

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

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No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055192	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/02/2026
NAME OF PROVIDER OR SUPPLIER Providence St Elizabeth Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 10425 Magnolia Blvd North Hollywood, CA 91601	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0759 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. Based on observation, interview, and record review, the facility failed to ensure its medication error rate was below five (5) percent (%) for two of five sampled residents (Residents 1 and 69) during the Medication Administration Facility Task conducted on 12/30/2025. The facility had seven (7) medication errors out of 29 observed opportunities on 12/30/2025 during the 9 a.m. routine medication pass (a structured process of administering medications to ensure residents receive medications safely, accurately, and timely), resulting in an overall medication error rate of 24.14%. The facility failed to:1. Obtain a physician's order to crush Resident 1's medications for administration via gastrostomy tube (g-tube, also known as an enteral tube - a soft tube inserted through the abdominal wall directly into the stomach, providing a way to deliver nutrition, fluids and medicine for individuals with swallowing difficulties). 2. Ensure Licensed Vocational Nurse 1 (LVN 1) flushed the g-tube with at least 15 milliliters (ml - a unit of measure for volume) of purified water between the administration of each of the following medications, as ordered by Resident 1's physician: a. Acetaminophen (a medication used as a pain reliever and fever [abnormally high body temperature] reducer)b. Methocarbamol (a medication used to treat muscle spasms [sudden, involuntary, and often painful tightening or contraction of one or more muscles] and stiffness caused by muscle or bone conditions and injuries)c. Multiple Vitamins-Minerals tablet (a dietary supplement containing essential nutrients the body needs to work properly and stay healthy).d. Potassium Chloride 10% solution (an electrolyte [essential minerals that help balance the level of fluid in the body] supplement used to treat or prevent low levels of potassium [an essential mineral and electrolyte vital for nerve signals, muscle contractions [including the heart], fluid balance, and blood pressure {BP} regulation] in the blood)e. Phenobarbital (medication that slows down the brain and central nervous system [CNS - made up of the brain and spinal cord, serves as a processing center that manages everything your body does], primarily used to control seizures [also known as epilepsy, a sudden, uncontrolled electrical disturbance in the brain which can cause uncontrolled jerking {movement}, blank stares, and loss of consciousness {a temporary state where a person becomes unaware of themselves and their surroundings})). f. Miralax (also known as polyethylene glycol 3350, a medication used to treat occasional constipation [problem with passing stool]). 3. Ensure LVN 1 administered at least eight ounces (oz. - unit for measuring weight or liquid volume) of water with Resident 1's Potassium Chloride solution as ordered by the physician. These deficient practices had the potential to cause Resident 1's g-tube to become clogged due to medication buildup or drug incompatibility (refers to the undesirable reaction between two or more medicines, or a drug and a solution, causing changes in appearance, stability, safety or effectiveness, when the solutions are combined in the same syringe, tubing, or bottle) which may alter drug effects, reduce medication effectiveness, or result in overdosing from residual medication. These failures placed Resident 1 at risk for poor medication absorption, gastrointestinal (GI- relating to the stomach and the intestines [long, tube-shaped organ in the abdomen]) complications, ineffective treatment, potential seizure activity, hospitalization, and even death.4. Ensure Licensed Vocational Nurse 2 (LVN 2) administered a medication in accordance with the physician's prescribed orders when LVN 2 failed to measure Resident 69's heart rate (HR) prior to administering Amlodipine (a medication used to treat high BP) on 12/30/2025 during the 9 (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 0759 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	LVN 1 poured 15 ml of Potassium Chloride oral solution 20 meq/15 ml into a medication cup. LVN 1 crushed one 30 mg Phenobarbital tablet and placed it into a medication cup. LVN 1 mixed the Miralax packet with approximately four to eight oz. of water in a drinking cup. LVN 1 donned (put on) a gown, mask, and gloves and placed the prepared medications on the bedside (place next to a resident's bed) table. LVN 2 identified Resident 1 using the armband and Point Click Care (PCC- an electronic healthcare record system). LVN 1 checked the g-tube placement by checking for residuals and listening for gurgling sounds using a stethoscope (a medical tool that helps healthcare providers listen to internal body sounds, like heartbeats, breathing, and gut noises, by amplifying them through earpieces connected to a chest piece, allowing for diagnosis of heart, lung, and intestinal issues) on the abdomen while flushing air into the g-tube. LVN 1 confirmed Resident 1's g-tube placement. LVN 1 flushed the g-tube with 15 ml of water. LVN 1 then took the crushed acetaminophen tablets, poured 15 ml of water in the cup, mixed the medication using the piston syringe (a medical device with a hollow barrel and a movable plunger used to inject or withdraw fluids from the body, featuring a nozzle for attaching needles or tubing, offering precise control for applications like wound irrigation, medication delivery, or lab use) tip, aspirated (pulling back on the plunger on the piston syringe to draw up medication) the medication into the syringe and administered the medication via Resident 1's g-tube. LVN 1 repeated this process for the crushed Methocarbamol tablets and the crushed Multiple Vitamins-Minerals tablet, administering each medication via the g-tube without flushing the g-tube with at least 15 ml of purified water between each medications. LVN 1 took the crushed Methocarbamol tablets, poured 15 ml of water in the cup, mixed the medication using the piston syringe tip, aspirated the medication into the syringe, and administered the medication via Resident 1's g-tube. LVN 1 took the crushed Multiple Vitamins-Minerals, poured 15 ml of water in the cup, mixed the medication using the piston syringe tip, aspirated the medication into the syringe, and administered the medication via Resident 1's g-tube. LVN 1 aspirated the 15 ml of Potassium Chloride oral solution and administered the medication via piston syringe through the g-tube, LVN 1 then added 15 ml of water to the empty medication cup to wash off remaining medication, aspirated the water mixed with the remaining solution, and administered the medication via Resident 1's g-tube. LVN 1 did not follow the physician's order to administer the Potassium Chloride with at least 8 oz. of water. LVN 1 took the crushed Phenobarbital, poured 15 ml of water in the cup, mixed the medication using the piston syringe tip, aspirated the medication into the syringe, and administered the medication via Resident 1's g-tube. LVN 1 took the Miralax solution and administered the medication via Resident 1's g-tube. Following medication administration, LVN 1 flushed Resident 1's g-tube with an additional 15 ml of water and re-connected the resident to the enteral feeding. (continued on next page)		

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F 0759 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During a review of the PC's Drug Interaction Screening (DIS) for Resident 1, undated, the DIS identified the following medications as having potential drug interactions with corresponding Drug Interaction Risk Ratings: 1. Monitor therapy - Multivitamins/Minerals and Phenobarbital (Barbiturates & CNS depressant [medications that slow brain activity causing relaxation and drowsiness] used for seizure control)* Summary: Multivitamins/Minerals may decrease serum (clear liquid part of blood where drug levels are measured to guide dosing) concentrations of Barbiturates. * Severity: Moderate * Reliability Rating Intermediate-Low* Patient Management: Monitor for decreased serum concentrations and reduced therapeutic effects of barbiturates in patients receiving concomitant (same time) multivitamins. 2. Monitor therapy - Phenobarbital and Acetaminophen* Summary: Phenobarbital may increase the metabolism (the body's way of breaking down medications into smaller, more dissolvable in water compounds that are easier to remove) of Acetaminophen. Specifically, increasing the formation of the hepatotoxic (a condition characterized by damage to the liver caused by exposure to harmful substances, such as certain medications, toxins, or chemicals) metabolite (any substance that is produced or used during your body's natural chemical processes) may be increased. * Severity Moderate * Reliability Rating Intermediate.* Patient Management: Monitor for increased hepatotoxicity if acetaminophen is combined with phenobarbital, as liver toxicity may occur at lower acetaminophen doses when used with phenobarbital. Additionally, consider monitoring for reduced acetaminophen effectiveness. 3. Monitor therapy - Phenobarbital (CNS Depressants) and Methocarbamol Summary: CNS Depressants may increase CNS depressant effects of Methocarbamol. * Severity Moderate * Reliability Rating: Intermediate-Low* Patient Management: Caution patients that concomitant use of other CNS depressants may potentiate the CNS depressant effects of methocarbamol. During a concurrent interview and record review on 12/31/2025 at 10:06 a.m., with the DON, facility Drug References (date not specified) and Resident 1's CP Report titled, Impaired neurological function related to complex central nervous system disorders and neuromuscular impairment., initiated on 12/30/2025 were reviewed. The DON stated the pharmacy representatives who conducted medication pass observations for LVN 1 were Contracted Licensed Vocational Nurse 1 (CLVN 1) and Contracted Licensed Vocational Nurse 2 (CLVN 2). The DON stated that facility staff contact the PC for medication-related questions and that the facility does not maintain a specific drug handbook or reference resource for reviewing potential drug interactions. The DON further stated there was no care plan developed and implemented on medication administration via g-tube in Resident 1's electronic health record. The DON stated the purpose of a care plan is to ensure staff understand the proper procedures for medication administration via g-tube, however, the DON stated that the physician's order to flush the g-tube between medications should have been sufficient to guide LVN 1. The DON stated she (DON) did not believe the absence of a g-tube medication administration care plan would have altered the outcome. The DON stated LVN 1's failure to flush the g-tube between medication administration could result in g-tube clogging and increase the risk for potential drug interactions. During a concurrent interview and record review on 12/31/2025 at 12:25 p.m., with CLVN 1, LVN 1's Medication Pass Observation Form, dated 8/5/2025, was reviewed. CLVN 1 stated she (CLVN 1) conducted the Medication Pass Observation for LVN 1 on 8/5/2025. CLVN 1 stated during the observation period, there were no residents with a g-tube that LVN 1 was caring for. CLVN 1 further (continued on next page)		

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Centers for Medicare & Medicaid Services

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F 0759 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	stated she (CLVN 1) discussed the P&P titled, General Guidelines for Administering Medication Via Enteral Tube, with LVN 1 however, no actual return demonstration of g-tube medication administration was observed. CLVN 1 stated she (CLVN 1) discussed the importance of flushing the g-tube in between medication administrations to promote drug absorption of t		

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that residents are free from significant medication errors. Based on observation, interview, and record review, the facility failed to: 1. Ensure one of five sampled residents (Resident 1) was free of any significant medication errors (the observed or identified preparation or administration of medications which are not in accordance with the prescriber's order, manufacturer's specifications, and accepted professional standards) when the facility failed to: A. Obtain a physician's order to crush Resident 1's medications for administration via gastrostomy tube (g-tube, also known as an enteral tube - a soft tube inserted through the abdominal wall directly into the stomach, providing a way to deliver nutrition, fluids and medicine for individuals with swallowing difficulties). B. Ensure Licensed Vocational Nurse 1 (LVN 1) flushed the g-tube with at least 15 milliliters (ml - a unit of measure for volume) of purified water between the administration of each of the following medications, as ordered by Resident 1's physician: a. Acetaminophen (a medication used as a pain reliever and fever [abnormally high body temperature] reducer)b. Methocarbamol (a medication used to treat muscle spasms [sudden, involuntary, and often painful tightening or contraction of one or more muscles] and stiffness caused by muscle or bone conditions and injuries)c. Multiple Vitamins-Minerals tablet (a dietary supplement containing essential nutrients the body needs to work properly and stay healthy).d. Potassium Chloride 10% solution (an electrolyte [essential minerals that help balance the level of fluid in the body] supplement used to treat or prevent low levels of potassium [an essential mineral and electrolyte vital for nerve signals, muscle contractions {including the heart}, fluid balance, and blood pressure {BP} regulation] in the blood)e. Phenobarbital (medication that slows down the brain and central nervous system [CNS - made up of the brain and spinal cord, serves as a processing center that manages everything your body does], primarily used to control seizures [also known as epilepsy, a sudden, uncontrolled electrical disturbance in the brain which can cause uncontrolled jerking {movement}, blank stares, and loss of consciousness {a temporary state where a person becomes unaware of themselves and their surroundings})). f. Miralax (also known as polyethylene glycol 3350, a medication used to treat occasional constipation [problem with passing stool]). C. Ensure LVN 1 administered at least eight ounces (oz. - unit for measuring weight or liquid volume) of water with Resident 1's Potassium Chloride solution as ordered by the physician. D. Ensure Resident 1 had a care plan addressing g-tube medication administration.E. Ensure the Director of Staff Development (DSD) observed LVN 1 administering medications via g-tube to ensure LVN 1 followed the standards of practice for g-tube medication administration.These deficient practices had the potential to cause Resident 1's g-tube to become clogged due to medication buildup or drug incompatibility (refers to the undesirable reaction between two or more medicines, or a drug and a solution, causing changes in appearance, stability, safety or effectiveness, when the solutions are combined in the same syringe, tubing, or bottle) which may alter drug effects, reduce medication effectiveness, or result in overdosing from residual medication. These failures placed Resident 1 at risk for poor medication absorption, gastrointestinal (GI- relating to the stomach and the intestines [long, tube-shaped organ in the abdomen]) complications, ineffective treatment, potential seizure activity, hospitalization, and even death.2. Ensure one of one sampled resident (Resident 74) investigated during Medication Administration was free of significant medication error when:A. LVN 3 failed to administer aspirin (a medication that acts primarily as a blood thinner to help prevent blood clots) as ordered by the physician.B. LVN 3 failed to follow the physician orders when omeprazole (a medication that works by reducing the amount of acid produced in your stomach) was administered after enteral feeding (giving liquid food and nutrients directly into the digestive system [stomach or small intestine] through a soft tube when someone can't eat or swallow normally, but their gut still works) was already started. These deficient practices had the potential for Resident 74 to not receive a therapeutic dose of aspirin and omeprazole. On 12/31/2025 at 3:20 p.m., while onsite at the facility, the State Survey Agency (SSA), during the facility's annual recertification survey, identified an Immediate Jeopardy (IJ - a situation in (continued on next page)		

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	which the facility's noncompliance with one or more requirements of participation has caused, or is likely to cause serious injury, harm, impairment, or death to a resident) under 42 CFR S483.45(f)(2) Resident are free of any significant medication errors. The Administrator and the Director of Nursing (DON) were notified on 12/31/2025 at 3:20 p.m. of the IJ situation due to the facility's failure to ensure Resident 1 was free of any significant medication error. On 1/2/2026 at 2:38 p.m., the ADM provided an IJ Removal Plan (a plan that identifies all actions the facility will take to immediately address the noncompliance that has resulted in the IJ situation) which included the following summarized actions: 1. On 12/30/2025 at 2:20 p.m., upon notification of the IJ, the facility's pharmacist a person who is professionally qualified to prepare and dispense medicinal drugs and advise on their use) conducted a medication regimen review (a thorough, ongoing evaluation of all medications a resident takes) for Resident 1 and recommended obtaining a phenobarbital level (a test that measures the concentration of phenobarbital in the bloodstream). 2. On 12/30/2025 at 4 p.m., the DON initiated a change of condition (COC - major decline or improvement in a resident's status that will not resolve without intervention) monitoring and care plan for Resident 1.3. On 12/30/2025 at 4 p.m., the ADM had a one-on-one (refers to individualized, one-on-one education provided to a single individual by a staff member or professional) discussion with LVN 1 to address identified root-cause issues, including lack of proficiency despite prior training and inability to recall medication administration procedures. 4. On 12/30/2025 at 4:50 p.m., Resident 1's was assessed by Resident 1's attending physician. 5. On 12/30/2025 at 5:30 p.m., Licensed Vocational Nurse 4 (LVN 4) administered Resident 1's medication in place of LVN 1.6. On 12/30/2025 at 7 p.m., all available licensed nurses, including LVN 1, received in-service (refers to on the job training and education for staff to update their skills, learn new procedures, meet regulatory requirements and stay current with best practices for resident care) training from the DON on medication administration via g-tube. 7. On 12/31/2025 at 7 p.m., the facility's pharmacy nurse consultant provided LVN 1 with one-on-one in-service education, including skills verification and competency assessment related to medication administration in accordance with the facility's policy and procedure (P&P) titled, Policy and Procedure: General Guidelines for Administering Medications Via Enteral Tube.8. On 12/31/2025, between 6 p.m. to 9 p.m., all available licensed nurses received in-service education and completed one-on-one medication administration skills competency validation through return demonstration, discussion, and question-and-answer with the pharmacy nurse consultant.9. Beginning 12/31/2025, LVN 1 and any licensed nurse observed to lack medication administration proficiency will be removed from medication administration duties until competency is demonstrated by successfully administering medications to at least five residents or a minimum of 25 medications with a medication error rate of no greater than five percent (5%), as observed by the DON.10. Any licensed nurses who were unavailable on 12/31/2025 will receive in-service education and skills competency validation from the DON, Pharmacy Consultant (PC), or designee regarding the P&P titled, General Guidelines for Administering Medications Via Enteral Tube and Administration Procedures For All Medications prior to working their next scheduled shift. All licensed nurses will complete in-service and skill check by 1/6/2026.11. Beginning on 12/31/2025, medication administration skills checks and competency assessments for all licensed nurses will be conducted monthly for three months by the pharmacy nurse consultant. All shifts, including nights, weekends, and holidays, will be included.12. On 1/1/2026, Resident 1's preliminary laboratory results (outcome of test indicating a resident's health status) were communicated to Resident 1's physician, who ordered phenobarbital 40 milligrams (mg - a unit of measure for weight) twice a day via g-tube, iron (a medication used to treat and prevent low blood levels of iron, a vital mineral essential crucial for bodily functions like growth and energy) 300 mg via g-tube daily, phenobarbital level in one week, and a complete blood count (CBC - a blood test that measures and evaluates red blood cells [which carry oxygen], white blood cells [which fight infection], and platelets [which help blood to clot {prevent excessive bleeding when injured}] and iron level (refers to the amount of iron in the blood) in six weeks.13. On 1/1/2026, LVN 1 was placed (continued on next page)		

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	on a Performance Improvement Plan and will not administer medications until medication proficiency is demonstrated, as determined by the DON.14. The Administrator will be reporting the results of the pharmacy consultant skills check and competency as well as the medication pass observation audits to the Quality Assurance (QA) committee for review and further recommendations as needed to ensure substantial compliance. Substantial compliance will be demonstrated by three consecutive monthly QA meetings with medication error rates of less than 5%. If substantial compliance is not achieved after three months, further actions will be initiated by the QA committee, and all nurses will continue to receive skills check competency and medication pass observation audits monthly for medication administration by the pharmacy consultant nurse and DON until such time facility is in substantial compliance. On 1/2/2026 at 4:30 p.m., while onsite at the facility, the SSA verified and confirmed the facility's full implementation of the IJ Removal Plan through observations, interviews, and record reviews, and determined the IJ situation regarding the facility's failure to ensure Resident 1 was free of any significant medication error was no longer present. The SSA removed the IJ situation, while onsite, on 1/2/2026 at 4:30 p.m. in the presence of the ADM and DON. Cross-reference F759. Findings: 1. During a review of Resident 1's admission Record (AR), the AR indicated the facility admitted the resident on 12/2/2025, with diagnoses including epilepsy, hemiplegia (total paralysis [loss of ability to move] of the arm, leg, and trunk on the same side of the body) and hemiparesis (a medical condition that causes weakness on one side of the body) following cerebral infarction (occurs as a result of disrupted blood flow to the brain due to problems with the blood vessels [tubular structure carrying blood through the tissues and organs] that supply it). During a review of Resident 1's History and Physical (H&P &ndash; a comprehensive assessment of a resident's medical condition), dated 12/5/2025, the H&P indicated Resident 1 does not have the capacity to understand and make decisions. During a review of Resident 1's Minimum Data Set (MDS- a resident assessment tool), dated 12/8/2025, the MDS indicated the resident rarely to never demonstrated the ability to make self-understood and understand others and had severely impaired cognitive skills (a significant decline in thinking, memory, and reasoning that makes it impossible for a person to live independently or perform daily tasks). The MDS further indicated the resident required a feeding tube and was prescribed a high-risk anticonvulsant medication (a type of drug that is used to prevent or treat seizures or convulsions by controlling abnormal electrical activity in the brain). During a review of Resident 1's Order Summary Report (OSR &ndash; a document that provides a consolidated, current list of all medications prescribed for a resident) for December 2025, the OSR indicated the following Physician Orders: a. Dated 12/11/2025. Acetaminophen oral tablet 325 mg. Give two tablets via g-tube three times a day for pain management not to exceed (NTE) three grams (gm- a unit of mass [weight]) of Acetaminophen from all sources within a 24-hour period. b. Dated 12/3/2025. Methocarbamol oral tablet 750 mg. Give two tablets via g-tube three times a day for muscle spasms. c. Dated 12/2/2025. Multiple Vitamins-Minerals tablet. Give one tablet via g-tube one time a day for supplement. d. Dated 12/3/2025. Potassium chloride 10% oral solution, 20 milliequivalent (meq - a unit of measurement) per 15 ml. Give 15 ml via g-tube one time a day for potassium supplement, give with at (continued on next page)		

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	least 8 oz. of water. e. Dated 12/2/2025. Phenobarbital oral tablet 30 mg. Give one tablet via g-tube two times a day for seizure. f. Dated 12/2/2025. Polyethylene Glycol 200 Liquid (Polyethylene Glycol 200) [sic &ndash; entry appears erroneous]. (Polyethylene Glycol 200 was possibly entered in error, as Polyethylene Glycol 3350 {Miralax} was observed during Medication Administration Facility Task on 12/30/2025). Give 17 gm via g-tube one time a day every Mon, Tue, Thu, and Fri for bowel management. Mix with four to eight oz. of water (prior to administration) and give via g-tube; Hold if with loose bowel movement (BM). g. Dated 12/2/2025. Enteral feeding order: Flush the feeding tube every shift with at least 15 ml of purified water between each medication. Flush one final time with at least 15 ml purified water after all medications are administered. The OSR for December 2025 reviewed on 12/30/2025 did not indicate a physician order for medications to be crushed before administration via g-tube. During a review of Resident 1's Care Plan (CP) Report titled, Impaired neurological function related to complex central nervous system disorders and neuromuscular (relating to nerves and muscles) impairment., initiated on 12/30/2025, the CP indicated an intervention to administer phenobarbital and methocarbamol as ordered and to monitor the resident's (Resident 1) therapeutic response and observe for adverse effects (an undesired effect of a drug or other type of treatment). During an observation on 12/30/2025 at 8:31 a.m., with LVN 1, during the Medication Administration Facility Task, observed LVN 1 in front of Resident 1's room preparing for the morning (9 a.m.) medication pass. LVN 1 removed the following medications from the medication cart: 1. Acetaminophen 325 mg oral tablets.2. Methocarbamol 750 mg oral tablets. 3. Multiple Vitamins-Minerals one tablet. 4. Potassium Chloride oral solution 20 meq/15 ml (10%).5. Phenobarbital 30 mg oral tablet6. Miralax 17 gm packet. LVN 1 crushed two 325 mg Acetaminophen tablets and placed them into a medication cup. LVN 1 crushed two 750 mg Methocarbamol tablets and placed them into a medication cup. LVN 1 crushed one Multiple Vitamins-Minerals tablet and placed it into a medication cup. LVN 1 poured 15 ml of Potassium Chloride oral solution 20 meq/15 ml into a medication cup. LVN 1 crushed one 30 mg Phenobarbital tablet and placed it into a medication cup. LVN 1 mixed the Miralax packet with approximately four to eight oz. of water in a drinking cup. LVN 1 donned (put on) a gown, mask, and gloves and placed the prepared medications on the bedside (place next to a resident's bed) table. LVN 2 identified Resident 1 using the armband and Point Click Care (PCC- an electronic healthcare record system). (continued on next page)		

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	LVN 1 checked the g-tube placement by checking for residuals and listening for gurgling sounds using a stethoscope (a medical tool that helps healthcare providers listen to internal body sounds, like heartbeats, breathing, and gut noises, by amplifying them through earpieces connected to a chest piece, allowing for diagnosis of heart, lung, and intestinal issues) on the abdomen while flushing air into the g-tube. LVN 1 confirmed Resident 1's g-tube placement. LVN 1 flushed the g-tube with 15 ml of water. LVN 1 then took the crushed acetaminophen tablets, poured 15 ml of water in the cup, mixed the medication using the piston syringe (a medical device with a hollow barrel and a movable plunger used to inject or withdraw fluids from the body, featuring a nozzle for attaching needles or tubing, offering precise control for applications like wound irrigation, medication delivery, or lab use) tip, aspirated (pulling back on the plunger on the piston syringe to draw up medication) the medication into the syringe and administered the medication via Resident 1's g-tube. LVN 1 repeated this process for the crushed Methocarbamol tablets and the crushed Multiple Vitamins-Minerals tablet, administering each medication via the g-tube without flushing the g-tube with at least 15 ml of purified water between each medications. LVN 1 took the crushed Methocarbamol tablets, poured 15 ml of water in the cup, mixed the medication using the piston syringe tip, aspirated the medication into the syringe, and administered the medication via Resident 1's g-tube. LVN 1 took the crushed Multiple Vitamins-Minerals, poured 15 ml of water in the cup, mixed the medication using the piston syringe tip, aspirated the medication into the syringe, and administered the medication via Resident 1's g-tube. LVN 1 aspirated the 15 ml of Potassium Chloride oral solution and administered the medication via piston syringe through the g-tube, LVN 1 then added 15 ml of water to the empty medication cup to wash off remaining medication, aspirated the water mixed with the remaining solution, and administered the medication via Resident 1's g-tube. LVN 1 did not follow the physician's order to administer the Potassium Chloride with at least 8 oz. of water. LVN 1 took the crushed Phenobarbital, poured 15 ml of water in the cup, mixed the medication using the piston syringe tip, aspirated the medication into the syringe, and administered the medication via Resident 1's g-tube. LVN 1 took the Miralax solution and administered the medication via Resident 1's g-tube. Following medication administration, LVN 1 flushed Resident 1's g-tube with an additional 15 ml of water and re-connected the resident to the enteral feeding. LVN 1 removed her (LVN 1) gown and gloves, washed her hands, and documented the medication administration. During a concurrent interview and record review on 12/30/2025 at 9:15 a.m., with LVN 1, in front of Resident 1's room, Resident 1's OSR for December 2025 and Medication Administration Record (MAR- a document tracking every medication given to a resident, detailing the drug, dose, time, route) for 12/30/2025 were reviewed. LVN 1 stated she (LVN 1) had been working in the facility since July 2025 and could not recall being observed or evaluated for medication administration via g-tube. LVN 1 stated that when she (LVN 1) administers medication via g-tube, each medication should be prepared in a separate medication cup and should not be mixed with other medications. LVN 1 further stated (continued on next page)		

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	that g-tube medications should be administered one at a time and that the tubing should be flushed with 15 to 30 ml of water, depending on the physician's order. LVN 1 stated that prior to medication administration, she (LVN 1) checks g-tube placement by instilling air into the tubing and listening for gurgling sounds. LVN 1 stated that if a medication is in powdered or crushed form, she (LVN 1) reconstitutes (to add liquid to a dry or powdered medication to make a solution) it by adding 15 ml of water to dissolve the medication for g-tube administration. LVN 1 stated she was supposed to pour the medication one at a time slowly through the barrel of the piston syringe by gravity for medication administration via g-tube, however, with Resident 1 she (LVN 1) decided to push the medication using the piston syringe because on a prior occasion, when she (LVN 1) was administering medications by gravity, the resident coughed and the medication spilled. LVN 1 stated each medication administration should be followed by flushing the g-tube with 10 to 15 ml of water in between. LVN 1 stated she (LVN 1) failed to flush the g-tube with 10 to 15 ml of water between medication administrations for Resident 1 and stated she forgot to perform the flushes. LVN 1 further stated that failure to flush the g-tube in between medication administration could result in clogging of the g-tube and might cause chemical and or drug interactions to Resident 1. LVN 1 stated there was a physician order within the enteral feeding orders to flush Resident 1's feeding tube with at least 15 ml of purified water between each medication. LVN 1 also stated there was a physician to give the 15 ml Potassium Chloride oral solution with at least eight oz. of water. LVN 1 stated she (LVN 1) did not administer the additional eight oz. of water when she gave the Potassium Chloride solution via g-tube. LVN 1 stated her (LVN 1) failure could result in gastric irritation for the resident. LVN 1 stated she (LVN 1) considered not flushing in between medication administration and not giving 8 oz of water with Potassium Chloride as ordered by Resident 1's physician, to be medication errors. During an interview on 12/30/2025 at 12:13 p.m., with the PC, the PC stated that when administering medications via g-tube, the licensed staff should flush the tubing between medications to ensure each medication fully passes through the tubing. The PC further stated that failure to flush the g-tube with water between medication administrations may result in potential medication interactions and potential clogging of the g-tube. The PC stated LVN 1 should have followed the physician's order to administer Potassium Chloride solution with at least eight oz. of water to prevent gastric irritation. The PC stated not following the physician's order to administer potassium chloride solution with the required amount (at least eight oz.) of water via g-tube and not flushing the g-tube with 15 ml of water in between medications constituted medication errors. During a concurrent interview and record review on 12/30/2025 at 1:07 p.m., with the DSD, LVN 1's Employee File was reviewed. The DSD stated there was no medication pass skills check list in LVN 1's file specifically for g-tube medication administration. The DSD stated he (DSD) observes licensed staff during medication passes via g-tube; however, he (DSD) has not observed LVN 1 performing g-tube medication administration at all. The DSD further stated that when he (LVN 1) observes licensed staff, he (LVN 1) does not complete any formal competency checklist. The DSD stated that during in-services, he instructs licensed staff that medications administered via g-tube should be flushed between each medication and should be given by gravity. The DSD stated the purpose of flushing the g-tube is to ensure that the medication is fully delivered and to prevent g-tube clogging. The DSD stated that not flushing the g-tube in between medication administration has the potential to result in chemical interactions between medications, which could harm the resident. The DSD also stated LVN 1 did not follow the physician's order to administer at least eight oz. of water with the Potassium Chloride solution for Resident 1, which could result in gastric irritation. The DSD stated that while new employees shadow experienced staff to ensure they are ready to care for residents in the facility, there is no formal nursing competency checklist for special procedures such as g-tube medication administration. The DSD further stated there should be a physician's order to crush (continued on next page)		

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	medications for g-tube administration. The DSD stated there was no order on Resident 1's OSR indicating to crush medications for g-tube administration. The DSD stated it was important to obtain an order to crush medications for g-tube administration for the provider to be aware that certain medications needed to be converted to another form prior to administration. The DSD stated failure to follow the physician's order to flush the g-tube with at least 15 ml of water between medications, and failure to administer Potassium Chloride solution with at least eight oz. of water via the g-tube, constitutes a medication error. During a concurrent interview and record review on 12/30/2025 at 2:14 p.m., with the DON, Resident 1's OSR for December 2025, MAR for 12/30/2025, and CP Report titled, Impaired neurological function related to complex central nervous system disorders and neuromuscular impairment., initiated on 12/30/2025 were reviewed. The DON stated medications administered via g-tube should be flushed with 10 to 15 ml of water in between each medication to prevent g-tube clogging and potential medication interactions that could be harmful to residents. The DON stated LVN 1 failed to flush Resident 1's g-tube between medication administrations placing Resident 1 at risk for g-tube clogging and potential medication interactions. The DON further stated Potassium Chloride solution, Methocarbamol, and Phenobarbital are significant medications associated with serious potential adverse reactions (any unwanted, unpleasant, or harmful effect that happens while you are using a medicine or having another medical treatment). The DON stated LVN 1 did not administer at least eight oz. of water with Potassium Chloride solution for Resident 1, placing Resident 1 at risk for gastric distress (uncomfortable digestive issues such as bloating, abdominal pain, cramping often signaling an upset stomach). The DON stated not following the physician's order to flush the g-tube with 15 ml of water in between medication administration and not giving at least eight oz. of water with potassium chloride solution are considered medication errors that could potentially lead to hospitalization. The DON stated Resident 1's OSR did not indicate an order to crush Resident 1's medications for administration via gastrostomy tube. The DON stated that obtaining a physician's order to crush medications is essential to ensure provider awareness that certain medications require conversion to an alternative form prior to administration. During a concurrent interview and record review on 12/30/2025 at 3:10 p.m. with LVN 1, LVN 1's Medication Pass Observation Form, dated 8/5/2025 and 12/17/2025, were reviewed. LVN 1 stated she (LVN 1) barely remembers being observed during medication passes. LVN 1 authenticated her signature on 8/5/2025, however the medication pass observation dated 12/17/2025 did not include a signature line, and LVN 1 stated she (LVN 1) does not recall being observed on that date. During an interview on 12/30/2025 at 4:42 p.m., with the Medical Director (MD), the MD stated LVN 1's clinical practice was deficient, with the potential to clog Resident 1's tubing and cause possible medication interactions. The MD further stated that his (MD) order for Potassium Chloride solution should have been followed and administered with at least eight oz. to prevent gastric irritation. During a review of the PC's Drug Interaction Screening (DIS) for Resident 1, undated, the DIS identified the following medications as having potential drug interactions with corresponding Drug Interaction Risk Ratings: 1. Monitor therapy - Multivitamins/Minerals and Phenobarbital (Barbiturates & CNS depressant [medications that slow brain activity causing relaxation and drowsiness] used for seizure control)* Summary: Multivitamins/Minerals may decrease serum (clear liquid part of blood where drug levels are measured to guide dosing) concentrations of Barbiturates. * Severity: Moderate * Reliability Rating Intermediate-Low* Patient Management: Monitor for decreased serum concentrations and (continued on next page)		

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	reduced therapeutic effects of barbiturates in patients receiving concomitant (same time) multivitamins. 2. Monitor therapy - Phenobarbital and Acetaminophen* Summary: Phenobarbital may increase the metabolism (the body's way of breaking down medications into smaller, more dissolvable in water compounds that are easier to remove) of Acetaminophen. Specifically, increasing the formation of the hepatotoxic (a condition characterized by damage to the liver caused by exposure to harmful substances, such as certain medications, toxins, or chemicals) metabolite (any substance that is produced or used during your body's natural chemical processes) may be increased. * Severity Moderate * Reliability Rating Intermediate.* Patient Management: Monitor for increased hepatotoxicity if acetaminophen is combined with phenobarbital, as liver toxicity may occur at lower acetaminophen doses when used with phenobarbital. Additionally, consider monitoring for reduced acetaminophen effectiveness. 3. Monitor therapy - Phenobarbital (CNS Depressants) and MethocarbamolSummary: CNS Depressants may increase CNS depressant effects of Methocarbamol. * Severity Moderate * Reliability Rating: Intermediate-Low* Patient Management: Caution patients that concomitant use of other CNS depressants may potentiate the CNS depressant effects of methocarbamol. During a concurrent interview and record review on 12/31/2025 at 10:06 a.m., with the DON, facility Drug References (date not specified) and Resident 1's CP Report titled, Impaired neurological function related to complex central nervous system disorders and neuromuscular impairment., initiated on 12/30/2025 were reviewed. The DON stated the pharmacy representatives who conducted medication pass observations for LVN 1 were Contracted Licensed Vocational Nurse 1 (CLVN 1) and Contracted Licensed Vocational Nurse 2 (CLVN 2). The DON stated that facility staff contact the PC for medication-related questions and that the facility does not maintain a specific drug handbook or reference resource for reviewing potential drug interactions. The DON further stated there was no care plan developed and implemented on medication administration via g-tube in Resident 1's electronic health record. The DON stated the purpose of a care plan is to ensure staff understand the proper procedures for medication administration via g-tube, however, the DON stated that the physician's order to flush the g-tube between medications should have been sufficient to guide LVN 1. The DON stated she (DON) did not believe the absence of a g-tube medication administration care plan would have altered the outcome. The DON stated LVN 1's failure to flush the g-tube between medication administration could result in g-tube clogging and increase the risk for potential drug interactions. During a concurrent interview and record review on 12/31/2025 at 12:25 p.m., with CLVN 1, LVN 1's Medication Pass Observation Form, dated 8/5/2025, was reviewed. CLVN 1 stated she (CLVN 1) conducted the Medication Pass Observation for LVN 1 on 8/5/2025. CLVN 1 stated during the observation period, there were no residents with a g-tube that LVN 1 was caring for. CLVN 1 further stated she (CLVN 1) discussed the P&P titled, General Guidelines for Administering Medication Via Enteral Tube, with LVN 1 however, no actual return demonstration of g-tube medication administration was observed. CLVN 1 stated she (CLVN 1) discussed the importance of flushing the g-tube in between medication administrations to promote drug absorption of the medication, to prevent clogging the g-tube, and reduce the risk of medication interaction with LVN 1. During a concurrent interview and record review on 12/31/2025 at 1:43 p.m. with CLVN 2, LVN 1's Medication Pass Observation Form, dated 12/17/2025 was reviewed. CLVN 2 stated she (CLVN 2) conducted the Med		

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility's licensed nursing staff failed to provide care in accordance with professional standards for two of two sampled residents (Residents 1 and 33) reviewed for subcutaneous (sq - under the skin) anticoagulant (medicine that slows down the blood's clotting process, preventing dangerous clots from forming in the heart or blood vessels) use and for one of one sampled resident (Resident 12) reviewed for insulin (a hormone that removes excess sugar from the blood, can be produced by the body or given artificially via medication) use by failing to rotate (a method to ensure repeated injections are not administered in the same area) sq heparin (a type of anticoagulant), enoxaparin (a type pf anticoagulant), and insulin. These deficient practices had the potential for adverse effects (unwanted, unintended result) of the same site subcutaneous administration of anticoagulants and insulin such as excessive bruising and bleeding, lipodystrophy (abnormal distribution of fat) and cutaneous amyloidosis (is a condition in which clumps of abnormal proteins called amyloids build up in the skin). Cross-reference F760. Findings: 1. During a review of Resident 1's admission Record (AR), the AR indicated the facility admitted the resident on 12/2/2025, with diagnoses including hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) and hemiparesis (weakness or the inability to move on one side of the body, making it hard to perform everyday activities like eating or dressing) following cerebral infarction (occurs as a result of disrupted blood flow to the brain due to problems with the blood vessels that supply it), quadriplegia (paralysis from the neck down, including legs, and arms, usually due to a spinal cord injury), and disorders of circulatory system (problems with the heart, blood vessels, or blood that stop oxygen and nutrients from getting to the body effectively). During a review of Resident 1's History and Physical (H&P), dated 12/5/2025, the H&P indicated the resident does not have the capacity to understand and make decisions. During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool), dated 12/8/2025, the MDS indicated the resident rarely to never had the ability to make self-understood and understand others and had severely impaired cognition (a person has significant problems with their mental abilities—such as thinking, remembering, and making decisions—to the extent that they can no longer live independently and require substantial help with everyday activities). The MDS indicated the resident was dependent to needing maximal assistance on mobility and activities of daily living (ADLs - activities such as bathing, dressing and toileting a person performs daily) and was on a high-risk drug class anticoagulant. During a review of Resident 1's Order Summary Report (OSR), dated 12/2/2025, the OSR indicated an order for Heparin Sodium (Porcine) Injection Solution 5000 units per milliliters (unit/ml, refers to the "concentration" or the "strength" of the medication) (Heparin Sodium (Porcine)). Inject 1 milliliter (ml - a unit of volume) subcutaneously every 12 hours for cerebrovascular accident (CVA - stroke, loss of blood flow to a part of the brain) prophylaxis (taking steps to prevent a disease or problem before it happens). Rotate injection sites. During a review of Resident 1's Location of Administration Report (LAR) of Heparin for 12/2025, the LAR indicated Heparin Sodium (Porcine) Injection Solution 500 unit/ml was administered on: 12/10/2025 at 9:26 a.m. on the Abdomen- Right Lower Quadrant (RLQ) 12/10/2025 at 8:22 p.m. on the Abdomen- RLQ (continued on next page)		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	12/15/2025 at 9:46 a.m. on the Abdomen- Left Upper Quadrant (LUQ) 12/16/2025 at 9 a.m. on the Abdomen- LUQ During a review of Resident 1's Care Plan (CP) Report titled, Anticoagulant therapy: Heparin Sodium (Porcine) Injection Solution for CVA prophylaxis, last revised on 12/28/2025, the CP indicated a goal of the resident will be free from discomfort or adverse reactions related to anticoagulant use through the review date and an intervention to administer medication per physician orders. During a concurrent interview and record review on 12/30/2025 at 3:38 p.m. with the Assistant Director of Nursing (ADON), Resident 1's Medical Diagnosis, OSR, LAR, and CP were reviewed. The ADON stated there was a physician's order for Heparin Sodium (Porcine) Injection Solution 5000 unit/ml (Heparin Sodium (Porcine)). Inject 1 ml subcutaneously every 12 hours for CVA prophylaxis. Rotate injection sites. The ADON stated the LAR indicated there were multiple instances where the licensed nurses did not rotate the Heparin administration sites to Resident 1. The ADON stated not following the physician's order to rotate insulin administration sites predisposes Resident 1 to severe bruising and bleeding at the frequented sites of administration. The ADON stated there was a care plan for anticoagulation therapy indicating a goal of the resident will be free from discomfort or adverse reactions related to anticoagulant use and an intervention to administer medication per physician's order was not followed. The ADON stated not following the physician's order and not rotating administration sites of Heparin as a professional nurse is considered a medication error. During a review of the facility's recent policy and procedure (P&P) titled, Injectable Medication Administration, last reviewed on 12/28/2025, the P&P indicated to administer medication via subcutaneous, intradermal and intramuscular routes in a safe, accurate, and effective manner. During a review of the facility-provided Highlights of Prescribing Information (HPI) on the use of Heparin Sodium Injection, for intravenous or subcutaneous use, with initial U.S. approval on 1939, the HPI indicated a different site should be used for each injection to prevent the development of massive hematoma. 2. During a review of Resident 33's AR, the AR indicated the facility admitted the resident on 12/3/2025, with diagnoses including closed fracture (a broken bone where the skin stays intact), difficulty walking and pulmonary fibrosis (scarred and thickened tissue around and between the air sacs called alveoli in the lungs). During a review of Resident 33's H&P, dated 12/4/2025, the H&P indicated the resident had the capacity to understand and make decisions. During a review of Resident 33's MDS, dated [DATE], the MDS indicated the resident had the ability to make self-understood and understand others and had an intact cognition (having a clear, sharp, and sound mind). The MDS indicated the resident was on a high-risk drug class anticoagulant medication. During a review of Resident 33's OSR, dated 12/3/2025, the OSR indicated an order for Enoxaparin Sodium Injection Solution Prefilled Syringe 40 mg/0.4 ml (Enoxaparin Sodium). Inject 40 mg subcutaneously one time a day for DVT PPX for 30 Days. Rotate injection sites. During a review of Resident 33's Location of Administration Report (LAR) of Enoxaparin Sodium for 12/2025, the LAR indicated Enoxaparin Sodium Injection Solution Prefilled Syringe 40 mg/0.4 ml was (continued on next page)		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	administered on: 12/20/2025 at 8:12 a.m. on the Abdomen-LUQ 12/21/2025 at 10:53 a.m. on the Abdomen- LUQ 12/23/2025 at 9:02 a.m. on the Abdomen- Left Lower Quadrant (LLQ) 12/24/2025 at 9:33 a.m. on the Abdomen- LLQ 12/27/2025 at 9:07 a.m. on the Abdomen- LLQ 12/28/2025 at 9:38 a.m. on the Abdomen- LLQ During a review of Resident 33's CP Report titled, Anticoagulant therapy: Enoxaparin Sodium Injection Solution Prefilled Syringe 40 mg/ 0.4 ml (Enoxaparin Sodium) for DVT PPX, initiated on 12/8/2025, the CP indicated a goal of the resident will be free from discomfort or adverse reactions related to anticoagulant use through the review date and an intervention to administer medication per physician orders. During a concurrent interview and record review on 12/30/2025 at 3:55 p.m. with the ADON, Resident 33's Medical Diagnosis, OSR, LAR, and CP were reviewed. The ADON stated there was a physician's order for Enoxaparin Sodium Injection Solution Prefilled Syringe 40 mg/0.4 ml (Enoxaparin Sodium). Inject 40 mg subcutaneously one time a day for DVT PPX for 30 Days. Rotate injection sites. The ADON stated the LAR indicated there were multiple instances where the licensed nurses did not rotate the Enoxaparin Sodium administration sites to Resident 33. The ADON stated not following the physician's order to rotate Enoxaparin Sodium administration sites predisposes Resident 33 to severe bruising and bleeding at the frequented sites of administration. The ADON stated there was a care plan for anticoagulation therapy indicating a goal of the resident will be free from discomfort or adverse reactions related to anticoagulant use and an intervention to administer medication per physician's order was not followed. The ADON stated not following the physician's order and not rotating administration sites of Heparin as a professional nurse is considered a medication error. During a review of the facility's recent P&P titled, Injectable Medication Administration, last reviewed on 12/28/2025, the P&P indicated to administer medication via subcutaneous, intradermal and intramuscular routes in a safe, accurate, and effective manner. During a review of facility-provided HPI on the use of Enoxaparin sodium injection. USP for subcutaneous use, with initial U.S. approval on 1993, the HPI indicated to alternate injection sites between the left and right anterolateral and left and right posterolateral abdominal wall. 3. During a review of Resident 12's AR, the AR indicated the facility admitted Resident 12 on 12/15/2025 with diagnoses including type two diabetes mellitus (DM 2 - a disorder characterized by difficulty in blood sugar control and poor wound healing), generalized muscle weakness, and difficulty walking. During a review of Resident 12's H&P, dated 12/16/2025, the H&P indicated Resident 12 did not have the capacity to understand and make decisions. During a review of Resident 12's MDS, dated [DATE], the MDS indicated Resident 12 had severely impaired cognition and was sometimes able to understand and make her needs known. The MDS further indicated Resident 12 required substantial or maximal assistance to total assistance from staff with all ADLs. The MDS indicated Resident 12 had (continued on next page)		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	a diagnosis of DM 2 and received insulin. During a review of Resident 12's CP titled, Diabetes, initiated on 12/28/2025, the CP indicated to administer Humalog kwikpen as ordered and monitor response and adverse symptoms as one of the interventions to maintain stable glycemic control to support healing and functional participation. During a review of Resident 12's OSR, dated 12/31/2025, the OSR indicated a physician's order dated 12/15/2025: - Humalog (a fast-acting insulin) kwikpen 100 unit per milliliter (unit/ml &ndash; a unit of measurement) solution pen injector. Inject as per sliding scale (the amount of insulin to be administered changes or slides up or down based on the person's blood sugar): if blood sugar (BS) is 70-15- = 0 unit, if BS is less than (< - a unit of measurement) 70 give orange juice (OJ) if awake and able to swallow then notify the physician (MD); 151-200 = two(2) units; 201- 250 = four (4) units; 251-300 = six (6) units; 301-350 = eight (8) units; 351-400 = ten (10) units; above 400 = 12 units then notify the MD, subcutaneously before meals and at bedtime for DM 2. Rotate injection sites. During a concurrent interview and record review on 12/31/2025 at 10:05 a.m. with the ADON, Resident 12's physician's orders, care plan, and location of administration sites for Humalog kwikpen for 12/2025 were reviewed. The ADON stated that Resident 12 had a physician's order for Humalog kwikpen per sliding scale as were administered as follows: - 12/16/2025 6:24 a.m. &ndash; left arm - 12/16/2025 11:30 a.m. - left arm - 12/22/2025 12:25 p.m. &ndash; RLQ - 12/22/2025 5:04 p.m. &ndash; RLQ - 12/23/2025 12:27 p.m. &ndash; RLQ - 12/24/2025 2:43 p.m. &ndash; RLQ - 12/24/2025 10:03 p.m. &ndash; RLQ - 12/25/2025 5:36 a.m. &ndash; RLQ The ADON stated that the administration sites for insulin should be rotated per standards of practice, manufacturer's guidelines, and per physician's order to prevent hardening or lumps in the skin. The ADON stated the location of administration sites for Resident 12's Humalog were not rotated. The ADON stated there was a physician's order to rotate administration sites and was not followed. The ADON stated Resident 12's administration sites should have been rotated to prevent pain, redness, irritation, and lumps on the resident's skin which can affect the absorption of the insulin. The ADON stated that not rotating Resident 12's insulin administration sites can be considered a medication error by not following physician's orders, manufacturer's guidelines, and professional standards of care. During a concurrent interview and record review on 12/31/2025 at 1:45 p.m. with the Director of Nursing (DON), Resident 12's physician's order, Humalog administration sites, Humalog manufacturer's specifications, and P&P on Medication errors and Adverse Actions were reviewed. The DON stated the licensed nurses are supposed to rotate insulin administration sites according to the physician's order, manufacturer's specifications, and accepted professional standards of practice per facility P&P. The DON stated Resident 12 had a physician's order for Humalog and the physician's order also indicated to rotate the injection sites. The DON stated Resident 12's Humalog injection sites were not rotated. The DON stated the manufacturer's specification for Humalog listed injection site reactions, and lipodystrophy as a few of the adverse reactions and injection sites should be rotated within the same region from one injection to the next to reduce the risk of lipodystrophy. The DON stated facility P&P and manufacturer's specifications were not followed and not rotating the injection sites placed Resident 21 at risk for injection site reactions and formation of lipodystrophy. During a review of the facility's P&P titled, Medication errors and Adverse Actions, last reviewed on 12/18/2025, the P&P indicated that: - Medication errors and adverse drug reactions must be reported to the resident's attending physician. - Medication Error means the observed or identified preparation of administration of medications or biologicals which is not in accordance with: a. The prescriber's order; b. Manufacturer's specifications regarding the preparation and administration of the medication or biological; c. Accepted professional standards and principles which apply to professionals providing services. Accepted professional standards and principles include the various practice regulations in each State, and current commonly accepted health standards established by national organizations, (continued on next page)		

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

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	boards, and councils. - Significant medication error means one which causes the resident discomfort or jeopardizes his or her health and safety. Significance may be subjective depending on the individual situations and duration. During a review of the facility provided manufacturer's specifications on Humalog dated 3/2013, the manufacturer's specifications indicated that adverse reactions associated with Humalog include hypoglycemia (low blood sugar), injection site reactions, lipodystrophy, pruritus (itching), and rash. The manufacturer's specification further indicated that Humalog administered by subcutaneous injection should be given in the abdominal wall, thigh, upper arm, or buttocks. Injection sites should be rotated within the same region (abdomen, thigh, upper arm, or buttocks) from one injection to the next to reduce the risk of lipodystrophy.		

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide pain management consistent with professional standards of practice and the residents' goals and preferences for two of two sampled residents (Resident 44 and 21) reviewed under the Pain Management care area by failing to: 1. Ensure the Licensed Nurse (LN) administered as needed (PRN) hydrocodone - acetaminophen (an opioid [also called a narcotic - powerful pain-reducing medication) per the physician's order and based on the assessed numeric pain rating scale (a standard pain scale with zero being no pain and ten [10] as the worst pain one can imagine) for Resident 44. 2. Ensure the LNs followed the physician's order to administer the pain medication according to the resident's pain level for Resident 21. These deficient practices had the potential to result in side effects from unnecessary administration of narcotics including constipation and mismanagement of resident pain resulting in limited resident participation in activities of daily living (ADLs-activities such as bathing, dressing and toileting a person performs daily), general activities, and mobility. Findings: a. During a review of Resident 44's admission Record (AR), the AR indicated the facility admitted the resident on 11/14/2025 with diagnoses that included hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) and hemiparesis (partial paralysis or weakness on one side of the body), metabolic encephalopathy a (general term that describes brain disease, damage, or malfunction usually related to inflammation within the body), polyneuropathy (a disorder of the peripheral nervous system that may result in pain, discomfort, and mobility issues), and peripheral vascular disease (PVD - a slow progressive narrowing of the blood flow to the arms and legs). During a review of Resident 44's Minimum Data Set (MDS &ndash; resident assessment tool) dated 11/20/2025, the MDS indicated the resident was able to understand others and was able to make himself understood. The MDS further indicated that the resident required substantial / maximal assistance from staff for toileting, bathing, upper and lower body dressing, and mobility.~The MDS indicated the resident was taking opioids, a high-risk drug class of medications (drugs that have a heightened risk of causing significant patient harm when they are used in error). During a review of Resident 44's Physician Order Summary, the Physician Order Summary indicated the following orders: - Hydrocodone - acetaminophen oral tablet five (5) - 325 milligrams (mg, a unit of measurement), give one (1) tablet by mouth every four (4) hours PRN for pain one (1)- six (6) out of 10, dated 11/14/2025. ~ - Hydrocodone - acetaminophen oral tablet five 5 - 325 mg, give two (2) tablets by mouth every 4 hours PRN for pain seven (7) to 10 out of 10, dated 11/14/2025. During a review of Resident 44's Care Plan (CP) titled, Has acute / chronic pain, initiated 11/15/2025, the CP indicated a goal that the resident would not have an interruption in normal activities of daily living During a concurrent observation and interview on 12/29/2025 at 9:25 a.m., Resident 44 lay in bed and stated he (Resident 44) often had pain and is given pain medication. Resident 44 stated the pain medication causes constipation. During a concurrent interview and record review on 12/31/2025 at 8:22 a.m. with Licensed Vocational (continued on next page)		

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Nurse (LVN) 3, LVN 3 reviewed Resident 44's physician orders, Medication Administration Record (MAR - a daily documentation record used by a licensed nurse to document medications and treatments given to a resident) for 12/2025, and Progress Notes for 12/2025. LVN 3 stated the facility process for administering PRN pain medication is the licensed nurse (LN) will first assess the resident for the location of pain, and the LN offers non-pharmacologic interventions. LVN 3 stated when non-pharmacologic interventions do not work, then the LN administers pain medication based on the numeric pain scale. LVN 3 stated the numeric pain level determines the amount of PRN pain medication administered to the resident. LVN 3 stated Resident 44 was able to verbalize the numeric pain scale level and received hydrocodone & acetaminophen 5/325 mg one tablet for pain level 1-6 and two tablets for pain level seven (7)-10. LVN 3 stated the LN documents the number of pain reported and the amount of medication administered in the MAR. LVN 3 stated if the LN documented the pain level in the MAR, then it was considered to be the resident's pain level at the time of administration. LVN 3 reviewed Resident 44's MAR and progress notes and noted the following regarding the PRN administration of one tablet of hydrocodone & acetaminophen 3/525 mg for pain one (1)- six (6): - On 12/1/2025 at 10:54 a.m., hydrocodone & acetaminophen one tablet was not administered per the physician's order when Resident 44's pain level was eight (8). - On 12/2/2025 at 1 a.m., hydrocodone & acetaminophen one tablet was not administered per the physician's order when Resident 44's pain level was 10. - On 12/2/2025 at 6 a.m., hydrocodone & acetaminophen one tablet was not administered per the physician's order when Resident 44's pain level was 10. - On 12/5/2025 at 6:20 a.m., hydrocodone & acetaminophen one tablet was not administered per the physician's order when Resident 44's pain level was seven (7). - On 12/6/2025 at 1 p.m., hydrocodone & acetaminophen one tablet was not administered per the physician's order when Resident 44's pain level was seven (7). - On 12/7/2025 at 2 a.m., hydrocodone & acetaminophen one tablet was not administered per the physician's order when Resident 44's pain level was seven (7). - On 12/7/2025 at 9 p.m., hydrocodone & acetaminophen one tablet was not administered per the physician's order when Resident 44's pain level was eight (8). - On 12/9/2025 at 6 a.m., hydrocodone & acetaminophen one tablet was not administered per the physician's order when Resident 44's pain level was eight (8). - On 12/14/2025 at 9:42 a.m., hydrocodone & acetaminophen one tablet was not administered per the physician's order when Resident 44's pain level was eight (8). LVN 3 stated there was no documented evidence that Resident 44 requested a lower dosage of pain medication when the one tablet of PRN hydrocodone & acetaminophen was administered. LVN 3 stated when a lower dose of pain medication is administered for a higher level of pain there is the potential that the pain medication would not be effective. LVN 3 stated there was also a missed opportunity for the physician to re-evaluate the resident's actual need for a higher dose, if one tablet was effectively treating Resident 44's higher level of pain. LVN 3 stated administering a lower dose of (continued on next page)		

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	narcotics can reduce the risk of side effects like gastrointestinal upset and constipation. LVN 3 then reviewed Resident 44's MAR and progress notes and noted the following regarding the PRN administration of two tablets of hydrocodone & acetaminophen 3/525 mg for pain seven (7)-10: - On 12/9/2025 at 4:59 p.m., hydrocodone & acetaminophen two tablets were not administered per the physician's order when Resident 44's pain level was four (4). - On 12/17/2025 at 11 a.m., hydrocodone & acetaminophen two tablets were not administered per the physician's order when Resident 44's pain level was 0. LVN 3 stated when the higher dose of hydrocodone & acetaminophen was not administered per the physician's orders, then it was more likely to result in side effects of narcotics like constipation in Resident 44. During a concurrent interview and record review on 12/31/2025 at 10:55 a.m. with LVN 4, LVN 4 reviewed Resident 44's physician orders and MAR for 12/2025 and noted the following: - On 12/6/2025 at 1 p.m., LVN 4 stated he administered hydrocodone & acetaminophen one tablet for a pain level of seven (7). LVN 4 stated he (LVN 4) did not remember what happened and did not know why only one tablet was administered when the resident's pain level indicated to administer 2 tablets. LVN 4 stated if it was documented then that is what happened. - On 12/9/2025 at 4:59 p.m., LVN 4 stated he administered hydrocodone & acetaminophen two tablet for a pain level of four (4). LVN 4 stated he did not remember what happened and did not know why two tablets were administered when the resident's pain level indicated to administer only 1 tablet. - On 12/17/2025 at 11 a.m., LVN 4 stated he administered hydrocodone & acetaminophen two tablets for a pain level of 0. LVN 4 stated it was a documentation error when the MAR indicated a pain level of 0 because the resident reported a pain level of seven (7). During a concurrent interview and record review on 12/31/2025 at 2:05 p.m. with the Director of Nursing (DON), the DON reviewed the facility policy and procedures (P&P) regarding medication administration and pain management. The DON stated the facility process for PRN pain medication administration is to use the numeric pain scale and follow the physician's orders for pain medication administration. The DON stated the facility P&P was not followed when Resident 44 was not administered narcotic pain medication per the physician's orders when the resident was administered the incorrect dose for the reported numeric pain level. The DON stated when the incorrect dose of narcotics was administered there was the potential to result in ineffective pain management leading to more frequent administration of pain medication and side effects like constipation in Resident 44. During a review of the facility P&P titled, Pain Management, last reviewed 12/18/2025, the P&P indicated, Policy. It is the policy. to ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, comprehensive and routine assessments, person-centered care plan, and the residents' goals and preferences. Procedure. 2. To the extent possible, staff will: . b. Evaluate existing pain and the causes. c. Manages or prevents pain, consistent with the comprehensive assessment and plan of care, current professional standards of (continued on next page)		

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	practice, and the resident's goals and preferences. 3. Pain will be identified and documented in the electronic health record (EHR). a. Using a scale of 1-10 is most common. Opioid treatment for pain is appropriately assessed and individualized for each resident. b. Medication(s) received, refused and response to medication will be documented on the Electronic Medication Administration Record (e-MAR). During a review of the facility P&P titled, Specific Medication Administration Procedures, last reviewed 12/18/2025, the P&P indicated, Policy. To administer medications in a safe and effective manner. Procedures. C. Review 5 Rights (3) times: . I.) Prior to removing the medication package/container from the cart/drawer; a. Check MAR/TAR for order.d. Check for vital signs, other tests to be done during/prior to medication administration. I. Obtain and record any vital signs or other monitoring parameters ordered or deemed necessary prior to medication administration. J. After administration, return to cart, replace medication container (if multi-dose and doses remain), and document administration in the MAR or TAR, and controlled substance sign out record, if indicated .M. When administering an as needed (PRN) medication, document reason for giving. b. During a review of Resident`21's admission Record, the admission Record indicated the facility admitted the resident on`12/10/2025,`with diagnoses including`sepsis (a life-threatening blood infection),`malignant neoplasm` (abnormal growth of tissues`that spread to other parts of the body)`of ovaries (female reproductive glands that make eggs and female hormones), and`generalized muscle weakness.` During a review of Resident`21's History and Physical (H&P) dated`12/10/2025, the H&P`indicated`Resident`21`had the capacity to understand and make decisions.`</p> <p>During a review of Resident`21's MDS, dated [DATE], the MDS indicated Resident`21`had`an intact`cognition (mental action or process of`acquiring`knowledge and understanding)`was able to understand others and make needs known. The MDS further`indicated`Resident 21`was independent with eating;`required`supervision or touching`assistance`with oral hygiene and personal hygiene;`substantial/maximal`assistance`with toileting hygiene, bathing,`lower body dressing, sit-to-stand,`and`toilet transfers;`partial/moderate`assistance`from staff with all other ADLs.`The MDS indicated Resident 21`was on`opioids. During a review of Resident`21's Order Summary Report, the Order Summary Report`indicated`the following`physician's orders`dated`12/10/2025:`</p> <p>Oxycodone`hydrochloride`oral`tablet`ten (10)`milligrams (mg &ndash; a unit of measurement)`give one tablet by mouth every`six (6)`hours as needed for`pain`four (4) to six (6) out of 10.`Do not give if`respiratory rate (RR)`is`less than (<`- a`unit of measurement)`12 or drowsy then notify`the physician (MD).` Oxycodone hydrochloride oral tablet`15`mg give one tablet by mouth every six (6) hours as needed for pain`seven (7) to`10`out of 10. Do not give if RR is < 12 or drowsy then notify the MD.` During a review of Resident 21's CP`on generalized chronic pain`related to malignant neoplasm of ovaries`initiated`on`12/11/2025, the CP`indicated`to follow pain scale to medicate`as ordered as`one of the interventions`to prevent interruption on normal activities due to pain.`</p> <p>During a review of the`MAR for 12/2025, the MAR`indicated`Resident 21 received the`following:` (continued on next page)		

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Oxycodone hydrochloride 10 mg tablet: 12/13/2025 at 3:54 a.m. for pain level of nine (9) out of 10 12/20/2025 at 8:09 p.m. for pain level of nine (9) out of 10 12/24/2025 at 11:54 p.m. for pain level seven (7) out of 10 Oxycodone hydrochloride 15 mg tablet: 12/18/2025 at 9:26 a.m. for pain level of zero (0) out of 10 12/25/2025 at 8:23 a.m. for pain level of 0 out of 10 12/26/2025 at 9:27 a.m. for pain level of out of 10 During a concurrent observation and interview on 12/29/2025 at 9:06 a.m., inside Resident 21's room, observed Resident 21 lying in bed, alert and verbally responsive. Resident 21 stated often had pain and is given pain medication as needed. During a concurrent interview and record review on 12/31/2025 at 8:45 a.m., reviewed Resident 21's physician's orders, CP, MAR for 12/2025, and progress notes with Assistant Director of Nursing (ADON). The ADON stated prior to administration of pain medications, the LN asks the residents for their pain level and location and administers the pain medication according to the resident's pain level and physician's order. ADON stated Resident 21 had a physician's order to administer oxycodone hydrochloride 10 mg tablet one tablet every six (6) hours as needed for pain level of four (4) to six (6) out of 10 and oxycodone 15 mg tablet one tablet every six (6) hours as needed for pain level of seven (7) to 10 out of 10. The ADON stated the CP on chronic pain indicated to follow pain scale to medicate as ordered. The ADON stated Resident 21 received oxycodone hydrochloride 10 mg tablet on 12/13/2025 at 3:54 a.m. and 12/20/2025 at 8:09 p.m. for pain level of nine (9) out of 10, 12/24/2025 at 11:54 p.m. for pain level of seven (7) out of 10. The ADON stated Resident 21 received oxycodone hydrochloride 15 mg tablet on 12/18/2025 at 9:26 a.m., 12/25/2025 at 8:23 a.m. and 12/26/2025 at 9:27 a.m. pain level of 0 out of 10. The ADON stated the oxycodone was not administered to Resident 21 according to MD order. The ADON stated the MD order should have been followed to properly address Resident 21's pain. The ADON stated there was no documentation in the progress notes that Resident 21 requested a lower dosage of the pain medication for pain level of seven (7) or nine (9) out of 10 or higher dose for pain level of 0 out of 10. The ADON stated when a lower dose of pain medication is administered to Resident 21 for a higher level of pain there is the potential that the pain medication would not be effective and can affect Resident 21's participation with ADLs and mobility. The ADON stated when the higher than needed dose of oxycodone hydrochloride was administered for pain level of 0 out of 10, then it was more likely to result in side effects of narcotics like constipation, gastric irritation, or drowsiness in Resident 21. During a concurrent interview and record review on 12/31/2025 at 9:22 a.m. reviewed Resident 21's physician's order and MAR for 12/2025 with LVN 3. LVN 3 stated the facility process for administering as needed pain medication is the LN will first assess the resident for the location of pain, and the LN offers non-pharmacologic interventions. LVN 3 stated when non-pharmacologic interventions do not work, then the LN administers pain medication based on the numeric pain scale. (continued on next page)		

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	LVN 3 stated the numeric pain level determines the amount of as needed pain medication administered to the resident. LVN 3 stated Resident 21 had a physician's order for oxycodone 10 mg tablet for pain level of four (4) to six (6) out of 10 and oxycodone 15 mg tablet for pain level of seven (7) to 10 out of 10. LVN 3 stated the MAR indicated she administered oxycodone hydrochloride 15 mg to Resident 21 on 12/18/2025 at 9:26 a.m. and she indicated that the pain level was 0 out of 10. LVN 3 stated she did not know why the pain level was documented as 0 out of 10. LVN 3 stated it was a documentation error when the MAR indicated a pain level of 0 because she will not administer the oxycodone hydrochloride if Resident 21's pain level was not between seven (7) to 10 out of 10. During a concurrent interview and record review on 12/31/2025 at 2:05 p.m. with the DON, the DON reviewed the facility P&P regarding medication administration and pain management. The DON stated the facility process for as needed pain medication administration is to use the numeric pain scale and follow the physician's orders for pain medication administration. The DON stated the facility P&P was not followed when Resident 21 was not administered narcotic pain medication per the physician's orders when the resident was administered the incorrect dose for the reported numeric pain level. The DON stated when the incorrect dose of narcotics was administered there was the potential to result in ineffective pain management leading to more frequent administration of pain medication and side effects like constipation in Resident 21. During a review of the facility P&P titled, Pain Management, last reviewed 12/18/2025, the P&P indicated: It is the policy of the facility to ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, comprehensive and routine assessments, person-centered care plan, and the residents' goals and preferences. To the extent possible, staff will Evaluate existing pain and the causes Manage or prevents pain, consistent with the comprehensive assessment and plan of care, current professional standards of practice, and the resident's goals and preferences. Pain will be identified and documented in the electronic health record (EHR) Using a scale of 1-10 is most common. Opioid treatment for pain is appropriately assessed and individualized for each resident. Medication(s) received, refused and response to medication will be documented on the Electronic Medication Administration Record (e-MAR). During a review of the facility P&P titled, Specific Medication Administration Procedures, last reviewed 12/18/2025, the P&P indicated, Medications are administered as prescribed in accordance with good nursing principles and practices and only by persons legally authorized to do so. Personnel authorized to administer medications do so only after they have been properly oriented to the facility's medication distribution system (procurement, storage, handling and administration). (continued on next page)		

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

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Medications are administered in accordance with written orders of the prescriber. When PRN medications are administered, the following documentation is provided: a. Date and time of administration, dose, route of administration (if other than oral). b. Complaints or symptoms for which the medication was given.		

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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 provide pharmaceutical services including procedures that assure the accurate acquiring and administering of all drugs and biologicals to meet the needs of each resident during an inspection of one (1) out of two (2) medication carts, Medication Cart 1 (MC 1) reviewed under the Medication Storage and Labeling Task by: 1. Failing to accurately account for two doses of controlled medications (medications with a high potential for abuse) affecting Resident 23 in one (1) of two (2) inspected medication carts, Medication Cart (MC) 1. This deficient practice increased the risk of diversion (the transfer of a medication from a lawful to an unlawful channel of distribution or use) of controlled medications and the risk that Resident 23 could have received too much or too little medication due to lack of documentation possibly resulting in serious health complications requiring hospitalization. 2. Failing to ensure Resident 23 received the 5 p.m. dose of pregabalin per physician's order on 12/13/2025 and 12/17/2025. This deficient practice placed Resident 23 at risk for complications and delay in the necessary care and services needed related to not receiving medications as prescribed by the physician such as worsening of pain. 3. Failing to ensure licensed nurses completed the incoming and outgoing Shift Change Narcotic Count Sheet (a form signed by the incoming and outgoing licensed nurse after reconciling narcotic medications) on 12/30/2025 For MC 1. This deficient practice had the potential to result in increased opportunity for medication diversion. Findings: a. During a review of Resident 23's admission Record (front page of the chart that contains a summary of basic information about the resident), the admission Record indicated the facility admitted Resident 23 on 12/12/2025 with diagnoses including type two (2) diabetes mellitus (DM 2 - a disorder characterized by difficulty in blood sugar control and poor wound healing) with diabetic neuropathy (nerve damage caused by high blood sugar from diabetes characterized by numbness, tingling, and burning pain), polyarthritis (a joint disease that involves at least five joints causing pain, stiffness, and swelling), and generalized muscle weakness. During a review of Resident 23's History and Physical (H&P) dated 12/16/2025, the H&P indicated Resident 23 had the capacity to understand and make decisions. During a review of Resident 23's Minimum Data Set (MDS, a resident assessment tool), dated 12/18/2025, the MDS indicated Resident 23 had an intact cognition (mental action or process of acquiring knowledge and understanding) and was able to understand and make her needs known. The MDS further indicated Resident 23 required setup or clean-up assistance with eating and oral hygiene, personal hygiene, totally dependent with toileting, bathing, lower body dressing, partial/moderate assistance with all other activities of daily living (ADLs - activities such as bathing, dressing and toileting a person performs daily). The MDS indicated Resident 23 received scheduled pain medication regimen. During a review of Resident 23's Order Summary Report dated 12/31/2025, the Order Summary Report indicated the following physician's orders dated 12/12/2025: - Hydrocodone-acetaminophen (also known as Norco, a strong prescription pain reliever medicine for moderate to severe pain) oral tablet five (5)-325 milligram (mg - a unit of measurement) give one tablet by mouth every four (4) as needed for pain level of four (4) to ten (10) out of 10 not to exceed three (3) grams (gm - a unit of measurement) of APAP (chemical name for acetaminophen) in 24 hours. Do not give if respiratory rate (RR) is less than (< - a unit of measurement) or drowsy then notify the physician (MD). - Pregabalin (also known as Lyrica, a prescription medication that treats nerve pain by calming overactive nerves in your body) oral capsule 75 mg give one capsule by mouth two times a day for neuropathic pain. Hold if RR is <12 or drowsy then notify the MD. During an observation of MC 1 on 2/25/25 at 2:07 PM with the Assistant Director of Nursing (ADON), the following discrepancies were found between the Controlled Medication Count Sheet (a log signed by the nurse with the date and time each time a controlled substance is given to a resident) and the medication card (a bubble pack from the dispensing pharmacy labeled with the resident's information that contains the individual doses of the (continued on next page)		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	medication) or physical inventory: 1. Resident 23's Controlled Medication Count Sheet for hydrocodone-acetaminophen 5-325 mg indicated 52 tablets were dispensed on 12/18/2025 and the physical inventory contained 41 tablets remaining. 2. Resident 23's Controlled Medication Count Sheet for Lyrica 75 mg indicated 28 capsules were dispensed on 12/19/2025 and the physical inventory contained seven (7) doses. During a concurrent interview and record review with the ADON, reviewed and compared Resident 23's medication administration records (MAR - a daily documentation record used by a licensed nurse to document medications and treatments given to a resident) for 12/2025, medication cards and the Controlled Medication Count Sheets for Norco and Lyrica, and the Shift Change Narcotic Count Sheet for Cart 1. The ADON stated: 1. Two tablets of Norco 5-325 mg oral tablets were removed on 12/21/2025 at 10:18 a.m. and one tablet on 12/25/2025 at 9:25 a.m. by Licensed Vocational Nurse (LVN) 2 but were not documented in the MAR. 2. Lyrica 75 mg oral capsules were documented in the MAR by LVN 4 as administered on 12/24/2025 and 12/25/2025 at 5 p.m. but the medication was not signed out in the Controlled Medication Count Sheet, and the expected inventory was supposed to be five capsules remaining instead of seven. 3. The Shift Change Narcotic Count Sheet Cart 1 was not signed off by the outgoing and incoming shift for 12/30/2025. The ADON stated that when administering controlled medications, the nurses are supposed to open the MAR, compare the bubble pack with the physician's order, and the Controlled Medication Count Sheet, remove the medication from the medication card, sign the Controlled Medication Count Sheet immediately and sign the MAR immediately after administration of the controlled medication. The ADON stated LVN 2 and LVN 4 should have signed Resident 23's MAR and Controlled Medication Count Sheet that the Norco and Lyrica were received by the resident. The ADON stated it is important to maintain accountability of controlled substances in order to prevent diversion or accidental overdose or underdosing to Resident 23. The ADON stated if Resident 23 received more often than prescribed, it could cause medical complications possibly leading to hospitalization or if Resident 23 did not receive the medications as prescribed, the resident could experience increased pain. The ADON stated incoming and outgoing licensed nurses (LNs) would count the narcotics and both licensed nurses would sign the Shift Change Narcotic Count Sheet form accepting the actual number on their shift for all residents that are receiving controlled medications. The ADON stated when the LNs do not sign the Shift Change Narcotic Count Sheet form on their shift it means the LNs did not do the counting. The ADON stated not counting the narcotics and not signing the Shift Change Narcotic Count Sheet, it had the potential for an opportunity for diversion of controlled medications. During an interview on 12/31/2025 at 10 a.m. with LVN 2, LVN 2 stated that she needs to sign out the doses of controlled medications on the Controlled Medication Count Sheet immediately after the medication is removed from the bubble pack. LVN 2 stated she (LVN 2) was unable to recall why she (LVN 2) did not sign the MAR and Controlled Medication Count Sheet. 2 further stated she (LVN 2) should have signed for the controlled medications she (LVN 2) removed for Resident 23 in the Controlled Medication Count Sheet and MAR immediately. LVN 2 stated it is important to maintain accountability of controlled substances in order to prevent diversion, accidental overdose to the resident. LVN 2 stated if Resident 23 received Norco more often than prescribed or not received as prescribed, it could cause medical complications such as increased pain and drowsiness possibly leading to hospitalization. During an interview on 12/31/2025 at 12:15 p.m. with the Director of Nursing (DON), the DON stated the outgoing and incoming LNs are supposed to count the narcotics and sign the Shift Change Narcotic Count Sheet form accepting the actual number of medications on their shift for all residents that are receiving controlled medications. The DON stated if the LNs did not sign the Shift Change Narcotic Count Sheet form on their shift it could mean that the LNs did not count the controlled medications and had the potential for an opportunity for diversion of controlled medications. The DON stated the LNs are supposed to open the MAR, compare the bubble pack with the physician's order, and the Controlled Medication Count Sheet, remove the medication from the medication card, sign the Controlled Medication Count Sheet immediately and sign the MAR immediately after administration of (continued on next page)		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the controlled medication. The DON stated LVN 2 and LVN 4 should have signed Resident 23's MAR and Controlled Medication Count Sheet that the Norco and Lyrica were received by the resident. The DON stated it is important to maintain accountability of controlled substances in order to prevent diversion or accidental overdose or underdosing to Resident 23. During a review of the facility's policy and procedure (P&P) titled, Medication Administration - General Guidelines, last reviewed on 12/18/2025, the P&P indicated: - Medications are administered as prescribed in accordance with good nursing principles and practices and only by persons legally authorized to do so. Personnel authorized to administer medications do so only after they have been properly oriented to the facility's medication distribution system (procurement, storage, handling and administration). - Medications are administered in accordance with written orders of the prescriber. - The individual who administers the medication dose records the administration on the resident's MAR/eMAR (electronic MAR) after the medication is given. At the end of each medication pass, the person administering the medications reviews the MAR/eMAR to ensure necessary doses were administered and documented. - The resident's MAR/eMAR is initialed by the person administering the medication, in the space provided under the date, and on the line for that specific medication dose administration - When PRN medications are administered, the following documentation is provided: a. Date and time of administration, dose, route of administration (if other than oral). b. Signature or initials of person recording administration. During a review of the facility's P&P titled, Controlled Substances, last reviewed on 12/18/2025, the P&P indicated: - Medications included in the Drug Enforcement Administration (DEA - a United States government agency tasked with enforcing laws that cover illegal distribution of controlled substances) classification as controlled substances are subject to special handling, storage, disposal, and recordkeeping in the facility, in accordance with federal and state laws and regulations. - Medications supplied by the provider pharmacy shall identify medications as controlled drugs, either as of the label or by sending a controlled drug count sheet with the medication or both. - Accurate accountability of all controlled drugs is maintained at all times. When a controlled substance is administered, the license nurse administering the medication immediately enters the following information on the accountability records and the MAR. 1. Date and time of administration (MAR, Accountability Record). 2. Amount administered (Accountability Record). 3. Remaining quantity (Accountability Record). 4. Initials of the nurse administering the dose, completed after the medication is actually administered (MAR, Accountability Record).		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to ensure safe and sanitary food storage and food preparation practices in the kitchen by: 1. Failing to ensure a bottle of salad dressing labeled with open date of 12/23/2025 was labeled with a best by date of 2/23/2026. 2. Failing to discard a bunch of parsley leaves inside a sealed plastic bag had brownish discoloration. 3. Failing to ensure a can of applesauce with dent was not placed in the shelf for dented cans. 4. Failing to ensure one (1) round shaped and 1 square shaped clean food containers were still wet and stacked in the clean and dried dishes/utensils section of the kitchen. 5. Failing to ensure eight (8) meal trays were stacked wet on the drying rack in the dishwashing room. These failures had the potential to result in harmful bacteria growth and cross contamination (transfer of harmful bacteria from one place to another) that could lead to foodborne illness (transfer of bacteria from one object to another) in 33 out of 35 medically compromised residents who received food from the kitchen. Findings: During an initial kitchen tour on 12/29/2025 at 7:50 a.m. with the Dietary Supervisor (DS), observed inside Refrigerator two (2) and the dry storage room the following: 1. A bottle of salad dressing labeled with open date of 12/23/2025 was labeled with a best by date of 2/23/2026. 2. A bunch of parsley leaves inside a sealed plastic bag and the leaves had brownish discoloration. 3. A can of applesauce with dent was placed in the shelf for non-dented cans. a. During a concurrent interview and record review on 12/29/2025 at 8:10 a.m., reviewed with the DS, the facility provided Dry Good Storage Guidelines dated 2023. The DS stated the kitchen staff follow the Dry Good Storage Guidelines when labeling with the best by date. The DS stated the Dry Good Storage Guidelines indicated bottled salad dressings should be refrigerated when opened and must be used within 1 month after opening. The stated the Dry Good Storage Guidelines was not followed. The DS stated the bottled salad dressing should have been labeled with the best by date of 1/23/2026 instead of 2/23/2026 and had the potential to cause illnesses such as upset stomach, nausea, vomiting or diarrhea to the residents if the salad dressing was past the date indicated in the Dry Good Storage Guidelines. b. During a concurrent observation and interview on 12/29/2025 at 8:20 a.m. inside the dry storage room with the DS, the DS stated the bunch of parsley leaves inside the plastic bag had moisture and some of the leaves had brownish discoloration and could be spoiled. The DS stated she usually checks all the food items in the kitchen every day and discard or throws away whatever is past the best by dates, spoiled, or with discolorations. The DS stated the parsley leaves could be spoiled and when served to the residents can cause illness and give them upset stomach, nausea, vomiting, or diarrhea. The DS stated the bag of parsley leaves with brownish discoloration should have been discarded timely. c. During a concurrent observation and interview on 12/29/2025 at 8:23 a.m. inside the dry storage room with the DS, the DS stated 1 can of applesauce with a dent was not removed from the shelf with the non-dented. The DS stated she usually checks the shelf for canned products for dents daily and place them in a separate shelf for the dented cans to return to the food supply company. The DS stated the seal on the dented cannot be used anymore as the seal was already compromised and can possibly cause food poisoning if used or served to the residents. d. During a concurrent follow up observation and interview on 12/29/2025 at 2 p.m., inside the kitchen with the DS, observed 1 round shaped and 1 square shaped clean food containers stacked were still wet in the clean and dried dishes/utensils shelf of the kitchen. The DS stated the round and square shaped food containers were stacked and not completely dried. The DS state food containers were still wet. The DS stated that prior to placing the food containers in the dried dishes/utensils shelf of the kitchen, the kitchen staff have to ensure that the equipment are completely dry. The DS stated bacteria can form when the food containers were stacked together and can cause foodborne illnesses in the residents. During a concurrent interview and record review on 1/16/2026 at 1:03 p.m., the facility provided Dry Goods Labeling Guideline was reviewed with Director of Nursing (DON). The DON stated the dry goods storage (continued on next page)		

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

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	guideline should be followed by the kitchen staff such as proper labeling of the salad dressing. The DON stated the Dry Goods Labeling Guideline indicated refrigerated salad dressing should be consumed within 1 month. The DON stated if consumed past the guideline, it placed the residents at risk for foodborne illnesses such as nausea, vomiting, and diarrhea. The DON stated kitchen equipment, utensils, food trays and containers should be completely dried before stacking together as bacteria can harbor or form in the between and may lead to foodborne illnesses. The DON stated any food items that have discoloration should be discarded to prevent serving to the residents and can cause illnesses such as nausea, vomiting, and diarrhea. During a review of the facility's policy and procedure titled, Labeling and Dating of Food, last reviewed 12/18/2025, the P&P indicated all food items in the storeroom, refrigerator, and freezer need to be labeled and dated based on established procedures for wither food safety or product rotation. The P&P further indicated the individual opening or preparing food shall be responsible for date marking at the time of processing. During a review of the facility's P&P titled, Dishwashing, last reviewed 12/18/2025, the P&P indicated all dishes will be properly sanitized through the dishwasher. The P&P further indicated: - Dishes are to be racked loosely without overlapping. - Dishes are to be air dried in racks before stacking and storing.		

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have a policy regarding use and storage of foods brought to residents by family and other visitors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to enforce its policy of storing food brought in by family or visitors in a way that it was either separate or easily distinguishable from facility food when there was no designated refrigerator space for residents with leftover foods from home or outside sources. This failure had the potential to result in a decrease in the residents' food intake leading to unintentional (without trying) weight loss and frustrations among 33 of 35 facility residents. Findings: During a concurrent observation and interview during a brief kitchen tour on 12/29/2025 at 7:57 a.m. with the Dietary Supervisor (DS), observed a transparent bin with lid inside Refrigerator 2 labeled Resident Food. The DS stated the bin was for residents' food items that required refrigeration and the food item must be in a sealed container in its original packaging. During another follow up interview on 12/29/2025 at 12 p.m. inside the kitchen with DS, the DS stated that opened items or leftover food from outside sources brought in by family or visitors are not allowed for storage in the kitchen refrigerator due to possible cross contamination (transfer of harmful bacteria from one person, object or place to another). The DS stated that if family members bring in food for the resident, the food must be consumed within two (2) hours and if not consumed, the food will be discarded because there was no designated refrigerator for residents for leftover foods in the kitchen and at the nurses' station. The DS stated the residents could feel frustrated if they are not able to store food from outside sources or home and eat it if there is no refrigerator to store. During an interview on 12/31/2025 at 12:34 p.m. with the Director of Nursing (DON), the DON stated the facility policy regarding food brought by family or visitors indicated that the family or visitors can bring food items requested by the resident and must be in a sealed container and in its original packaging and stored in the kitchen refrigerator. The DON stated there is a bin with lid inside the kitchen refrigerator labeled Resident Food. The DON stated if the family or visitor brings food, the resident must consume the food within two hours, or it will be discarded as the facility does not have a refrigerator in the nurses' station and leftovers cannot be stored in the kitchen refrigerator which can cause cross contamination. The DON stated that food requiring refrigeration cannot be left out as it could spoil and cause illnesses. The DON stated residents may or may not be frustrated as a potential outcome if they are not able to store their food items that were from their family or friends. The DON stated it was important to encourage food from home or outside sources for residents who have low intake, or with food preferences such as cultural preferences other than what the facility can provide. During a review of the facility's policy and procedure (P&P) titled Food Brought by Family or Visitor, last reviewed 12/18/2025, the P&P stated: - Food brought to a resident by family/visitors must be accepted by the resident; inspected before facility storage; and stored and served in accordance with food safety professional standards. - The use of outside food is a possible intervention for residents with low intake, distinct food preferences, cultural/ethnic preferences. This intervention preserves the residents' right to self-determination to the greatest extent possible. - The facility kitchen will only store food that is sealed in manufacturer packaging. Food [NAME] from home in an already opened, non-sealed container will not be allowed to be stored in the facility kitchen. - Perishable prepared foods will be discarded in the morning of the next day by the designated dietary staff. - Prepared food is best consumed within 1 to 2 hours after removal from temperature control to minimize foodborne illness risk. It is recommended that the prepared food not be held over if it requires a second reheat. Prepared foods will be discarded after 2 hours.		

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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 maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections by failing to: 1. Ensure Resident 73's personal bag was not stored on the ground during a tour of the Laundry Facilities on 12/30/2025. This deficient practice had the potential to spread communicable diseases among residents, staff, and visitors. 2. Ensure the Enhanced Barrier Precaution (EBP, an infection control intervention designed to reduce transmission of multidrug-resistant organisms [MDRO, microorganisms, mainly bacteria, that are resistant to one or more classes of antibiotics] that uses targeted gown and glove use during high contact resident care activities) sign was posted by the door leading into the room of one (1) of one (1) sampled resident (Resident 21) reviewed under infection control. This deficient practice had the potential to spread infections and illnesses to residents, visitors, and staff. 3. Ensure the ice scooper was not left open to air and exposed to environmental contaminants. The deficient practice had the potential to cause adverse effects (the undesired, unwanted, or harmful things that happen as a result, even if you follow the instructions correctly) on residents such as food-borne illnesses. Findings: a) During a review of Resident 73's admission Record (AR), the AR indicated the facility admitted the resident on 12/30/2025, with diagnosis that included chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing), acute on chronic respiratory failure (serious condition that develops when the lungs cannot get enough oxygen into the blood) with hypoxia (low oxygen in the tissues), pulmonary fibrosis (a lung disease that occurs when lung tissue becomes damaged and scarred), and malignant neoplasm of breast (breast cancer). During a review of Resident 73's History and Physical (H&P) dated 12/31/2025, the H&P indicated the resident had the capacity to understand and make decisions. During a Facility's Laundry Tour on 12/30/2025 at 3:35 p.m., with Laundry Attendant (LA) 1 and the Maintenance Supervisor (MS), observed a green bag placed directly on the ground and behind the door in the clean linen area. LA 1 stated he (LA 1) was temporarily storing a new resident's green bag on the floor behind the door until LA 1 was able to label the resident's clothing located inside the bag. LA 1 then stated nothing should be placed on the floor in the laundry area. LA 1 stated all items should be elevated off the floor. The MS exited the laundry area and stated all resident personal belongings, including the resident's green bag, should be kept off the floor because of the potential of transferring something dirty from the floor to the resident by cross contamination (the process by which bacteria or other microorganisms are unintentionally transferred from one substance or object to another, with harmful effect). During an interview on 12/31/2025 at 9:45 a.m. with the Infection Preventionist (IP), the IP stated the green bag belonged to Resident 73 and should not have been stored on the floor in the laundry area because the floor is dirty. The IP stated when Resident 73's bag was stored on the floor it created a cross-contamination issue with the potential that the dirty bag could be placed on a clean surface resulting in the surface becoming contaminated with bacteria that could spread to a resident. During a concurrent interview and record review on 12/31/2025 at 2:05 p.m. with the Director of Nursing (DON), the DON reviewed the facility policy and procedures (P&P) regarding infection prevention. The DON stated resident personal items should be kept off the floor for infection control (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	practices to ensure the bag does not become dirty from the floor and then unknowingly the bag is used in a way that causes cross contamination. The DON stated the facility P&P was not followed. During a review of the facility P&P titled, Laundry Services, last reviewed 12/18/2025, the P&P indicated, POLICY: It is the policy of this facility that careful precautionary procedures must be followed by laundry personnel to prevent the spread of infectious diseases to other staff members, residents and visitors PROCEDURES: General: 2. The supervisor of laundry services will work closely with the infection control designee to establish and maintain consistent high standards. 6. All laundry employees will be expected to attend in-service programs pertaining to infection control. During a review of the facility P&P titled, Storing Personal Belongings in Laundry Room, last reviewed 12/18/2025, the P&P indicated, Purpose. To maintain a safe, clean, and sanitary environment for residents, staff, and visitors by preventing personal belongings from being stored directly on the floor. Policy Statement. Personal belongings shall not be placed or stored on the floor in resident rooms, laundry room or common areas. All personal items must be kept in designated storage areas to reduce infection risk, prevent falls, and maintain compliance with safety and housekeeping standards. Procedure. 1. Resident Personal Belongings. Personal items (e.g., clothing, shoes, bags,) must be stored in: - Closets - Drawers - Cabinets - Shelving units - Over-bed tables or designated hooks. Items may not be placed directly on the floor. 2. Staff Responsibilities Staff should routinely monitor resident rooms, laundry and common areas for items placed on the floor. 3. Infection Control. Items found on the floor are considered contaminated. Compliance. Failure to follow this policy may result in: Increased infection risk. b) During a review of Resident 21's admission Record, the admission Record indicated the facility admitted the resident on 12/10/2025, with diagnoses including sepsis (a life-threatening blood infection), malignant neoplasm (abnormal growth of tissues that spread to other parts of the body) of ovaries (female reproductive glands that make eggs and female hormones), and generalized muscle weakness. During a review of Resident 21's History and Physical (H&P) dated 12/10/2025, the H&P indicated Resident 21 had the capacity to understand and make decisions. During a review of Resident 21's Minimum Data Set (MDS, a resident assessment tool), dated 12/16/2025, the MDS indicated Resident 21 had an intact cognition (mental action or process of acquiring knowledge and understanding) was able to understand others and make needs known. (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The MDS further indicated Resident 21 was independent with eating; required supervision or touching assistance with oral hygiene and personal hygiene; substantial/maximal assistance with toileting hygiene, bathing, lower body dressing, sit-to-stand, and toilet transfers; partial/moderate assistance from staff with all other ADLs. During a review of Resident 21's Order Summary Report, the Order Summary Report indicated the following physician's orders dated 12/10/2025: - Enhanced Barrier Precautions: PPE (personal protective equipment - clothing and equipment that is worn or used to provide protection against hazardous substances and/or environments) required for high resident contact care activities. Indication: peripherally inserted central catheter (PICC - a long, thin tube inserted through a vein in the arm and passed through to the larger veins near the heart used for long-term intravenous access) line every shift. - Flush PICC line catheter on right upper arm (RUA) every day shift as maintenance. - Change injection cap when visibly soiled, if removed, or disconnected as needed. During a review of Resident 12 care plan (CP) for PICC line in RUA, initiated on 12/11/2025, the CP indicated to use EBP to keep the resident free of complications. During a concurrent observation and interview on 12/29/2025 at 9:06 a.m. inside Resident 21's room, observed Resident 21 lying in bed, awake, alert, and verbally responsive. Resident 21 stated she (Resident 21) was transferred from an acute hospital due to severe infection in her blood and had a PICC line placed in the RUA sometime in October. Observed Resident 21 with two (2) lumens (refers to the cavity or channel within a tube or tubing) PICC line catheter on the RUA dated 12/28/2025. Observed disposable gowns and gloves on a rack attached to the wall inside Resident 21's room. During an observation on 12/29/2025 at 9:29 a.m., outside Resident 21's room, observed there was no EBP sign posted by the wall. During a concurrent observation and interview on 12/29/2025 at 9:45 a.m. outside Resident 21's room with the Infection Preventionist (IP). The IP stated she just placed the EBP sign by the door as she was just notified that Resident 21 had a PICC line on the RUA. The IP stated Resident 21 had a PICC line since admission date of 12/10/2025. The IP stated the nurse who admitted Resident 21 and received the order from the physician should have implemented the EBP and placed the EBP sign by the door outside the room. During an interview on 12/29/2025 at 9:49 a.m. with Certified Nursing Assistant (CNA) 2, CNA 2 stated staff were reminded during huddle at the start of the shift regarding proper hand hygiene and wearing of PPEs during high contact resident care activities for residents on EBP. CNA 2 stated if there was a sign for EBP by the door outside a resident's room, staff are supposed to perform hand hygiene prior to putting on gown and gloves and entering the room for showers and ADLs. CNA 2 stated she did not remember seeing the EBP sign outside Resident 21's room until the IP placed the sign today. CNA 2 stated the EBP sign should have been placed as soon as possible. CNA 2 stated if the EBP sign was not placed timely, it placed Resident 21 at risk to get infection and potentially spread the infection to other residents and staff. (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent record review and follow up interview on 12/31/2025 at 10:06 a.m. with the IP, Resident 21's physician's orders, photograph of the wall without the EBP sign, and CP were reviewed. The IP stated Resident 21 had orders to place on EBP due to PICC line use, and PICC line care. The IP stated the CP indicated to use EBP to keep the resident free of complications. The IP stated the photograph of the wall by the door entrance dated 12/29/2025 at 9:29 a.m. showed that the EBP sign was not in place. The IP stated the EBP sign should have been placed by the door entrance on the day Resident 21 was admitted to the facility as it placed Resident 21 at risk for acquiring infection from staff who provided care to a resident with infection and to prevent the spread of infection in the facility to other staff and residents. During an interview on 12/29/2025 at 2:30 p.m. with the Director of Nursing (DON), the DON stated Resident 21 had a PICC line when admitted on [DATE] and a physician order was received to place Resident 21 on EBP due to presence of PICC line. The DON stated whoever the nurse was during admission should have placed the EBP sign and the IP is in charge of monitoring who are the residents with indwelling medical devices such as PICC line to ensure the proper precautions are being implemented. The DON stated Resident 21 did not have an EBP sign placed outside the door to remind staff to don (put on) and doff (take off) PPE during high contact resident activity. The DON stated the EBP sign should have been placed outside Resident 21's room as it had the potential for the spread of infection between residents and staff and placed Resident 21 at risk for getting infection. During a review of the facility's policy and procedure (P&P) titled IPCP Standard and Transmission-Based Precautions, last reviewed on 12/18/2025, the P&P indicated: - It is the policy of the facility to implement infection control measures to prevent the spread of communicable diseases and conditions. Procedure: 3. Enhanced Barrier Precautions (EBP): used on conjunction with standard precautions and expand the use of PPE through the use of gown and gloves during high contact resident care activities that provide opportunities for indirect transfer of MDROs to staff hands and clothing when indirectly transferred to residents or from resident-to-resident. a. PPE: the use of gown and gloves for high contact resident care activities is indicated for nursing home residents with wounds and/or indwelling medical devices During a review of the facility's P&P titled Infection Prevention and Control Program, last reviewed on 12/18/2025, the P&P indicated: - The infection prevention and control program is a facility-wide effort involving all disciplines and individuals and is an integral part of the quality assurance and performance improvement program. The elements of the infection prevention and control program consist of coordination/oversight, surveillance, data analysis, antibiotic stewardship, outbreak management, prevention of infection, and employee health and safety. The program is carried out by the facility infection preventionist. - It is the policy of this facility to provide the necessary supplies, education, and oversight to ensure healthcare workers perform hand hygiene based on accepted standards. (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	c) During an observation on 12/29/2025 at 8:38 a.m., while doing resident screening, near the kitchen door hallway of the facility, observed a blue ice chest on wheels with the ice scooper placed inside an open container beside the ice chest. During a concurrent observation and interview on 12/29/2025 at 8:40 a.m., with the Infection Preventionist (IP), near the kitchen door entrance, observed a blue ice chest on wheels with the ice scooper placed inside an open container beside the ice chest. The IP stated the ice scooper should be covered because leaving them open to air exposes the ice scooper to environmental contaminants such as bacteria and viruses that when ingested by the resident can cause gastric infections. During a concurrent interview and record review on 12/31/2025 at 4:10 p.m., with the Assistant Director of Nursing (ADON), the ADON stated the ice scoopers should be protected inside a plastic container to prevent them from environmental contaminants such as bacteria, dust, and viruses. The ADON stated the ice scoopers are used to scoop ice for resident's drinks and when the ice scooper is contaminated and used to scoop for ice on a resident drinking their favorite drinks it can cause gastric infection that can make them ill. The ADON stated the staff did not follow their policy on ice procedures. During a review of the facility's recent policy and procedure (P&P) titled Ice Procedures, last reviewed on 12/18/2025, the P&P indicated ice is to be handled properly to prevent infection. Procedure: 2. A covered plastic or stainless-steel container will be used to hold the scoop. The PM dishwasher will run this container through the dish machine daily. During a review of the facility's recent P&P titled Infection Prevention and Control Program, last reviewed on 12/18/2025, the P&P indicated the infection prevention and control program is a facility-wide effort involving all disciplines and individuals and is an integral part of the quality assurance and performance improvement program. The elements of the infection prevention and control program consist of coordination/oversight, surveillance, data analysis, antibiotic stewardship, outbreak management, prevention of infection, and employee health and safety. The program is carried out by the facility infection preventionist. It is the policy of this facility to provide the necessary supplies, education, and oversight to ensure healthcare workers perform hand hygiene based on accepted standards. Goals -Identify and correct problems relating to infection control.		

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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 its policy for antibiotic (medication used to treat infection) stewardship (efforts in long-term care facilities to ensure that antibiotics are used only when necessary and appropriate [means prescribing the right drug at the right dose at the right time for the right duration]) program and infection prevention and control program for four of four sampled residents (Residents 12, 1, 33, and 41) reviewed for antibiotic use by failing to ensure: 1. Failing to ensure Resident 12 meets the criteria for the use of sulfamethoxazole and trimethoprim double strength (also known as Bactrim DS, a combination of two antibiotics used to treat bacterial infections in the ear, sinus, throat, lungs, and skin) for urinary tract infection (UTI - an infection in the bladder/urinary tract). 2. Failing to ensure Resident 12 was monitored for adverse side effects (an unintended, negative health outcome or unwanted event that occurs as a result of a treatment, medication, or exposure to a substance) for the use of Bactrim DS while receiving the medication. 3. Resident 1's Amoxicillin (an antibiotic used to treat infections caused by bacteria) had a specific indication for its use and had monitoring for its adverse effects. 4. Resident 1's Diflucan (a prescription antifungal medication used to treat infections caused by fungus or yeast) had a monitoring for its adverse effects. 5. Resident 33's Methenamine Hippurate (a urinary antiseptic used as preventive treatment for recurrent urinary tract infections (UTIs, occur when bacteria enter the urinary tract through the urethra and begin to spread in the bladder) indicated an end date and had monitoring for its adverse effects. 6. Resident 41's Bactrim had monitoring for its adverse effects. These failures had the potential to increase antibiotic resistance (when bacteria develop the ability to withstand the effects of antibiotics, making it difficult or impossible to treat infections) from unnecessary or inappropriate antibiotic use and had the potential for the residents to experience an unmonitored adverse reaction. Findings: 1. During a review of Resident 12's admission Record (AR - front page of the chart that contains a summary of basic information about the resident), the AR indicated the facility admitted Resident 12 on 12/15/2025 with diagnoses including type two diabetes mellitus (DM 2 - a disorder characterized by difficulty in blood sugar control and poor wound healing), generalized muscle weakness, and difficulty walking. During a review of Resident 12's History and Physical (H&P), dated 12/16/2025, the H&P indicated Resident 12 did not have the capacity to understand and make decisions. During a review of Resident 12's Minimum Data Set (MDS - a resident assessment tool), dated 12/21/2025, the MDS indicated Resident 12 had severely impaired cognition (mental action or process of acquiring knowledge and understanding) and was sometimes able to understand and make her needs known. The MDS further indicated Resident 12 required substantial or maximal assistance to total assistance from staff with all activities of daily living (ADLs - activities such as bathing, dressing and toileting a person performs daily). During a review of Resident 12's Order Summary Report (OSR), dated 12/31/2025, the OSR indicated a physician's order dated 12/28/2025 for Bactrim DS (sulfamethoxazole-trimethoprim) oral tablet 800-160 milligrams (mg &ndash; a unit of measurement) give one (1) tablet by mouth two (2) times a day for UTI for seven (7) days. During a review of Resident 12's SBAR (situation, background, assessment, recommendation - a communication tool used by healthcare workers when there is a change of condition among the residents) Communication Form, dated 12/26/2025, the SBAR Communication Form indicated Resident 12 had increased confusion or disorientation and was trying to get out of bed and temperature of 98.3 degrees Fahrenheit (F &ndash; a unit of measurement) but did not have any other symptoms of UTI such as, but not limited to, dysuria (difficulty in urinating), urgency, frequency, and gross hematuria (blood in the urine that is visible in the naked eye). The SBAR Communication Form further indicated, the physician ordered a urinalysis (UA - a test that examines the urine to check for various health issues) with culture and sensitivity (a test that checks the urine for bacteria that may be causing an infection and determine effective treatment. During a review of Resident 12's SBAR (continued on next page)		

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Communication Form, dated 12/28/2025, the SBAR Communication Form indicated Resident 12 had increased confusion and temperature of 98F. The SBAR Communication Form further indicated the UA result was relayed to the physician with new order to start Resident 12 on Bactrim DS oral tablet 800-160 mg give 1 tablet by mouth 2 times a day for UTI for 7 days. During a review of Resident 12's Loeb's Minimum Criteria for Initiating Antibiotic Therapy (a set of guidelines that helps healthcare providers decide when to start antibiotics for residents in long-term care facilities) form, dated 12/29/2025, the Loeb's Minimum Criteria for Initiating Antibiotic Therapy form indicated under the criteria for suspected UTI without catheter, Resident 12 did not meet any of the criteria such as dysuria, urgency, frequency, and gross hematuria. The Loeb's Minimum Criteria for Initiating Antibiotic Therapy form further indicated under the criteria for fever where the focus of infection is unknown, Resident 12 did not meet both criteria required as Resident 12 only had increased confusion but did not have a temperature of more than 100F. During a review of Resident 12's care plan (CP) on infection of the urinary tract initiated on 12/28/2025, the CP indicated to administer antibiotic as ordered by the physician for the resident to have minimal to no complications related to infection. During a review of Resident 12's Medication Administration Record (MAR - a daily documentation record used by a licensed nurse to document medications and treatments given to a resident), dated 12/29/2025, the MAR indicated Resident 12 received the first dose of Bactrim DS on 12/28/2025 at 5 p.m. During a review of Resident 12's UA result, dated 12/27/2025, the UA result indicated Resident 12 had 2 plus blood in the urine and the normal range should be negative (did not find the substance), many bacteria in the urine and the normal range is none, and the white blood cells (WBC, a type of cell in the urine) that helps the body fight infections and other diseases) were more than 50 HPF (high power field &ndash; a unit of measurement for volume) and the normal range should zero (0) to four (4). During a review of Resident 12's Change in Condition (CIC) Follow Up Nurses Notes form, dated 12/28/2025 to 12/30/2025, the CIC Follow Up Nurses Notes form did not indicate Resident 12 was monitored for adverse side effects of antibiotic use on 12/29/2025 and 12/30/2025 7 a.m. to 7 p.m. shift. During a concurrent interview and record review on 12/31/2025 at 8:14 a.m. with the Infection Preventionist (IP), Resident 12's physician's orders, UA results, SBAR Communication form, dated 12/26/2025 and 12/28/2025, MAR, for 12/2025, CIC Follow Up Nurses Notes form, dated 12/28/2025 to 12/30/2025, and Loeb's Minimum Criteria for Initiating Antibiotic Therapy form, dated 12/29/2025, were reviewed. The IP stated if a resident had an order for antibiotics, she (IP) utilizes Loeb's Minimum Criteria for Initiating Antibiotic Therapy form by checking if the resident meets the minimum criteria and the use of the antibiotic is appropriate. The IP stated the nurses are supposed to monitor the residents on antibiotics for adverse side effects every shift for the duration of the antibiotics and notify the physician immediately. The IP stated Resident 12 had a physician's order for Bactrim DS 2 times a day for 7 days on 12/28/2025 but did not have any fever and signs and symptoms of UTI, therefore Resident 12 did not meet any of the minimum criteria required according to the Loeb's Minimum Criteria for Initiating Antibiotic Therapy form. The IP stated an abnormal UA result was not one of the criteria in the Loeb's Minimum Criteria for Initiating Antibiotic Therapy form. The IP stated Resident 12 did not have any monitoring for adverse side effects for the use of Bactrim DS on 12/29/2025 and 12/30/2025 7a.m. to 7 p.m. shift. The IP stated Resident 12 should have been monitored for adverse side effects every shift. The IP stated if Resident 12 was not monitored for the adverse effects of antibiotics, Resident 12 could have adverse reactions, which could result in delay in physician notification and delay in resident care. The IP stated she should have notified the physician that Resident 12 did not meet the minimum criteria required for the use of antibiotics for UTI as it placed Resident 12 at risk for development of resistance to most antibiotics which makes infections harder to treat. During a concurrent interview and record review on 12/31/2025 at 1:30 p.m. with the Assistant Director of Nursing (ADON), Resident 12's physician's orders, UA results, SBAR Communication form, dated 12/26/2025 and 12/28/2025, MAR, for 12/2025, CIC Follow Up Nurses Notes form, dated 12/28/2025 to 12/30/2025, were reviewed. The ADON stated Resident 12 had an (continued on next page)		

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	abnormal UA result, the SBAR Communication form indicated increased confusion and temperatures of 98.3F and 98F and a physician's order for Bactrim D 800-160 mg 1 tablet 2 times a day for 7 days for UTI. The ADON stated nurses are supposed to monitor the residents for adverse side effects of antibiotic use every shift and document in the CIC Follow Up Nurses Notes. The ADON stated Resident 12 did not have monitoring documented for adverse side effects of antibiotic on 12/29/2025 and 12/30/2025 7 a.m. to 7 p.m. shift. The ADON stated Resident 12 should have been monitored for adverse side effects of antibiotic use which placed Resident 12 at risk for notifying the physician and a delay in care the resident needed. During a review of the facility's policy and procedure (P&P) titled, Antibiotic Stewardship, last reviewed on 12/18/2025, the P&P indicated: It is the policy of this facility to implement an Antibiotic Stewardship Program (ASP) that is incorporated in the overall Infection and Prevention and Control Program which will promote appropriate use of antibiotics while optimizing the treatment of infections, at the same time reducing the possible adverse events associated with antibiotic use. This policy has the potential to limit antibiotic resistance in the post-acute care setting improving treatment efficacy and resident safety. Antibiotic Stewardship refers to a set of commitments and actions designed to optimize the treatment of infections while reducing the adverse effects associated with antibiotic use. This can be accomplished through improving antibiotic prescribing, administration, and management practices reducing inappropriate use to ensure that residents receive the right antibiotic for the right indication, dose, and duration. Action: a. Facility may consider a time-out (TO) practice. A time-out can be considered a stop order of an antibiotic when a diagnostic test or symptoms of resident do not support the diagnosis of infection. These practices include improving the evaluation and communication of clinical signs and symptoms when a resident is first suspected of having an infection, optimizing the use of diagnostic testing, and implementing an antibiotic review process for all antibiotics prescribed in the facility. Antibiotic reviews provide clinicians with an opportunity to reassess the ongoing need for and choice of an antibiotic when the clinical picture is clearer and more information available. Tracking: a. IP or designee will be responsible for infection surveillance and MDRO (multidrug resistant organism &ndash; a germ or bacteria that is resistant to many organisms) tracking. b. IP or designee will collect and review data. 2. During a review of Resident 1's AR, the AR indicated the facility admitted the resident on 12/2/2025, with diagnoses including sepsis (a life-threatening blood infection), presence of cerebrospinal fluid drainage device (often called a shunt, is a thin tube system surgically placed to drain excess fluid from around the brain or spine, redirecting it to another body area (like the abdomen or heart) where it can be reabsorbed), and acute respiratory failure (a life-threatening condition that occurs when fluid leaks from small blood vessels in the lungs and builds up in the air sacs). During a review of Resident 1's H&P, dated 12/5/2025, the H&P indicated the resident does not have the capacity to understand and make decisions. During a review of Resident 1's MDS, dated [DATE], the MDS indicated the resident rarely to never had the ability to make self-understood and understand others and had severely impaired cognition (a person has significant problems with their mental abilities&mdash;such as thinking, remembering, and making decisions&mdash;to the extent that it majorly interferes with their daily life and they can no longer live independently). The MDS indicated the resident was on a high-risk drug class antibiotic. During a review of Resident 1's Order Summary Report (OSR), the OSR indicated an order for: - 12/4/2025 Amoxicillin-Pot Clavulanate Tablet 875-125 mg. Give 1 tablet via gastrostomy tube (g-tube - a soft tube placed through the belly wall directly into the stomach, acting as a shortcut for delivering food, fluids, and medicine when someone cannot eat enough or safely by mouth, ensuring they get essential nutrition and hydration) every 12 hours for bacterial infection for 7 days and give 1 tablet via g-tube one time only for bacterial infection until 12/04/2025. - 12/10/2025 Diflucan Oral Tablet 200 mg (Fluconazole). Give 1 tablet via g-tube one (continued on next page)		

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	time a day for oral thrush (a type of fungal infection) for 7 days. The OSR dated 12/30/2025 did not indicate any orders for monitoring for adverse effect on the use of Amoxicillin and Diflucan. During a review of Resident 1's CP Report titled, Is at risk for adverse reaction related to Amoxicillin-Pot Clavulanate Tablet 875-125 mg for g-tube insertion, last revised on 12/12/2025, the CP indicated a goal of the resident will be free of adverse drug reactions through the review date and an intervention to discuss with resident and family the number and type of medications resident is taking and the potential for drug interactions and side effects from over-medication. During a review of Resident 1's CP Report titled, Is at risk for adverse reaction related to Diflucan Oral Tablet 200 mg (Fluconazole)., last revised on 12/23/2025, the CP indicated a goal of the resident will be free of adverse drug reactions through the review date and an intervention to monitor for possible signs and symptoms of adverse drug reaction: falls, weight loss, fatigue, incontinence, agitation, lethargy, confusion, agitation, depression, poor appetite, constipation, and gastric upset. During a concurrent interview and record review on 12/30/2025 at 3:43 p.m. with the Assistant Director of Nursing (ADON), Resident 1's Medical Diagnosis, OSR, MAR, and CP. The ADON stated there was an order for two antibiotics that were completed in 12/2025, they were Amoxicillin-Pot Clavulanate Tablet 875-125 mg. Give 1 tablet via g-tube every 12 hours for bacterial infection for 7 Days and give 1 tablet via g-tube one time only for bacterial infection until 12/4/2025 and Diflucan Oral Tablet 200 mg (Fluconazole). Give 1 tablet via g-tube one time a day for oral thrush for 7 days. The ADON stated the order for Amoxicillin-Pot Clavulanate Tablet 875-125 mg. Give 1 tablet via g-tube every 12 hours for bacterial infection for 7 days should have been clarified with the attending physician by the licensed nurses because the indication was not specific. The ADON stated the indication bacterial infection is not enough justification for the use of the antibiotic and there were multiple missing monitoring for adverse effect on the use of Amoxicillin in the resident's electronic healthcare record. The ADON also stated there was an order for Diflucan Oral Tablet 200 mg (Fluconazole). Give 1 tablet via g-tube one time a day for oral thrush for 7 days and the licensed staff did not do a every shift monitoring for adverse effect on the use of Diflucan. The ADON stated antibiotics should have a valid specific indication for their use, an end date, and should be monitored for adverse effects on its use every shift. The ADON stated the failure of the licensed staff to clarify the indication of the Amoxicillin's use and to monitor the adverse effects of Amoxicillin and Diflucan had predisposed the resident to antibiotic resistance and they failed to monitor if the antibiotic is working and to intervene if the resident had been experiencing adverse effects. During a concurrent interview and record review on 12/31/2025, at 1:11 p.m., with the Infection Preventionist (IP), Resident 1's Diagnosis, OSR, MAR, and CP were reviewed. The IP stated the order for Resident 1's Amoxicillin should have been clarified with the attending physician as the indication was not specific, indicating bacterial infection is not enough to justify its use. The IP stated she screens the resident for appropriate antibiotic use and the antibiotic orders should have a specific indication, an end date, and should have monitoring for its adverse effects. The IP stated the Amoxicillin and Diflucan orders of Resident 1 did not have an order for monitoring for adverse effects of its use. The IP stated the staff failed to monitor for adverse effects of the two antibiotics that predisposed the resident to its adverse effects and antibiotic resistance. During a review of the facility's recent P&P titled, Antibiotic Stewardship, last reviewed on 12/18/2025, the P&P indicated it is the policy of this facility to implement an Antibiotic Stewardship Program (ASP) that is incorporated in the overall Infection and Prevention and Control Program which will promote appropriate use of antibiotics while optimizing the treatment of infections, at the same time reducing the possible adverse events associated with antibiotic use. During a review of the facility-provided Highlights of Prescribing Information (HPI) on the use of Amoxil (amoxicillin) capsules, tablets, or powder for oral suspension, with initial U.S. approval in 1974, the HPI indicated warnings and precautions of: -Anaphylactic reactions: Serious and occasional fatal anaphylactic reactions have been reported in patients on penicillin therapy. Serious anaphylactic reactions require immediate emergency treatment with supportive measures. -Clostridium difficile (continued on next page)		

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	diarrhea (ranging from mild diarrhea to fatal colitis. Evaluate if diarrhea occurs. During a review of the facility-provided Information on the use of Diflucan (Fluconazole Tablets) (Fluconazole Injection- for intravenous infusion only) (Fluconazole for Oral Suspension), revised 5/2011, the Information indicated warnings: 1. Hepatic (relating to the liver - body part that filters toxins from the blood, help digest food, and store energy) Injury. 2. Anaphylaxis (a severe, sudden, potentially fatal allergic reaction). 3. Dermatologic (relating to the skin, hair, nails, and mucous membranes) . Etc. 3. During a review of Resident 33's AR, the AR indicated the facility admitted the resident on 12/3/2025, with diagnoses including closed fracture (a broken bone where the skin stays intact), retention of urine (when a person is unable to empty the urine from the bladder and the urine may back up into the kidneys [part of the body that filters blood]), gastro-esophageal reflux disease (GERD - a chronic condition where stomach acid frequently flows back up into the esophagus [food pipe] because the muscle at the end of the esophagus does not close properly, causing irritation and symptoms like heartburn, regurgitation, and difficulty swallowing). During a review of Resident 33's H&P, dated 12/4/2025, the H&P indicated the resident had the capacity to understand and make decisions. During a review of Resident 33's MDS, dated [DATE], the MDS indicated the resident had the ability to make self-understood and understand others and had intact cognition (having a clear, sharp, and sound mind). During a review of Resident 33's OSR, dated 12/15/2025, the OSR indicated an order for Methenamine Hippurate Oral Tablet 1 gram (gm - a unit of weight) (Methenamine Hippurate). Give 1 tablet by mouth two times a day for prophylaxis (PPX - taking action to prevent something bad from happening, usually a disease or infection, before it starts) for UTI. During a review of Resident 33's CP Report titled, Is at risk for adverse reaction related to Methenamine Hippurate Oral Tablet 1 gm. Give 1 tablet by mouth two times a day for supplement, initiated on 12/4/2025, the CP indicated a goal of the resident will be free of adverse drug reactions through the review date and an intervention to discuss with resident and family the number and type of medications the resident is taking and the potential for drug interactions and side effects from over-medication. During a concurrent interview and record review on 12/30/2025, at 3:59 p.m., with the ADON, Resident 33's Medical Diagnosis, OSR, MAR, and CP were reviewed. The ADON stated the licensed staff should have clarified the order with the attending physician because there was no end date on the use of Methenamine Hippurate and there was no order to monitor for its adverse effects. The ADON stated the medication was for UTI prophylaxis but somehow it needs a certain date to reevaluate its use because the antibiotic tends to be resistant to infection if used for a longer period of time. The ADON also stated he did not find any monitoring for its adverse effects on the resident's electronic chart. The ADON stated it was important to monitor for its adverse effects to know if the medication needed to be adjusted or discontinued. During a concurrent interview and record review on 12/31/2025, at 1:18 p.m., with the IP, Resident 33's Medical Diagnosis, OSR, MAR, and CP were reviewed. The IP stated there was no end date for the drug due to the resident was having recurrent UTIs. The IP stated there should be monitoring for adverse effects on the use of Methenamine Hippurate to determine if the medication is working and if it needed to be adjusted. The IP stated it was important to monitor for its adverse effect for the healthcare team to intervene right away and relieve the resident from unnecessary discomforts the drug may bring. During a review of the facility's recent P&P titled, Antibiotic Stewardship, last reviewed on 12/18/2025, the P&P indicated it is the policy of this facility to implement an Antibiotic Stewardship Program (ASP) that is incorporated in the overall Infection and Prevention and Control Program which will promote appropriate use of antibiotics while optimizing the treatment of infections, at the same time reducing the possible adverse events associated with antibiotic use. During a review of the facility-provided Information on the use of Hiprex (methenamine Hippurate tablets USP), revised 12/2017, the Information indicated to reduce the development of drug-resistant bacteria and maintain the effectiveness of Hiprex (methenamine Hippurate tablets USP) and other antibacterial drugs, Hiprex should be used only to treat or prevent infections that are proven or strongly suspected to be caused by bacteria. Precautions Prescribing Hiprex in the absence (continued on next page)		

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	of a proven or strongly suspected bacterial infection or a prophylactic indication is unlikely to provide benefit to the patient and increases the risk of the development of drug-resistant bacteria. 4. During a review of Resident 41's AR, the AR indicated the facility admitted the resident on 12/2/2024, with diagnoses including traumatic subarachnoid hemorrhage (bleeding in the space surrounding the brain as a direct result of a head injury), acute kidney failure (the rapid (less than 2 days) loss of the kidneys' ability to remove waste and help balance fluids and electrolytes in the body), and dysphagia (difficulty swallowing). During a review of Resident 41's H&P, dated 12/29/2025, the H&P indicated the resident does not have the capacity to understand and make decisions. During a review of Resident 41's MDS, dated [DATE], the MDS indicated the resident had the ability to make self-understood and understand others and had intact cognition. During a review of Resident 41's OSR, dated 12/28/2025, the OSR indicated an order for Bactrim DS Oral Tablet 800-160 mg (Sulfamethoxazole-Trimethoprim). Give 1 tablet by mouth every 12 hours for UTI for 5 days. During a review of Resident 41's CP Report titled, Resident has infection of the UTI, initiated on 12/28/2025, the CP indicated a goal of the resident will have minimal to no complications related to infection through the course of treatment. During a concurrent interview and record review on 12/30/2025, at 4:28 p.m., with the ADON, Resident 41's Medical Diagnosis, OSR, MAR, and CP were reviewed. The ADON stated there was an order for Bactrim on Resident 41 however, there was no monitoring for adverse reaction on the use of the antibiotic by the licensed staff done. The ADON stated there should be monitoring for adverse effects of the drug so that they could adjust the medication and intervene if the resident exhibits signs and symptoms of adverse effect caused by the antibiotic. During a concurrent interview and record review on 12/31/2025 at 1:20 p.m. with the IP, Resident 41's Medical Diagnosis, OSR, MAR, and CP were reviewed. The IP stated there was no monitoring for adverse effect on the use of Bactrim on Resident 41. The IP stated the licensed staff should have monitored for the adverse effect of the medication to help the attending physician adjust or discontinue the dose of the medication. During a review of the facility's recent P&P titled Antibiotic Stewardship, last reviewed on 12/18/2025, the P&P indicated it is the policy of this facility to implement an Antibiotic Stewardship Program (ASP) that is incorporated in the overall Infection and Prevention and Control Program which will promote appropriate use of antibiotics while optimizing the treatment of infections, at the same time reducing the possible adverse events associated with antibiotic use. During a review of the facility provided Information on the use of Bactrim Sulfamethoxazole and trimethoprim DS (double strength) tablets and tablets USP, revised 6/2013, the Information indicated precautions: - Development of drug-resistant bacteria - Folate (a type of vitamin) deficiency - Hemolysis (the breakdown or destruction of red blood cells)- Hypoglycemia (low blood sugar)- Phenylalanine (a protein building block the body needs, but cannot make) metabolism (the body's internal process of turning food and drinks into the energy it needs to function) Etc.		

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. Based on observation, interview, and record review, the facility failed to maintain the residents' right to privacy and confidentiality by failing to: 1. Ensure Licensed Vocational Nurse (LVN) 2 did not leave an unattended computer screen in a public area displaying a resident's personal clinical information and Medication Administration Record (MAR, a record of all medications taken by a resident on a day-to-day basis) for one randomly sampled resident (Resident 23). 2. Provide privacy when LVN 2 administered Resident 6's scheduled morning medications in the activity room. This deficient practice had resulted in unauthorized exposure of the resident's medical care and treatment resulting in violation of the resident's right to privacy with the potential to cause psychosocial harm. Findings: a. During a review of Resident 23's admission Record (AR), the AR indicated the facility admitted the resident on 12/12/2025, with diagnoses that included morbid obesity (a serious health condition that results from an abnormally high body mass), pulmonary fibrosis (a lung disease that occurs when lung tissue becomes damaged and scarred), and diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing). During a review of Resident 23's Minimum Data Set (MDS &ndash; resident assessment tool) dated 12/18/2025, the MDS indicated the resident was able to understand others and was able to make herself understood. The MDS further indicated that the resident was dependent on staff for toileting, bathing, and lower body dressing. During a review of Resident 23's History and Physical (H&P), the H&P indicated the resident had the capacity to understand and make decisions. During an observation on 12/29/2025 at 12:20 p.m., observed Medication Cart 1 unattended by staff in the hallway outside Room A with the monitor screen turned on. While standing in the hallway, the surveyor was able to view the monitor screen displaying Resident 23's full name, photo, date of birth , age, allergies, code status, most recent vital signs, weight, and MAR. Observed LVN 2 was inside Room A attending to a resident while standing behind a closed curtain that separated the computer from LVN 2. During a concurrent observation and interview on 12/29/2025 at 12:23 p.m., observed LVN 2 exit Room A and stated that she (LVN 2) left the monitor screen on with Resident 23's MAR visible from the hallway while she (LVN 2) was inside another resident's room. LVN 2 stated she (LVN 2) should not have left the monitor on and open to Resident 23's MAR because of the Health Insurance Portability and Accountability Act (HIPAA, a federal law that sets standards protecting sensitive health information from disclosure). LVN 2 stated she (LVN 2) was sorry and should have closed the monitor screen prior to leaving Medication Cart 1 in the hallway to attend to another resident. During a concurrent interview and record review on 12/31/2025 at 2:05 p.m. with the Director of Nursing (DON), the DON reviewed the facility policy and procedures (P&P) regarding resident privacy of medical records. The DON stated the facility P&P is that resident personal information is protected. The DON stated the computers on the medication carts have privacy screens that can be turned on when the licensed nurse is not near the computer to protect personal information, like resident medications, from being seen by others. The DON stated LVN 2 could also have just turned off the monitor screen, but she did not. The DON stated the facility P&P was not followed when LVN 2 left the computer unattended with the screen open to Resident 23's personal clinical information and MAR potentially affecting the resident psychosocially resulting in the resident to have distrust of the facility staff. (continued on next page)		

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility P&P titled, Medication Administration-General Guidelines, last reviewed 12/18/2025, the P&P indicated, Medications are administered as prescribed in accordance with good nursing principles and practices and only by persons legally authorized to do so. Personnel authorized to administer medications do so only after they have been properly oriented to the facility's medication distribution system (procurement, storage, handling and administration). privacy is maintained always for all resident information (e.g., MAR) [by closing the MAR book/covering the MAR sheet or computer screen] when not in use. During a review of the facility P&P titled, Resident / Patient Confidentiality, last reviewed 12/18/2025, the P&P indicated, POLICY: All resident Health Information is confidential and protected by HIPAA Law. HIPAA DEFINITION-The Health Insurance Portability and Accountability Act. HIPAA is a federal law that is designed to protect the privacy and security of patient health information. Privacy Rule-The HIPAA Privacy Rule establishes national standards to protect individuals' medical records and other personal health information and applies to health plans, health care clearinghouses, and those health care providers that conduct certain health care transactions electronically. The Rule requires appropriate safeguards to protect the privacy of personal health information, and sets limits and conditions on the uses and disclosures that may be made of such information without patient authorization. All staff, volunteers, and vendors must not disclose any medical information about a resident, either, verbally, written, or electronically. During a review of the facility P&P titled, Dignity and Privacy, last reviewed 12/18/2025, the P&P indicated, POLICY. It is the policy of this facility that all residents be treated with kindness, dignity and respect. PROCEDURES: 1. The staff shall display respect for Resident's when speaking with, caring for, or talking about them, as constant affirmation of their individuality and dignity as human beings. b. During a review of Resident 6's admission Record (AR), the AR indicated that the facility admitted the resident on 11/4/2025 with diagnoses including wedge compression fracture (the front side of the bone collapses, resulting in wedge-shaped vertebra [backbones supporting the body and protecting the spinal cord (a bundle of nerves that extends from the base of the brain to the lower back)]) of first lumbar vertebra, dysphagia (difficulty swallowing), and immunodeficiency (a state in which the immune system's ability to fight infectious diseases and cancer is compromised or entirely absent) due to conditions. During a review of Resident 6's History and Physical (H&P), dated 11/6/2025, the H&P indicated the resident had the capacity to understand and make decisions. During a review of Resident 6's Minimum Data Set (MDS-a resident assessment tool), dated 11/10/2025, the MDS indicated the resident usually understand others and usually make himself understood. The MDS indicated that the resident required assistance with eating, toileting hygiene, shower/bathe self, upper and lower body dressing, and personal hygiene. During a review of Resident 6's Care Plan (CP) Report focused on Cognitive Loss, dated 11/6/2025, the CP Report indicated the resident with goals of maintaining current level of cognitive function with interventions which included to maintain consistent daily routines for waking, meals, therapies, and bedtime to reduce confusion, and support orientation. During an observation on 12/29/2025 at 9:58 a.m., in the activity room, LVN 2 administered medications to Resident 6. Resident 6 was observed sitting on a wheelchair and sharing a table facing (continued on next page)		

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	two other residents. During a concurrent interview and record review on 12/29/2025 at 10:10 a.m. with LVN 2, reviewed Resident 6's Medication Administration Record for 12/29/2025. LVN 2 stated she (LVN 2) gave Resident 6 his morning medications. LVN 2 stated she (LVN 2) went to the resident's room and he (Resident 6) was not there and found him in the activity room and administered the medications there. LVN 2 stated she (LVN 2) gave Resident 6's morning medications including blood pressure medications: amlodipine, metoprolol, and other medications including Cymbalta (an antidepressant medication), clopidogrel (an antiplatelet medication used to prevent blood clots), methocarbamol (muscle relaxant), tamsulosin (an alpha blocker used to relax the muscles in the prostate and bladder and improves urine flow), Zenpep (an enzyme replacement medication), aspirin (an anti-inflammatory medication and in low doses prevent blood clots), senna (stimulant laxative), and Percocet (medication used for the relief of moderate to moderately severe pain). During an interview on 12/29/2025 at 2:07 p.m. with Resident 6, Resident 6 stated he (Resident 6) always takes his medications in his room and takes his pain medication before his therapy. Resident 6 stated he (Resident 6) takes his medications, including his pain medication, every day. Resident 6 stated today the nurse gave his medications in the dining room (activity room). Resident 6 stated he (Resident 6) needed to take his pain medication before his therapy, but that was the first time he (Resident 6) was taking his medications in the dining room. Resident 6 stated he (Resident 6) prefers to take his medications in his room. During an interview on 12/31/2025 at 4:25 p.m. with Assistant Director of Nursing (ADON), the ADON stated the medications should be provided at the bedside for privacy and confidentiality of the resident. The ADON stated the licensed nurse should have asked the resident what his preferences are when taking his medications and follow the resident's preferences. During a review of the facility's policy and procedure (P&P), titled, Resident / Patient Confidentiality, last reviewed 12/18/2025, the P&P indicated, POLICY: All resident Health Information is confidential and protected by HIPAA Law. HIPAA DEFINITION-The Health Insurance Portability and Accountability Act. HIPAA is a federal law that is designed to protect the privacy and security of patient health information. Privacy Rule-The HIPAA Privacy Rule establishes national standards to protect individuals' medical records and other personal health information and applies to health plans, health care clearinghouses, and those health care providers that conduct certain health care transactions electronically. The Rule requires appropriate safeguards to protect the privacy of personal health information, and sets limits and conditions on the uses and disclosures that may be made of such information without patient authorization. All staff, volunteers, and vendors must not disclose any medical information about a resident, either, verbally, written, or electronically. During a review of the facility's P&P titled, Dignity and Privacy, last reviewed 12/18/2025, the P&P indicated, that it is the policy of this facility that all residents be treated with kindness, dignity and respect. The P&P indicated its procedures including: 1. The staff shall display respect for Resident's when speaking with, caring for, or talking about them, as constant affirmation of their individuality and dignity as human beings.		

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. Based on observation, interview, and record review, the facility failed to ensure residents were treated with respect and dignity including the right to be free from physical restraints (any manual method, physical or mechanical device, material or equipment that is attached or adjacent to the resident's body that he or she cannot easily remove that restricts freedom of movement or normal access to one's body) for one (1) of one (1) sampled resident (Resident 12) reviewed for physical restraints by failing to obtain a physician's order, informed consent, and complete a restraint assessment prior to placement of bed pad alarm (a pad with sensors that will alarm when a resident stands up unassisted to help prevent falls by alerting staff). These deficient practices had the potential to result in the restriction of the resident's freedom of movement, a decline in physical functioning, psychosocial harm, physical harm from entrapment, and death of residents. Findings: During a review of Resident 12's admission Record (front page of the chart that contains a summary of basic information about the resident), the admission Record indicated the facility admitted Resident 12 on 12/15/2025, with diagnoses including type two (2) diabetes mellitus (DM 2 - a disorder characterized by difficulty in blood sugar control and poor wound healing), generalized muscle weakness, and difficulty walking. During a review of Resident 12's History and Physical (H&P) dated 12/16/2025, the H&P indicated Resident 12 did not have the capacity to understand and make decisions. During a review of Resident 12's Minimum Data Set (MDS, a resident assessment tool), dated 12/21/2025, the MDS indicated Resident 12 had severely impaired cognition (mental action or process of acquiring knowledge and understanding) and was sometimes able to understand and make her needs known. The MDS further indicated Resident 12 required substantial or maximal assistance to total assistance from staff with all activities of daily living (ADLs - activities such as bathing, dressing and toileting a person performs daily). During a review of Resident 12's Order Summary Report dated 12/31/2025, the Order Summary Report did not indicate a physician's order for the use of bed pad alarm. During a review of Resident 12's paper and electronic health records, the paper and electronic health records did not indicate a consent that was obtained from the Resident 12's responsible party for the use of the bed pad alarm. During a review of Resident 12's fall risk evaluation dated 12/15/2025, the fall risk evaluation indicated that Resident 12 was at high risk for falls. During a review of Resident 12's care plan (CP) on risk for falls initiated on 12/15/2025 last revised on 12/28/2025, the CP indicated bed alarm to remind the resident or staff of unassisted transfers from bed as one of the interventions so the resident will remain free from falls. During a concurrent observation and interview on 12/29/2025 at 10:25 a.m. inside Resident 12's room with the Infection Preventionist (IP), the IP stated Resident 12 had a bed alarm and the bed alarm was functioning well as evidenced by the presence of a green. The bed alarm made a loud beeping sound when the two (2) buttons were pressed. During a concurrent interview and record review on 12/31/2025 at 11:20 a.m. with the Assistant Director of Nursing (ADON), Resident 12's physician's orders, informed consents, CP, and restraint assessment were reviewed. The ADON stated a device used in any form that the resident is unable to remove freely can be considered a restraint and should have a physician's order, informed consent, and restraint assessment prior to application of the restraint. The ADON stated Resident 12 did not have a physician's order, informed consent obtained from the responsible party, and restraint assessment completed prior to application of bed pad alarm. The ADON stated there should have been a physician's order, informed consent, and a completed restraint assessment prior to applying the bed pad alarm to Resident 12 even if the bed pad alarm was a family preference. The ADON stated that when the bed pad alarm activates during movement, the sound startles Resident 12 and restricts movement. During an interview on 12/31/2025 at 11:45 a.m. with the DON, the DON stated prior to application of restraints, the staff are supposed to try the least restrictive measures first. The DON stated if the least restrictive measures did not work, the LN is (continued on next page)		

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	supposed to obtain an order from the physician for the type of restraint needed, the reason for the restraint is required, confirm informed consent from the family with explanation of risks and benefits to give them a chance to decline or agree with the plan, and complete a restraint assessment to ensure the type of restraint to be used is appropriate. The DON stated Resident 12 had a previous order for a bed pad alarm and was discontinued on 12/28/2025. The DON stated the previous physician's order did not indicate that the physician obtained informed consent from the family to explain the risks and benefits of the restraint use. The DON stated if the family insisted on not removing the bed pad alarm, it should have been care planned, obtain a new physician's order, obtain informed consent from the family, and complete a restraint assessment prior to reapplying the bed pad alarm. The DON stated applying the restraint without a physician's order, informed consent, and restraint assessment is not honoring Resident 12's right to be restraint free which can result in a decline in physical functioning. During a review of the facility's policy and procedure (P&P) titled, Restraint, Physical, last reviewed on 12/18/2025, the P&P indicated that it is the facility's policy to only use restraints as a last resort in the least restrictive manner when it is considered medically necessary. - Physical Restraint - any manual method or physical or mechanical device, material, or equipment attached or adjacent to the resident's body that the individual cannot remove easily, which restricts freedom of movement or normal access to one's body. - All resident will be assessed on admission, quarterly, annually, and with significant change of status for the use and appropriateness of physical restraints. - If it is determined that a resident requires the use of a restraint, then further assessment will be done. - Any resident using a restraint will have a current order with the following components: the exact type of restraint, circumstances for usage, the medical reason for usage, a release/exercise statement. - Any resident using a physical restraint must have a current signed consent in the clinical chart that identifies the risks/benefits of the restraint, the medical symptom for the restraint usage, and alternatives to the restraint - The facility may not use restraints in violation of the regulation solely based on a legal surrogate or representative's request or approval.		

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to develop a baseline care plan for one of two sampled resident (Resident 44) reviewed for Pain Management by failing to develop a care plan that identified resident-centered interventions per facility policy and procedure (P&P) regarding Resident 44's use of as needed (PRN) hydrocodone - acetaminophen (an opioid [also called a narcotic - powerful pain-reducing medication]). This deficient practice had the potential to result in miscommunication among facility staff and a delay in care or lack of delivery of care and services for the resident. Findings: During a review of Resident 44's admission Record (AR), the AR indicated the facility admitted the resident on 11/14/2025 with diagnoses that included hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) and hemiparesis (partial paralysis or weakness on one side of the body), metabolic encephalopathy a (general term that describes brain disease, damage, or malfunction usually related to inflammation within the body), polyneuropathy (a disorder of the peripheral nervous system that may result in pain, discomfort, and mobility issues), and peripheral vascular disease (PVD - a slow progressive narrowing of the blood flow to the arms and legs). During a review of Resident 44's Minimum Data Set (MDS - resident assessment tool), dated 11/20/2025, the MDS indicated the resident was able to understand others and was able to make himself understood. The MDS further indicated that the resident required substantial / maximal assistance from staff for toileting, bathing, upper and lower body dressing, and mobility.~The MDS indicated the resident was taking opioids, a high-risk drug class of medication (drugs that have a heightened risk of causing significant patient harm when they are used in error). During a review of Resident 44's Physician Order Summary, the Physician Order Summary indicated the following orders: - Hydrocodone - acetaminophen oral tablet five (5) - 325 milligrams (mg - a unit of measurement), give one (1) tablet by mouth every four (4) hours PRN for pain 1- six (6) out of 10, dated 11/14/2025 and discontinued and re-ordered on 12/26/2025. - Hydrocodone - acetaminophen oral tablet 5 - 325 mg, give two (2) tablets by mouth every 4 hours PRN for pain seven (7) to 10 out of 10, dated 11/14/2025 and discontinued and re-ordered on 12/26/2025.~ During a review of Resident 44's Care Plan (CP) titled, Has acute / chronic pain, initiated 11/15/2025, the CP indicated a goal that the resident would not have an interruption in normal activities of daily living. The CP listed the following interventions: anticipate need for pain relief and respond immediately to any complaint of pain; identify, record and treat resident's existing conditions which may increase pain and or discomfort; observe and report changes in usual routine, sleep patterns, decrease in functional abilities, decrease ROM, withdrawal or resistance to care; pain assessment every shift; and report to nurse any change in usual activity attendance patterns or refusal to attend activities related to signs or symptoms or complaints of pain or discomfort. During a review of Resident 44's Hospital Discharge summary, dated [DATE], the Hospital Discharge Summary indicated the resident was hospitalized from [DATE] to 12/26/2025. During a concurrent observation and interview on 12/29/2025 at 9:25 a.m., Resident 44 lay in bed and stated he (Resident 44) often had pain and is given pain medication. Resident 44 stated the pain medication causes constipation. During a concurrent interview and record review on 12/31/2025 at 8:22 a.m. with Licensed Vocational Nurse (LVN) 3, Resident 44's physician orders, Medication Administration Record (MAR - a daily documentation record used by a licensed nurse to document medications and treatments given to a resident) for 12/2025, and CPs were reviewed. LVN 3 stated baseline CPs are completed when a resident is readmitted . LVN 3 stated the baseline CP indicates the main focuses of each resident's care with specific goals and interventions for each discipline to provide the care to meet those goals. LVN 3 stated that when a resident has acute or chronic pain it is important to include the use of opioid medication in the CP because it is a resident specific intervention used to achieve the goal for acute or chronic pain relief. LVN 3 stated Resident 44 was (continued on next page)		

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	readmitted on [DATE], verbalized pain, and receives hydrocodone - acetaminophen pain management. LVN 3 stated Resident 44's CP regarding acute / chronic pain should include an intervention for the administration of opioid pain medication, but it did not. LVN 3 stated when Resident 44's did not have a baseline CP that included the use of opioids there was the potential for ineffective care and poor pain management resulting in a decline in the resident's functional mobility, an increase in depression, or unrecognized side effects of opioids like constipation. During a concurrent interview and record review on 12/31/2025 at 2:05 p.m. with the Director of Nursing (DON), the facility policy and procedures (P&P) regarding CPs and pain management were reviewed. The DON stated baseline CPs include the minimum healthcare information to provide basic care to a resident upon admission or readmission. The DON stated the facility P&P indicates physician's orders are included in the baseline CP. The DON stated Resident 44's physician order for the use of PRN hydrocodone - acetaminophen tablets to treat pain should have been included in the baseline CP because the medication was an important intervention for pain management, but it was not included. The DON stated the facility P&P was not followed with the potential to result in staff not knowing how to provide care for pain management to Resident 44. During a review of the facility's P&P titled, Pain Management, last reviewed 12/18/2025, the P&P indicated, Policy. It is the policy. to ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, comprehensive and routine assessments, person-centered care plan, and the residents' goals and preferences. Procedure. 2. To the extent possible, staff will: . b. Evaluate existing pain and the causes. c. Manages or prevents pain, consistent with the comprehensive assessment and plan of care, current professional standards of practice, and the resident's goals and preferences. 4. Management: a. The care plan will include preventative or care interventions (pharmacological and non?pharmacological) to manage and/or prevent pain and consider the resident needs, preferences and goals. During a review of the facility's P&P titled, Comprehensive Person - Centered Care Planning, last reviewed 12/18/2025, the P&P indicated, Policy. It is the policy of this facility that the interdisciplinary team (IDT) shall develop a comprehensive person? centered care plan for each resident that includes measurable objectives and timeframes to meet a resident's medical, nursing, mental and psychosocial needs that are identified in the comprehensive assessment. The IDT team will also develop and implement a baseline care plan for each resident, within 48 hours of admission, that includes minimum healthcare information necessary to properly care for each resident and instructions needed to provide effective and person-centered care that meet professional standards of quality care. Definitions. Resident's Goal - refers to the resident's desired outcomes and preferences for admission, which guide decision-making during care planning. Interventions - are actions, treatments, procedures, or activities designed to meet an objective. Objective - is a statement describing the results to be achieved to meet the resident's goals. Person-centered care - means to focus on the resident as the locus of control and support the resident in making their own choices and having control over their daily lives. Procedure: 1. Within 48 hours of the resident's admission, the facility will develop and implement a baseline care plan that includes instructions needed to provide effective and person-centered care. 2. The baseline care plan will include the minimum healthcare information necessary to properly care for a resident including, but not limited to: a) Initial goals based on admission orders, b) Physician orders.		

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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 interview and record review, the facility failed to ensure necessary treatment and care was provided for one of three sampled residents (Resident 43). The facility failed to: 1. Ensure licensed nurse assessed and monitored Resident 43's change of condition (COC- a sudden, clinically important deviation from a patient's baseline in physical, cognitive [ability to think, and understand] behavioral, or functional status which without immediate intervention, may result in complications or death) when Resident 43 complained of urinary symptoms. 2. Ensure Licensed Nurses notify the physician of the change of condition and carry out physician order for laboratory test ordered on 12/28/2025. 3. Develop a care plan for symptoms of urinary tract infection (UTI - an infection in the bladder/urinary tract) These deficient practices has the potential for delay of care and services with the potential of worsening Resident 43's condition. Findings: During a review of Resident 43's admission Record, the admission Record indicated Resident 43 was admitted on [DATE] with diagnosis that included encephalopathy (a brain disease that alters brain function or structure), generalized muscle weakness, and sepsis (a life-threatening blood infection). During a review of Resident 43's Minimum Data Set (MDS - a resident assessment tool), dated 12/4/2025, the MDS indicated Resident 43's cognition (mental action or process of acquiring knowledge and understanding) was moderately impaired. The MDS indicated Resident 43 requires substantial/maximal assistance with toileting hygiene, bathing, dressing and partial/moderate assistance with eating, and personal hygiene. The MDS indicated Resident 43 is dependent on staff for mobility with sitting to stand, chair/bed to chair transfer and toilet transfer. The MDS also indicated Resident 43's has urinary incontinence (the loss of bladder control). During an interview on 12/29/2025 at 12:58 p.m. with Resident 43, Resident 43 stated she was feeling discomfort when she urinates and has reported it to staff. Resident 43 stated she is continent and uses the bathroom with assistance, however, at times she is incontinent and staff change her when needed. During subsequent interview with Resident 43 on 12/30/2025 at 8:30 a.m., Resident 43 stated she continues to have tingling sensation when she urinates. During a concurrent interview and record review on 12/30/2025 at 9:22 a.m. with Licensed Vocational Nurse (LVN) 4, Resident 43's physician orders dated 12/28/2025 dated and Medication Administration Record (MAR) dated 12/2025 were reviewed. The physician's order indicated urinalysis and culture and sensitivity (UA C/S - a test that checks the urine for signs of infection and if present, identifies which bacteria causing the infection) to be performed in the morning, one time only for one day. The MAR reflected the UA C/S order, with LVN 5's initials recorded at 10:10 p.m. LVN 4 stated the MAR indicated the urine had been collected by LVN 5. LVN 4 further stated there was no documentation of a change in condition and no care plan addressing Resident 43's urinary symptoms. During a concurrent interview and record review on 12/30/2025 at 10:02 a.m. with Director of Nursing (DON), Resident 43's nursing progress notes dated 12/28/2025 and Physician orders dated 12/28/2025 were reviewed. DON stated that the LVN's nursing progress notes indicated Resident 43 was continent of bladder, urine clear, denies urinary complaints. DON stated there was no assessment performed for Resident 43's complaint of urinary symptoms and no change of condition documentation found in Resident 43's records. DON stated that when residents complain of abnormal urinary symptoms, licensed nurse is expected to assess the resident and document findings, inform the physician and carry out what physician orders, including obtaining and sending urine to laboratory if ordered. The DON stated the physician order indicated UA C&S and the order was not carried out since the laboratory request was not done. The DON explained that entering the laboratory request informs the laboratory of the physician order and it is what alerts the laboratory to pick up the urine specimen (urine collected from resident) from the facility. During an interview on 12/30/2025 at 11:51 a.m. with LVN 5, (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	LVN 5 stated LVN 6 told him Resident 43 needed a urine sample collected for UA C&S. LVN 5 stated that while obtaining urine from Resident 43, Resident 43 complained of intermittent discomfort during urination. LVN 4 stated he did not notify the physician since LVN 6 told him she already completed SBAR Situation, Background, Assessment, Recommendation (SBAR - communication framework widely used in healthcare setting to ensure clear, concise, and organized information exchange among team members). LVN 5 stated he collected the urine but did not enter the laboratory request as LVN 6 told him his only responsibility was to collect the sample. LVN 5 also stated he did not develop a care plan because the nurse who completes the change of condition and SBAR also develops the care plan. LVN 5 stated as the charge nurse, it was his responsibility to ensure Resident 43 was appropriately assessed, physician notified, change of condition/SBAR completed, physician orders are carried out and a care plan developed. LVN 5 stated he should have sought more information from LVN 6 and verified what he was being told. LVN 5 stated UA and C&S are laboratory tests to detect infection. LVN 5 stated when specimen is not received by laboratory, it causes a delay in treatment, symptoms continue and may get worse, possibly leading to sepsis (a life-threatening complication of an infection). During an interview on 12/30/2025 at 2:08 p.m. with LVN 6, LVN 6 stated she informed LVN 5 on 12/28/2025 that Resident 43 had an order for UA C&S and urine sample was needed. LVN 6 stated she was assigned as desk nurse that evening and did not have any direct encounter with Resident 43 during her shift. During an interview on 12/31/2025 at 4:35 p.m. with Assistant Director of Nursing (ADON), ADON stated when a resident presents with urinary symptoms, the licensed nurse is required to conduct a thorough assessment, initiate a change of condition, notify the physician, carry out physician orders, notify the family, and develop a care plan. Additionally, documentation of 72-hour monitoring for the change of condition must be completed. The ADON further stated that the laboratory requisition should have been completed when the urine was obtained from Resident 43 by the licensed nurse who collected the urine. Without the laboratory requisition completed, the specimen does not get processed and there would be no test results to report to the physician for physician to decide the care and treatment for the resident. The ADON stated this results in delay of care and if there is an actual infection, places the resident at risk for complications that may lead to hospitalization. ADON also stated not having a care plan may cause resident's condition to get worse since without a care plan, there are no planned interventions and treatment specific to the problem the resident is experiencing. During a review of the facility's policies and procedures (P&P) titled, Charting and Documentation, last reviewed 12/18/2026, the P&P indicated The purpose of this procedure is to provide 1. A complete account of the resident's care, treatment, response to the care, signs, symptoms, etc. as well as the progress of the resident's care. 3. The facility as well as other interested parties, with a tool for measuring the quality of care provided to the resident. 4. Nursing service personnel with a record of the physical and mental status of the resident. 5. Assistant in the development of a Plan of Care for each resident. 6. The element of quality medical nursing care. During a review of the facility's P&P titled, Change of Condition last reviewed 12/18/2025, the P&P indicated 1. If, at any time, it is recognized by any one of the team members that the condition or care of the resident changed, the Licensed Nurse or Nurse Supervisor should be made aware. Examples would be (but not limited to). any signs of infection. The P&P indicated the nurse will perform and document assessment of the resident and identify need for additional interventions, considering implementation of existing orders or nursing interventions or through communication with the resident's provider using SBAR or similar process to obtain new order or interventions. 3. The resident will then be placed on the 24-Hour Report and Nursing will provide no less than three (3) days of observation, documentation, and response to any interventions. During a review of the facility's P&P titled, Urine, last reviewed 12/18/2025, the P&P indicated After obtaining urine specimen: 5. Record procedure in the resident's chart, noting color, consistency. During a review of the facility's (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	P&P titled, Physicians Orders, Telephone Orders, last reviewed 12/18/2025, the P&P indicated, 4. All orders must include the date and time received and must be noted by the professional staff taking the order (i.e. licensed nurse, therapist, dietician, pharmacist). 5. When noting orders, if the licensed staff member is not able to implement the order (i.e., physician needs to be contacted for clarification, authorization needs to be obtained, scheduling and transportation need to be arranged, or other reasons) then the following procedure is followed to ensure follow-up and timely implementation of the order. If the physician does not respond within 24 hours, the licensed staff will notify the Director of Nursing who will involve the Administrator and/or Medical Director to ensure a response from the physician. During a review of the facility's P&P titled, Comprehensive Person-Centered Care Planning, last reviewed 12/18/2025, the P&P indicated, It is the policy of the facility that the interdisciplinary team (IDT) shall develop a comprehensive person-centered care plan for each resident that includes measurable objectives and timeframes to meet a resident's medical, nursing, mental and psychological needs that are identified in the comprehensive assessment.6. The residents' comprehensive plan of care will be reviewed and/or revised by the IDT after each assessment, including both the comprehensive and quarterly review assessment.		

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. Based on observation, interview, and record review, the facility failed to ensure the staff providing care and services to the resident who has a feeding tube (are soft plastic tubes through which liquid nutrition travels through the gastrointestinal tract [the series of organs that food and liquids pass through as they are digested, absorbed, and leave the body as feces]) are aware of, competent in, and utilize facility protocols regarding feeding tube nutrition and care for one of one sampled resident (Resident 1) reviewed for tube feeding by failing to ensure Resident 1's water flush bag was labeled with the resident's name, room number, rate of infusion, and initials of the licensed nurse who hung the water flush bag. This deficient practice had the potential to result in altered nutritional status that can lead to over or under hydration, gastrointestinal (GI, relating to stomach and intestines) infection to the resident. Findings: During a review of Resident 1's admission Record (AR), the AR indicated the facility admitted the resident on 12/2/2025, with diagnoses including dysphagia (difficulty swallowing), gastrostomy (a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems), and pneumonitis (inflammation (swelling and irritation) of the lung tissue) due to inhalation of food and vomit. During a review of Resident 1's History and Physical (H&P), dated 12/5/2025, the H&P indicated the resident did not have the capacity to understand and make decisions. During a review of Resident 1's Minimum Data Set (MDS, a resident assessment tool), dated 12/8/2025, the MDS indicated the resident rarely to never had the ability to make self-understood and understand others and had severe cognitive impairment (a significant decline in thinking, memory, and reasoning that makes it impossible for a person to live independently or perform daily tasks like managing medications, paying bills, or even understanding the meaning of things). The MDS indicated the resident was dependent to needing maximal assistance on mobility and activities of daily living (ADLs, activities such as bathing, dressing and toileting a person performs daily). The MDS indicated the resident had a feeding tube in place. During a review of Resident 1's Order Summary Report (OSR), dated 12/7/2025, the OSR indicated an order for Enteral Feed (a way of providing nutrition directly into the gastrointestinal (GI) tract through an enteral access device (feeding tube) that is placed with its tip in the stomach or small intestine) order during every shift. Flush feeding tube with 30 milliliters per hour (mL/hr, describes a rate of flow or consumption over a specific period of time) for (x) 20 hours (total 600ml/day). During a review of Resident 1's Care Plan (CP) Report titled, Feeding Tube. Impaired swallowing related to severe neurologic impairment. This condition places the resident at risk for aspiration nutritional compromise, and tube-related complications if feeding tube care is not consistently maintained, last revised on 12/30/2025, the CP indicated a goal of resident will remain free of side effects or complications related to tube feeding through review date, and an intervention of the resident being dependent on tube feeding and water flushes. See MD orders for current feeding orders. During a concurrent observation and interview on 12/29/2025 at 8:33 a.m., with Treatment Nurse (TN) 1, observed with TN 1 Resident 1's water flush bag was only labeled with the date and time that the bag was changed. TN 1 stated the water flush bag should be labeled with the following as well, the resident's name, room number, rate of infusion, and initials of the licensed nurse who hung the water flush bag to ensure they are giving the right amount of water flushes to the resident and the water is not sitting in the water bag for a longer period of time harboring growth of viruses or bacteria in the water flush bag that can cause residents to get sick. During a concurrent interview and record review on 12/31/2025 at 4:10 p.m., with the Assistant Director of Nursing (ADON), the ADON stated that the water flush bag should be treated like a feeding closed container for enteral feeding. The ADON stated the water flush bag should be labeled with the name of the resident, room number, date and time it was hung, the rate of infusion, and the initials of the licensed staff who hung them. Reviewed with the ADON the policy and procedure titled Enteral Formulas, Administration of Closed (continued on next page)		

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	System. The ADON stated the licensed staff did not follow their policy and procedure as the licensed nurse who hung the water flush bag only indicated the date and time it was hung. The ADON stated it was important to ensure the name of the resident, room number, the date and time it was hung, the rate of infusion, and the initials of the nurse who hung the bag was indicated on the water flush bag to ensure they were giving the right hydration to the right patient, right formula, right time, right dose, and right route to the resident and to prevent medication error. During a review of the facility's recent policy and procedure (P&P) titled Enteral Formulas, Administration of Closed System, last reviewed on 12/18/2025, the P&P indicated it is the policy of this facility that All residents requiring tube feedings will be set up on continuous feeding pumps, after appropriate diagnoses have been obtained for justification of pump, administering adequate tube feeding formula according to established criteria outcomes, utilizing closed system products when applicable according to the Formula Indication Guide. This policy provides a means to safely administer a complete nutritional feeding to the resident using a premixed formula in a closed container system protecting formula from exposure to harmful contaminants. Procedures: 6. Label formula container with resident's name, room #, date, starting time, rate @ ml/hr, and your initials.		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on observation, interview, and record review, the facility failed to ensure respiratory care provided to residents was consistent with professional standards of practice for one of one sampled resident (Resident 1) reviewed for respiratory care by failing to ensure Resident 1's suction canister (a container used in medical settings to collect bodily fluids like mucus, blood, or other secretions) that have been drawn out of a patient's body using a medical suction machine) was labeled with the date it was last changed. The deficient practice had the potential for residents to develop complications such as shortness of breath, desaturation (low levels of oxygen in the blood), and respiratory infections. Findings: During a review of Resident 1's admission Record (AR), the AR indicated the facility admitted the resident on 12/2/2025, with diagnoses including gastrostomy (a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems), dysphagia (difficulty swallowing), and pneumonitis (inflammation of the lung tissue) due to inhalation of food and vomit. During a review of Resident 1's History and Physical (H&P), dated 12/5/2025, the H&P indicated the resident did not have the capacity to understand and make decisions. During a review of Resident 1's Minimum Data Set (MDS, a resident assessment tool), dated 12/8/2025, the MDS indicated the resident rarely to never had the ability to make self-understood and understand others and had severely impaired cognition (a person has significant problems with their mental abilities-such as thinking, remembering, and making decisions-to the extent that they can no longer live independently and require substantial help with everyday activities). The MDS indicated the resident was dependent to needing maximal assistance on mobility and activities of daily living (ADLs, activities such as bathing, dressing and toileting a person performs daily). During a review of Resident 1's Order Summary Report (OSR), dated 12/17/2025, the OSR indicated an order of oral suction if needed (PRN) for excessive secretions. Every six (6) hours as needed for excess secretions. During a review of Resident 1's Care Plan (CP) Report titled, At risk for severe acute respiratory infection related to exposure of transmissible respiratory disease, initiated on 12/5/2025, the CP indicated a goal that the resident will be free of signs and symptoms (s/sx) of infection through the review date. During a concurrent observation and interview on 12/29/2025, at 8:33 a.m., with Treatment Nurse (TN) 1, inside Resident 1's room, observed Resident 1's suction canister containing whitish fluid inside the canister about less than 100 milliliters (ml, a unit of volume) labeled with the name of the resident. TN 1 stated the suction canister should be labeled with the name of the resident and the date the suction canister was provided or changed to know when to change them again. TN 1 stated they change the suction canister weekly and as needed. TN 1 stated they label the suction canister with the name of the resident and the date it was provided to know when to change them again and for infection control purposes. TN 1 stated using the suction canister for a prolonged period of time can predispose the resident to respiratory infections due to bacteria and viruses that can grow on the suction canister and the system as a whole. During an interview and record review on 12/31/2025, at 4:10 p.m., with the Assistant Director of Nursing (ADON), the ADON stated the licensed staff should have labeled the suction canister of Resident 1 with the date it was last changed to ensure they were not using the suction canister for more than allowable time. The DON stated using the suction canister for a prolonged period of time can predispose the resident to upper respiratory tract infection (URTI, an infection of the nose, sinuses, throat, and voice box (larynx)) due to growth of bacteria and viruses in the suction system. The DON stated they change the suction canister every week and PRN. The ADON stated the staff did not follow their policy on suction machines. During a review of the facility's recent policy and procedure (P&P) titled Suction Machine, Cleaning of, last reviewed on 12/18/2025, the P&P indicated it is the policy of this facility to handle all equipment in such a manner as to eliminate or reduce to a minimum the spread of disease. Note: 2. While in use, reusable suction catheter shall be stored inside a plastic set-up bag. Suction canister and catheter will be dated when (continued on next page)		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	replaced weekly and as needed. During a review of the facility's recent P&P titled Infection Prevention and Control Program, last reviewed on 12/18/2025, the P&P indicated the infection prevention and control program is a facility-wide effort involving all disciplines and individuals and is an integral part of the quality assurance and performance improvement program. The elements of the infection prevention and control program consist of coordination/oversight, surveillance, data analysis, antibiotic stewardship, outbreak management, prevention of infection, and employee health and safety. The program is carried out by the facility infection preventionist. It is the policy of this facility to provide the necessary supplies, education, and oversight to ensure healthcare workers perform hand hygiene based on accepted standards. Goals - Identify and correct problems relating to infection control.		

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observe each nurse aide's job performance and give regular training. Based on interview and record review, the facility failed to ensure that employee files contained documentation of required performance evaluation for one of two sampled Certified Nursing Assistant (CNA) 2. This failure had the potential to negatively impact on the quality and safety of resident care delivery. Findings: During an interview on 12/30/2025 at 8:39 a.m. with CNA 2, CNA 2 stated she has been working in the facility two years. During a concurrent interview and employee records review for CNA 2 on 12/30/2025 at 9:30 a.m. with Director of Staff Development (DSD), the DSD stated CNA 2's original hire date was on 11/4/2024. DSD stated that CNA 2 does not have any performance evaluation on file. The DSD stated all employee files, including CNA 2, went missing after previous DSD left employment in September 2025. The DSD stated he is responsible for completing CNAs' performance evaluations as the current DSD effective 9/3/2025. The DSD stated performance evaluations are completed annually in the month the CNA was hired. The DSD stated CNA 2's hire date under new facility ownership was 6/1/2025 and therefore the DSD will be completing CNA 2's performance evaluation June 2026. The DSD stated performance evaluations assess staff performance, identify weaknesses, and determine training needs. DSD stated that performance evaluation ensures a CNA is competent in providing resident care. During an interview on 12/31/2025 at 4:35 p.m. with Assistant Director of Nursing (ADON), ADON stated employee performance evaluations assess competency. ADON stated that completing evaluations as required is critical to resident safety. ADON explained that failing to conduct evaluations could lead to unsafe care and potential harm to residents. During a review of [Facility] 2025 Facility Assessment, dated 9/2025, the assessment indicated, 3. Regular Reviews: Conduct regular performance evaluations to assess staff effectiveness and identify areas of improvement. During a review of the facility's policy and procedure titled, Performance Evaluations, last reviewed 12/18/2025, the P&P indicated, 1. Performance evaluations provide a vehicle for two-way communication between the Supervisor/Department Head and the employee to discuss the employee's work performance, including but not limited to the employee's initiative, work ethic, attitude, working relationships with others, job knowledge and other job-related factors. 2. Performance evaluations should occur on, but not limited to, the following occasions: .B. On the employee's annual date of anniversary hire.5. The Supervisor/Department Head will evaluate the employee's performance using the applicable performance evaluation form. 13. The completed evaluation form must be retained in the employee's personnel file.		

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. Based on observation, interview, and record review, the facility failed to follow the established and alternative menu per resident preferences and facility policy and procedure (P&P) to meet resident nutritional needs by failing to provide a resident's request for a salad or cauliflower on the lunch tray on 12/29/2026 for one of three sampled residents (Resident 44) reviewed under the Food care area. This deficient practice had the potential to result in resident dissatisfaction and malnutrition. Findings: During a review of Resident 44's admission Record (AR), the AR indicated the facility admitted the resident on 11/14/2025 with diagnoses that included hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) and hemiparesis (partial paralysis or weakness on one side of the body), metabolic encephalopathy (a general term that describes brain disease, damage, or malfunction usually related to inflammation within the body), type two (2) diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), and dysphagia (difficulty eating) following cerebral infarction (CVA- a stroke). During a review of Resident 44's Minimum Data Set (MDS - resident assessment tool) dated 11/20/2025, the MDS indicated the resident was able to understand others and was able to make himself understood. The MDS further indicated that the resident required substantial / maximal assistance from staff for toileting, bathing, upper and lower body dressing, and mobility. During a review of Resident 44's Physician Order Summary, the Physician Order Summary indicated the following dietary orders: -Controlled consistent carbohydrate diet (CCHO - specialized diet for people with DM), soft (texture of food) and bite sized, thin liquids, aspiration precautions (a set of practices to prevent food or liquids from entering the airway and lungs instead of the stomach), dated 12/30/2025. During a review of Resident 44's Care Plan (CP) titled, (Resident 44) is diagnosed with Type two (2) DM with hyperglycemia (high blood sugar), initiated 11/18/2025, the CP indicated a goal that the resident would have no complications related to DM. The CP included an intervention to offer substitutes for foods not eaten. During a review of Resident 44's Nutrition Evaluation and Registered Dietician Review, dated 12/28/2025, the Nutrition Evaluation and Registered Dietician Review indicated to provide weekly menu and alternative menu for daily reference. During a concurrent observation and interview on 12/29/2025 at 9:25 a.m., Resident 44 was lying in bed while Certified Nursing Assistant (CNA) 2 stood at bedside. Resident 44 stated he did not like the facility food. Observed CNA 2 stated Resident 44 could place a request for an alternative menu choice and CNA 2 read the Alternative Menu aloud to the resident. Resident 44 stated to CNA 2 that he (Resident 44) preferred to have a fruit plate with cottage cheese and a salad for lunch. Observed CNA 2 wrote the word salad and circle Fruit Plate with Cottage Cheese, on the Alternative Menu. During a concurrent observation and interview on 12/29/2025 at 12:28 p.m., observed Resident 44 sat in bed with the lunch tray in front of the resident. Observed a fruit plate with cottage cheese, but no salad was on the tray. Resident 44 stated they (did not specify who) came and told him he could not have a salad. During a concurrent observation, interview, and record review on 12/29/2025 at 12:30 p.m. with CNA 2, CNA 2 reviewed Resident 44's Alternative Menu and stated the salad was crossed off and replaced with cauliflower. CNA 2 stated there was no salad or cauliflower on Resident 44's lunch tray. Observed CNA 2 walked to the facility kitchen and spoke with the Dietary Supervisor Assistant (DSA). The DSA stated the DSA spoke with Resident 44 prior to lunch and explained that Resident 44's specialized diet did not allow salad. The DSA stated Resident 44 agreed to have cauliflower from the regular menu. The DSA stated Resident 44 should have been provided with cauliflower on the lunch tray, but the kitchen staff forgot to add it. Observed the DSA take a bowl of chopped cauliflower to Resident 44's room and stated to Resident 44 that she (DSA) was sorry the cauliflower was forgotten. During a concurrent interview on 12/30/2025 at 12:33 p.m. with the Dietary Supervisor (DS), the DS stated on 12/29/2026 a bowl of cauliflower should have been provided on Resident 44's lunch tray because the cauliflower provides nutrition and the resident (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Providence St Elizabeth Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 10425 Magnolia Blvd North Hollywood, CA 91601	
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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	agreed to have the cauliflower in place of the requested salad. The DS stated the kitchen forgot to provide the requested cauliflower on the resident's tray potentially resulting in the resident not eating enough. The DS stated Resident 44's preferences for lunch food items were not followed on 12/29/2025. During a concurrent interview and record review on 12/31/2025 at 2:05 p.m. with the Director of Nursing (DON), the DON reviewed the facility P&P regarding food preferences. The DON stated the facility process is to make sure residents are fed within their specialized diet and to provide the food items requested. The DON stated if Resident 44 stated he wanted cauliflower, then cauliflower should have been provided to the resident, but it was not. The DON stated it was important to provide resident food preferences there is a potential to cause psychosocial issues like feeling sad when their requests are not provided. During a review of the facility P&P titled, Food Preferences, last reviewed 12/18/2025, the P&P indicated, POLICY: Resident's food preferences will be adhered to within reason. Substitutes for all foods disliked will be given from the appropriate food group.		

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations (including nights and weekends) and emergencies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to accurately update the 2025 Facility Assessment (an evaluation of the physical environment necessary to meet the needs of the residents) for two of three sampled residents (Residents 74 and 1) to reflect care, and competency (a combination of knowledge, skills, abilities, and behaviors that enable an individual to perform a task or role successfully) of staff for gastrostomy (g-tube-a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems) tube medication administration. These deficient practices had the potential for the facility to not provide needs of the residents with g-tube and delay necessary care and services. Findings: During a review of Resident 74's admission Record, the admission Record indicated the facility admitted Resident 74 on 6/1/2023, and readmitted on [DATE], with diagnoses that included encounter attention to gastrostomy, acute respiratory failure (a sudden, life-threatening condition where the lungs cannot adequately get enough oxygen into the blood or remove carbon dioxide) with hypoxia (when your body tissues don not get enough oxygen), and unspecified (unconfirmed) Alzheimer's Disease (a disease characterized by a progressive decline in mental abilities). During a review of Resident 1's admission Record, the admission Record indicated the facility admitted Resident 1 on 12/2/2025, with diagnoses that included spastic quadriplegic (the most severe form of cerebral palsy, characterized by severe muscle stiffness affecting all four limbs, the trunk, and often the face) cerebral palsy (a condition marked by impaired muscle coordination and/or other disabilities, typically caused by damage to the brain before or at birth), atelectasis (the partial or complete collapse of a lung) and attention to gastrostomy. During a review of facility's 2025 Facility Assessment, dated 9/2025, the Facility Assessment indicated, Resident Support/Care Needs, Our Facility cares for many different residents with various types of care needs. The list below identifies the most common or frequently provided services in these general categories. General Care: .Medications- Awareness to limitations and/or assessments for self-administration of medications. Administration of medications based on provider orders and resident need by route - including oral, nasal, buccal (by mouth), sublingual (applied under the tongue), topical (applied to a specific surface of the body), subcutaneous (under the skin), rectal, intravenous (within the vein), intramuscular (into the muscle), inhaled, vaginal, ophthalmic (related to eyes). Staff training/education and competencies: Our Facility makes a good faith effort to provide the staff training/education and competencies necessary to provide the level and types of support and care needed for our resident population. Our Facility has identified the following competencies that may be utilized by our staff. Medication administration: includes injectable (delivered directly into the body using a syringe or needle), oral, subcutaneous and topical. During an interview on 1/1/2026 at 11:58 a.m., with the Director of Nursing (DON), the DON stated the Facility Assessment indicates the population the facility, the capacity, number of staff on regular basis. The purpose of the Facility Assessment was to make a list and identify the needs of the facility on how to care for the residents on regular basis. The DON stated the facility had issues with g-tube medication administration. The DON stated the Facility Assessment did not indicate general care of residents with enteral tube (delivering nutrition or medication directly into the digestive system, often via a tube). The DON stated the Facility Assessment should have been updated because the facility currently had two residents (Residents 74 and 1) on g-tube. The DON stated the Facility Assessment did not contain staff competencies on g-tube medication administration. The DON stated the Facility Assessment should have been updated annually and as needed and the facility had two chances of updating it when Resident 74 was admitted on [DATE], and readmitted on [DATE], and another chance was on 12/2/2025, when the facility admitted Resident 1 but on both dates the facility did not update the (continued on next page)		

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Facility Assessment. During a concurrent interview, and record review on 1/1/2026, at 12:39 p.m., with the DON, facility's policy and procedure (P&P), titled, Facility Assessment, dated 9/2017, and last reviewed on 4/2025, the P&P indicated, The facility will review and update the assessment at least annually and as necessary whenever there is, or the facility plans for any change that would require a substantial modification (big or major change that significantly alters the nature, value, function, or safety of something) to any part of the assessment. 1. The facility will use the assessment to evaluate its resident population and identify the resources needed to provide the necessary person-centered care and services the residents require. a. The assessment will be used to assist in making decisions about direct care staff needs, as well as the facility's capabilities to provide services to the residents. b. The facility will use a competency-based approach (a teaching and learning approach that assesses students' ability to demonstrate knowledge and skills rather than the amount of time) focusing on ensuring that each resident is provided care that allows the resident to maintain or attain their highest practicable physical, mental, and psychosocial (the interrelation of social factors and individual thought and behavior) well-being. 2. The facility assessment will include the following: a. Resident population profile including numbers, diseases/conditions, physical and cognitive disabilities, acuity, and ethnic/cultural/religious factors that impact care. b. Services and care offered based on resident needs (includes types of care resident population requires) c. Facility resources needed to provide competent care for residents, including staff, staffing plan, staff training/education and competencies, education and training, physical environment and building needs, and other resources, including agreements with third parties, health information technology resources and systems, a facility-based and community-based risk assessment, and other information as applicable. 4. The facility will be review and update the assessment annually or whenever the facility plans for any change that would require a modification to any part of the assessment. The DON stated admitting Residents 74 and 1 with enteral tube was a substantial and needs modification of the Facility Assessment.		

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to maintain accurate clinical records in accordance with accepted professional standards and practices for two of two sampled residents (Resident 44 and 21) reviewed for Pain Management by failing to: 1. Ensure Licensed Vocational Nurse (LVN) 4 accurately documented in the medication administration record (MAR - a daily documentation record used by a licensed nurse to document medications and treatments given to a resident) the assessed numeric pain rating scale (a standard pain scale with zero being no pain and ten [10] as the worst pain one can imagine) number for the administration of (PRN) hydrocodone - acetaminophen (an opioid [also called a narcotic - powerful pain-reducing medication) when the pain level was documented as zero on 12/17/2025 at 11 a.m. for Resident 44. 2. Ensure LVN 3 accurately documented in the MAR the resident's pain level on 12/18/2025 for Resident 21. This resulted in inaccurate documentation in Resident 44 and 21's electronic health record (EHR- a digital version of a patient's medical history maintained by healthcare providers (HCP) to share across different HCPs to help improve coordination and continuity of care). Findings: a. During a review of Resident 44's admission Record (AR), the AR indicated the facility admitted the resident on 11/14/2025, with diagnoses that included hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) and hemiparesis (partial paralysis or weakness on one side of the body), metabolic encephalopathy a (general term that describes brain disease, damage, or malfunction usually related to inflammation within the body), polyneuropathy (a disorder of the peripheral nervous system that may result in pain, discomfort, and mobility issues), and peripheral vascular disease (PVD - a slow progressive narrowing of the blood flow to the arms and legs). During a review of Resident 44's Minimum Data Set (MDS &ndash; resident assessment tool) dated 11/20/2025, the MDS indicated the resident was able to understand others and was able to make himself understood. The MDS further indicated that the resident required substantial / maximal assistance from staff for toileting, bathing, upper and lower body dressing, and mobility.~The MDS indicated the resident was taking opioids, a high-risk drug class of medication (drugs that have a heightened risk of causing significant patient harm when they are used in error). During a review of Resident 44's Physician Order Summary, the Physician Order Summary indicated the following orders: - Hydrocodone - acetaminophen oral tablet five (5) - 325 milligrams (mg, a unit of measurement), give one (1) tablet by mouth every four (4) hours PRN for pain one (1)- six (6) out of 10, dated 11/14/2025 and discontinued and re-ordered on 12/26/2025. - Hydrocodone - acetaminophen oral tablet five 5 - 325 mg, give two (2) tablets by mouth every 4 hours PRN for pain seven (7) to 10 out of 10, dated 11/14/2025 and discontinued and re-ordered on 12/26/2025.~ During a concurrent observation and interview on 12/29/2025 at 9:25 a.m., Resident 44 lay in bed and stated he (Resident 44) often had pain and is given pain medication. During a concurrent interview and record review on 12/31/2025 at 8:22 a.m. with Licensed Vocational Nurse (LVN) 3, LVN 3 reviewed Resident 44's physician orders, MAR for 12/2025, and Progress Notes (continued on next page)		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	for 12/2025. LVN 3 stated the facility process for administering PRN pain medication is the licensed nurse (LN) will first assess the resident for the location of pain, and the LN offers non-pharmacologic interventions. LVN 3 stated when non-pharmacologic interventions do not work, then the LN administers pain medication based on the numeric pain scale. LVN 3 stated the numeric pain level determines the amount of PRN pain medication administered to the resident. LVN 3 stated Resident 44 was able to verbalize the numeric pain scale level and received hydrocodone &ndash; acetaminophen 5/325 mg one tablet for pain level 1-6 and two tablets for pain level 7-10. LVN 3 stated the LN documents the number of pain reported and the amount of medication administered in the MAR. LVN 3 stated if the LN documented the pain level in the MAR, then it was considered to be the resident's pain level at the time of administration. LVN 3 reviewed Resident 44's MAR and progress notes and noted the following regarding the PRN administration of 2 tablets of hydrocodone &ndash; acetaminophen 3/525 mg for pain 7-10: - On 12/17/2025 at 11 a.m., hydrocodone &ndash; acetaminophen two tablets were not administered per the physician's order when Resident 44's pain level was 0. LVN 3 stated based on the MAR documentation, Resident 44 did not have pain, and the administration of opioid pain medication was not warranted at that time. During a concurrent interview and record review on 12/31/2025 at 10:55 a.m. with LVN 4, LVN 4 reviewed Resident 44's physician orders and MAR for 12/2025 and noted the following: - On 12/17/2025 at 11 a.m., LVN 4 stated he administered hydrocodone &ndash; acetaminophen two tablets for a pain level of 0. LVN 4 stated he (LVN 4) remembered that Resident 44 had a high-level of 7/10 pain on 12/17/2025 at 11 a.m. LVN 4 then stated it was a documentation error when the MAR indicated a pain level of 0 because the resident reported a pain level of 7. During a concurrent interview and record review on 12/31/2025 at 2:05 p.m. with the Director of Nursing (DON), the DON reviewed the facility policy and procedures (P&P) regarding medication administration, pain management, and documentation. The DON stated the facility process for PRN pain medication administration is to use the numeric pain scale, follow the physician's orders for pain medication administration, and accurately document the pain level in the MAR. The DON stated the importance of accurate pain level documentation is that the MAR is the basis for the review of pain assessments and interventions by the interdisciplinary team. The DON stated inaccurate pain assessments could affect future interventions based on that documented data. The DON stated the facility P&P was not followed when LVN 4 did not accurately document Resident 44's pain level in the MAR because the documentation was not a complete account of the resident's care and treatment. The DON stated a complete account includes the accurate documentation of the pain level assessment. During a review of the facility P&P titled, Pain Management, last reviewed 12/18/2025, the P&P indicated, Policy. It is the policy. to ensure that pain management is provided to residents who require such services, consistent with professional standards of practice . Procedure. 3. Pain will be identified and documented in the electronic health record (EHR). a. Using a scale of 1-10 is most common. Opioid treatment for pain is appropriately assessed and individualized for each resident. During a review of the facility P&P titled, Specific Medication Administration Procedures, last reviewed 12/18/2025, the P&P indicated, Policy. To administer medications in a safe and effective manner. M. When administering an as needed (PRN) medication, document reason for giving. (continued on next page)		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility P&P titled, Charting and Documentation, last reviewed 12/18/2025, the P&P indicated, The purpose of this procedure is to provide: 1. A complete account of the resident's care, treatment, response to the care, signs, symptoms, etc., as well as the progress of the resident's care. 2. Guidance to the physician in prescribing appropriate medications and treatments. 3. The facility, as well as other interested parties, with a tool for measuring the quality of care provided to the resident. 4. Nursing service personnel with a record of the physical and mental status of the resident. 5. Assistant in the development of a Plan of Care for each resident. 6. The elements of quality medical nursing care. 7. A legal record that protects the resident, physician, nurse and the facility. Documentation pertaining to special observations and monitoring should include: . f. All pertinent observations. b. During a review of Resident 21's admission Record, the admission Record indicated The facility admitted the resident on 12/10/2025, with diagnoses including sepsis (a life-threatening blood infection), malignant neoplasm (abnormal growth of tissues that spread to other parts of The body) of ovaries (female reproductive glands that make eggs and female hormones), and generalized muscle weakness. During a review of Resident 21's History and Physical (H&P) dated 12/10/2025, the H&P indicated Resident 21 had the capacity to understand and make decisions. During a review of Resident 21's MDS, dated [DATE], the MDS indicated Resident 21 had an intact cognition (mental action or process of acquiring knowledge and understanding) was able to understand others and make needs known. The MDS further indicated Resident 21 was independent with eating; required supervision or touching assistance with oral hygiene and personal hygiene; substantial/maximal assistance with toileting hygiene, bathing, lower body dressing, sit-to-stand, and toilet transfers; partial/moderate assistance from staff with all other ADLs. The MDS indicated Resident 21 was on opioids. During a review of Resident 21's Order Summary Report, The Order Summary Report indicated the following physician's orders dated 12/10/2025: - Oxycodone hydrochloride oral tablet ten (10) mg give one (1) tablet by mouth every six (6) hours as needed for pain four (4) to six (6) out of 10. Do not give if respiratory rate (RR) is less than (< - a unit of measurement) 12 or drowsy then notify the physician (MD). - Oxycodone hydrochloride oral tablet 15 mg give one (1) tablet by mouth every 6 hours as needed for pain seven (7) to 10 out of 10. Do not give if RR is < 12 or drowsy then notify The MD. During a review of Resident 21's CP on generalized chronic pain related to malignant neoplasm of ovaries initiated on 12/11/2025, the CP indicated to follow pain scale to medicate as ordered as one of the interventions to prevent interruption on normal activities due to pain. During a review of the MAR for 12/2025, the MAR indicated Resident 21 received oxycodone hydrochloride 15 mg tablet on 12/18/2025 at 9:26 a.m. for pain level of zero (0) out of 10. During a concurrent observation and interview on 12/29/2025 at 9:06 a.m., inside Resident 21's room, observed Resident 21 lying in bed, alert and verbally responsive. Resident 21 stated often had pain and is given pain medication as needed. (continued on next page)		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 12/31/2025 at 8:45 a.m., with Assistant Director of Nursing (ADON), Resident 21's physician's orders, CP, MAR for 12/2025, and progress notes were reviewed. The ADON stated Resident 21 had a physician's order to administer oxycodone hydrochloride 10 mg tablet one tablet every six hours as needed for pain level of four (4) to six (6) out of 10 and oxycodone 15 mg tablet one tablet every six hours as needed for pain level of seven (7) to 10 out of 10. The ADON stated the CP on chronic pain indicated to follow pain scale to medicate as ordered. The ADON stated Resident 21 received oxycodone hydrochloride 15 mg tablet on 12/18/2025 at 9:26 a.m. for pain level of 0 out of 10. The ADON stated the oxycodone was not administered to Resident 21 according to MD order. The ADON stated The MD order should have been followed to properly address Resident 21's pain. The ADON stated There was no documentation in the progress notes that Resident 21 requested pain medication for pain level of 0 out of 10 on 12/18/2025 at 9:26 a.m. The ADON stated it could be a documentation error which can result in inaccurate medical record and can affect the physician's assessment or perception that Resident 21 was receiving the pain medication even if there was no pain. The ADON stated Resident 21 can also experience side effects from the use of narcotics such as constipation, gastric irritation, or drowsiness if the dosage amount is not necessary. During a concurrent interview and record review on 12/31/2025 at 9:22 a.m. reviewed Resident 21's physician's order and MAR for 12/2025 with LVN 3. LVN 3 stated the facility process for administering as needed pain medication is the licensed nurse (LN) will first assess the resident for the location of pain, and the LN offers non-pharmacologic interventions. LVN 3 stated when non-pharmacologic interventions do not work, then the LN administers pain medication based on the numeric pain scale. LVN 3 stated the numeric pain level determines the amount of as needed pain medication administered to the resident. LVN 3 stated Resident 21 had a physician's order for oxycodone 10 mg tablet for pain level of four (4) to six (6) out of 10 and oxycodone 15 mg tablet for pain level of seven (7) to 10 out of 10. LVN 3 stated the MAR indicated that she (LVN 3) administered oxycodone hydrochloride 15 mg to Resident 21 on 12/18/2025 at 9:26 a.m. and she (LVN 3) indicated that the pain level was 0 out of 10. LVN 3 stated she (LVN 3) did not know why the pain level was documented as 0 out of 10. LVN 3 stated it was a documentation error when the MAR indicated a pain level of 0 because she (LVN 3) will not administer the oxycodone hydrochloride if Resident 21's pain level was not between seven (7) to 10 out of 10. LVN 3 stated she (LVN 3) should have ensured that the documentation of Resident 21 pain level was accurately entered in the MAR to ensure accuracy in the medical record which can affect the physician's judgement upon evaluation of the pain medication use and the pain not properly managed. During a concurrent interview and record review on 12/31/2025 at 2:05 p.m. with The Director of Nursing (DON), The DON reviewed the facility policy and procedures (P&P) regarding medication administration and pain management. The DON stated the facility process for as needed pain medication administration is to use the numeric pain scale and follow the physician's orders for pain medication administration. The DON stated the facility P&P was not followed when Resident 21 was not administered narcotic pain medication per the physician's orders when the resident was administered the incorrect dose for the reported numeric pain level. The DON stated when the incorrect dose of narcotics was administered there was the potential to result in ineffective pain management leading to more frequent administration of pain medication and side effects like constipation in Resident 21. The DON stated that when Resident 21 was given too much pain medication, it could lead to inaccurate assessment of how much narcotics they actually need and could result to side effects such as constipation and gastric irritation. The DON stated that Resident 21's pain level was not (continued on next page)		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	documented accurately on 12/18/2025 at 9:26 a.m. by LVN 3. The DON stated LVN 3 stated should have documented Resident 21's pain level accurately because it is one of the bases of assessments by the other LNs and physician and can affect the interventions that will be provided to Resident 21. During a review of the facility P&P titled, Pain Management, last reviewed 12/18/2025, the P&P indicated: - It is the policy of the facility to ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, comprehensive and routine assessments, person-centered care plan, and the residents' goals and preferences. - To the extent possible, staff will a. Evaluate existing pain and the causes b. Manage or prevents pain, consistent with the comprehensive assessment and plan of care, current professional standards of practice, and the resident's goals and preferences. - Pain will be identified and documented in the electronic health record (EHR) a. Using a scale of 1-10 is most common. - Opioid treatment for pain is appropriately assessed and individualized for each resident. - Medication(s) received, refused and response to medication will be documented on The Electronic Medication Administration Record (e-MAR). During a review of the facility P&P titled, Specific Medication Administration Procedures, last reviewed 12/18/2025, the P&P indicated: - Medications are administered as prescribed in accordance with good nursing principles and practices and only by persons legally authorized to do so. Personnel authorized to administer medications do so only after they have been properly oriented to the facility's medication distribution system (procurement, storage, handling and administration). - Medications are administered in accordance with written orders of the prescriber. - When PRN medications are administered, the following documentation is provided: a. Date and time of administration, dose, route of administration (if other than oral). b. Complaints or symptoms for which the medication was given. During a review of the facility's P&P titled, Documentation, last reviewed on 12/18/2025, the P&P indicated that the purpose of documentation is provide the following: - A complete account of the resident's care, treatment, response to the care, signs, symptoms, as well as the progress of the resident's care. (continued on next page)		

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055192	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/02/2026
NAME OF PROVIDER OR SUPPLIER Providence St Elizabeth Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 10425 Magnolia Blvd North Hollywood, CA 91601	
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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- The facility, as well as other interested parties, with a tool for measuring the quality of care provided to the resident. - Guidance to the physician in prescribing appropriate medications and treatments.		

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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 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. Based on interview and record review, the facility failed to ensure one of two sampled Certified Nursing Assistant (CNA) 2 completed mandatory dementia (a progressive state of decline in mental abilities) management and abuse prevention training. This deficient practice has the potential to lead into insufficient staff training, posing significant risks for the residents, including potential injury, neglect, and abuse. Findings: During a concurrent interview and record review on 12/30/2025 at 9:30 a.m. with the Director of Staff Development (DSD), CNA 2's employee file was reviewed and the DSD stated CNA 2's original hire date was 11/02/2024. During a subsequent concurrent interview and record review on 12/31/2025 at 12:24 p.m. with the DSD, in-service attendance records were reviewed. The DSD stated there was no documentation showing that CNA 2 attended any in-service training on abuse or dementia management prior to June 2025. The DSD stated since June 2025, abuse in-service trainings were provided on 7/25/2025, 9/5/2025, 9/26/2025, 11/20/2025, and 12/29/2025 with each lasting one hour. The Course Title: Abuse: Abuse Coordinator/Reporting Abuse In-Service Attendance Record and the Course Title: Types of Abuse In-Service Attendance Record were reviewed. Attendance records indicated CNA 2 attended the sessions on 7/25/2025, 9/26/2025, and 12/29/2025, however, CNA 2's name and signature were absent from the records for the sessions on 9/5/2025 and 11/20/2025. The DSD confirmed that CNA 2 attended three of the five abuse in-service trainings. The DSD further stated that dementia management in-service trainings were provided on 10/14/2025 and 12/01/2025. Attendance records for both sessions did not include CNA 2's name or signature, and the DSD confirmed that CNA 2 did not attend either dementia management training. The DSD stated CNAs are required to complete four hours of abuse training every two years and five hours of dementia training annually. The DSD stated CNA 2 did not meet these training requirements. The DSD emphasized the importance of dementia management training to ensure CNA can appropriately care for residents with dementia and noted that meeting training requirements is essential for delivering quality care to all residents . The DSD stated that there is no system in place to ensure staff who missed in-service training receive it later. During an interview on 12/31/2025 at 4:35 p.m. with the Assistant Director of Nursing (ADON), the ADON stated CNAs are required to have training on abuse and dementia upon hire and annually. The ADON stated that caring for residents with dementia can be challenging especially Without adequate and proper training, CNAs would be unable to effectively manage or safely care for residents with this condition. During a review of the facility's policy and procedure (P&P) titled, Nurse Aide Training, last reviewed 12/18/2025, the P&P indicated, 1. The facility will implement a training program based on the facility assessment and state and federal requirements and consistent with expected roles . 4. A minimum of 12 hours of nurse aide training per year is required under S483.95(g)(1). The training must be sufficient to ensure the continuing competence of the nurse's aides, which may require more than 12 hours of training per year to meet identified staff or resident needs . 5. Each program shall include at least the following: .Abuse, neglect, exploitation, misappropriation of resident property, and reporting requirements.Dementia management and resident abuse prevention training.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055192	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/02/2026
NAME OF PROVIDER OR SUPPLIER Providence St Elizabeth Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 10425 Magnolia Blvd North Hollywood, CA 91601	
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 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 that 17 of 25 resident rooms (Rooms 1, 2, 3, 4, 5, 12, 13, 14, 15, 16, 17, 18, 19, 22, 23, 25 and 26) met the square footage (sq - a measurement of the area of a two-dimensional space) requirement of 80 sq feet (ft-unit of length) per resident in multiple resident rooms. This deficient practice had the potential to have inadequate space for resident care and mobility. Findings: During an interview on 12/29/2025 at 2:35 p.m. with the resident council group interview attendees, the attendees stated they have enough room space. During an observation from 12/29/2025 to 1/2/2026, residents residing in rooms with an application for variance had enough space for residents to move freely inside the rooms. There was adequate room for the operation and use of wheelchair, walkers, or canes. The room variance did not affect the care and services provided by nursing staff for the residents. During a review of the letter titled, Re: Request for Room Variance Waiver, dated 12/30/2025, the letter indicated the Administrator submitted the application for the room variance waiver for 17 resident rooms. The room variance waiver letter indicated the following rooms did not meet the 80 square feet (sq ft - a unit of measurement) per resident requirement per federal regulation:- room [ROOM NUMBER], two residents, 153.2 actual sq ft.- room [ROOM NUMBER], two residents, 153.31 actual sq ft.- room [ROOM NUMBER], two residents, 152.33 actual sq ft.- room [ROOM NUMBER], three residents, 224.83 actual sq ft.- room [ROOM NUMBER], two residents, 152.96 actual sq ft.- room [ROOM NUMBER], two residents, 153.18 actual sq ft.- room [ROOM NUMBER], two residents, 152.96 actual sq ft.- room [ROOM NUMBER], two residents, 153.18 actual sq ft.- room [ROOM NUMBER], two residents, 155.11 actual sq ft.- room [ROOM NUMBER], two residents, 152.5 actual sq ft.- room [ROOM NUMBER], two residents, 153.25 actual sq ft.- room [ROOM NUMBER], two residents, 152.5 actual sq ft.- room [ROOM NUMBER], two residents, 153.08 actual sq ft.- room [ROOM NUMBER], two residents, 151.46 actual sq ft.- room [ROOM NUMBER], four residents, 295.45 actual sq ft.- room [ROOM NUMBER], four residents, 294.51 actual sq ft.- room [ROOM NUMBER], four residents, 285.46 actual sq ft.- room [ROOM NUMBER]. The minimum requirement for two (2) bedrooms should be at least 180 sq ft. The minimum requirement for three (3) bedrooms should be at least 240 sq ft. The minimum requirement for four (4) bedrooms should be at least 320 sq ft. The letter further indicated that No residents in these rooms are hindered, nor adversely affected by the limited room size. There is adequate room for the operation and use of wheelchairs, walkers, and other like aides. After careful evaluation of this facility's building plan, the Quality Assurance Committee has reached the conclusion that the waiver on room size will not in any way threaten the health, safety, and happiness of any the residents. During a review of the facility's policy and procedure (P&P) titled, Resident Rooms, the P&P indicated that It is the policy of this facility that a resident room must: 1. Be designed and equipped for adequate nursing care, comfort, and privacy of residents. 2. Accommodate no more than four residents. 3. Measure at least 80 square feet per resident in multiple resident bedrooms, and at least 100 square feet in a single resident room.		