STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055173	A. Building B. Wing	04/24/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Folsom Care Center	510 Mill Street Folsom, CA 95630

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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: 1. Medication storage rooms were kept secure when the automatic closing mechanism failed and the door was unlocked and accessible;2. Two of two medication storage room refrigerators were not monitored according to facility policy and procedure (P&P), and temperatures were not accurately documented;3. Emergency medications were not stored according to manufacturer specifications;4. Medication brought by family for Resident 69 was not labeled in accordance with facility P&P; and5. Medication carts were not kept locked and secure when unattended by nursing staff. These failures had the potential for diversion of medications, residents exposed to medications with unsafe or reduced potency, and incorrect or unsafe administration of medication from the absence of labeling on the container.Findings: 1. During a medication pass (med pass) observation on [DATE] at 8:22 a.m. with Licensed Nurse 3 (LN 3), LN 3 was observed preparing two medications for Resident 103 including aspirin (a medication to prevent blood clots) EC (enteric coated, a special delayed release coating to prevent stomach irritation) 81 milligrams (mg, a unit of measurement), 1 tablet. During a concurrent observation and interview on [DATE] at 8:30 a.m. with LN 3, LN 3 looked in the medication cart and stated the aspirin was not available for administration but would check in the automated dispensing cabinet (ADC, a computerized, secure medication storage device located at the nursing station that allows for decentralized, automated storage, tracking, and dispensing of medications). LN 3 went into the medication storage room where the ADC was located, and when she was finished, she walked out without looking back to ensure the automatic closing mechanism shut and locked the door. When asked if the door had shut completely, LN 3 turned back and confirmed the door was ajar and shut it. During a second observation and interview on [DATE] at 9:39 a.m. with LN 3, LN 3 went back to the medication storage room with the ADC. LN 3 exited the room and the door again did not shut completely. LN 3 began to walk away and when it was brought to her attention that the door was unlocked, she turned around and went back to shut it. During a concurrent observation and interview on [DATE] at 11:17 a.m. with Head of Maintenance (HM), the HM was observed working on the automatic closing mechanism of the medication storage room that housed the ADC. The HM stated there was a problem with the closing mechanism and the lodge mechanism was not fitting with the door. The HM stated it appeared that someone had adjusted it in the past, but he needed to make additional adjustments for it to lock correctly. During a review of the facility's P&P titled, ID-1 Storage of Medications, dated 3/2018, the P&P indicated, Policy: Medications and biologicals are stored safely, securely, and properly, following manufacturer's recommendations or those of the supplier. The medication supply is accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications. 2. During a concurrent observation, interview, and record review on [DATE] at 10:08 a.m. with LN 11, the Sutter Station Medication Room Medication Refrigerator Daily Temperature Records were reviewed. LN 11 stated the refrigerator temperature was monitored by the morning and night nursing shifts. LN 11 reviewed the temperature (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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	records dated [DATE] to [DATE] and confirmed there were multiple shifts where nursing staff did not document that the temperature was monitored. A review of the Medication Refrigerator Daily Temperature Record (for the dates reviewed) indicated nursing staff did not monitor the temperature for 14 shifts. LN 11 stated staff possibly forgot to document on the log. A review of the refrigerator temperature for the day shift indicated nursing staff documented the temperature as 40 degrees Fahrenheit every single day. Two digital readouts on the exterior of the refrigerator were observed. LN 11 confirmed the digital readout nursing staff was recording read 4.0 C (Celsius). LN 11 stated she would do research to confirm that 4.0 C was the same as 40 degrees Fahrenheit (as documented by nursing staff). During a concurrent interview and record review on [DATE] at 10:37 a.m. with LN 11, the Natoma Station Medication Storage Room Medication Refrigerator Daily Temperature Records were reviewed. LN 11 confirmed multiple nursing shifts had not documented that the refrigerator temperature was routinely monitored and stated medications could be expired or lose potency if not monitored twice daily. A review of the Medication Refrigerator Daily Temperature Record (for the dates reviewed) indicated nursing staff did not monitor the temperature for 11 shifts. During a concurrent observation, interview, and record review on [DATE] at 11:05 a.m. with the Registered Nurse/Unit Manager (RN/UM), the Sutter Station Medication Storage Room Medication Refrigerator Daily Temperature Records were reviewed. The RN/UM confirmed the digital readout indicated 4.0 C and the day shift nursing staff had documented the temperatures as 40 degrees. The RN/UM stated 4.0 Celsius was different than 40 degrees Fahrenheit. During an interview and record review on [DATE] at 1:54 p.m. with LN 2, LN 2 reviewed the temperatures she had documented for the Sutter Station Medication Storage Room Refrigerator and confirmed she was documenting the 4.0 C digital readout as the temperature inside the refrigerator. LN 2 stated she thought 4.0 Celsius was the same as 40 degrees Fahrenheit. During an interview on [DATE] at 2:01 p.m. with the DON, the DON stated he had reviewed the medication storage room temperature monitoring logs and confirmed they were incomplete and incorrectly documented. The DON stated the digital centigrade readout that LN 2 was documenting was the temperature the refrigerator was set to be at. The DON stated every nursing shift was expected to document the refrigerator temperature three times a day, and at a minimum, twice a day. The DON stated it was important to do twice daily temperature monitoring to be able to correct deviations. During an interview on [DATE] at 10:46 a.m. with the CP, the CP stated nursing staff should be monitoring and documenting medication refrigerator temperatures twice a day. During a review of the facility's P&P titled, ID-1 Storage of Medications, dated 3/2018, the P&P indicated, Procedures. K. Medications requiring ?refrigeration'. are kept in a refrigerator with a thermometer to allow temperature monitoring. 3. During a concurrent interview and inspection on [DATE] at 10:12 a.m. with LN 11, the Sutter Medication Storage Room Refrigerator was inspected. The refrigerator had a clear glass door and inside was an E-Kit (a sealed box that contains emergency medications). The E-Kit was removed from the refrigerator and two clear glass vials lorazepam (a medication to treat severe seizures in an emergency) 2 milligrams/milliliter (mg/ml, a unit of measurement) were identified inside. The manufacturer's labeling on the vial indicated, Protect from light. LN 11 confirmed the manufacturer's labeling and stated the Sutter Medication Storage Room light always stayed on. LN 11 stated if the medication was exposed to light, it had the potential to lose potency and not be as effective when used in an emergency. During a concurrent interview and inspection on [DATE] at 10:37 a.m. with LN 11, the Natoma Station Medication Storage Refrigerator was inspected. The refrigerator was identical to the Sutter Station Medication Refrigerator with a clear glass door. Inside the refrigerator was an E-Kit that contained two clear glass vials lorazepam 2 mg/ml injectable. The manufacturer's labeling on the vials indicated, Protect from light. LN 11 confirmed the manufacturer's labeling and stated the light in the Natoma Station Medication Storage Room also stayed on at all times. During an interview on [DATE] at 2:06 p.m. with the DON, the DON confirmed the lorazepam in the refrigerated E-Kits needed to be protected from light. The DON stated exposure to light could potentially degrade the medication since the manufacturer had labeled it to be protected (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	from light.During an interview on [DATE] at 10:48 a.m. with the CP, the CP stated if a light sensitive medication was not in a light protected vial, it needed to be in a light protective bag or in a drawer. The CP stated the lorazepam was not entirely protected from light and exposure to light increased the degradation of the medication. A review of the manufacturer's labeling for lorazepam 2 mg/ml injectable dated 2/2021 indicated, Store in a refrigerator. PROTECT FROM LIGHT. Use carton to protect contents from light. During a review of the facility's P&P titled, ID-1 Storage of Medications, dated 3/2018, the P&P indicated, Policy: Medications and biologicals are stored safely, securely, and properly, following manufacturer's recommendations or those of the supplier. 4. During a concurrent interview and inspection on [DATE] at 10:39 a.m. with LN 11, the Natoma Station Medication Storage Refrigerator was inspected. Inside the refrigerator was a manufacturer's sample box of medication for Ozempic (a medication to treat diabetes) 2 mg/3 ml prefilled injectable pen with Resident 69's name written on it in black permanent marker. The box did not have any labeling on it to indicate where the medication was dispensed from, prescriber's name, or directions for use. LN 11 confirmed the finding and stated all medications that were delivered to the facility from the supplier pharmacy always had a pharmacy label on it. During a concurrent observation and interview on [DATE] at 10:43 a.m. with RN/UM, Resident 69's Ozempic was inspected. RN/UM confirmed the Ozempic did not have a label on it. He stated all medications stored in the facility for a specific resident needed a label on it because the label verified there was a physician's order for it, tells nursing staff which resident it was for, and what the dose was. During an interview on [DATE] at 2:07 p.m. with the DON, the DON stated Resident 69's family wanted to supply the Ozempic so they brought it into the facility. The DON stated if a medication was brought in by family for a resident, it needed to be sealed and have a pharmacy label or printed instructions on it from the physician on the package. During a review of the facility's P&P titled, IC-7 Medications Brought to the Facility by a Resident or Family Member, dated 3/2018, the P&P indicated, Procedures: A. Use of medications brought to the facility by a resident or family member on admission (i.e. not delivered directly from any pharmacy) is allowed only when the following conditions are met. 4. The medication container is clearly labeled in accordance with facility procedures for medication labeling and packaged in a manner consistent with facility guidelines for medications. 5. During a concurrent observation and interview on [DATE] at 8:32 a.m. with LN 13 at the Sutter Nursing Station, a medication cart was observed unlocked and unattended, accessible to residents passing by. LN 13 confirmed the med cart was unlocked and unattended. LN 13 confirmed she walked away from the cart without locking it and stated, I forgot. LN 13 stated they were not to leave med carts unlocked and unattended for safety reasons. She stated that locking the cart was essential to ensure its contents remained secure and inaccessible to residents. During an interview on [DATE] at 9:45 a.m. with the DON, the DON stated the med carts were to be kept locked when unattended to ensure the safety of the medications and the safety of the residents During a review of the facility's P&P titled, IIA-2 Medication Administration- General Guidelines, dated 3/2018, the P&P indicated, Procedures. B. Administration. 13. During administration of medications, the medication cart is kept closed and locked when out of sight of the medication nurse.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. Based on observation, interview, and record review, the facility failed to ensure professional standards were followed when: Nursing staff did not wear appropriate personal protective equipment (PPE) while handling hazardous medication (medications that can cause serious effects including cancer, organ toxicity, fertility problems, genetic damage, and birth defects if not handled appropriately). Pain medication was not administered in accordance with the physician's order.An unclear PRN (as need) psychotropic medication order for Resident 11 was not clarified for indication for use prior to administration. These failures had the potential to result in worsening resident health conditions and unwanted exposure to hazardous medications leading to health complications. Findings: 1. During a medication pass observation on 4/21/26 at 7:50 a.m. with Licensed Nurse 2 (LN 2), LN 2 was observed preparing four medications for Resident 63 including mycophenolate mofetil (a medication to suppress the immune system) 500 milligrams (mg, a unit of measurement), two tablets. The pharmacy label affixed to the bubble pack indicated the medication was hazardous. LN 2 prepared the medications without wearing gloves or any other personal protective equipment. A review of Resident 63's medical record indicated a physician's order for mycophenolate mofetil 500 mg, give two tablets by mouth two times a day for immunosuppression related to sarcoidosis of lung (a rare disease where the immune system goes into overdrive, creating tiny, inflamed, solid lumps called granulomas in the lungs and lymph nodes), dated 3/14/25. During an interview on 4/21/26 at 1:27 p.m. with LN 2, LN 2 stated nursing staff were made aware of special handling requirements for hazardous medications by the pharmacy. LN 2 stated the pharmacy wrote it on the bubble pack, or it would be written in the directions on the pharmacy label. LN 2 stated the pharmacy would also place a sticker on the bubble pack to alert that the medication was hazardous. LN 2 stated she was not aware mycophenolate was a hazardous medication that required PPE and said, I just saw it right now. LN 2 stated it was important to wear gloves when handling hazardous medications, so it did not touch their hands or other things. During an interview on 4/22/26 at 1:47 p.m. with the Director of Nursing (DON), the DON stated hazardous medications included special instructions on the order. He stated nursing staff added the special instructions in the order or the pharmacist would identify it on the monthly review if it was not included. The DON stated a message would pop up for nursing staff in the E-MAR (electronic medication administration record). He stated nursing staff were expected to wear gloves when handling hazardous medication and it was important to do so for self-protection. The DON stated when the order for Resident 63 was discontinued the prior day, the special handling instructions for wearing gloves were not included. During a telephone interview on 4/23/26 at 10:40 a.m. with the Consultant Pharmacist (CP), the CP stated nursing staff were made aware of hazardous medications in the facility through education provided by the pharmacy as well as recommendations he made when reviewing resident drug regimens. The CP stated nursing staff should wear gloves during the preparation and administration of mycophenolate. 2. A review of Resident 86's medical record indicated she was admitted to the facility in December 2023 with diagnoses including osteoarthritis (a joint disease where the smooth, slippery cartilage cushioning the ends of bones breaks down) and spondylolisthesis (a spine condition where a backbone slips out of its proper position and moves forward, backward, or sideways over the bone below it). A review of Resident 86's physician's orders indicated an order for hydrocodone/acetaminophen (a potent opioid medication to treat pain) 5/325 mg, give one tablet by mouth every four hours as needed for severe pain (7-10) (pain scale of 0 to 10, with 10 being the highest level of pain), NTE (not to exceed) 3 grams of Tylenol in 24 hours from all sources, dated 9/3/25. A review of Resident 86's medication administration record (MAR) dated April 2026 indicated nursing staff administered hydrocodone/acetaminophen to Resident 86 for pain levels below parameters (specific, pre-determined safety rules that tell a nurse when it is appropriate to administer a dose of medication if a resident's pain level falls within a specified range) ordered by the physician on the following (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	dates: 4/3/26 pain level 5, 4/4/26 pain level 5, 4/5/26 pain level 6, 4/5/26 pain level 5, 4/6/26 pain level 6, 4/9/26 pain level 6, 4/10/26 pain level 5, 4/11/26 pain level 0, 4/11/26 pain level 5 at 6:36 p.m. and again at 11:05 p.m., 4/12/26 pain level 6, 4/12/26 pain level 5, 4/13/26 pain level 6 at 3:40 a.m. and again at 1:12 p.m., 4/17/26 pain level 5, 4/18/26 pain level 5, 4/19/26 pain level 6, 4/19/26 pain level 5, 4/20/26 pain level 6 at 3:33 a.m. and again at 1:30 p.m., and 4/21/26 pain level 6 at 8:28 a.m. and again at 1:37 p.m. During a concurrent interview and record review on 4/22/26 at 2:43 p.m. with the DON, Resident 86's physician order for hydrocodone/acetaminophen was reviewed. The DON confirmed the order indicated to administer for pain level seven to 10. The DON stated Resident 86 had a physician's order for ibuprofen (a nonsteroidal anti-inflammatory medication to treat pain) indicated for moderate pain levels of five and six. He stated Resident 86 knew what she wanted and was insistent on it so nursing staff should have contacted the physician to update the parameters for the hydrocodone/acetaminophen order or administered ibuprofen when the resident reported pain levels five and six. 3. A review of Resident 11's medical record indicated he was admitted to the facility in March 2025 with diagnoses including dementia with other behavioral disturbance (globally referred to agitation including anxiety) and adjustment disorder with mixed disturbance of emotions and conduct (a condition where a person experiences both emotional distress such as anxiety, depression and behavioral issues such as aggression and acting out). A review of Resident 11's medical record indicated a physician's order for lorazepam (a medication to treat anxiety) 0.5 mg, give one tablet by mouth every four hours as needed for anxiety manifested by continuous shouting for 14 days and give two tablets by mouth every 4 hours as needed for severe anxiety manifested by continuous shouting for 14 days, dated 4/22/26. During a concurrent interview and record review on 4/24/26 at 12:57 p.m. with LN 1, Resident 11's lorazepam order was reviewed. LN 1 stated the order was unclear and should have been clarified. LN 1 stated the order was confusing for nursing staff who were not familiar with Resident 11's baseline mood. During a concurrent interview and record review on 4/24/26 at 1:37 p.m. with the DON, Resident 11's lorazepam order was reviewed. The DON confirmed the order was unclear and stated nursing staff should have clarified it. During a review of the facility's policy and procedure (P&P) titled, Section II: Medication Administration Preparation and General Guidelines IIA-2, dated 3/2018, the P&P indicated, Medication Administration-General Guidelines Policy: Medications are administered as prescribed in accordance with good nursing principals and practices. Procedures. B. Administration. 2. Medications are administered in accordance with written orders of the attending physician. 3. If a dose seems excessive considering the resident's age and condition, or a medication order seems to be unrelated to the resident's current diagnoses or conditions, the nurse calls the provider pharmacy for clarification prior to the administration of the medication or if necessary contacts the prescriber for clarification.

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observe each nurse aide's job performance and give regular training. Based on interview and record review, the facility failed to ensure four out of five sampled employee personnel records included annual performance evaluations (formal, written, mandated processes typically occurring annually and during probationary periods to assess skill, knowledge, and work habits).This failure had the potential to result in poorly trained and managed employees, decreased quality of care provided, and safety risks for a vulnerable population.Findings: During a concurrent interview and record review on 4/23/26 at 8:53 a.m. with the Director of Staff Development (DSD) and the Administrator (Adm), the Certified Nursing Assistants (CNAs) personnel records reviewed did not have a completed Annual Performance Evaluations (APE). The Adm stated the APE's had not been completed in a while. The Adm indicated the performance evaluations have not been on the facility's radar and the employee performance evaluations were not completed as required. The Adm stated the performance evaluations were used to ensure the staff perform up to current laws and regulations and maintain the staff skills for patient care. The Adm confirmed the DSD and the Admin conducted walking rounds, walked the halls and observed the CNAs, and if the DSD noticed a trend, then those issues were discussed during the staff in-services. The DSD stated, Performance evaluations are a great way to determine what in-services are needed to be taught throughout the facility.During an interview on 4/23/26 at 10:40 a.m. with the Director of Nursing (DON), the DON confirmed the performance evaluations were completed on the employees Anniversary Date of Hire (ADOH). The DON confirmed the performance evaluations have not been done for quite a while. The DON indicated the importance of the annual performance evaluation was used as a tool to know how the staff were doing, and the performance issues to identify, and if additional trainings were needed. The DON stated, The Unit Managers (UMs) on each station should do the performance evaluation for the staff in their units. The CNAs APE had not been done.During a concurrent interview and review on 4/23/26 at 12:30 p.m. with the DON, the DON reviewed the following employees' personnel files and confirmed the employee files did not have a completed APE for the following CNAs:CNA 3 - ADOH 7/1/25 (not due);CNA 5 - ADOH 1/23/25;CNA 6 - ADOH 1/23/25;CNA 7 - ADOH 1/3/24; andCNA 8 - ADOH 7/30/24 terminated 2/28/26. The DON indicated he had not done a performance evaluation in a long time, and stated, Some of the managers did not have a completed annual performance evaluation for quite some time now.During an interview on 4/23/26 at 1:52 p.m. with the UM, the UM indicated she had been in the facility for 11 years. The UM stated she personally had not had a performance evaluation in years. A request was made for Performance Evaluation policies and procedures, but none was provided by the end of survey.

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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. Based on observation, interview, and record review, the facility failed to ensure: Nursing staff disposed of medication that was prepared but not administered in accordance with facility policy and procedure;Medications for destruction were disposed of in a manner that limited potential for diversionEmergency medications (E-kit) were replaced timely for a census of 84;Two of 2 randomly selected medication cart controlled drug sign-in/sign-out sheets (a sheet used to reconcile inventory of controlled medications in the medication cart by the outgoing and incoming nurse during a shift change) were signed by the outgoing and incoming nursing shift. These failures resulted in the facility not having accurate accountability of controlled medications and potential for abuse or misuse of these medications, the potential for emergency medications to be unavailable when needed, and the potential for not meeting the residents' therapeutic needs or worsening of their medical conditions.1. During a medication pass (med pass) observation on 4/21/26 at 8 a.m. with Licensed Nurse 2 (LN 2), LN 2 was observed preparing medications for Resident 63, including metoprolol succinate (a medication to treat high blood pressure) ER (extended release) 25 milligrams (mg, a unit of measurement), one tablet. LN 2 reviewed Resident 63's vitals and stated she would not administer the metoprolol because his blood pressure fell below the parameters (specific, pre-determined safety rules that tell a nurse or caregiver to skip a dose of medication if a resident's vital signs or lab results are not in a safe range). During the same medication pass observation on 4/21/26 with LN 2, LN 2 placed the metoprolol tablet in a cup then placed the paper cup in the top drawer of the medication cart (med cart). LN 2 stated she would later dispose of it in a container in the medication storage room. During an interview on 4/21/26 at 8:47 a.m. with LN 3, LN 3 stated prepared medications that were not administered to the residents were to be disposed of right away and not at the end of a med pass. She stated it could be a slippery slope, and she did not want to hang onto refused pills and get them confused with other medications. During a concurrent interview and inspection on 4/21/26 at 10:01 a.m. with LN 2, LN 2's med cart was inspected. LN 2 opened her med cart and inside the drawer was the one white pill (from the med pass observation 2 hours earlier) in a cup still in right hand side of the med cart. LN 2 stated she collected dropped or refused doses of medication during med pass in the top drawer and disposed of them when she passed by the medication storage room that contained the drug disposal container. LN 2 pulled out a small drug destruction container located in the med cart and stated it was designated for the destruction of controlled substances. During a concurrent interview and inspection on 4/22/26 at 1:20 p.m. with LN 4, the Natoma 1 Med Cart was inspected. LN 4 stated if she was in the middle of med pass she would place noncontrolled medications that needed to be destructed in a paper cup in the drawer of the med cart and then dispose of them in the medication storage room at the end of her shift. LN 4 then removed a paper cup from the med cart and inside was eight tablets. LN 4 stated she could also use a drug destruction container that was located on the med cart but stated it filled up quickly so she saved the pills to destruct them in a larger container in the medication storage room. During an interview on 4/22/26 at 2:09 p.m. with the Director of Nursing (DON), the DON stated non-narcotic medications that were refused or dropped should have been placed in the drug destruction container inside the med cart. The DON stated nursing staff should have been disposing medication right away because if it is saved in the med cart it could potentially be administered to a resident by mistake. During a telephone interview on 4/23/26 at 10:29 a.m. with the Consultant Pharmacist (CP), the CP stated nursing staff were expected to destruct dropped or refused medication right then and there at the med cart using the drug destruction container located inside it. During a review of the facility's policy and procedure (P&P) titled, Preparation and General Guidelines, dated 3/2018, the P&P indicated, IIA-2 Medication Administration-General Guidelines. Procedures. A. Preparation. 4. Once the medication and dose have been confirmed, the medication is ready to be removed from the prescription packaging. b. If for any reason, once (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	removed from the packaging, the resident refuses some or all of the medications, the refused medications are destroyed at the medication cart per facility procedures. C. Medications removed from the prescription packaging and refused by the resident are not kept (on the cart, in the nurse's pocket, in the medication room) for attempts at administering at a later time. 2. During a concurrent interview and inspection of the Sutter Medication Storage Room on 4/21/26 at 10:26 a.m. with LN 11, a large white plastic container with a blue pop-open lid was observed. Inside the container were hundreds of tablets, capsules, injectable vials with medication inside and unopened vials of medication for nebulization. The opening of the container was large enough to allow one to reach inside and either pull out or pour medication out. No other substance or liquid was mixed in the container, and the medications were in their original form. LN 11 confirmed the observation and stated the medications were retrievable. During an interview on 4/22/26 at 2:12 p.m. with the DON, the DON stated nursing staff were expected to add liquid of some kind, cat litter, or coffee grounds initially to start a new medication destruction container in the med storage room. The DON stated it was important for the container to have another substance in it to limit the potential for diversion. During a telephone interview on 4/23/26 at 10:32 a.m. with the CP, the CP stated the medication destruction containers located in the medication storage room were for nonnarcotic medications that were discontinued or not going home with a resident. CP confirmed that from a diversion standpoint, the opening of the container was large enough for medications to be easily removed if they were kept in there in their original form. During a review of the facility's P&P titled, IE-E Medication Destruction, dated 3/2018, the P&P indicated, Procedures. J. Unintentional Wasting of Medication Doses 2. If a single dose of medication is accidentally contaminated or is otherwise unusable, (dropped, spilled, touched, refused by the resident, etc.), the following policies and procedures will apply: a. Non-controlled drugs (prescription and non prescription) - single doses may be destroyed by the nurse preparing the dose for administration. Destruction is accomplished by discarding the crushed/capsule emptied medication dose in the ?medication waste/[branded product for drug destruction]/[branded product for drug destruction]' container on the cart.' 3. During a concurrent observation and interview on 4/21/26 at 10:56 a.m. in the Mill Station Medication Storage Room with Registered Nurse/Unit Manager (RN/UM), the Injectable/Sublingual/Nasal/Oral Suspension E-Kit was observed with a red plastic tie indicating it had been opened by nursing staff. Inside the E-Kit was a log. RN/UM opened the E-Kit and emergency kit log (a document completed by nursing staff whenever a medication is removed from the emergency supply) was dated 4/11/26, 10 days prior. RN/UM stated nursing staff were expected to reorder a used E-Kit right away. He confirmed it was expected that the E-Kit would have already been replaced and stated the timeline for replacing an opened E-Kit was 48 to 72 hours. RN/UM stated it was important used E-Kits were replaced timely to ensure nursing staff did not open them in need of medication only to find that the supply had been exhausted. During an interview on 4/22/26 at 1:57 p.m. with the DON, the DON stated nursing staff were expected to reorder an opened E-Kit immediately and it should be replaced within 72 hours. The DON stated nursing staff routinely check E-Kits to see if any had been opened and if they were, they were expected to reorder them. The DON stated he would rather have nursing staff reorder an E-Kit 20 times than to not have it replaced at all. During a telephone interview on 4/23/26 at 10:27 a.m. with the CP, the CP stated once an E-Kit was opened, nursing staff were expected to notify the pharmacy and reorder it. The CP stated the pharmacy was to replace the used E-Kit within three days. During a review of the facility's P&P titled, IC-3 Emergency Pharmacy Service and Emergency Kits, dated 3/2018, the P&P indicated, Procedures. Procedures. G. As soon as possible, the nurse records the medication use on the medication order form and notifies the pharmacy for replacement of the kit by transmitting the entire order for the resident and indicating that the first dose was used from the kit. The nurse flags the kid with a red color-coded lock to indicate need for replacement of kit. K. If exchanging kits, opened kits are replaced with sealed kits within 72 hours of opening. If replacing used medications, the replacement doses are added to the kit within 72 hours of opening. 4. During a concurrent interview and record (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	review 4/21/26 at 1:54 p.m. with LN 12, the Floor Narcotic and Emergency Kit Release for the Mill Station Medication Cart was reviewed. LN 12 stated nursing staff were expected to document between shifts that they completed a narcotic count. LN 12 confirmed there were many shifts where nursing staff had not documented that the narcotic count was done. A review of the record, dated 2/1/26 to 4/21/26, indicated 95 missing signatures between nursing shift changes. During a concurrent interview and record review on 4/21/26 at 3:46 p.m. with LN 2, the Floor Narcotic and Emergency Kit Release for the Sutter Station Medication Cart was reviewed. LN 2 confirmed nursing staff were expected to count the narcotics between shift change and document the count was completed on the form. LN 2 confirmed there were missing signatures and stated sometimes nursing staff forgot to sign it. A review of the record, dated 2/1/26 to 4/21/26, indicated 37 missing signatures between nursing shift changes. During an interview on 4/22/26 at 2 p.m. with the DON, the DON stated nursing staff were expected to count and document on the shift-to-shift count sheet that the count was performed between shift change. During a review of the facility's P&P titled, ID-3 Controlled Medication Storage, dated 3/2018, the P&P indicated, Procedures. D. At each shift change, a physical inventory of all controlled medications is conducted by two licensed nurses and is documented on the controlled medication accountability record.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. Based on observation, interview, and record review, the facility had a 7.69% error rate when three medication errors out of 39 opportunities were observed during a medication pass for three of nine Residents (Residents 73, 84, and 103). This failure resulted in medications not given in accordance with the prescriber's order and potential to affect the residents' clinical conditions. 1. During a medication pass (med pass) observation on 4/21/26 at 8:22 a.m. with Licensed Nurse 3 (LN 3), LN 3 was observed preparing two medications for Resident 103 including aspirin (a medication to prevent blood clots) EC (enteric coated, a special delayed release coating to prevent stomach irritation) 81 milligrams (mg, a unit of measurement), 1 tablet. A review of Resident 103's physician's orders indicated an order for aspirin delayed release 81 mg, give one tablet by mouth two times a day for VTE (venous thromboembolism, dangerous blood clots that form in the veins) prophylaxis (prevention) for 30 days, dated 4/16/26. LN 3 looked in the medication cart and stated the aspirin was not available for administration but would check in the automated dispensing cabinet (ADC, a computerized, secure medication storage device located at the nursing station that allows for decentralized, automated storage, tracking, and dispensing of medications). LN 3 stated enteric coated aspirin was stocked in the ADC and the chewable aspirin was stocked in the facility's over the counter (OTC) drug supply. LN 3 went to the medication storage room where the ADC was located and logged into the ADC computer system. LN 3stated the medication was not available to be dispensed under Resident 103's profile and would need to contact the pharmacy to add it. During a concurrent interview and observation on 4/21/26 at 9:39 a.m. with LN 3, LN 3 checked Resident 103's profile in the ADC computer system and confirmed it was still not available to be dispensed. During an interview on 4/21/26 at 9:55 a.m. with LN 3, LN 3 stated the aspirin order for Resident 103 was still not showing up in the ADC computer system so she would call the pharmacy again. During a concurrent observation and interview on 4/21/26 at 10:40 a.m. (over 2 hours after the initial med pass observation) with LN 3, LN 3 was holding Resident 103's aspirin EC 81 mg tablet in a dispensed pouch from the ADC. She stated the medication order was now in the ADC and she went to administer the medication to Resident 103. During an interview on 4/22/26 at 1:47 p.m. with the Director of Nursing (DON), the DON stated aspirin EC 81 mg tablets were stocked in the facility's OTC drug supply located in the same room as the ADC. The DON stated LN 3 could have located it in one of the cabinets to administer to Resident 103. The DON stated the late administration of aspirin at 10:40 a.m. was a medication error. During a review of the facility's policy and procedure (P&P) titled, IC-1 Ordering and Receiving Medications from the Dispensing Pharmacy, dated 3/2018, the P&P indicated, Policy: Medications and related products are received from the dispensing pharmacy on a timely basis. Procedures A. Ordering Medications from the Dispensing Pharmacy. 2. If not automatically refilled by the pharmacy, repeat medications (refills) are written on a medication order form, electronic transmission, or ordered by peeling the reorder strip from the label and placing it in the appropriate area on the order form provided by the pharmacy for that purpose and ordered as follows: a. Reorder medication three to four days in advance of need to assure an adequate supply is on hand. 2. During a med pass observation on 4/21/26 at 8:47 a.m. with LN 3, LN 3 was observed preparing 10 medications for Resident 73 including Multaq (a prescription medicine used to lower the chance of hospitalization for atrial fibrillation, an irregular, rapid heart rate caused by faulty electrical signals in the heart) 400 mg, 1 tablet. A review of Resident 73's physician's orders indicated an order for Multaq 400 mg, give one tablet by mouth two times a day for A-Fib (atrial fibrillation) with morning and evening meals. Hold for SBP (systolic blood pressure, a measurement of the maximum force of blood pushing against artery walls when the heart beats) below 110 and HR (heart rate) below 60, dated 3/30/26. During the same medication pass observation on 4/21/26 at 9:28 a.m.with LN 3, LN 3 entered Resident 73's room and administered all prepared medications. During a concurrent interview and record review on 4/22/26 at 8:40 a.m. with LN 3, LN 3 reviewed Resident 73's physician's order (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	for Multaq and confirmed it indicated to administer with a meal. LN 3 stated the residents in her assigned hall received breakfast by 7:45 a.m. She stated if a med pass went late and a medication was ordered to be given with food she normally asked the resident if they still felt full before administering the medication. She stated if the resident reported that they did not feel full she would first offer a snack before administering the medication. LN 3 acknowledged the administration was approximately two hours after breakfast was served and stated she should have offered Resident 73 pudding or crackers when she administered the Multaq. LN 3 searched the internet to locate administration information for Multaq and stated the absorption and efficacy increased when it was given with a meal. A review of the manufacturer's labeling for Multaq, dated 6/2011, indicated, Absorption. bioavailability (the amount the body absorbs) of dronedarone (generic for Multaq) without food is low, about 4%. It increases to approximately 15% when dronedarone is administered with a high fat meal. During an interview on 4/22/26 at 2:40 p.m. with the DON, the DON stated he would consider medication administration up to an hour after a meal to be considered given with food. He stated if it had been over two hours nursing staff were expected to give something extra to the resident like a snack with the medication or a glass of milk. During a telephone interview on 4/23/26 at 10:24 a.m. with the Consultant Pharmacist (CP), the CP stated administration of Multaq with a meal helps with the absorption of the medication to be as stable as possible. CP stated if Multaq was not administered with food, the bioavailability could be affected. During a review of the facility's P&P titled, IIA-2 Medication Administration- General Guidelines, dated 3/2018, the P&P indicated, Policy: Medications are administered as prescribed in accordance with good nursing principles and practices. Procedures. B. Administration. 2. Medications are administered in accordance with written orders of the attending physician. 10. Medications are administered within 60 minutes of scheduled time, except before or after meal orders, which are administered based on mealtimes. 3. During a medication pass observation on 4/23/26 at 8:24 a.m. with LN 1, LN 1 was observed preparing nine medications for Resident 84, including ferrous sulfate (a medication to treat low iron levels) 220 mg/5 ml elixir, 7 ml. A review of Resident 84's physician's orders indicated an order for ferrous sulfate elixir 220 mg/5 ml, give 7 ml via PEG-tube (percutaneous endoscopic gastrostomy, a soft, flexible tube placed directly into the stomach through a small, temporary abdominal incision to provide nutrition, liquids, and medication when someone cannot swallow or eat enough by mouth) one time a day for supplement, dated 1/23/26. During the same medication pass observation on 4/23/26 with LN1, LN 1 poured ferrous sulfate into a plastic medicine cup and stated she measured between the 5 ml and 10 ml graduation marks to estimate 7 ml. LN 1 then stated she should have used a syringe and went to the medication storage room to obtain one. LN 1 returned to the medication cart and used a luer lock syringe (a medical tool with a twist-and-lock tip that secures a needle or tubing in place) to measure the ferrous sulfate. LN 1 measured and squirted into a medicine cup 3 ml, 2 ml, and 2 ml to equal 7 ml. LN 1 stated she used the bottom of the two rings of the rubber stopper (the black tip of the plunger that creates an airtight seal and is used to read measurements) each time she drew up the ferrous sulfate to measure Resident 84's dose. A review of Medical Mathematics, an online textbook designed to prepare students to apply math concepts in health care settings, in the section titled, 5.6 Reading Syringes, the article indicated, Identify where the end of the plunger is. A. The liquid inside the syringe will take up space up to the edge of the plunger inside the syringe. This edge is what should be compared to the graduated measurements to determine how much liquid is inside the syringe. The plunger inside the syringe is large and usually shows two sharp edges where the rubber is touching the inside of the syringe barrel. The edge you are looking at is always going to be the edge close to the tip of the syringe, not the edge close to where your fingers are holding the flanges and plunger rod. (https://ecampusontario.pressbooks.pub/sccmedicalmath/chapter/reading-syringes/; accessed 4/28/26) During an interview on 4/23/26 at 9:04 a.m. with LN 1, LN 1 stated she was not aware she had incorrectly measured Resident 84's ferrous sulfate when she used the bottom ring and not the top ring of the rubber stopper. During a concurrent observation and interview on 4/23/26 at 11:30 a.m. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	with the DON and LN 1, LN 1 went to the medication storage room and retrieved a luer lock syringe (identical to the one she used to measure Resident 84's ferrous sulfate). LN 1 showed the DON the syringe and demonstrated how she had measured the medication using the bottom ring of rubber stopper instead of the top. The DON confirmed that was not the correct way to measure with the syringe. During a review of the facility's P&P titled, Section II: Medication Administration Preparation and General Guidelines IIA-2 Medication Administration- General Guidelines, dated 3/2018, the P&P indicated, Policy: Medications are administered as prescribed in accordance with good nursing principles and practices. Procedures A. Preparation. 2. An adequate supply of disposable containers and equipment. is maintained on the medication cart for the administration of medications.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observation and interview, the facility failed to implement infection control and prevention practices when:1. Laundry Staff 1 (LS 1) reused a gown after handling soiled linens;2. Incentive spirometers (IS, a handheld device designed to encourage deep breathing) were not labeled for 3 out of 22 sampled residents (Resident 21, Resident 56, Resident 101). These failures increased the potential for the spread of infections among vulnerable residents.Findings: 1. During a concurrent observation and interview on 4/23/26 commencing at 9:36 a.m. with LS 1 in the laundry room, LS 1 was observed putting on gown and gloves and sorting soiled linens in separate bins, then LS 1 removed the gown [rolled into a ball] and placed it on the top of the shelf. LS 1 removed washed clothes from two washers and placed them in the dryers. LS 1 walked back to the shelf, took a previously used gown, put it on, put on a new pair of gloves, loaded soiled linens into two washers, and started the washing cycles. LS 1 stated that she reused the same gown throughout her eight (8) hour shift. LS 1 agreed the used gown was likely contaminated after the first use when handling soiled linens. During an interview on 4/24/26 at 11:43 a.m. with the Infection Prevention and Control Nurse (IPCN), the IPCN confirmed that she expected no reuse of gowns in the laundry room, as it increased the risk of cross-contamination and the spread of infection. During a review of the facility's policy and procedure (P&P) titled, Laundry Department, undated, the P&P indicated, Careful precautionary procedures must be followed by laundry personnel to prevent the spread of infectious diseases to other staff members, residents and visitors. All soiled linen is potentially infectious.Prior to sorting or handling of soiled linen, protective clothing with long sleeve gown is to be placed over uniform, gloves and mask are to be worn. Protective clothing is to be secured in the back and must be worn continually through the machine loading process. When all washers are full, remove gown, gloves and mask. Dispose of in the trash or washer as appropriate. 2. During a review of Resident 21's admission Record (AR), dated 4/24/26 (print date), the AR indicated that Resident 21 was admitted to the facility in March of 2026 with diagnoses which included chronic respiratory failure (breathing or gas exchange problems) and dependence on supplemental oxygen. During a review of Resident 56's AR, dated 4/24/26 (print date), the AR indicated that Resident 56 was readmitted to the facility in April of 2026 with diagnoses which included aftercare for surgery on the digestive system and dysphagia (difficulty swallowing). During a review of Resident 101's AR, dated 4/24/26 (print date), the AR indicated that Resident 101 was readmitted to the facility in April of 2026 with diagnoses which included pulmonary fibrosis (lung disease, scarring of lung tissue, shortness of breath) and multiple rib fractures. During an observation on 4/21/26 at 8:44 a.m. in Resident 101's room, two IS were observed unlabeled on the nightstand by Resident 101's bed. During an observation on 4/21/26 at 8:50 a.m. in Resident 56's room, an unlabeled IS was seen on the nightstand by Resident 56's bed. During an observation on 4/21/26 at 9:17 a.m. in Resident 21's room, an unlabeled IS was seen on the nightstand by Resident 21's bed. During a concurrent observation and interview on 4/23/26 commencing at 2:22 p.m. with the IPCN, the IPCN walked into Resident 21's, 56's, and 101's rooms and confirmed that all three residents had unlabeled IS at the bedside. The IPCN further stated that the IS were personal items and needed to be labeled. During an interview on 4/24/26 at 11:43 a.m. with the IPCN, the IPCN confirmed that not labeling IS increased the risk of cross-contamination (spread of infections). During a review of the facility's P&P titled Theft and Loss, revised 5/17, the P&P indicated, Personal articles, other than clothing, brought into the facility should be engraved with the resident's name on the article or other methods of identification.

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. Based on interview and record review, the facility failed to ensure informed consent was obtained prior to the administration of as needed (PRN) lorazepam (a psychotropic medication to treat anxiety) for one of 22 sampled residents (Resident 3). This failure increased the potential for Resident 3's Responsible Party (RP) to not be informed of the risks and benefits of the medication and possible alternatives.A review of Resident 3's medical record indicated he was admitted to the facility in October 2025 with diagnoses which included dementia, Alzheimer's disease (a progressive disease that destroys memory and other important mental functions), depression, and anxiety. A review of Resident 3's medical record indicated the following physician's orders for lorazepam:- Lorazepam 0.5 milligram (mg, a unit of measurement): Give 0.5 mg by mouth in the afternoon for anxiety manifested by restlessness related to anxiety disorder, dated 4/22/26- Lorazepam 0.5 mg: Give one tablet by mouth every 8 hours as needed for anxiety manifested by restlessness related to anxiety disorder for 14 days, dated 4/22/26 During a concurrent interview and record review on 4/23/26 at 5 p.m. with Licensed Nurse 1 (LN 1), Resident 3's informed consents were reviewed. LN 1 stated an informed consent was obtained from a resident or their RP before psychotropic medication was initiated. LN 1 stated sometimes multiple doses for the same medication were combined onto one consent. LN 1 reviewed Resident 3's consents and stated she only saw one obtained for the routine dose and not the PRN dose. During a concurrent interview and record review on 4/23/26 at 5:10 p.m. with the Director of Nursing (DON), Resident 3's informed consents were reviewed. The DON stated he looked but did not see a consent for Resident 3's as needed lorazepam order. The DON stated each order for Resident 3's lorazepam required its own form. During a review of the facility's policy and procedure (P&P) titled, Medication Management, dated 3/2018, the P&P indicated, Procedures.2. The resident is evaluated before initiating, withdrawing, or withholding medication(s), or using non-pharmacologic approaches. A. The extent of the evaluation will vary according to the resident's current condition but may include.6. Refusal of care and treatment, including the basis for declining it and the identification of pertinent alternatives.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to implement a care plan intervention for the use of eyeglasses for one of 22 sampled residents (Resident 8), when Resident 8's glasses were not applied.This failure had the potential to negatively affect Resident 8's communication needs and quality of life.Findings:A review of Resident 8's admission record indicated she was admitted in Fall 2021 with diagnoses which included a history of bed confinement status (inability to leave the bed due to illness, injury, or severe frailty), bilateral cataracts (where the natural, clear lens inside your eye becomes cloudy or foggy), and Alzheimer's disease (a disease characterized by a progressive decline in mental abilities).During a review of Resident 8's Care Plan Report (CPR), dated [DATE], the CPR indicated, The resident has impaired visual function, with interventions that included environmental factors and use of glasses for visual support.During a review of Resident 8's Valuable List (VL), dated [DATE], the VL indicated two pair of eyeglasses were present on admission.During an observation on [DATE] at 9:57 a.m. in Resident 8's room, Resident 8 was found lying in the bed with eyes open without glasses in place. During an interview with Resident 8's Responsible Party (RP) on [DATE] at 9:16 a.m., the RP stated Resident 8 wore glasses and reported they had not observed Resident 8 wearing glasses during visits. The RP stated glasses were important to Resident 8's dignity and quality of care.During a concurrent observation and interview on [DATE] at 9:23 a.m. with Resident 8 in Resident 8's room, Resident 8 was found lying in the bed with eyes open without glasses in place. During a concurrent interview and record review on [DATE] at 10:37 a.m. with Certified Nursing Assistant (CNA) 9, Resident 8's Valuable List was reviewed. CNA 9 confirmed Resident 8 had two pair of glasses and stated she was expected Resident 8 to have glasses on to avoid eye injury.During a concurrent observation and interview on [DATE] at 10:43 a.m. with Unit Manager (UM) 1 in resident 8's room, Resident 8 was found lying in the bed with eyes open without glasses in place. UM 1 retrieved Resident 8's glasses from a drawer and confirmed the glasses frame was broken. UM 1 confirmed the RP had requested the glasses for Resident 8 to use and that glasses were important to assist with reading and recognition of caregivers. During an interview on [DATE] at 12:33 p.m. with CNA 4, CNA 4 stated residents had the right to wear glasses if requested by the RP.During an interview on [DATE] at 11:59 a.m. with the Social Services Director (SSD), the SSD stated residents' glasses were listed on a residents' VL and confirmed that Resident 8's broken glasses were expected to be reported to SSD.During an interview on [DATE] at 8:51 am. with CNA 9, CNA 9 indicated Resident 8's RP requested that Resident 8 wore glasses and the last time they saw Resident 8 with glasses on was 8 months ago. CNA 9 stated staff found out resident needs by referring to the care plan or family and that it was important for Resident 8 to wear the glasses, and stated, Even if we don't know if [Resident 8] can see, it is still important.she might like them for fashion and to look beautiful.During an interview on [DATE] at 8:51 am. with LN 8, LN 8 stated she has not seen Resident 8 wore glasses in the last three months. During an interview on [DATE] at 11:15 a.m. with the Director of Nursing (DON), the DON stated glasses were expected to be worn, the care plan to be followed, and could cause unhappiness in a resident if they do not have their glasses.During a review of the facility's policy and procedure (P&P) titled, Federal Resident Rights, dated 2025, the P&P indicated, Respect and Dignity: you have the right to be treated with respect and dignity, including the right to.retain and use personal possessions.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to maintain a safe environment for one of 22 sampled residents (Resident 80), when wheelchair footrests were found in Resident 80's room walking pathway. This failure had the potential risk to result in accidents or injuries of Resident 80. Findings:A review of Resident 80's admission record indicated she was admitted in Spring 2026 with diagnoses which included history of falling, muscle weakness, abnormalities of gait and mobility (difficulty walking and moving around), lack of coordination, and osteoporosis (disease that makes bones weak, thin, and brittle, causing them to break easily).A review of Resident 80's Minimum Data Set (MDS- a federally mandated resident assessment tool), dated [DATE], the MDS indicated that Resident 80 had decision-making capacity, at risk for falls, and required a wheelchair, walker, and staff assistance for mobility.A review of Resident 80's Care Plan Report (CPR), dated [DATE], the CPR indicated Resident 80 was a high risk for falls and included interventions to modify the environment and maintain floors free from clutter.A review of Resident 80's Progress Notes (PN), dated [DATE], the PN indicated Resident 80 had a recent fall and was found lying on the floor next to her bed while attempting to go to the bathroom.During a concurrent observation and interview on [DATE] at 9:47 a.m. with Resident 80 in Resident 80's room, wheelchair footrests were found lying on the floor directly within Resident 80's walking pathway to the restroom. Resident 80 stated she could get up and use the restroom independently when necessary.During a concurrent observation and interview on [DATE] at 9:50 a.m. with Licensed Nurse (LN) 7, LN 7 confirmed the wheelchair footrests were in Resident 80's walking pathway and stated they were not expected to be in front of the door and should have been placed under the table to prevent tripping accidents.During a concurrent observation and interview on [DATE] at 12:33 p.m. with Certified Nursing Assistant (CNA) 4, CNA 4 stated pathways should have been kept clear to reduce fall risk and pointed to multiple areas of a resident room which included the front of the bathroom door to identify intended walking paths that should have been unobstructed.During a concurrent observation and interview on [DATE] at 1:11 p.m. with LN 5, LN 5 stated pathways should have been kept clear to prevent falls and injury. During an interview on [DATE] at 11:15 a.m. with the Director of Nursing (DON), the DON stated it was the expectation that obstructions should be moved and stored safely to avoid falls.During a request of the facility's Fall policy and procedure on [DATE] at 11:22 a.m., the facility was unable to provide a specific Fall Policy.During a review of the facility's policy and procedure (P&P) titled Resident Rights, dated 4/2017, the P&P indicated, Safe environment.residents have the right to a safe, clean and homelike environment.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident?s drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure one of 22 sampled residents (Resident 8) remained free from unnecessary medication, when Resident 8 was prescribed and administered with antibiotics (ABX, medications that treat bacterial infections) for prophylactic (preventative medical measure or medication designed to stop a disease, infection, or health condition before it occurs) for a urinary tract infection (UTI, an infection in the bladder/urinary tract).This failure had the potential for antibiotic resistance and infection.Findings:A review of Resident 8's admission record indicated she was admitted in Fall 2021 with diagnoses which included history of bed confinement status (inability to leave the bed due to illness, injury, or severe frailty), pressure ulcer (localized, pressure-related damage to the skin and/or underlying tissue usually over a bony prominence), and Alzheimer's disease (a disease characterized by a progressive decline in mental abilities).A review of Resident 8's Minimum Data Set (MDS - a federally mandated resident assessment tool), dated [DATE], the MDS indicated Resident 8 did not have the capacity to make decisions.During review of Resident 8's Care Plan Report (CPR), dated [DATE], the CPR indicated Resident 8 had the inability to communicate needs and included interventions: Monitor/record/report to MD for s/sx [signs and symptoms] of UTI [urinary tract infection: pain, burning, blood tinged urine, cloudiness, no output, deepening of urine color, increased pulse, increased temp, Urinary frequency, foul smelling urine, fever, chills, altered mental status, change in behavior, change in eating patterns .for [Resident 8's] incontinence and urinary catheter [a hollow tube inserted into the bladder to drain or collect urine].A review or Resident 8's Order Summary Report (OSR, physician's orders), dated [DATE], the OSR indicated, Sulfamethoxazole-Trimethoprim (ABX)Tablet 800-160 MG Give 1 tablet via NG-Tube in the morning for UTI prophylaxis.A review of Resident 8's Progress Note (PN), dated [DATE], the PN indicated, [Resident 8] received antibiotics for UTI prevention although having Urine clear yellow in color. No urinary complaints.During a concurrent interview and record review on [DATE] at 9:37 a.m. with LN 4, Resident 8's medical record was reviewed. LN 4 confirmed Resident 8 received ABX for frequent UTI's. LN 4 was unable to find documented positive culture or UTI symptoms. LN 4 stated that Resident 4's ABX were a request from Resident 8's Responsible Party (RP) and KN 4 indicated having unneeded ABX can cause resistance especially if nothing was being treated. LN 4 further stated it was the expectation that staff or the antibiotic stewardship (management of antibiotic prescribing to ensure the right drug, dose, and duration were used only when necessary) was followed to avoid unnecessary ABX.During a concurrent interview and record review on [DATE] at 11:01 a.m. with the Infection Prevention and Control Nurse (IPCN), Resident 8's laboratory reports were reviewed. The IPCN confirmed Resident 8's most recent positive urine culture in 2021 and there were no documentation of a positive urine culture (UC) or symptoms supporting UTI. The IPCN further confirmed Resident 8's UC during Resident 8's recent hospital admission in [DATE] recommended recollection and repeat testing recommended should have been completed when readmitted . The IPCN confirmed that Resident 8's ABX had not met the facilities Antibiotic Stewardship program McGeer Criteria (standardized, evidence-based definitions used to identify infections in long-term care (LTC) facilities) and stated that Resident 8's ABX were unnecessary and caused a risk to family, staff, and the public being exposed to a resistant bug.During an interview on [DATE] at 11:10 a.m. with Unit Manager (UM) 2, UM 2 stated the expectation was that readmissions from the hospital be treated like a new admission and that Resident 8's UC should have been completed to avoid unnecessary treatment, resistance, kidney and other health issues especially for the elderly.can cause fungal infection causing women health issues. UM 2 further stated, We want to make sure our residents are not treated for what they are not needed based off our antibiotic stewardship.During an interview on [DATE] at 11:15 a.m. with the Director of Nursing (DON), the DON stated the expectation was that Resident 8's ABX were reviewed and that unnecessary ABX could (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	create a super bug and could cause a risk to residents and other residents.During an interview on [DATE] at 2:43 p.m. with the Medical Director (MD), the MD confirmed that Resident 8's antibiotics had no indication, and the MD stated that although Resident 8's RP was educated there was no indication for the ABX.During a review of the facility's policy and procedure (P&P) titled, Infection Control Monitoring and Surveillance, undated, the P&P indicated, .will utilize the McGeer Criteria for Long Term Care Surveillance Updated 2012 and recommended by the Society for Healthcare epidemiology of America and other leading entities specializing in long term care epidemiology.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on interview and record review, the facility failed to ensure accurate records were maintained for one of 22 sampled residents (Resident 3) when the physician updated Resident 3's bisoprolol (medication to treat high blood pressure) order to remove hold parameters (specific, pre-determined safety rules that tell a nurse or caregiver to skip a dose of medication if a resident's vital signs or lab results are not in a safe range) for blood pressure medication and nursing staff did update Resident 3's medication order to reflect the change. This failure resulted in an inaccurate medication order for Resident 3 and had the potential for Resident 3 to not receive blood pressure lowering medicine when it was scheduled to be administered.Findings: A review of Resident 3's medical record indicated he was admitted to the facility in October 2025 with diagnosis including high blood pressure and atherosclerosis (the slow buildup of fats, cholesterol, and other substances inside artery walls, making them thick, stiff, and narrow). A review of Resident 3's medical record indicated a physician's order for bisoprolol 5 milligrams (mg, a unit of measurement), give 5 mg by mouth at bedtime for HTN (hypertension). Hold for SBP (systolic blood pressure, pressure in your arteries when your heart muscle squeezes and pumps blood out to the body) < 110, pulse < 60, dated 11/11/25. During a concurrent interview and record review on 4/23/26 at 3:12 p.m. with Licensed Nurse 1 (LN 1), Resident 3's order for bisoprolol was reviewed. LN 1 confirmed the order indicated hold parameters but the prompt in the computer system that directed nursing staff to measure and document blood pressure and pulse prior to administration had been removed. LN 1 reviewed Resident 3's medical record and stated the physician and removed the parameter to take Resident 3's blood pressure before administering bisoprolol because the resident's blood pressure had stabilized and no longer required daily monitoring. LN 1 reviewed Resident 3's medical record and stated it had been approximately four months since the physician removed the hold parameter, but it had not been updated on the medication order with the pharmacy. During an interview on 4/24/26 at 3:20 p.m. with the Director of Nursing (DON), the DON confirmed he had reviewed Resident 3's physician's order for bisoprolol and stated when an order was updated the facility was responsible for updating the order with the pharmacy. He stated the order for Resident 3's bisoprolol should have been updated with the pharmacy to reflect the removal of hold parameters but had not been. During a review of the facility's policy and procedure (P&P) titled, IC-1 Ordering and Receiving Medications from the Dispensing Pharmacy, dated 3/2018, the P&P indicated, Policy: Medications and related products are received from the dispensing pharmacy on a timely basis. Procedures A. Ordering Medications from the Dispensing Pharmacy. 2. If not automatically refilled by the pharmacy, repeat medications (refills) are written on a medication order form, electronic transmission, or ordered by peeling the reorder strip from the label and placing it in the appropriate area on the order form provided by the pharmacy for that purpose and ordered as follows. b. The nurse who reorders the medication is responsible for notifying the pharmacy of changes in directions for use or previous labeling errors. During a review of the facility's policy and procedure (P&P) titled, Medical Records for Residents, dated 9/2012, the P&P indicated, Procedure. 8. Medical records shall be current and kept in detail consistent with good medical and professional practice based on the services provided to each resident.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. Based on the interview and record review, the facility failed to implement the antibiotic stewardship protocol when the physician was not notified that McGeer's criteria (standardized surveillance definitions used in long-term care facilities to detect infections) for diagnosis of urinary tract infection (UTI) were not met for one resident (Resident 53) in a census of 84. This failure increased the potential for Resident 53 to receive unnecessary antibiotics.Findings: During a review of Resident 53's admission Record (AR), dated 4/24/26 (print date), the AR indicated Resident 53 was admitted to the facility in April of 2026 with diagnoses which included ischemic heart disease (a condition where reduced blood flow to the heart muscle causes, or threatens to cause, tissue damage due to a lack of oxygen and nutrients) and coronary angioplasty (implants in the vessels of the heart). During a review of Resident 53's Medication Administration Record (MAR - a daily documentation record used by a licensed nurse to document medications and treatments given to a resident) for April 2026, the MAR indicated that Resident 53 was prescribed and received doxycycline (a broad-spectrum antibiotic) 100 mg (milligram, unit of mass) twice daily during 4/7/26 -4/10/26 for a total of 8 doses. During a concurrent interview and record review on 4/24/26 at 11:43 a.m. with the Infection Prevention and Control Nurse (IPCN), the facility's antibiotic stewardship program practices were reviewed, and the IPCN provided sample records of McGeer's criteria for Resident 53, completed for UTI on 4/7/26. The IPCN confirmed that the criteria for UTI were not met. The document did not contain the physician's acknowledgment of McGeer's criteria conclusions. The IPCN stated that she did not notify the physician of the McGeer's criteria outcomes. During an interview on 4/24/26 at 1:08 p.m. with the IPCN, the IPCN stated that if the physician was not notified and informed of the McGeer's criteria outcomes, the resident could be at a higher risk of receiving unnecessary antibiotics. During a review of the facility's policy and procedure (P&P) titled Antibiotic Stewardship Program, undated, the P&P indicated, . [The facility] has engaged in improving in the following action items.An antibiotic review process, also known as antibiotic time-out (ATO) for all antibiotics prescribed in the facility. ATOs prompt clinicians to reassess the ongoing need for a choice of an antibiotic when the clinical picture is clearer and more information available. ATO can be considered a stop order of an antibiotic when diagnostic test results or symptoms of resident do not support the diagnosis of infection.

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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 ensure 13 of 32 resident rooms (rooms 100/102, 101/103, 104/106, 105/107, 108/110, 112/114, 200/202, 201/203, 204/206, 205/207, 208/210, 209/211, and 212/214) accommodated no more than four residents in each room.This failure had the potential to result in inadequate space for the provision of residents' care. Findings: During a review of a facility letter, dated 4/24/26, the letter indicated thirteen rooms would accommodate five residents each, with one shared bathroom. The letter further indicated, .Every resident has a reasonable amount of privacy as well as appropriate furnishings and storage in the noted rooms .the rooms have sufficient space for nursing staff to provide care and for residents to ambulate and use assistive devices. During an observation of the facility on 4/21/26 at 8:07 a.m., there were multiple rooms contained more than four residents. Rooms 100/102, 101/103, 104/106, 105/107, 108/110, 112/114, 200/202, 201/203, 204/206, 205/207, 208/210, 209/211, and 212/214 were configured with a solid wall from floor to ceiling divided the space, with a shared bathroom and one exit door shared by five residents. Two beds were configured on one side of the wall and three beds were configured on the other side of the wall. Each bed had a privacy curtain to separate the residents. During a concurrent observation and interview on 4/24/26 at 10:42 a.m. with the Maintenance Supervisor (MS), measurements were taken of room [ROOM NUMBER]/110. The MS confirmed room [ROOM NUMBER] was configured with two beds and a shared bathroom; the measured living space per resident was 117.5 sq. ft. room [ROOM NUMBER] was configured with three beds; the measured living space per resident was 88 sq. ft. per resident. During an interview on 4/21/26 at 9:17 a.m. with Resident 86 (Res 86) in room [ROOM NUMBER], when asked if there was enough space, Res 86 stated she did not have problems with her space in her room and could move about easily. During an interview on 4/23/26 at 9:08 a.m. Resident 7 (Res 7) in room [ROOM NUMBER], Res 7 stated she maneuvered her wheelchair, got into the bathroom, or transferred in and out of bed with assistance and had no problems with her room space. During an interview on 4/23/26 at 10:08 a.m. with Licensed Nurse 5 (LN 5), LN 5 stated she provided care for rooms accommodating five residents. LN 5 stated there was sufficient space and maneuvered residents' beds and equipment. LN 5 stated space was adequate and assisted residents with wheelchairs and walkers. LN 5 stated there were no complaints from residents' families regarding the space. During an interview on 4/23/26 at 10:44 a.m. with Certified Nursing Assistant 3 (CNA 3), CNA 3 stated he was assigned to rooms accommodating five residents and he did not have issues and maneuvered residents and it was doable. The Department recommends granting a room waiver per the facility request.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure 11 of 32 resident rooms (rooms 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, and 310) met the minimum requirement of 80 square feet (sq. ft.) per resident.This failure had the potential to result in inadequate space for the provision of residents' care.Findings: During a review of a facility letter, dated 4/24/26, the letter indicated 11 rooms measured less than 80 sq. ft. per resident. The letter further indicated, Each resident will have a reasonable amount of privacy as well as appropriate furnishings and storage space .the rooms provide sufficient space for nursing staff to provide care and for residents to ambulate and use assistive devices. During an observation of room [ROOM NUMBER] on 4/23/26 at 10:32 a.m., staff assisted a resident using a walker in the room. Both the staff member and resident had adequate space to maneuver without complaints. During an interview on 4/23/26 at 10:44 a.m. with Certified Nursing Assistant 3 (CNA 3), CNA 3 stated he was assigned to rooms 300-310. CNA 3 stated he did not have issues and maneuvered residents or their equipment. CNA 3 stated he could not remember any incidents of family or residents complaining about space. During an interview on 4/23/26 at 3:45 p.m. with Licensed Nurse 5 (LN 5), LN 5 stated she oversaw staff assigned to rooms 300-310. LN 5 stated she had not received complaints from residents or family members about room space. LN 5 stated there was enough space for residents to get to the bathroom either using their walkers or wheelchairs. During a concurrent observation and interview on 4/24/26 at 10:32 a.m. with the Maintenance Supervisor (MS), measurements were taken of room [ROOM NUMBER]. The MS confirmed room [ROOM NUMBER] was configured to accommodate two beds; the measured living space per resident was 72.5 sq. ft. During an interview on 4/24/26 at 11 a.m. with Administrator (ADM), the ADM stated he had not received complaints from residents or family about space in rooms 300-310. The Department recommends granting a room waiver per the facility request.