STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055160	A. Building B. Wing	01/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pavilion on Pico Healthcare & Wellness Centre, LP	5916 W. Pico Boulevard Los Angeles, CA 90035

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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure:Proper resident identification prior to medication administration (MedPass) when licensed vocational nurse (LVN) 1did not check identification (ID) band before MedPass for one of four sampled resident (Resident 66).The physician's orders for pain medication were clarified and accurately implemented for one of one sampled resident (Resident 66.)Controlled substances were separated and secured in accordance with regulatory standards when lorazepam (medication that helps calm anxiety, relax muscles and help with sleep) 2mg/ml oral solution was found in refrigerator in medication room [ROOM NUMBER] stored next to other medications.Controlled substance disposition log was completed in accordance with regulatory requirements and the facility's policy when observed multiple controlled substance disposition logs were missing Director of Nursing's (DON) signatures.These deficient practices had the potential to result in medication errors, including administration of medications to the wrong residents placing residents at risk for adverse outcomes, lack of accountability and traceability for controlled substances, increasing the risk of medication diversion, regulatory noncompliance, potential for Resident 66 to receive inadequate pain management due to inconsistent medication administration.Findings: 1. During a review of Resident 66's admission Records, the admission Records indicated Resident 66 was originally admitted to the facility on [DATE], then readmitted to the facility on [DATE], with diagnoses including hemiplegia (severe weakness or total paralysis of one entire side of the body) and hemiparesis (weakness, numbness, or reduced movement on one side of the body) following cerebral infarction (stroke), hypertension (high blood pressure), severe obesity (having an excessive amount of body fat). During a review of Resident 66's Minimum Data Set ([MDS]-a resident assessment tool) dated 1/19/2026, the MDS indicated Resident 66 has moderate cognitive impairment (a noticeable decline in memory, thinking, or judgment). The MDS indicated that Resident 66 requires Substantial/Maximal assistance (helper does more than half the effort) with toileting hygiene, shower, and requires partial/moderate assistance (helper does less than half the effort) with upper body dressing and personal hygiene. During a concurrent observation of MedPass and interview on 1/21/2026 at 9:05 a.m. with Licensed Vocational Nurse (LVN) 1, LVN 1 failed to identify Resident 66 prior to medication administration. LVN 1 stated that she did not identify Resident 66's identification (ID) band before administering his medications. LVN 1 stated that residents must be identified before administering medications with two identifiers, such as resident's ID band and computer picture. LVN 1 stated that not checking ID bands can potentially lead to medication error and harm the residents. LVN 1 observed not wearing gloves while assisting Resident 66. LVN 1 stated it is very important to wear gloves when touching (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	pills for medication administration so not to contaminate medication pill when administered to the resident. During an interview on 1/22/2026 at 12:20 p.m. with the DON, the DON stated that before administering any medication, it is essential to identify the resident by checking at least two identifiers, such as the resident's ID band and the resident's photograph in the electronic medical record (EMR). The DON explained that failure to properly identify the resident could result in medication errors, such as administering the wrong medication or dose, and may place the resident at risk for harm or adverse outcomes. The DON stated that during medication administration, LVNs are required to wear gloves. The DON stated that failure to wear gloves may place both residents and staff at risk for contamination. During a review of the facility's policy and procedure (P&P) titled Medication Administration revised on 6/26/2025, the P&P indicated The licensed Nurse will verify the resident's identity before administering the medication using the 6 rights of medication administration. 2. During a review of Resident' 66 admission Record, the admission record indicated Resident 66 was admitted to the facility on [DATE]. Resident 66's diagnoses included but are not limited to right knee replacement, hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body), cognitive communication deficit (a communication impairment caused by underlying cognitive issues—such as memory, attention, or executive function deficits—rather than primary language or speech disorders), schizophrenia (a mental illness that is characterized by disturbances in thought), bipolar disorder (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs). During a review of Resident 66's Minimum Data Set (MDS - a comprehensive assessment and care screening tool) dated 1/10/2026, the MDS indicated Resident 66 had moderately cognitive impairment. Resident 66 had functional limitation in range of motion on his lower extremity. During a concurrent observation and interview on 1/20/2026 at 9:41 p.m. with Resident 66 in his room, Resident 66 was moaning in pain. Resident 66 stated he did not ask for pain medications because no one helps him, he always tells staff his pain is never taken care of, and nothing is done. During an interview on 1/21/2026 with Resident 66 in his room, Resident 66 reported experiencing severe pain, rating it as a 10 out of 10, and stated that he frequently informs the staff about his unrelieved discomfort. During a review of Resident 66's Physician's Orders, dated 1/21/2026, Resident 66's Physician's Orders indicated Resident 66 had the following pain medication orders as needed for pain: Hydrocodone-Acetaminophen Tablet 10-325 mg (Norco 10), give 1 tablet by mouth as needed for severe pain (8-9) every 4 hours as needed Hydrocodone-Acetaminophen Tablet 5-325 mg (Norco 5), give 1 tablet by mouth as needed for moderate pain (5-7) every 6 hours as needed. During a review of Resident 66's Medication Administration Record (MAR) dated 1/1/2026 – 1/31/2026, the MAR indicated Resident 66 received the following medications 3 hours and 42 minutes apart on 1/17/2026: (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Hydrocodone-Acetaminophen tablet 10-325 MG; given at 10:56 a.m. Hydrocodone-Acetaminophen tablet 5-325 MG; given at 2:38 p.m. During an interview on 1/21/2026 at 10:54 a.m. with Licensed Vocational Nurse (LVN) 1, LVN 1 stated that she could administer a dose of Norco 5 two hours after a given dose regardless of ordered frequency of the medication. During an interview on 1/22/2026 at 9 a.m. with the Pharmacist (PHARM), the PHARM stated that aligning the time frequencies reduces the likelihood of errors and misinterpretations for nursing staff. The PHARM stated that if a resident receives a Norco 10 at 10:56 a.m., the next dose of pain medication should be administered at 2:38 p.m. (6 hours after the previous dose). The PHARM advised that nurses follow the Norco 5 guidelines, which state that doses should be taken every 6 hours to avoid side effects like heavy sedation, confusion, central nervous system depression, and possible overdose. 3. During a concurrent observation of medication room and interview on 1/21/2026 at 11:35 a.m. with LVN 1, it was observed lorazepam oral solution 2mg/ml placed in the refrigerator together with other medications. LVN 1 stated she was unable to identify whether controlled medications were required to be stored separately from other medications in the refrigerator. During a subsequent interview on 1/22/2026 at 12:25 p.m. with the DON, the DON stated that it was acceptable for controlled medications in refrigerator to be placed next to other medications, if they were under two locks. The DON stated only emergency kit medications must be separated and locked separately. 4. During a concurrent review of Controlled Substance Disposition Log (used to track the receipt, use, and disposal of controlled medications) and interview on 1/22/2026 at 12:05 p.m. with the DON, the logs dated 10/2025 through 12/ 2025 were incomplete – specifically, multiple entries were missing DON signatures. The DON explained that when controlled medications are discontinued, licensed nurses bring them to the DON for reconciliation. The DON and the licensed nurse reconcile the medication, document the quantity disposed, date the entry, and sign the Controlled Substance Disposition Log. Meanwhile medications awaiting destruction will then be stored in a double locked drawer in DON's room. Destruction of controlled medications is conducted every 3 months and as needed in the presence of the facility's pharmacist. At that time, both the DON and the pharmacist sign off on the Controlled Substance Disposition Log, documenting the date and quantity of medications destroyed. The DON stated that the multiple Controlled Substance Disposition Logs dated 10/2025-12/2025 were missing DON signatures required to be placed upon destruction of controlled medications. During a review of the facility's policy and procedures (P&P) titled Medication Storage in The Facility revised on 6/20/2025, the P&P indicated Controlled substances that require refrigeration are stored within a locked box within the refrigerator. This box must be attached to the inside of the refrigerator.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure safe provisions of pharmaceuticals services by: Failing to ensure that the medication label matched the physician order for Resident 14.Failing to label medications with expiration dates including two compounded vancomycin HCl (a powerful antibiotic used to treat severe infections caused by bacteria that are resistant to other drugs) intravenous (IV) infusion bags for Resident 42 were not labeled with expiration date and escitalopram (medication to treat depression) for Resident 63 was not labeled with expiration date. These deficient practices had the potential to result in administration of expired medications, reduced therapeutic effectiveness and compromised resident safety and medication errors. Findings: During a review of Resident 14's admission Records, the admission Records indicated Resident 14 was originally admitted to the facility on [DATE], then readmitted to the facility on [DATE], with diagnoses including metabolic encephalopathy (a reversible brain dysfunction caused by chemical imbalances, toxins, or organ failure (like liver or kidney disease) rather than physical injury), UTI, bacteremia (the presence of bacteria in the bloodstream), type I Diabetes Mellitus ([DM]-a disorder characterized by difficulty in blood sugar control and poor wound healing). During a review of Resident 14's Minimum Data Set ([MDS]-a resident assessment tool) dated 11/14/2025, the MDS indicated Resident 14 is cognitively intact (has sufficient judgment, planning, organization, self-control) with no significant impairment. The MDS indicated that Resident 14 is dependent (helper does all the effort) with toileting hygiene, shower, lower body dressing, putting on/taking off footwear. During a review of Resident 14's Order Summary Report dated 1/22/2026 , the order summary report indicated physician order for levofloxacin (a strong, broad-spectrum antibiotic used to treat bacterial infections) 250 mg 2 tablets by mouth one time a day for urinary tract infection (UTI) for 5 days. During a concurrent observation of medication pass and interview on 1/21/2026 at 8:00 a.m. with Licensed Vocational Nurse (LVN) 2, the label on Resident 14's levofloxacin bubble pack sheet indicated levofloxacin 500 mg 1 tablet by mouth one time a day for UTI for 5 days. LVN 2 stated that the physician order and the label on the bubble pack sheet are not matching. LVN 2 stated that she can still administer the medication because the dosage would be the same. LVN 2 then stated that labels on the medication must match the physician order. LVN 2 stated the discrepancy should be communicated with the physician and pharmacy for clarification and correction. LVN 2 further stated if the order and labels are not verified properly, patient could receive double dose, which would lead to medication error and patient harm. 2. a. During a review of Resident 42's admission Records, the admission Records indicated Resident 42 was originally admitted to the facility on [DATE], then readmitted to the facility on [DATE], with diagnoses including pressure ulcer (localized damage to the skin and/o r underlying tissue usually over a bony prominence) of sacral region (area over the tailbone/lower back), osteomyelitis (inflammation of bone or bone marrow, usually due to infection) of vertebra, dysphagia (difficulty swallowing). During a review of Resident 42's MDS dated [DATE] indicated that Resident 42 is cognitively intact with no significant impairment. The MDS indicated that Resident 42 is dependent with toileting hygiene, shower, lower body dressing, putting on/taking off footwear. During a review of Resident 42's Order Summary Report dated 1/15/2026 indicated order for vancomycin HCl 900 mg IV over 90 minute at a rate of 179 ml/hr, every 24 hours. During a concurrent observation of medication room and interview on 1/21/2026 at 11:35 a.m. with LVN 1, it was observed two compound vancomycin IV infusion bags for Resident 42 in refrigerator without expiration dates. LVN 1 stated all medications must be labeled with expiration date. LVN 1 further stated that administering medications without expiration date may cause decreased efficacy and harm the resident. 2. b. During a review of Resident 63's admission (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Records, the admission Records indicated Resident 63 was admitted to the facility on [DATE] with diagnoses including fibromyalgia (long-term condition that involves widespread body pain), asthma (a condition that causes airways to swell, narrow and fill with mucus), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest). During a concurrent observation of medication cart 1 and interview on 1/21/2026 at 11:50 a.m. with LVN 1, it was observed escitalopram for Resident 63 without expiration date. LVN 1 stated all medications must be labeled with expiration date. Administering medications without expiration date may cause decreased efficacy and harm the residents. During an interview on 1/22/2026 at 12:20 p.m. with Director of Nursing (DON), the DON stated if there is discrepancy between a medication order and the label on the bubble pack, it needs to be addressed immediately. DON stated that the pharmacy must be contacted to obtain a corrected medication matching the physician order. The DON further stated that if the discrepancy is not corrected, it could result in a medication error, potentially leading to reduced medication efficacy. During a review of the facility's policy and procedures (P&P) titled Medication Storage in The Facility updated in 6/20/2025, indicated Facility should assure that infusion therapy labels include the: Resident name, medication name, Date of preparation, Initials of compounder, Ancillary labeling, and Expiration date. The Medication Storage in The Facility P&P indicated Drugs re-packaged by the pharmacy staff will generally carry an expiration date.

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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 standard infection prevention control practices (a set of practices that prevent or stop the spread of infections or diseases in the healthcare setting) were followed when:Eight of 16 sampled bleach wipe containers' lids were not kept close when not in use.Minimum Data Set Nurse (MDSN) and Certified Nursing Assistant (CNA) 3 did not wear personal protective equipment (PPE-protective items or garments worn to protect the body or clothing from hazards that can cause injury and to protect residents from cross-transmission) before entering the resident's room who was on enhanced barrier precautions (EBP- infection control measures for high-risk residents, to reduce the spread of multidrug-resistant organisms [MDROs]) due to multiple open wounds for two of two sampled residents (Resident 48 and 11.)These failures had the potential to expose the residents to increase risk of infection transmission.Findings: 1.During an observation on 1/21/2026 at 1:30 p.m.on the nursing floor, eight of 16 sampled bleach wipe containers' lids were open in multiple places on the nursing floor throughout the facility. During a concurrent observation and interview on 1/21/2026 at 1:48 p.m. with the Infection Prevention Nurse (IPN), the IPN observed 8 out of 16 bleach wipe containers were open throughout the facility nursing floor. The IPN stated that if the containers are not properly closed, the wipes will not be able to eliminate bacteria, potentially leading to increased risk of infection for residents, visitors, and staff. During a review of the facility's 'Microdot' bleach wipes' manufacturing product label, the label indicated, Keep these wipes in a tightly closed container, when not in use. It also indicated Snap center flap down when finished to retain moisture. During a review of the facility's policy and procedure (P&P) titled, IPC413 Emerging Infectious Diseases, revised 11/6/2023, the P&P indicated, Centers will use appropriate infection prevention and control measures, education strategies, environmental decontamination, and antimicrobial stewardship to mitigate, prevent and manager emergent infectious diseases. 2a. During a record review of Resident 48's admission record indicated Resident 48 was admitted on [DATE] with a diagnoses of cellulitis (a skin infection that causes swelling and redness) of right lower limp, cellulitis of left lower limp, urinary tract infection (UTI- an infection in the bladder/urinary tract), chronic ulcer of other part of right lower leg, and peripheral vascular disease (PVD - a slow progressive narrowing of the blood flow to the arms and legs). During Record review of Resident 48's Minimum Data set [MDS- resident assessment tool), dated 12/12/2025 indicated that Resident 48's cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decisions was intact. The MDS indicated that Resident 48 needs substantial/maximum assistance (helper does more than half the effort) of toileting, shower, lower body dressing and putting on/taking off footwear. Resident 48 needs supervision or touching assistance for eating, oral hygiene and personal hygiene. During a record review of Resident 48's care plan report titled, Skin Integrity Risk Management dated on 12/5/2025, indicated The resident has potential impairment to skin integrity of the bilateral legs r/t cellulitis with open lesions. (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 observation on 1/20/26 at 9:14 a.m., with the MDSN, MDSN entered Resident 48's room without a gown, grabbed the resident's urinal, emptied it in the toilet, and placed it back on the bed, with visibly soiled linens and brown stains. During interview on 1/20/26 at 9:28 a.m. with MDSN, MDSN stated that she only wore gloves to empty Resident 48's urinal and there was no need to wear a gown because the sign outside Resident 48 room does not indicate that staff must wear gown while emptying urinal, MDSN stated she only wear a gown during high contact activities. During a concurrent interview on 1/22/2026 at 12:45 p.m. with the Director of Nurses (DON), DON stated that staff must wear PPE during high contact activities such as bathing, toileting and feeding when caring for residents on EBP. During a review of the facility's policies and procedures titled, Infection Control, revised on 6/20/2025, indicated that the infection control policies and procedures apply equally to all facility staff.control infections in the facility and maintain a safe, sanitary, and comfortable environment for personnel, residents. 2b. During a review of Resident's 11 admission Record, the record indicated the facility admitted the resident on 11/20/25, with diagnoses including but not limited to Alzheimer's Disease (a disease characterized by a progressive decline in mental abilities), dysphagia (difficulty swallowing) and 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 11's Minimum Data Set (MDS, a standardized care screening and assessment tool), dated 11/27/25, the MDS indicated the resident is dependent (relies on someone else) in completing activities of daily living (ADLs, activities such as bathing, dressing and toileting a person performs daily). During an observation on 1/20/26 at 10:34 a.m. in Resident 11's room, an EBP sign was posted at the doorway entrance and a cart filled with PPE. During a concurrent observation and interview on 1/21/26 at 7:59 a.m. with CNA 3 in Resident 11's room, CNA 3 was feeding Resident 11. CNA 3 was not wearing a gown or gloves while feeding and holding Resident 11's hand. CNA 3 stated that she saw the EBP sign but forgot to wear PPE. CNA 3 stated the purpose of PPE is to protect residents and staff from the spread of infection. During an interview on 1/21/26 at 10:50 a.m. with Registered Nurse (RN) 1, RN 1 stated staff are supposed to wear a gown and gloves when feeding residents on EBP because it is a high-contact activity. RN 1 stated that failing to wear PPE when indicated can spread infection to medically compromised (a weakened immune system that cannot fight infections as easily as it should) residents. During an interview on 1/22/26 at 12:45 p.m. with the Director of Nursing (DON), the DON stated that PPE for EBP should be worn when helping with ADLs. DON stated ADLs include toileting, mobility and feeding. DON stated that staff are expected to wear PPE to prevent the transmission of pathogens. During a review of the facility's policy and procedure (P&P) titled, Infectious Disease Management, dated 2022, the P&P indicated, Manage patient care according to Center for Disease Control and (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	state/local health department recommendations. During a review of the Los Angeles County Department of Public Heath (LACDPH) document titled, Enhanced Barrier Precautions, dated September 2024, the LACDPH document indicated to wear gloves and a gown for high-contact resident care activities such as dressing, grooming, bathing, changing bed linens and feeding.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to implement an antibiotic stewardship program (a coordinated program that promotes the appropriate use of drugs used to treat infections, including antibiotics), for antibiotic use protocol (official procedure or system of rules) for two of three sample residents (Resident 47 and 14) by failing to ensure Resident 47 and 14 met the urinary tract infection ([UTI]- infection in the urine) criteria (a standard by which something may be decided) prior to starting an antibiotic.This deficient practice had the potential to cause adverse side effects and placed Resident 47 and 14 at risk for antibiotic resistance (when bacteria/germs change in some way that reduces or eliminates the effectiveness of drugs, chemicals, or other agents designed to cure or prevent infections) associated with the use of inappropriate antibiotic therapy.Findings:During a review of Resident 47's admission Records, the admission Records indicated Resident 47 was admitted to the facility on [DATE] with diagnoses including osteomyelitis of vertebra (infection of a spine bone), pressure ulcer of sacral region (a skin wound on the tailbone/lower back caused by long-term pressure), UTI, dysphagia (difficulty swallowing).During a review of Resident 47's Minimum Data Set ([MDS]-a standardized assessment and care screening tool) dated 10/28/2025, the MDS indicated Resident 47 has moderate cognitive impairment, could understand others and make herself understood. The MDS indicated that Resident 47 required substantial/maximal assistance (helper does more than half the effort) with toileting, shower, lower body dressing and personal hygiene.During a concurrent interview and record review on 1/22/2026 at 7:05 a.m. with IPN, records indicated that Resident 47 was prescribed antibiotic treatment on 1/9/2025. The Record indicated the following:Resident 47's Order Summery Report dated 1/9/2025 indicated physician order for cephalexin (antibiotic used to kill bacteria causing infections, particularly in the skin, throat, ears, and urinary tract) 500mg (unit of measurement) 1 capsule by mouth three times a day for urinalysis ([UA]- a simple, common laboratory test that examines a urine sample [pee in a cup] to check for signs of infection) WBC (a blood cell that helps attack infection or injury in the body) >50 for 7 days.Resident 47's Lab Results Report dated 1/8/2026, UA results indicated WBC > 50, Urine Culture (laboratory test that grows bacteria from a urine sample to detect and identify the specific germ causing a UTI) results indicated presence of multi-drug-resistant (bacteria that have become resistant to three or more types of commonly used antibiotics) Escherichia Coli (a type of bacteria commonly found in the intestines of healthy people and animals) in urine.Resident 47's Change in Condition Evaluation dated 1/9/2026, it did not indicate documented signs or symptoms of infection.During an interview on 1/22/2026 at 7:03 a.m. with Infection Prevention Nurse (IPN), the IPN stated that the facility follows an antibiotic stewardship program to ensure antibiotics are prescribed appropriately and only when clinical criteria are met. The IPN stated that the facility uses McGeer criteria (standardized, strict definitions used to identify and track infections [like UTI, pneumonia, or influenza] in long-term care settings) to determine if a resident meets criteria for initiation of antibiotics for infection. The IPN stated McGeer criteria require clinical symptoms of infection, supporting laboratory results and a documented medical diagnosis to be met. The IPN stated if one of the three components is missing, the McGeer criteria are not met, and antibiotic therapy should be reevaluated.The IPN stated that laboratory findings alone do not meet McGeer criteria and that symptoms are required to justify antibiotic use.During a review of Resident 14's admission Records, the admission Records indicated Resident 14 was originally admitted to the facility on [DATE], then readmitted to the facility on [DATE], with diagnoses including metabolic encephalopathy (a reversible brain dysfunction caused by chemical imbalances, toxins, or organ failure (like liver or kidney disease) rather than physical injury), UTI, bacteremia (the presence of bacteria in the bloodstream), type I Diabetes Mellitus ([DM]-a disorder characterized by difficulty in blood sugar control and poor wound healing).During a review of Resident 14's MDS dated [DATE], the MDS indicated Resident 14 (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	is cognitively intact (has sufficient judgment, planning, organization, self-control) with no significant impairment. The MDS indicated that Resident 14 is dependent (helper does all the effort) with toileting hygiene, shower, lower body dressing, putting on/taking off footwear.During a subsequent interview and record review on 1/22/2026 at 7:15 a.m. with IPN, Resident 14's Order Summary Report dated 1/22/2026 indicated physician order for Macrobid (antibiotic capsule used specifically to treat or prevent bladder infections) 100 mg 1 capsule by mouth two times a day for UTI for 5 days with a start date 1/19/2025, levofloxacin (a strong, broad-spectrum antibiotic used to treat bacterial infections) 250 mg 2 tablets by mouth one time a day for UTI for 5 days with a start date 1/20/2025.Further record review indicated:No documentation of change in condition related to Resident 14's diagnosis of UTI and antibiotic treatment.No documentation of initiation and implementation of care plan addressing Resident 14's diagnosis of UTI and antibiotic treatment.No documentation of infection control surveillance assessment (the active, ongoing tracking of infections and safety practices in healthcare to prevent outbreaks) related to Resident 14's diagnosis of UTI and antibiotic treatment.The IPN stated that all residents prescribed antibiotics must be included in the surveillance log and assessed as part of the antibiotic stewardship program. The IPN further stated that failure to monitor antibiotic use and document clinical justification does not meet facility protocol for antibiotic stewardship.During an interview on 1/22/2026 at 12:10 p.m. with Director of Nursing (DON), the DON stated that when a resident started on antibiotics, the facility is expected to follow its antibiotic stewardship process, infection control surveillance must be initiated, McGeer criteria must be verified, a change of condition assessment must be completed, and a care plan must be developed and initiated to address the identified infection and treatment. Not completing these actions may result in inappropriate antibiotic use, and potential harm to the resident.During a review of facilities Policies and Procedures (P&P) revised on 5/20/2021, titled Antibiotic Stewardship, indicated The Facility will implement an antibiotic Stewardship Program (ASP) to promote appropriate use of antibiotics optimizing the treatment of infection, reducing the threat of antibiotic resistance, reducing adverse events associated with antibiotic use and Improve outcomes for Residents.

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	055160	A. Building B. Wing	01/22/2026

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. Based on interview and record review the facility failed to ensure to provide documented evidence for two of four sample employees (Medical Director and Infection Prevention Nurse (IPN)) Corona virus ([COVID-19] - contagious infectious disease) vaccination status and the provision of education on benefits and potential side effects. This failure had the potential to result in staff and residents contracting COVID-19 which can cause serious illness, hospitalization, and death.Findings: During a concurrent interview and record review on 1/22/2026 at 7:15 a.m., with the IPN 1, employee records (Medical Directors and IPN 2's) indicated no documentation of COVID-19 vaccination status and the provision of education on benefits and potential side effects and offering of the COVID - 19 vaccine. The IPN 1 stated that the facility must maintain documentation related to staff COVID - 19 vaccinations, including COVID - 19 vaccination status, education provided regarding the benefits and potential side effects of the COVID - 19 vaccine, and documentation that the COVID - 19 vaccine was offered. During an interview on 1/22/2026 at 12:10 p.m. with Director of Nursing (DON), the DON stated that all staff, including the Medical Director and IPN 2, are required to have COVID-19 vaccination screening completed upon hire and that ongoing vaccination records must be maintained. The DON stated that COVID - 19 vaccination documentation must be kept current and maintained in both the facility records and individual employee files to ensure compliance with infection prevention requirements and to protect resident and staff safety. During a review of the facility's policy and procedures (P&P) titled, COVID-19 Vaccination Program, reviewed on 6/20/2025, the P&P indicated the following: All Health Care Personnel (HCP) are required to be fully vaccinated (having received primary series of COVID-19 vaccines) and boosted (once booster eligible) against COVID - 19 secondary to the State Public Health Officer Order. Vaccination against COVID-19 is a condition of employment unless the HCP has a medical or religious waiver. For HCP, transcribe all the information from the vaccination card or a copy of the card into the employee's health file as proof they are fully vaccinated.

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. Based on interview and record review, the facility failed to obtain written informed consent (voluntary agreement to accept treatment and/or procedures after receiving education regarding the risks, benefits, and alternatives offered) for the use of psychotropic medication (chemical substances that affect the brain, modifying mood, thought, emotions and behavior to treat mental illnesses) prior to administering Divalproex (a mood stabilizer medication used for aggression, disruptive behaviors and mood episodes) for one of one sampled resident (Resident 3). This failure resulted in a violation of Resident 3's right to make an informed decision before taking Divalproex and receiving 22 doses of Divalproex. Findings: During a review of Resident 3's admission Record, the record indicated the facility admitted the resident on 4/20/21, with diagnoses including but not limited to schizoaffective disorder (a mental illness that affects thoughts, mood and behavior), depression (a mood disorder that causes a persistent feeling of sadness and loss of interest in activities), and dementia (a progressive state of decline in mental abilities). During a review of Resident 3's Minimum Data Set (MDS, a resident assessment tool), dated 12/23/25, the MDS indicated the resident is moderately cognitively impaired (poor decision making and requires increased supervision or cues to complete daily activities). During a review of Resident 3's physician's order, dated 5/1/25, the order indicated to give one tablet of Divalproex 250 milligram (mg, a unit of measure) by mouth one time a day for schizoaffective behavior manifested by aggressive behavior presented as cursing at roommate and staff. During a review of Resident 3's medical records, the medical records did not indicate any documented evidence of informed consent for the use of Divalproex in Informed Consent Documentation or Verification of Informed Consent. During a review of Resident 3's Medication Administration Record (MAR), dated 1/2026, the MAR indicated that Resident 3 received Divalproex every morning from 1/1/26 to 1/22/26, a total of 22 doses. During a concurrent interview and record review on 1/22/26 at 12:16 p.m. with the Director of Nursing (DON), Resident 3's medical record was reviewed. The record indicated no documented evidence of informed consent for the use of Divalproex. The DON stated staff should obtain written informed consent prior to the administration of psychotropic medications. During an interview on 1/22/26 at 3:35 p.m. with Medical Records (MR), MR stated there is no written informed consent for the use of Divalproex in Resident 3's medical record. During a review of the facility's policy and procedures (P&P) titled, Behavior/Psychoactive Medication Management, dated 2022, the P&P indicated, Facility must obtain a resident's written informed consent for treatment using psychoactive drugs and consent renewal every 6 months.

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure one of three sampled resident (Resident 7) was not offered a gradual dose reduction (GDR, stepwise tapering of a dose to determine if symptoms, conditions, or risks can be managed by a lower dose or if the dose or medication can be discontinued) when taking antipsychotic (prescription medications used to treat psychosis) medication to be free from unnecessary medications. This failure had the potential to result in Resident 7 to receive antipsychotic medication without GRD or ongoing evaluation of continued need and placing the resident at risk for adverse medication effects. Findings: During record review of Resident 7's^admission record, the admission record indicated Resident 7 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including hypothyroidism (thyroid gland isn't producing enough hormones), dementia (a progressive state of decline in mental abilities), and adult failure to thrive. During a record review of Resident 7's Minimum Data set (MDS-a resident assessment tool), dated 10/27/2025 indicated^Resident 7's cognition (mental ability decisions of daily living)^was intact. The MDS indicated Resident 7 was dependent on personal hygiene, putting on/taking off footwear and showers. The MDS indicated that Resident 7 needed maximal assistance with eating, oral hygiene, toileting, and lower body dressing; however, the facility did not complete the MDS Section D (mood). Staff did not complete the Staff Assessment of Resident 7's mood or document symptom present, symptom frequency, or a total severity score and therefore did not assess and document Resident 7's mood status. During a review of Resident 7's Order Summary Report dated 01/2026 indicated an active order of Risperidone (antipsychotic medication^that treats mental health conditions) oral tablet 4 milligram at bedtime, effective 9/18/2025 prescribed for schizoaffective (hallucinations and delusions, and mood disorder symptoms, such as depression) disorder m/b auditory (hearing) hallucination (an experience involving the apparent perception of something not present). During a concurrent interview and record review of Resident 7's electronic medical chart with the Director of Nursing (DON) on 1/22/2026 at 12:11 p.m., the DON stated that the interdisciplinary team (IDT- team members from different departments working together with a common purpose to set goals and make decisions that ensure residents receive the best care) met on 9/26/25 and no GRD was offered to Resident 7. DON stated there are no progress notes from social services or Medical Doctor (MD) indicating that a gradual dose reduction was attempted. DON stated that GRD should be offered to Resident 7 quarterly. DON stated consultant pharmacists comes to the facility and reviewed Resident 7's medication regimen on 9/24/25 and did not make any new recommendations to decrease risperidone. DON states that the Resident 7 did not have a diagnosis of schizophrenia and should have been a trialed for a medication dose reduction. During a review of Resident 7's care plan report titled Resident (Resident 7) uses antipsychotic medication r/t schizophrenia dated on 1/25/2024, indicated the goal, the resident will reduce the use of psychotropic medication through the review date. The care plan intervention indicated, Consult with pharmacy, MD to consider dosage reduction when clinically appropriate at least quarterly .review behaviors/interventions and alternate therapies attempted and their effectiveness as per facility policy. During a concurrent interview and record review of Resident 7's pharmacist recommendations titled Consultant Pharmacist's medication Regimen Review dated on 9/25/25 with the DON on 1/22/2026 at 12:11 p.m. did not indicate recommendations for gradual dose reduction or continued justification for ongoing use of Risperidone. During a review of the facility's^policy and procedures (P&P)^titled, Behavior/Psychoactive Medication Management updated 6/20/25,^indicated,^ the licensed nurse will collaborate with the healthcare practitioner, family, resident, and IDT members, to identify the contributing factors related to the resident's mood/behavior and non-medication interventions to be implemented.the IDT will reassess the effectiveness or the psychoactive (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	medication at least quarterly during IDT Care plan meeting or psychoactive behavior management committee.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure Minimum Data Set(MDS- a resident assessment tool) assessment accurately reflect resident status for one of five sampled residents (Resident 19). This failure had the potential to result in inaccurate assessment of the resident's condition, leading to inappropriate care planning, monitoring and interventions.Findings: During record review of Resident 19's^admission record indicated Resident 19 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including dementia (a progressive state of decline in mental abilities), Alzheimer's disease (a disease characterized by a progressive decline in mental abilities) and history of falling.^^^ During a record review of the Resident 19's MDS, dated [DATE] indicated^Resident 19's cognition (mental ability to make decisions of daily living)^was severely impaired. The MDS indicated Resident 19^was dependent (helper does all the efforts. Resident does none of the efforts to complete the activity) of eating, oral hygiene, toileting, shower, upper body dressing, lower body dressing, putting on/taking off footwear, and personal hygiene.^ During a review of Resident 19's Nurses Progress Notes dated 10/29/2025 at 11:54p.m., Licensed Nurse documented that Resident 19 returned from general acute care hospital (GACH) at 11:50p.m. with a right hip fracture (broken bone) from a fall. During a concurrent interview and record review with Registered Nurse (RN) 1 on 1/22/2026 at 7:44 a.m., Resident 19's Clinical admission assessment dated [DATE] timed 6:16p.m. was reviewed. RN 1 stated Resident 19's Clinical admission Assessment was not completed accurately because not all questions were answered including the safety section. RN 1 stated that the assessment is inaccurate because of not properly filling up the questions indicating that Resident 19 is not a high risk for falls. During an interview and record review with Minimum Data Set (MDS) Nurse on 1/22/2026 at 10:40 a.m., Resident 19's of Resident Clinical assessment dated [DATE] was reviewed. MDS nurse stated that Resident 19's re-admission assessment was not completed accurately. Specifically, the assessment section J of the MDS titled, Health Conditions incorrectly addressed the question asking whether the resident had sustained any fractures related to a fall in the 6 months prior to admission/entry or reentry. MDS nurse stated that Resident 19 was re-admitted with a right hip fracture on 11/3/2025 and that the question should have been triggered properly to ensure resident receive the care needed. MDS stated that it was important to accurately assess the residents to be able to provide the proper care they need. During a review of the facility's policy and procedures (P&P) titled Resident Assessment Instrument (RAI) reviewed on 6/20/2025 indicated, The facility will utilize RAI process as the basis for the accurate assessment of each resident's functional capacity and health status.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to meet professional standards of quality for one of four sample residents (Resident 14) when Licensed Vocational Nurse (LVN) 2 was observed crushing medications without a physician's order. This failure had a potential to result in medication ineffectiveness, compromised therapeutic outcomes, and adverse health effects for Resident 14.Findings: During a review of Resident 14's admission Records, the admission Records indicated Resident 14 was originally admitted to the facility on [DATE], then readmitted to the facility on [DATE], with diagnoses including metabolic encephalopathy (a reversible brain dysfunction caused by chemical imbalances, toxins, or organ failure (like liver or kidney disease) rather than physical injury), urinary tract infection (UTI), bacteremia (the presence of bacteria in the bloodstream), type I Diabetes Mellitus ([DM]-a disorder characterized by difficulty in blood sugar control and poor wound healing). During a review of Resident 14's Minimum Data Set ([MDS]-a resident assessment tool) dated 11/14/2025, the MDS indicated Resident 14 is cognitively intact (has sufficient judgment, planning, organization, self-control) with no significant impairment. The MDS indicated that Resident 14 is dependent (helper does all the effort) with toileting hygiene, shower, lower body dressing, putting on/taking off footwear. During a concurrent observation of medication pass and interview on 1/21/2026 at 8:00 a.m. with LVN 2, LVN 2 prepared following medications for Resident 14 scheduled to be administered during morning medication pass:Macrobid (a medication to treat UTI) 100 mg 1 capsule by mouth two times a day for UTI for 5 days,Aripiprazole (a medication to treat mental conditions) 20 mg 1 tablet by mouth one time a day for bipolar disorder (a mental health condition causing severe mood swings),Buspirone (a medication to treat anxiety) 10 mg two tablets by mouth one time a day for anxiety,Gabapentin (a medication that calms overactive nerves to treat nerve pain) 300 mg 1 capsule by mouth three times a day for neuropathic pain (chronic pain caused by damaged or malfunctioning nerves),Metoprolol tartrate (a medication to treat high blood pressure) 25 mg 1 tablet by mouth two times a day for cardiac arrhythmia (abnormal heart rhythm).Vitamin C (a supplement that helps fight infections, heal wounds, and keep tissues healthy) 500 mg 1 tablet by mouth one time a day in the morning for supplement.Levofloxacin 500 mg 1 tablet by mouth one time a day for UTI for 5 days.LVN 2 stated that Resident 14 was on pureed diet (texture-modified food for those who can't handle solid food) and started crushing all above listed tablets and emptying all capsules into medication cups, mixing them with apple sauce. LVN 2 administered all medications to Resident 14. During a concurrent interview on 1/21/2026 at 2:00 p.m. with LVN 2 and record review of Resident 14's physician's order, LVN 2 stated that medications could be crushed with a physician order indicating may crush all crushable medications. LVN 2 stated there was no physician order for May crush all crushable medications. LVN 2 stated there might be medications that should not be crushed, and if they are crushed, the medications may not work as intended for the residents. During a concurrent interview and record review on 1/21/2026 at 2:05 p.m. with Registered Nurse (RN) 1 of Residents 14 physician's orders, the physician order indicated no documentation may crush all crushable medications and no care plan initiated to address Resident 14's needs or preferences for crushed medications. During an interview on 1/22/2026 at 12:30 p.m. with DON, the DON stated that taking medications in a crushed form was acceptable if it was the resident's preference, however there are medications that should not be crushed. The DON stated that physicians need to be aware of resident's preference and an order allowing medications to be crushed must be placed. During a review of the facility's policy and procedures (P&P) titled Medication Administration revised in 6/26/2025, the P&P indicated If the resident has difficulty swallowing pills, the licensed Nurse will notify the physician to discuss the possibility of a different form of the medication i.e. crushed, liquid or suspension. If the medication is to be crushed, a physician order is required.

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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 one of three sampled residents (Resident 19) care was not delayed when transportation failed to pick up Resident 19 on 10/28/25 per physician's orders. This failure had the potential to place the resident at risk for delayed treatment and care.Findings: During record review of Resident 19'sˆadmission record,ˆthe admission record indicated Resident 19 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including dementia (a progressive state of decline in mental abilities), Alzheimer's disease (a disease characterized by a progressive decline in mental abilities) and history of falling.ˆˆˆ During a record review of the Resident 19's Minimum Data set (MDS-a resident assessment tool), dated 10/17/2025 indicatedˆResident 19's cognition (mental ability decisions of daily living)ˆwas severely impaired. The MDS indicated Resident 19ˆwas dependent (helper does all the efforts. Resident does none of the efforts to complete the activity) of eating, oral hygiene, toileting, shower, upper body dressing, lower body dressing, putting on/taking off footwear, and personal hygiene.ˆ During a record review of Resident 19's Nursing ProgressˆNotesˆdated 10/28/2025, theˆnursing progressˆnotes indicated,ˆ MD came to review residentˆ(Resident 19's)ˆchartˆ(medical chart)ˆand assessedˆresident today with an orderˆto transferˆ(Resident 19 to a GACH)ˆfor further evaluation and treatment due to recent fall. During aˆrecordˆreview of Resident 19's Order Summary Report dated 10/28/2025ˆindicated,ˆ May transfer residentˆ(Resident 19)ˆto acute hospitalˆ(GACH)ˆfor further evaluation r/tˆ(relateˆto)ˆs/p fall. For possible direct admit to acute hospital.ˆˆ During an interview and record review with the Director of Nursing (DON) on 1/22/2026 at 2:44 p.m., Resident 19'sˆprogress notesˆwere reviewed. The DONˆstatedˆResident 19 was not transferredˆto GACHˆfor further evaluationˆand treatmentˆrelated to theˆfallˆas per MD's orders datedˆ10/28/2025 because there wasˆtransportationˆdelay.ˆThe DONˆstatedˆthat licensed nurses areˆresponsibleˆfor arranging and coordinating transportationˆfor the residents.ˆThe DONˆstatedˆthat when there is aˆresidentˆdirect admit orderˆto a GACH, the facility must wait for bedˆavailability at the GACH.ˆThe DON furtherˆstatedˆthat if the resident is not transferred during certain hours, the facilityˆis required toˆfollow up and inform the MD to communicate andˆdetermineˆif there are any alternative treatments that can be provided while the residentˆremainsˆin the facility. The DON acknowledged that nursing staff did not document that the MD was notified of the delay in transferringˆResident 19ˆaccording toˆMDˆorderˆdatedˆ10/28/2025.ˆ During a phone interview on 1/23/2026 at 3:27 p.m. with Resident 19's DPOA, DPOA stated that the facility informed her that Resident 19 was not transferred to GACH on 10/28/25 because the transportation team did not come get her until the next morning.they did not have the opportunity to get her due to conflict in the schedule. DPOA stated that the facility informed her that they brought in extra staff to assist Resident 19 from falling and implemented bilateral mats. During a review of the facility'sˆpolicy and procedures (P&P)ˆtitled, Change in Condition updated 6/20/25,ˆindicated,ˆ a licensed nurse will notify the resident's physician and legal representative when a decision to transfer or discharge the resident from the facility.licensed nurse will document the following:ˆ the time the physician was contacted, the method by which he was contacted, the response time, and whether or not orders were received, update care plan to reflect the residents current status.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. Based on observation, interview and record review, the facility failed to follow the physician's order for fluid restriction (limits total daily liquid intake) for one of one sampled resident (Resident 4). This failure had the potential to result in inaccurate fluid intake documentation leading to fluid overload (too much fluid in the body) and hospitalization for Resident 4. Findings; During a review of Resident 4's admission Record, dated January 2026, the admission Record indicated the facility admitted the resident on 11/7/25, with diagnoses including but not limited to urinary tract infection (UTI, an infection in the bladder/urinary tract), chronic obstructive pulmonary disease (COPD, a chronic lung disease causing difficulty in breathing) and congestive heart failure (CHF, a heart disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling). During a review of Resident 4's Minimum Data Set (MDS, a standardized care screening and an assessment tool), dated 12/22/25, the MDS indicated the resident requires maximum assistance (helper does more than half the efforts to complete a task) with activities of daily living (ADLS, activities such as bathing, dressing and toileting a person performs daily). During a review of Resident 4's physician's order, dated 11/7/25, the order indicated hemodialysis (a treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidneys have failed) every Tuesday, Thursday and Saturday. During a review of Resident 4's physician's order, dated 12/30/25, the order indicated fluid restriction of 1,000 milliliters (ml, a unit of measure) a day as follows: dietary = 360 ml, nursing 7:00 a.m. to 3:00 p.m. shift = 340 ml, nursing 3:00 p.m. to 11:00 p.m. shift = 200 ml, and nursing 11:00 p.m. to 7:00 a.m. shift = 100 ml. During an interview on 1/21/26 at 1:39 p.m. with Certified Registered Nurse (CNA) 4, CNA 4 stated CNAs are responsible for charting all fluids, including water, juice, milk, coffee and those given during medication administration in Fluid Intake. CNA 4 stated it is important to accurately document fluid intake to prevent fluid overload. During an interview on 1/22/2026 at 9:24 a.m. Licensed Vocational Nurse (LVN) 2, LVN 2 stated duplicate documentation is inaccurate documentation. LVN 2 stated if a shift did not accurately document fluid intake, it would throw off the total recorded fluid intake for the day and could result in going over the ordered fluid restriction amount. During a concurrent interview and record review on 1/22/2026 at 9:28 a.m. with Registered Nurse (RN) 1, Resident 4's Fluid Intake, dated January 2026 was reviewed. The Fluid Intake indicated, on 1/4/2026, Resident 4's total fluid intake was 1,100 ml. RN 1 stated fluid restriction orders were not followed because the total fluid intake exceeded 1,000 ml. RN 1 stated not adhering to fluid restriction can cause edema (swelling of body tissues caused by excess fluid) and shortness of breath. During a concurrent interview and record review on 1/22/2026 at 1:22 p.m. with the Director of Nursing (DON), Resident 4's Fluid Intake, dated January 2026 was reviewed. The Fluid Intake indicated, on 1/4/2026, Resident 4's total fluid intake for the day was 1,100 ml, including the two 500 ml entries at 2:45 p.m. and one 100 ml entry at 5:00 PM. DON stated the entries at 2:45 p.m. were either duplicate documentation or documentation at incorrect time. DON stated staff inaccurately documented and did not follow the fluid restriction order. During a review of the facility's policy and procedures (P&P) titled, Dialysis Management, dated 2022, the P&P indicated, Diet and fluid restrictions will be followed as ordered.

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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 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 the following for one of five sampled residents (Resident 21): 1. Resident 21 was assessed for risk of entrapment from bed rails prior to installation.2. Nursing staff implemented physician orders to maintain resident safety for seizure precautions. 3.Resident 21's bed dimensions were appropriate for the resident's size and weight.4. Staff obtained proper consent prior to using bilateral upper and lower side rails for Resident 21. These failures had the potential to result in serious physical injury, including entrapment, restricted movement during a seizure, or falls with injury, due to the use of four side rails (a device that attaches to the side of the bed).Findings: During a record review of Resident 21's admission record indicated Resident 21 was admitted on [DATE] with a diagnoses of seizures (a sudden, uncontrolled electrical disturbance in the brain which can cause uncontrolled jerking, blank stares, and loss of consciousness), hydrocephalus (abnormal buildup of cerebrospinal fluid in the brain leading to damage), and gastro-esophageal reflux disease (GERD-severe acid reflux where stomach acid frequently flows backward into the throat) without esophagitis (swelling of the lining of the esophagus). During a record review of Resident 21's Minimum Data set [MDS-a resident assessment tool), dated 11/21/25 indicated that Resident's cognitive was intact. The MDS indicated that Resident 21 is independent with eating, needs setup or clean up assistance with upper body dressing, requires supervision or touching assistance with oral hygiene, lower body dressing and with personal hygiene. During an observation on 1/21/26 at 10:32 a.m. Resident 21 was observed lying in bed facing the doorway covered with white blanket to Residents 21's shoulder with four side rails up, side rails were not padded, no floor mats on the side of resident 21's bed and the bed was in the low position. During a review of Resident 21's Order Summary Report dated 1/22/2026 indicated physician's orders in effect as of 2/19/2025 for Resident 21 that required:Bilateral padded side rails to decrease potential injury r/t seizure.May order Bilateral side rails up padded and floormat for seizure precaution and fall risk. During a review of Resident 21's medical record on 1/21/2025 at 9:33 a.m. revealed no documentation of alternatives attempted, no documentation of risk of entrapment and no evidence of the resident 21's or representative's informed consent for four bed rail use. There was no care plan addressing bed rail use or potential entrapment. During an interview with Licensed Vocational Nurse 2 (LVN 2) on 1/21/2026 at 10:36 a.m., LVN 2 stated that all four side rails were raised at the family's request while maintenance cleaned Resident 21's floor mats. LVN 2 reported that floor mats and padded side rail covers had been removed for cleaning and no alternative measures were attempted prior to using four side rails. LVN 2 further stated that Resident 21 should have padded side rails to prevent injury during seizures and floor mats due to a history of falls. During an interview and record review with Maintenance Director (MD) on 1/21/2026 at 11:44a.m., MD stated that he was responsible for measuring side rails for all residents upon admission and on a monthly basis. During an interview and record review with Maintenance Director (MD) on 1/21/2026 at 11:44a.m., MD stated that he was responsible for measuring side rails for all residents in the facility upon admission and on a monthly basis. The MD stated that Resident 21's side rails were measured on 12/2/2025; however, he did not measure four side rails. The MD further stated that the side rail measuring log dated 12/3/2025 did not include measurements for the lower side rails because staff had just added them for safety. MD stated that it was important to measure all side rails to prevent any injury, stating that Resident 21 could become entrapped between the rails. During an interview and record review with Registered Nurse 1 (RN 1) on 1/21/2026 at 11:24 a.m., RN 1 stated that there was no care plan initiated for side rails because Resident 21's four side rails were implemented for risk for falls since Resident 21 has a history of falls. During subsequent interview with RN 1 on 1/21/2026 at 11:24 a.m., (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	RN 1 stated that the care plan for at risk for falls did not include Resident 21's four side rails, padded side rails or bilateral floor mats. RN 1 stated that the facility needed to implement other alternatives prior to installing four side rails or any bed rails. RN 1 further stated that it was important to include interventions in Resident21's care plan since it was part of Resident 21's personalized plan of care. RN1 stated that Resident 21's informed consent dated 2/20/2025 indicated bilateral side rails did not include the four side rails. RN 1 further stated that the informed consent was obtained via telephone, and it was incomplete due to missing a second nurse's signature. RN 1 emphasized the importance of assessing residents before side rails are used for safety reasons, as some residents may be at risk of entrapment. During a review of the facility's policy and procedures (P&P) titled, Bed Rails dated 6/20/2025, indicated the licensed nurse will complete the Bed Rail evaluation prior to the use and or installation of any bed rail, upon admission, re-admission, change in bed or mattress, and a change in mobility status. The P&P also indicated a care plan will be developed regarding the use of bed rails.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that medication error rate was less than five percent (5%). Two (2) medication errors out of twenty-six (26) opportunities resulted in an overall error rate of 7.69%, affecting two of four residents (Residents 14 and 45) observed during medication administration (MedPass) when:The physician order for levofloxacin (a strong, broad-spectrum antibiotic used to treat bacterial infections) for Resident 14 in electronic medical records (EMR) did not match the medication dose and directions listed on the bubble pack label.Licensed Vocational Nurse (LVN) 2 was unable to locate the prescribed strength of Vitamin D3 (supplement that supports bone health) for Resident 45 in medication cart 1, LVN 2 failed to follow up with the physician to clarify the discrepancy and obtain further instructions.These deficient practices increased the risk that Residents 14 and 45 may experience adverse reactions, complications, that could lead to a decline in the residents' condition, harm, or hospitalization.Findings:During a review of Resident 14's admission Records, the admission Records indicated Resident 14 was originally admitted to the facility on [DATE], then readmitted to the facility on [DATE], with diagnoses including metabolic encephalopathy (a reversible brain dysfunction caused by chemical imbalances, toxins, or organ failure (like liver or kidney disease) rather than physical injury), urinary tract infection ([UTI] - infection in the urine), bacteremia (the presence of bacteria in the bloodstream), type I Diabetes Mellitus ([DM]-a disorder characterized by difficulty in blood sugar control and poor wound healing).During a review of Resident 14's Minimum Data Set ([MDS]-a resident assessment tool) dated 11/14/2025, the MDS indicated Resident 14 is cognitively intact (has sufficient judgment, planning, organization, self-control) with no significant impairment. The MDS indicated that Resident 14 is dependent (helper does all the effort) with toileting hygiene, shower, lower body dressing, putting on/taking off footwear.During a concurrent observation of Med Pass and interview on 1/21/2026 at 8:00 a.m. with LVN 2, LVN 2 prepared following medications for Resident 14 scheduled to be administered during morning MedPass:Macrobid (a medication to treat UTI) 100 mg (unit of measurement) 1 capsule by mouth two (2x) times a day for UTI for 5 days,Aripiprazole (a medication to treat mental conditions) 20 mg 1 tablet by mouth one time a day for bipolar disorder (a mental health condition causing severe mood swings),Buspirone (a medication to treat anxiety) 10 mg two tablets by mouth one time a day for anxiety,Gabapentin (a medication that calms overactive nerves to treat nerve pain) 300 mg 1 capsule by mouth three times a day for neuropathic pain (chronic pain caused by damaged or malfunctioning nerves),Metoprolol tartrate (a medication to treat high blood pressure) 25 mg 1 tablet by mouth two times a day for cardiac arrhythmia (abnormal heart rhythm).Vitamin C (a supplement that helps fight infections, heal wounds, and keep tissues healthy) 500 mg 1 tablet by mouth one time a day in the morning for supplement.Levofloxacin 500 mg 1 tablet by mouth one time a day for UTI for 5 days.During a subsequent interview on 1/21/2026 at 8:00 a.m. with LVN 2, LVN 2 stated levofloxacin label on the bubble pack sheet did not match the physician's order in EMR, the physician order dated 1/22/2026 indicated order for levofloxacin 250 mg 2 tablets by mouth one time a day for UTI for 5 days. LVN 2 stated that she can still administer the medication because the dosage would be the same. LVN 2 stated Resident 14 was on pureed diet (texture-modified food for those who can't handle solid food) and started crushing all above listed tablets and emptying all capsules into medication cups, mixing them with apple sauce. LVN 2 administered all medications to Resident 14.During an interview on 1/21/2026 at 2:00 p.m. with LVN 2, LVN 2 stated that labels on the medication must match the physician order. LVN 2 stated the discrepancy should be communicated with the physician and pharmacy for clarification and correction. LVN 2 stated if the order and labels are not verified properly, patient could receive double dose, which would lead to medication error and patient harm. LVN 2 further stated that medications could be crushed with a physician order indicating may crush medications.During a concurrent (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	interview on 1/21/2026 at 2:00 p.m. and record review with LVN 2, LVN 2 stated physician order did not indicate May crush medications. LVN 2 added there are medications that should not be crushed, and if they are crushed, the medications may not work as intended for the residents.During a review of Resident 45's admission Records, the admission Records indicated Resident 45 was originally admitted to the facility on [DATE], then readmitted to the facility on [DATE], with diagnoses including chronic atrial fibrillation (an irregular and often very rapid heart rhythm), type 2 DM, anemia (a condition where the body does not have enough healthy red blood cells).During a review of Resident 45's MDS dated [DATE], the MDS indicated Resident 45 is cognitively intact, with no significant impairment. The MDS indicated that Resident 45 is independent (completes the activity by themselves with no assistance from a helper) with most of the activities of daily living (ADL).During a concurrent observation of medication administration and interview on 1/21/2026 at 9:30 a.m. with LVN 2, Vitamin D3 125 mcg (5,000 IU), one capsule by mouth, was scheduled to be administered to Resident 45 at 9:00 a.m. LVN 2 was unable to locate the medication in medication cart 1. LVN 2 stated that Vitamin D3 125 mcg was a prescription medication for Resident 45.During a review of Resident 45's electronic medication administration record (eMAR) on 1/21/2026 at 12:30 p.m., the eMAR indicated no documentation of Vitamin D3 administration scheduled at 9:00 a.m. for Resident 45.During a review of Resident 45's Progress notes dated 01/22/2026, Progress notes indicated no documentation of physician notification related to missing medication with instructions on what actions needed to be taken.During an interview on 1/22/2026 at 12:30 p.m. with the Director of Nursing (DON), the DON stated that any discrepancy between a medication order and the label on the bubble pack is an issue that must be addressed immediately. The DON explained that the pharmacy should be contacted to obtain a corrected label. The DON further stated that failure to correct such discrepancies could result in a medication error, potentially reducing the medication's efficacy.The DON also stated that administering medications in crushed form is acceptable if it is the resident's preference; however, certain medications should not be crushed. The DON emphasized that physicians must be informed of the resident's preference, and an order authorizing medications to be crushed must be in place.During a subsequent interview on 1/22/2026 at 12:25 p.m. with DON, the DON stated that if a medication is ordered but not available in the medication cart, the nurse must immediately contact the physician to notify the physician that the medication is unavailable. The DON stated that the nurse must follow the physician's instructions regarding whether the dose can be skipped, delayed or substituted. This process ensures resident safety, prevents missed or inappropriate medication administration.During a review of the facility's policy and procedure (P&P) titled Medication Administration revised in 6/26/2025, the P&P indicated The licensed Nurse will verify the resident's identity before administering the medication using the 6 rights of medication administrationi. Right Resident: Confirm with two identifiers.ii. Right Medication: Verify against the MAR and pharmacy label.iii. Right Dose: Ensure accuracy based on provider order.iv. Right Route: Confirm oral, topical, injection, etc.v. Right Time: Administer within ordered time window.vi. Right Documentation: Immediately document after administration.If the resident has difficulty swallowing pills, the licensed Nurse will notify the physician to discuss the possibility of a different form of the medication i.e. crushed, liquid or suspension. If the medication is to be crushed, a physician order is required.

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F 0911 Level of Harm - Potential for minimal harm Residents Affected - Some	Ensure resident rooms hold no more than 4 residents; for new construction after November 28, 2016, rooms hold no more than 2 residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to meet the requirements of no more than four residents per room for 2 of 20 resident rooms (rooms [ROOM NUMBERS]).This failure had the potential to result in inadequate space to provide sufficient nursing care and privacy for the residents.Findings:During a tour of the facility for an unannounced recertification survey visit on 1/22/2026 at 12:57 p.m., Resident rooms [ROOM NUMBERS] were observed to have five residents per room. The residents in rooms [ROOM NUMBERS] were observed to have enough space for residents to move freely inside the room. rooms [ROOM NUMBERS] had adequate space in the room for the residents to operate and use their wheelchairs, walkers, and canes. The room variance did not affect the care and services provided by the nursing staff. During an interview on 1/22/2026 at 12:51 p.m. with the Occupational Therapist (OT) 1, OT 1 stated she can move around the room easily and did not have any obstacles hindering patient care. During an interview on 1/22/2026 at 1:10 p.m. with the Certified Nurse Assistant (CNA 1), CNA 1 stated she can move around the room easily and did not have any obstacles hindering patient care.During an interview on 1/22/2026 at 1:15 p.m. with Resident 35, Resident 35 was asked if he had any concerns regarding his room space, and he stated he did not have any concerns or issues regarding his living space.During a review of the facility's client accommodation analysis form completed on 1/22/2026, the form indicated rooms [ROOM NUMBERS] housed five beds per room.On 1/22/2026, the administrator (ADM) submitted a letter requesting a waiver for rooms with more than four residents per room for the following rooms:room [ROOM NUMBER] with five residentsroom [ROOM NUMBER] with five residents. During the recertification survey on 1/22/2026, staff interviews stated there were no concerns regarding the size of the rooms.During an interview on 1/22/2026, at 1:44 p.m. with the Administrative Assistant (AA), AA stated the facility submitted a written request for the continued room waiver although the room sizes do not impede resident care.

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F 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms. Based on observation, interview and record review, the facility failed to provide at least 80 square feet (sq. ft. -unit of measurement for space) per resident in their bedroom for 17 of 20 resident rooms, (Rooms 4, 5, 6, 7, 8, 9, 10,11, 14, 15, 16, 17, 18, 19, 20, 21, and 22). This failure had the potential to result in inadequate useable living space for all the residents and working space for the health caregivers, which could affect the quality of life for the residents.Findings: During a review of the Request for Room Size Waiver letter submitted by the Administrator, dated 1/22/2026, the letter indicated 17 resident rooms in the facility do not meet the requirement of at least 80 square feet per resident per federal regulation. The letter indicated the rooms do not pose any kind of risk to the care and services the facility provides for the residents. Each room has access to the outside and provides ample sunlight and ventilation. The following rooms provided are less than 80 Sq. Ft. pr resident: Room Size (length and width) Floor Area (square feet) #of beds 4^^^^^^^ 14 ft. x 10 ft. ^ ^^^^^^^^ 140^^Sq. Ft.^^ ^^^^^^^^ 2 5^^^^^^^ 14 ft. x 10 ft. ^^^ ^^^^^^^^ 140^^Sq. Ft.^^ ^^^^^^^^ 26^^^^^^^ 14 ft. x 10 ft. ^^^ ^^^^^^^^ 140^^Sq. Ft.^^ ^ ^^^^^^^^ 2 7^^^^^^^ 14 ft. x 10 ft. ^^ ^^^^^^^^ 140^Sq. Ft.^^ ^^ ^^^^^^^^ 2 8^^^^^^^ 14 ft. x 10 ft. ^ ^ ^^^^^^^^ 140 Sq. Ft.^^ ^ ^^^^^^^^ 2 9^^^^^^^ 14 ft. x 10 ft. ^^ ^^^^^^^^ 140^^Sq. Ft.^^ ^^^^^^^^ 2 10^^^^^^ 20 ft. x 10 ft.^^ ^^^^^^^^ 200^^Sq. Ft.^^ ^^^^^^^^ 3 11^^^^^^ 20 ft. x 10 ft.^^^^ 200^^Sq. Ft.^^ ^^^^^^^^ 3 14^^^^^^ 20 ft. x 10 ft.^ ^^^^^^^^ 200^^Sq. Ft.^^ ^^^^^^^^ 3 15^^^^^ 20 ft. x 10 ft.^ ^ ^^^^^^^^ 200^^Sq. Ft.^^ ^^^^^^^ ^^^^^^^^ 3 16^^^^^ 20 ft. x 10 ft.^ ^^^^^^^^ ^ ^ ^^^^^^^^ 200^^Sq. Ft.^^ ^^^^^^^^ 3 17^^^^^^ 20 ft. x 10 ft.^ ^^^^^^ 200 ^Sq. Ft.^^ ^^^^^^^^ 3 18^^^^^^ 20 ft. x 10 ft.^^ ^^^^^^^^ 200^^Sq. Ft.^^ ^^^^^^^^ 3 19^^^^^^ 20 ft. x 10 ft.^^ ^^^^^^^^ 200 Sq. Ft.^^ ^^^^^^^^ 3 20^^^^^^ 20 ft. x 10 ft.^^^^^^^^^ 200^ Sq. Ft.^^ ^^^^^^^ 3 21 ^^^^^ 20 ft. x 10 ft.^^^^^^^^^ 200 Sq. Ft.^^ ^^^^^^^^ 3 22 ^^^^^ 20 ft. x 10 ft.^ ^^^^^^^^ 200^^Sq. Ft.^^ ^^^^^^^^ 3 According to the federal regulation, the minimum square footage for a two bedroom is at least 160 sq. ft and three bedrooms are at least 240 sq. ft. During multiple observations of the residents' rooms from 1/20/2026-1/22/2026, the residents had ample space to move freely inside the rooms. There were sufficient spaces to provide freedom of movement for the residents and for nursing staff to provide care for the residents. There were also sufficient spaces for bedside tables, side tables and resident care equipment. During an interview on 1/22/2026 at 12:51 p.m. with the Occupational Therapist (OT) 1, OT 1 stated she can move around the room easily and did not have any obstacles hindering patient care. During a concurrent observation and interview on 1/22/2026, at 12:57 p.m., with the Maintenance Director (MD), the MD used a tape measurer to measure the size of the room from the window to the door for the length, then measuring from wall to the start of the closet horizontally for the width. The MD stated, this is how I measure to verify the size of the rooms, there are no complaints about the size of the rooms, and the staff and residents can move around with no issues. During an interview on 1/22/2026 at 1:10 p.m. with the Certified Nurse Assistant (CNA 1), CNA 1 stated she can move around the room easily and did not have any obstacles hindering patient care. During an interview on 1/22/2026 at 1:15 p.m. with Resident 35, Resident 35 was asked if he had any concerns regarding his room space, and he confirmed that he did not have any concerns or issues regarding his living space. During an interview on 1/22/2026, at 1:44 p.m. with the Administrative Assistant (AA), AA stated the facility submitted a written request for the continued room waiver although the room sizes do not impede resident care.