DON stated they should be labeled with the resident’s initials and room number to prevent urinals from becoming mixed up. During a review of the facility’s policy and procedure (P&P) titled, “Infection Prevention and Control Program,” last revised 4/2025, the P&P indicated an element of the program was infection prevention with a goal to decrease the infection risk to residents and personnel. The P&P indicated the facility would provide supplies and equipment with the goal of disposable equipment being safely used. During a review of the facility’s policy and procedure (P&P) titled, “Infection Control: Personal Care Items,” last revised 4/2025, the P&P indicated the facility would ensure proper hygiene and safety for personal care items. The P&P indicated items must be stored in designated personal storage areas and must be labeled with residents’ name. b. During a review of Resident 122’s admission Record (AR), the AR indicated Resident 122 was admitted to the facility on [DATE] with diagnoses that included end stage renal disease (ESRD, irreversible kidney failure), dependence on renal dialysis (a treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidney(s) have failed), and stage 2 pressure ulcer (partial-thickness loss of skin, presenting as a shallow open sore or wound) on the left buttock. During a review of Resident 122’s Minimum Data Set (MDS, a resident assessment tool), dated 4/24/2025, the MDS indicated Resident 122 had moderately impaired cognition (ability to understand and process information). The MDS indicated Resident 122 required partial/moderate assistance (helper did less than half the effort) with eating, substantial/maximal assistance (helper did more than half the effort) with oral hygiene and dependent (helper did all the effort and resident did none of the effort to complete the activity) with toileting, shower, upper and lower body dressing and personal hygiene. During a review of Resident 122’s Order Summary Report (OSR), dated 6/29/2025, the OSR indicated Resident 122 was on EBP and personal protective equipment (PPE, clothing and equipment that is worn or used to provide protection against hazardous substances and/or environments) were required for high resident care activities for indwelling medical devices (a device inserted into the body and remains there for a period of time, either temporarily or permanently to serve a specific medical purpose) and history of MDRO. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation inside Resident 122’s room and interview on 7/7/2025 at 10:27 am with the Restorative Nurse Assistant (RNA), Resident 122 was in bed, on Resident 122’s back with the RNA providing range of motion (ROM, a type of physical activity designed to improve capabilities of joints and muscles) exercises. The RNA was not wearing PPE. The RNA stated Resident 122 was on dialysis, with chest Permanent catheter (Permacath, tunneled hemodialysis catheter, a type of central venous catheter used for long-term dialysis access) for dialysis access. The RNA stated she should have worn gowns and gloves while performing ROM exercises on Resident 122 to prevent cross contamination. During an interview on 7/9/2025 at 10:52 am with the Director of Nursing (DON), the DON stated all staff should wear PPE while providing direct contact care activities, like ROM exercises to all EBP residents to prevent cross contamination of infection. During a review of the facility’s policy and procedure (P&P) titled, “Infection Control,” revised 3/2024, the P&P indicated, “Enhanced Barrier Protection (EBP) used in conjunction with standard precautions and expand the use of PPE through the use of gown and gloves during high-contact resident care activities that provide opportunities for indirect transfer of MDROs to staff hands and clothing then indirectly transferred to residents or from resident-to-resident. The use of gowns and gloves for high-contact resident care activities is indicated, when contact precautions do not otherwise apply, for nursing home residents with indwelling medical devices include but are not limited to central lines, peripherally inserted central catheter (PICC) lines, urinary catheters, feeding tubes, and tracheostomies. ” c. During a review of Resident 61’s admission Record (AR), the AR indicated Resident 61 was originally admitted on [DATE] and readmitted on [DATE] with diagnoses that included but not limited to urinary tract infection (happens when tiny germs [bacteria] get into the urinary system [is a part of the body that makes and gets rid of pee] and cause irritation and swelling that can make it uncomfortable to pee), unspecified Escherichia coli (E. Coli- a type of bacteria that can make a person sick, causing stomach troubles like diarrhea), sepsis (a serious illness where the body reacts badly to an infection, like a bad cold or a cut, and can cause other parts of your body to get hurt), chronic viral hepatitis C (occurs when the virus persists in the body for more than six months, and can lead to serious liver [cleans the blood, helps digest food, and stores vitamins and sugar] damage if left untreated), bacteremia (when there is bacteria present in the blood), resistance (to fight against) to multiple antibiotics (special medicines that help with bacterial infections). During a review of Resident 61’s History & Physical (H&P), dated 5/11/2025, the H&P indicated Resident 61 had the capacity to understand and make decisions. During a review of Resident 61’s Minimum Date Set (MDS- a resident assessment tool), dated 6/24/2025, the MDS indicated Resident 61 required substantial assistance (helper does more than half the effort) for toileting hygiene, shower/bathing, lower body dressing and putting on/taking off footwear. Resident 61 required partial assistance (helper does less than half the effort) for upper body dressing. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 61’s Physicians Orders dated 6/30/2025, the order indicated, “Enhanced barrier precautions (EBP- a set of infection control measures designed to reduce the spread of multi-drug-resistant organisms [bacteria or other microorganisms that have developed resistance to multiple classes of antibiotics]): PPE (Personal Protective Equipment- refers to items like masks, gowns, and gloves that healthcare workers wear to protect themselves) required for high resident contact are activities, indications: wounds and indwelling device.” During a review of Resident 53’s AR, the AR indicated Resident 53 was originally admitted on [DATE] with a diagnosis that included but not limited to aftercare following joint replacement surgery (pain management, physical therapy, and a gradual return to activity), presence of right artificial hip joint (a person has undergone a surgical procedure to replace the natural right hip joint with an artificial one), elevated white blood cell count (indicates the body is fighting off an infection or inflammation), need for assistance with personal care. During a review of Resident 53’s Physicians Orders dated 6/11/2025, the order indicated, “Enhanced barrier precautions: PPE required for high resident contact are activities, indications: wounds.” During a review of Resident 53’s MDS dated [DATE], the MDS indicated Resident 53 is dependent (helper does all of the effort, Resident does none of the effort to complete the activity) for toileting hygiene, shower/bathing, lower body dressing and required substantial assistance for personal hygiene and upper body dressing. During a review of Resident 53’s Care Plan (CP) initiated 6/12/2025, the CP indicated Resident 53 had altered respiratory status/difficulty breathing related to acute respiratory failure with hypoxia. The listed Interventions indicated to “use Enhance Barrier Precautions”. During a review of Resident 53’s H&P, dated 6/13/2025, the H&P indicated Resident 53 had the capacity to understand and make decisions. During an observation on 7/07/2025 at 8:34 AM, an EBP sign was posted, and a small PPE container was outside Resident 61 and 53’s door. A Call light (a device that allows residents to summon assistance from staff) for Resident 61’s and Resident 53’s room was turned on. During observation on 7/07/2025 at 8:36 AM, CNA3 was observed outside Resident 61 and 53’s room preparing to go inside. CNA3 donned (placed) a gown and gloves and walked inside the room to assist Resident 61 while using her cell phone. Resident 61 asked CNA3 to assist her with getting her dressed for a doctor’s appointment. CNA3 pulled the privacy curtain and began assisting Res 61. During an observation on 7/07/2025 at 8:41 AM, Resident 53 was observed attempting to get out of bed and asked for CNA3’s assistance to go to the bathroom. CNA3 while with Resident 61 pulled the privacy curtain back and told Resident 61 she would be back because she needed to help Resident 53 to the bathroom. CNA3 walked over to Resident 53 ‘s bed, having not removed the PPE’s she was wearing while assisting Resident 61 and proceeded to assist Resident 53 to sit up in bed and up to Resident 53’s walker. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During the same observation on 7/07/2025 at 8:47 AM, CNA3 assisted Resident 53 to the bathroom. After CNA3 assisted Resident 53 in the bathroom, CNA3 placed Resident 53 on the toilet. CNA3 did not remove CNA3’s PPEs before or after assisting Resident 53 to the bathroom. Leaving Resident 53 in the bathroom, CNA3 walked back to Resident 61’s closet, opened the closet, and touched multiple clothing items without removing or placing new PPEs. During observation on 7/07/2025 at 8:55 AM, CNA3 continued assisting Resident 61 with dressing without removing PPEs. During an interview with the Director of Nursing (DON) on 7/07/2025 at 12:36 PM, the DON stated that staff need to wear a gown and gloves for EBP and before assisting another resident they must remove PPEs and perform hand hygiene. The DON stated, “It’s considered cross contamination, and it would be harmful to residents since staff would be spreading germs and bacteria. Not removing used PPEs or reusing PPEs is not a safe practice.” Per the DON, it is the staff’s responsibility to protect vulnerable patients on EBP who might have wounds, medical devices, or have been previously colonized (the patient might be a carrier of certain bacteria) or infected with MDROs (a person has a microbial infection [caused by bacteria] that is resistant to multiple classes of antibiotics), because these residents are at a higher risk of transmitting these organisms or higher risk for infection. During an interview with CNA4 on 7/07/2025 at 2:20 PM, CNA4 stated that PPE’s must be worn when assisting and coming into close contact with a resident that is on EBP. Per CNA4, if assisting two residents, PPE must be discarded and there must be new PPE placed before assisting a different resident. CNA4 stated if the same PPE is worn while assisting multiple residents, there can be cross contamination (the transfer of harmful bacteria from one person to another) and it defeats the purpose of infection control. CNA4 stated that gowns and gloves used during high-contact activities and PPEs act as a barrier to prevent the bacteria from transferring onto staff's hands and clothing, which can spread to other patients. During a concurrent interview with the IPN on 7/08/2025 at 3 PM, the IPN stated, “EBP is reverse isolation to protect the resident from the staff providing close contact care.” Per the IP, staff need to wear a gown, gloves and mask when providing close contact care to a resident on EBP to prevent cross contamination or place the resident at risk of an infection by close contact of bacteria or germs. The IP stated, “It is not acceptable for a staff to provide close contact care to one particular resident and then proceed to assist another resident to the bathroom without removing the PPEs. The staff must perform proper hand hygiene and place new PPEs on before assisting a new resident.” The IP stated this is harmful to a resident and can potentially cause harm, and infection to the resident. During a review of the Policy and Procedure (P &P), titled, “Infection Prevention and Control Program, “revised 6.2021; 1.2022; 10.2022; 12.2023; 4.2025, the P&P indicated, “The facility personnel will conduct themselves and provide care in a way that minimizes the spread of infection. (b). Facility personnel will wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During review of the P&P titled, “IPCP Standard and Transmission-Based Precautions”, revised 7.22; 10.2022; 12.2023; 3.2024, the P&P indicated, “Enhanced Barrier Protection (EBP): used in conjunction with standard precautions and expand the use of PPE through the use of gown and gloves during high-contact resident care activities that provide opportunities for indirect transfer of MDROs to staff hands and clothing then indirectly transferred to residents or from resident-to-resident. (Example: residents with wounds and indwelling medical devices are at especially high risk of both acquisition of and colonization with MDRO. Examples of high-contact resident care activities requiring gown and glove use for Enhanced Barrier Precautions include: i. Dressing ii. Transferring iii. Providing Hygiene iv. Changing briefs or assisting with toileting v. Device care or use d. During a review of Resident 34's AR, the AR indicated Resident 34 was initially admitted to the facility on [DATE] and readmitted on [DATE], with diagnoses that included Urinary tract infection (UTI- infection that affects part of the urinary tract), and Acute Kidney Injury (AKI- kidneys suddenly stop working properly.) During a review of Resident 34's MDS dated [DATE], the MDS indicated Resident 34 had intact cognition for daily decision making. The MDS indicated Resident 34 was dependent on staff for toileting hygiene, showering/bathing self, lower body dressing and putting on/taking off footwear. During a review of Resident 34's PO dated 7/4/2025, the PO indicated for licensed staff to cleanse Resident 34’s left lower back nephrostomy site with normal saline, pat dry then cover with border gauze dressing every shift. During a review of Resident 34's PO dated 7/4/2025, the PO indicated for licensed staff to cleanse Resident 34’s right lower back nephrostomy site with normal saline, pat dry then cover with border gauze dressing every shift. During a review of Resident 34's untitled care plan (CP) dated 7/4/2025, the CP indicated Resident 34 had acute renal failure and the CP indicated to implement EBP. During an observation on 7/7/2025 at 9:06 am together with the Director of Staff and Development (DSD), Resident 34 was awake, lying in bed. The facility DSD was not wearing a gown while inside Resident 34's room while checking Resident 34’s nephrostomy site, tubing and bag. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 7/7/2025 at 9:09 am with the DSD, the DSD stated, Resident 34 had bilateral nephrostomy. The DSD stated Resident 34 needed to be placed on EBP. The DSD stated there was no EBP signage posted and there was no PPE cart outside Resident 34’s room to alert staff or visitors to wear proper PPE before entering Resident 34’s room. The DSD stated she did not wear a gown because she did not know Resident 34 was on EBP and had nephrostomy tube. The DSD stated gown and gloves needed to be worn while providing direct care to Resident 34 to prevent the spread of infection. During an interview on 7/9/2025 at 12:36 pm with the facility’s Director of Nursing (DON), the facility DON stated Resident 34 needed to be placed on EBP due to the presence of indwelling device. The DON stated PPE cart and EBP signage needed to be outside Resident 34’s room to alert staff and visitors what PPE to wear before going inside Resident 34’s room. During a review of the facility’s P&P titled, “Infection Prevention Control Program Standard and Transmission– Based Precautions,” revised on 3/2024, the P&P indicated EBP used in conjunction with the standard precautions and expand the use of PPE through the use of gown and gloves during high-contact resident care activities that provide opportunities for indirect transfer of MDRO’s to staff hands and clothing then indirectly transferred to residents or from resident to resident. The P&P indicated the use of gown and gloves for high-contact resident care activities is indicated for wounds and/or indwelling medical devices regardless of known MDRO infection or colonization. The P&P indicated indwelling medical devices include, but are not limited to central lines, peripherally inserted central catheter lines, urinary catheters, feeding tubes and tracheostomies. The P&P indicated, examples of high contact resident care activities requiring gown and gloves use for EBP include: device care or use: … indwelling urinary catheter.

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 bed alarm was functioning properly for one of two sampled residents (Resident 10), to alert staff when Resident 10 attempted to get up unassisted.This deficient practice had the potential to result in residents being at risk for further falls. Findings:During a review of Resident 10's admission Record (AR), the AR indicated the facility originally admitted the resident on 3/22/2023, and readmitted the resident on 4/18/2025, with diagnoses that included Parkinson's disease (is a brain condition that causes problems with movement, mental health, sleep, pain and other health issues), encephalopathy (brain disease or brain damage.) and abnormality of gait and mobility, During a review of Resident 10's Minimum Data Set (MDS) dated [DATE], the MDS indicated Resident 10 had intact cognition. The MDS indicated Resident 10 required moderate assistance (helper does less than half the effort) with mobility in chair/bed-to chair transfer, sit to stand, walking 10 feet.During a review of the Order Summary Report (OSR) for July 2025, the OSR indicated that they may have sensor pads in bed and wheelchair to alert staff when resident is getting up unassisted.During an observation on 7/8/2025 at 3:40 PM, there was a yellow-colored box placed on the left top part of the bed. The Assistant Director of Nursing (ADON) when asked how staff would check if the bed alarm was functioning, the ADON stated the facility would use three different kinds of alarms, and to check this alarm the resident had to get up. Resident 10 was assisted to get up from the bed to the wheelchair and the yellow alarm sounded. There was a yellow-colored alarm on the wheelchair, Resident 10 was assisted to stand up from the wheelchair, the wheelchair alarm did not make a sound. The ADON assisted Resident up from the wheelchair and fixed the pad on the wheelchair and assisted Resident 10 to stand again, the wheelchair alarm did not make a sound. The ADON switched the yellow alarm to a white colored alarm, then assisted Resident 10 to get up from the wheelchair, the wheelchair alarm made a sound.During an interview on 7/9/2025 at 4:21 PM, the Director of Nursing (DON) stated there was no monitoring to check functionality of bed and wheelchair alarms. The DON stated there was no Policy and Procedure regarding the use of tab alarms. When asked what policy, or guidance or monitoring the staff would use to check if the alarm was functioning or not, the DON did not answer.During a review of the facility's Policy and Procedure (P&P) titled Physical Environment, Equipment Maintenance dated 4/2025, the P&P indicated it is the policy of the facility to establish procedures for routine and non-routine care of equipment and to ensure that equipment remains in good working order for resident and staff safety.During a review of the facility's P&P titled Environmental, Maintenance Policy dated 1/2025, the P&P indicated the facility ensures that the building, equipment, and overall environment remains safe, clean and functional for resident, staff and visitors.