STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055199	A. Building B. Wing	03/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Horizon Health & Subacute Center	3034 E Herndon Fresno, CA 93720

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49949 Based on observation, interview, and record review, the facility failed to ensure residents were treated with respect and dignity in an environment that promotes and enhances quality of life for two of six sampled residents (Residents 1 and 74) when Certified Nursing Assistants (CNA's 2 and 3) stood to fed them lunch. This failure violated Residents 1 and 74's right to be offered a dignified dining experience and made Resident 1 feel uncomfortable and disrespected. Findings: During an observation on 3/3/25 at 1:25 p.m. in the dining room, CNA 2 stood while she fed Resident 74 during lunchtime. CNA 2 spoke to Resident 74 while she stood over her, not sitting at eye level. During an interview at 3/3/25 at 1:46 p.m. with CNA 2, CNA 2 stated she should have sat down with Resident 74 during mealtime. CNA 2 stated she should have sat down on a chair next to Resident 74 and made sure she was at eye level when she fed him. CNA 2 stated Resident 74 could have felt uncomfortable and rushed when she stood to fed him. CNA 2 stated Resident 74 could have choked on his food when she did not feed him at eye level. CNA 2 stated she did not remember the last time she had an in-service on how to feed residents training. During a review of Resident 74's Admission Record (AR- document containing resident demographic information and medical diagnosis) dated 3/6/25, the AR indicated, Resident 74 was admitted to the facility on [DATE]. The AR indicated, Resident 74 's diagnosis included, cerebral infraction (stroke-a condition where blood flow to the brain is interrupted, causing brain cells to die), visuospatial deficit (difficulties in understanding and interpreting visual and spatial information, leading to problems with spatial awareness, object recognition, and navigation.) expressive language disorder (a condition that affects a person's ability to communicate their thoughts and ideas through spoken or written language), visual disturbances (any changes in vision that affect the ability to see clearly or comfortable) and pain. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 74's Minimum Data Set (MDS - a resident assessment tool used to identify cognitive [mental processes] and physical functional level assessment), dated 1/26/25 the MDS, indicated, Resident 74 had a Brief Interview for Mental Status (BIMS - a test given by medical professionals to determine cognitive understanding on a scale of 1-15) score of 3 (a score of 0-7 suggests severe cognitive impairment, 8-12 suggests moderately impaired, 13-15 suggests cognitively intact) indicating Resident 74 was severely cognitive impaired. During a review of Resident 74's Care Plan (CP- a structured document that outlines the specific healthcare needs of a residents and the interventions necessary to meet those needs), dated revision 2/6/24, the CP indicated, Resident 74 assist with meals set up and hand to mouth assist as needed. During an observation on 3/3/25 at 1:42 p.m. in Resident 1's room, CNA 3 stood next to Resident 1 and fed her during lunch. During an interview on 3/3/25 at 1:50 p.m. in Resident 1's room, Resident 1 stated she needed help during meals. Resident 1 stated she felt uncomfortable and did not like when CNA's stood when they fed her. Resident 1 stated she felt disrespected and bad. During an interview with on 3/3/25 at 1:53 p.m. with CNA 3, CNA 3 stated she helped Resident 1 with meals. CNA 3 stated, Resident 1 required assistance all the time and was fully dependent (relying on another person or thing for support) with meals. CNA 3 stated she should have sat down when she fed Resident 1's lunch. CNA 3 stated Resident 1 could have felt rushed and could not have gotten a pleasurable dining experience. CNA 3 stated Resident 1 could have felt uncomfortable or a lack of dignity when she stood to fed Resident 1. CNA 3 stated she was not sure when the last in-service was for meal assistance. During a review of Resident 1's AR dated 3/6/25, the AR indicated, Resident 1 was admitted to the facility on [DATE] with diagnosis of quadriplegia (a medical condition characterized by the partial or complete loss of motor and sensory function in all four limbs (arms and legs), contracture left elbow, contracture left wrist, contracture right elbow and right wrist, muscle spasm, neuromuscular dysfunction (group of conditions that affect the nerves (neuromuscular system) and muscles) and pain. During a review of Resident 1s MDS dated [DATE] the MDS, indicated, Resident 1 had a Brief Interview for Mental Status (BIMS - a test given by medical professionals to determine cognitive understanding on a scale of 1-15) score of 15 (a score of 0-7 suggests severe cognitive impairment, 8-12 suggests moderately impaired, 13-15 suggests cognitively intact) indicating Resident 1 was cognitively intact. During a review of Resident 1's CP, dated revision 3/2/20, the CP indicated, The Resident requires total staff assistance to eat. During an interview on 3/05/25 at 3:29 p.m. with Licensed Vocation Nurse (LVN) 1, LVN 1 stated, The CNA's should be sitting at eye level with residents during dining. LVN 1 stated, CNA's could have made residents feel uncomfortable and intimidated by standing over them. LVN 1 stated, Sitting with them [resident] makes them feel comfortable and easy for meals. LVN 1 stated, It is part of a dignity for residents. LVN 1 stated, residents could have choked on food and might not eat or felt rushed. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/07/25 at 12:33 p.m. with the Director of Nursing (DON) the DON stated, the staff should have sat down at eye level during assistance with meals. The DON stated, Sitting down provided dignity and respect for the residents. The DON stated resident psychosocial wellbeing (a person's overall mental, emotional and social health) was better when staff sat down during dining. The DON stated, the residents could have felt undignified (lack of dignity). The DON stated the residents could have felt no human connection and compassion when staff stood over during meals. The DON stated, We all are responsible to ensure the residents were treated with dignity. During a review of the facility' policy and procedure (P&P) titled, Assistance with Meals dated 3/2022, the P&P indicated, Residents shall receive assistance with meals in a manner that meets the individual needs of each resident . Resident who cannot feed themselves will be fed with attention to safety, comfort and dignity for example. A. not standing over residents while assisting them with meals .

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49949 Based on observation, interview and record review the facility failed to ensure one of six sampled residents (Resident 53) had the right to make choices about aspects of his life in the facility when his choice to have a shower on a Saturday instead of a Friday was not honored. This failure resulted in Resident 53's skin on his upper cheat and left upper arm becoming red, dry and itchy leading to him scratching himself opening the skin and the potential for an increased risk for infection. Findings: During a review of Resident 53's Admission Record (AR- document containing resident demographic information and medical diagnosis) dated [DATE], the AR indicated, Resident 53 had diagnoses of end stage renal disease (condition where the kidneys have permanently lost their ability to function properly), diabetes mellitus (a chronic metabolic disorder characterized by high blood sugar (glucose) level), heart failure (when the heart muscle doesn't pump blood as well as it should) , hypertensive heart disease (a condition that develops when high blood pressure (hypertension) damages the heart over time), pain and history of falls. During a review of Resident 53's Minimum Data Set (MDS - a resident assessment tool used to identify cognitive [mental processes] and physical functional level assessment), dated [DATE] the MDS, indicated Resident 53 had a Brief Interview for Mental Status (BIMS - a test given by medical professionals to determine cognitive understanding on a scale of ,d+[DATE]) score of 15 (a score of ,d+[DATE] suggests severe cognitive impairment, ,d+[DATE] suggests moderately impaired, ,d+[DATE] suggests cognitively intact) indicating Resident 53 was cognitively intact. During a review of Resident 53's Care Plan Report (CPR- comprehensive document that outlines a resident's health status, treatment goals, and interventions to achieve optimal outcomes) dated [DATE], the CPR indicated, [box] Focus: It is my preferences to have showers before breakfast on assigned shower days . [box]Goal: I will not experience any dignity complications through next review . [box]Interventions/Task: Resident's wishes will be honored . During a review of Resident 53's Progress Notes (PG- written records that document a resident 's health and care) dated [DATE], the PG indicated, . New self-inflicted scratch noted to left triceps . During a review of Resident 53's PG dated [DATE] at 11:59 p.m., the PG indicated, Resident refused shower and bed bath x 3. Educate the resident risk/benefits. During a review of Resident 53's PG dated [DATE] [Friday] at 11:22 p.m., the PG indicated, Resident refused shower and bed bath x 3. Educate the resident risk/benefits. During a review of Resident 53's PG dated [DATE] at 10:07 p.m., the PG indicated, Resident refused shower x3, CNA [Certified Nursing Assistant] and writer ask resident if he would like a bed bath instead resident refused. (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 53's PG dated [DATE] [Friday] at 9:24 p.m., the PG indicated, Resident refused shower and bed bath x 3, resident said that he don't like to take shower on his dialysis days. Educate the resident risk/benefits. During a review of Resident 53's PG dated [DATE] [Friday] at 10:50 p.m., the PG indicated, Resident refused shower and bed bath x 3. Educate the resident risk/benefits. During a review of Resident 53's PG dated [DATE] at 10:09 p.m., the PG indicated, Resident refused shower and bed bath x 3. Educate the resident risk/benefits. During a review of Resident 53's PG dated [DATE] [Friday] at 9:59 p.m., the PG indicated, Resident refused shower and bed bath x 3. CNA and writer went in resident room ask if he would like a bed bath instead. Resident still refused. During a review of Resident 53's PG dated [DATE] at 11:29 p.m., the PG indicated, Resident refused shower and bed bath x 3. Educate the resident risk/benefits. During an observation and interview on [DATE] at 10:44 a.m. in Resident 53's room, Resident 53 had scattered scratches to his upper chest and both upper arms. Resident 53 stated his skin was itchy from not being able to shower. Resident 53 stated, I have showers on Tuesdays and Fridays. Resident 53 stated, I go to dialysis on Mondays, Wednesdays and Fridays. Resident 53 stated he was too tired to shower on his dialysis days. Resident 53 stated, he needed a shower due to his skin being itchy and dry. Resident 53 stated he was notified his shower days were on Tuesday and Saturdays when he was admitted to the facility. Resident 53 stated he notified the CNAs and nurses, and no one is doing anything about it. During an interview on [DATE] at 2:07 p.m. with Certified Nursing Assistant (CNA) 4, CNA 4 stated, Resident 53's shower days were on Tuesday and Fridays. CNA 4 stated Resident 53 refused showers on Friday last week when she was working. CNA 4 stated she notified the nurses when Resident 53 refused his showers. CNA 4 stated nurses were responsible to speak to the residents when they refused showers. CNA 4 stated residents chosen shower days should have been honored. CNA 4 stated residents have the right to choose their shower days, and it was their choice. CNA 4 stated Resident 53 could have felt neglected and felt the facility did not honor their wishes. CNA 4 stated residents and could have gotten upset and refused the schedule shower days. During an interview at [DATE] at 3:04 p.m. with License Vocation Nurse (LVN) 1, LVN 1 stated, We have a shower sheet, it has the date, the CNA and nurse will sign it. LVN 1 stated, each resident will get a shower sheet. LVN 1 stated, Residents were asked if they wanted bed bath when they refused showers. LVN 1 stated nurses should have document the reason a resident refused showers. LNV 1 stated Resident 53 could have refused to shower due to being tired from dialysis. LVN 1 stated, 'It is important because it is his right and he has the right to take showers on the days he wants. LVN 1 stated there was a potential for Resident 53's skin to have breakdown when he did not get showered. LVN 1 stated, his skin can get itchy skin which can potential causes bleeding and infection. LVN 1 stated it is all of our responsibility, nurse social services, CNA, unit manager, ADON [Assistant Director of Nursing] and DON [Director of Nursing], it is the staff's responsibility to ensure his wishes are honor. (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on [DATE] at 4:50 p.m. with LVN 3, LVN 3 stated, she was not sure about the process about changing the resident's showers days. LVN 3 stated she was not sure who made the schedule for the showers. LVN 3 stated, residents' choices were important to meet their needs and wellbeing. LVN 3 stated residents could have been depressed, upset and felt like their rights were not being honored. LVN 3 stated residents had a right to change their shower days. During an interview on [DATE] at 5:11 p.m. with LVN 4, LVN 4 stated, the process at the facility when Resident 53 refused showers was the nurses were supposed to talk to him and try to figure out how to help him when he refused his showers. LVN 4 stated, the nurses should have asked why Resident 53 refused the showers on the days he was scheduled. LVN 4 stated Resident 53 could have itchy skin and had potential for skin breakdown. LVN 4 stated Resident 53 was at risk for infection from broken skin. LVN 4 stated, they should be talking to him and figure out what to do. LVN 4 stated, Resident 53 should have been involved with his care and should had a say in his care. LVN 4 stated, We have not identified the reason why he is refusing, LVN 4 stated, We only identify he would like his shower early on Tuesday, but do not know why he is refusing showers on Friday. LVN 4 stated, His needs and choices were not meet. During an interview on [DATE] at 12:17 p.m. with the Director of Nursing (DON) the DON stated, We should be able modify schedule as needed. The DON stated, The CNA should report to the charge nurse so it could be modified. The DON stated, The staff should have changed the showers to Saturdays to accommodate to his choice. The DON stated, residents had the right to get showers on the days requested. The DON stated Resident 53 was uncleaned when he refused showers. The DON stated, refusing showers could affect his dignity, safety and had increased risk for a urinary tract infection (UTI-an infection of the urinary tract, which includes the bladder, kidneys, ureters, and urethra). The DON stated, Resident 53 could have had skin issue such as dryness and changes in skin condition. The DON stated, his choice was not honored. During a review of facility's policy and procedure titled, Resident's Rights, dated ,d+[DATE], the P&P indicated, Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's rights to . self-determination [having the right to control one's own life and [NAME], encompassing the ability to make choices, set goals, and advocate for oneself] .

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41608 Based on observation, interview and record review, the facility failed to provide a comfortable and homelike environment for one of eight residents (Resident 55), when the facility did not respond to Resident 55's complaint of air from the vent in his room blowing on his face. This failure resulted in Resident 55 feeling cold, frustrated, and uncomfortable in his bed. Findings: During a concurrent observation and interview on 3/3/25 at 11:16 a.m. with the caregiver of Resident 55 in his room, a small white trash bag taped to the side of the over the bed table (a rolling table designed to be positioned over a bed, providing a stable surface for activities like eating, reading, or working while in bed), was observed waving back and forth as if being blown by the wind. The table was placed over the bed where the resident's upper body and head would have been if the resident had been in the bed. Resident 55 was sitting at the end of his bed in a wheelchair watching the television that belonged to the A bed and Resident 55 was in B bed. Resident 55's caretaker stated, .he was unable to watch tv from in his bed, because he preferred to sit at the end of his bed as much as possible to avoid the wind being blown on him by the vent. The caretaker stated, . maintenance had come into the room and looked at the vent and told her there was not anything that could be done . During a review of Resident 55's Record of Admission (AR), dated 3/6/25, the AR indicated, Resident 55 was admitted to the facility on [DATE], with diagnoses which included, Encephalopathy (a disorder or disease that affects the function or structure of the brain), dysphagia (difficulty swallowing), Parkinson's Disease (a progressive neurological disorder that affects movement, balance, and coordination), Anemia (a condition in which the body does not have enough healthy red blood cells or hemoglobin), and Neoplasm of Thyroid (a tumor of the thyroid). During a review of Resident 55's Minimum Data Set (MDS-a resident assessment tool used to identify resident cognitive, physical abilities and needs), dated 2/11/25, the MDS indicated, Resident 55's Brief Interview for Mental Status (BIMS-screening tool used to assess resident cognition status on a scale of 0 to15 [0-6 severe cognitive deficit, 7-12 moderate cognitive deficit, 13-15 no cognitive deficit), score was 3 out of 15 which indicated, Resident 55 had a severe cognitive deficit. During a concurrent observation and interview on 3/6/25 at 9:09 a.m. with Certified Nursing Assistant (CNA) 7, in Resident 55's room, CNA 7 put her hand near the top of Resident 55's bed and stated she could feel the wind being blown on her hand. CNA 7 stated, . the air is blowing on the resident's face . it has not been corrected . the air still blows on the resident's face . the family states that the resident complains that it was cold, and he uncomfortable . Maintenance is aware, and they would be the ones [department], to fix the a/c [air conditioning] . (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 3/6/25 at 9:15 a.m. with Licensed Vocational Nurse (LVN) 4, the Horizon Health and Subacute Deficiency Report (DR), dated 1/2/25 was reviewed. The DR indicated, on 1-2-25, cold air coming from the vent in Resident 55's room was reported. The DR was marked and initialed as completed (date and time of completion was not listed). LVN 4 stated, . a Maintenance Log [DR], is kept in a binder at each Nurse Station, items needing repair are placed on the log . once the issue has been placed on the log the maintenance department is responsible for investigating and correcting the issue . Resident 55's maintenance issue has not been corrected . During a concurrent observation, and interview on 3/6/25 at 11:10 a.m. with the Maintenance Director (MD), in Resident 55's room, Resident 55 was observed sitting up in his bed with his blankets pulled up under his chin, the wind from the vent was blowing the white tag on Resident 55's blanket. The MD stated, . the wind from the vent was blowing on the residents head and if the resident is uncomfortable the air vents can be moved to prevent the air from blowing on him, it is an easy fix and I do not know why it has not been done . The MD stated, This is not what my expectations are for my staff, this is not a home like environment for the resident. During a review of the facility's policy and procedure (P&P), titled, Homelike Environment dated 2/2021, indicated, . Staff provides person-centered care that emphasizes the residents' comfort, independence and personal needs and preferences . comfortable and safe temperatures .

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48424 Based on observation, interview, and record review, the facility failed to develop and implement a comprehensive person centered care plan for four of 12 residents (Residents 66, 72, 118 and 114) when: 1. Resident 66's divalproex sodium (a medication used to treat involuntary movements and mental disorders) care plan (a detailed document that outlines a patient's individual healthcare needs) had interventions for lithium (mood stabilizing medicine used to treat certain mental illnesses) and not divalproex sodium (an anticonvulsant [anti-seizure] medication also used as a mood stabilizer). This failure had the potential to cause Resident 66's divalproex sodium administration side effects such as weight loss, loose stools, and drowsiness to go unmonitored. 2. Resident 72 had no documentation describing behaviors to be monitored for in the medication care plan for Escitalopram (medication used to treat depression and generalized anxiety disorder). 3. Resident 118 had no documentation describing behaviors to monitored for in the care plan for the antipsychotic medication Olanzapine (antipsychotic medication used to treat mental disorders including schizophrenia [a chronic mental health conditional characterized by significant disruptions in thought processes, perceptions, emotions and behavior] and bipolar disorder [a chronic mental health condition characterized by extreme shifts in mood, energy and behavior]). These failures had the potential to result in Residents 72 and Resident 118 not having their mental and psychosocial (pertaining to the influence of social factors on an individual ' s mind or behavior, and to the interrelation of behavioral and social factors) needs met. 4. Resident 114 did not have a care plan to monitor for side effects of Apixaban (anticoagulant - prevent blood clots from forming). This failure put Resident 114 at risk for harm by not identifying and monitoring for harmful side effects such as bleeding, bruising, and passing out. Findings: (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1. During a concurrent interview and record review on 3/4/25 at 1:32 p.m. with Licensed Vocational Nurse (LVN) 8, Resident 66's Care Plan, dated 3/4/25 and Order Summary Report, dated 3/4/25 were reviewed. The Order Summary Report indicated, give 1500 milligrams (mg- a unit of measurement) by mouth in the evening related to schizophrenia (mental health condition characterized by significant disruptions in thought processes, emotions, and behavior) . The Care Plan indicated, . Focus . Receiving anticonvulsant medications [divalproex sodium] as a mood stabilizer . Interventions/Tasks . Administer LITHIUM as ordered by physician. Monitor for side effects and effectiveness [every] SHIFT . Monitor/ report PRN (as needed) and adverse reactions of LITHIUM therapy . LVN 8 stated the divalproex sodium needed to have a care plan specific to it in order to properly monitor the side effects of the medication. LVN 8 stated the interventions for Resident 66's divalproex sodium were all about lithium and not divalproex sodium. LVN 8 stated Resident 66's divalproex sodium care plan should have included interventions for divalproex sodium and not lithium. LVN 8 stated having the wrong medication's interventions on the care plan could have caused Resident 66 to have unmonitored symptoms from the divalproex sodium such as weight loss, loose stools, and drowsiness. During an interview on 3/7/25 at 11:12 a.m. with the Director of Nursing (DON), the DON stated Resident 66's Care Plan should have had interventions for the divalproex sodium and not for lithium. The DON stated having an inaccurate care plan could lead to Resident 66's needs not being addressed. The DON stated Resident 66's Care Plan should have been individualized to better serve him. During a review of Resident 66's Admission Record (AR- a document that provides resident contact details, a brief medical history, level of functioning, preferences, and wishes), dated 3/6/25, the AR indicated, Resident 66 was admitted to the facility on [DATE], with the following diagnoses: schizophrenia, altered mental status (change in the way the brain thinks), insomnia (condition making sleeping difficult), traumatic brain injury (an injury to the brain caused by an external force, such as a bump, blow, jolt, or penetrating object). During a review of the facility's policy and procedure (P&P) titled, Care Plans Comprehensive, dated 2001, the P&P indicated, .7. The comprehensive, person-centered care plan: a. includes measurable objectives and timeframes; b. describes the services that are to be furnished to attain or maintain the resident's highest practicable, mental, and psychosocial wellbeing .c. includes the residents stated goals . and desired outcomes . care plans interventions are chosen only after data gathering, proper sequencing of events, careful consideration of the relationship between the resident's problem area and their causes . when possible interventions address the underlying source(s) of the problem area(s), not just symptoms or triggers . 51134 2. During a review of Resident 72 ' s Admission Record (AR) dated 3/6/25, the AR indicated, Resident 72 was admitted to the facility on [DATE]. The AR indicated, . Diagnosis Information . Major Depressive Disorder (mental health condition characterized by persistent feelings of sadness hopelessness and loss of interest or pleasure in activities) . schizoaffective disorder (mental health condition that combines symptoms of schizophrenia and a mood disorder, such as depression or bipolar disorder) . anxiety disorder (condition in which a person has excessive worry and feelings of fear, dread and uneasiness) . (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 72 ' s Care Plan (CP) (a written document that outlines a resident ' s individual healthcare needs, goals and nursing interventions required to achieve those goals) dated 6/11/24, the CP indicated, Focus: Receiving antidepressant medication [related to] medical diagnosis: Depression, [as evidenced by]: [blank area with no documentation]. Medication: [escitalopram]. At risk for adverse drug reaction. Date initiated: 06/11/2024 Revision on: 10/09/2024 . During a concurrent interview and record review on 3/6/24 at 4:34 p.m. with Licensed Vocational Nurse (LVN) 3, Resident 72 ' s CP for escitalopram dated 6/11/24 was reviewed. The CP indicated, Focus: Receiving antidepressant medication [related to] medical diagnosis: Depression, [as evidenced by]: [blank area with no documentation] . LVN 3 stated Resident 72 ' s care plan was incomplete and should have included what behaviors to observe for. LVN 3 stated it was important to have behaviors (a resident ' s actions, reactions and conduct) to monitor for in the care plan so those caring for the resident can be aware of and monitor for those behaviors. LVN 3 stated it is important to have behaviors listed to monitor for behavior changes and update behavior monitoring if needed. 3. During a review of Resident 118 ' s AR dated 3/6/25, the AR indicated, Resident 118 was admitted to the facility on [DATE]. The AR indicated, . Diagnosis Information . Alzheimer ' s disease (a disease characterized by a progressive decline in mental abilities) . unspecified psychosis (a diagnosis used when there is not enough information to diagnose a specific psychotic disorder), major depressive disorder, adjustment disorder with mixed anxiety and depressed mood (mental health condition characterized by a combination of symptoms of anxiety and depression that develop in response to a significant stressor) . During a review of Resident 118 ' s CP dated 8/22/24, the CP indicated, Focus: Receiving antipsychotic medication [related to] Medical Diagnosis: delirium [serious disturbance in mental abilities that results in confused thinking and reduced awareness of surroundings], [as evidenced by]: [blank area with no documentation]. Medication: [Olanzapine]. At risk for adverse drug reaction. Revision Date 8/22/2024 . During a review of Resident 118 ' s CP dated 8/22/24, the CP indicated, Focus: Receiving antipsychotic medication [related to] Medical Diagnosis: delirium [as evidenced by]: psychosis [manifested by] visual and auditory hallucinations [an experience involving the apparent perception of something not present] ARB having conversations with unknown people . Date initiated: 08/22/2024. Revision on 03/06/2025 . During an interview on 3/6/25 at 11:37 a.m. with LVN 2, LVN 2 indicated the CP for Olanzapine Resident 118 is incomplete and missing behaviors to observe for. LVN 2 stated if the care plan does not specify what behaviors to observe for, staff will not know what behaviors to monitor for. During an interview on 3/6/25 at 4:37 p.m. with LVN 3, LVN 3 stated Resident 118 ' s CP for Olanzapine was revised but prior to the revision the CP was incomplete, and behaviors were missing from the care plan. LVN 3 stated it was important to have a complete care plan because behaviors change LVN 3 stated a complete care plan was important for those caring for the resident could be aware of and monitor the resident for the behaviors listed. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 3/7/25 at 9:15 a.m. with the Director of Nursing (DON), the DON stated the care plans that did not have behaviors included were incomplete care plans. The DON stated there must be a target behavior (specific actions) listed so a nurse can monitor specifically if that medication is effective for that behavior and nurses know what behavior to observe for. During a review of the facility ' s policy and procedure (P&P) titled, Care Plans, Comprehensive Person-Centered dated 2001, the P&P indicated, .7. The comprehensive, person-centered care plan: . b. describes the services that are to be furnished to attain or maintain the residents highest practicable physical, mental and psychosocial well-being . 11. Assessments of residents are ongoing and care plans are revised as information about the residents and the residents ' condition change . 41608 4.During a concurrent observation and interview on 3/3/25 at 11:20 a.m. with Resident 114 in her room, Resident 114 was sitting up in her room in her wheelchair watching television. Resident 114 stated she has had a fall in the past and now she uses the wheelchair to prevent falling again. During a review of Resident 114's Admission Record (AR), (a document containing pertinent resident profile information) dated 3/6/25, the AR indicated, Resident 114 was admitted to the facility on [DATE], with diagnoses which included Anemia (a condition that develops when your blood produces a lower-than-normal amount of healthy red blood cells, history of falls, urinary tract infection, adult failure to thrive (decline in overall health and well-being, marked by symptoms like unintentional weight loss, reduced appetite, and decreased physical function), and Depression (a mental health condition characterized by a persistent low mood and loss of interest in activities). During a review of Resident 114's Minimum Data Set (MDS-a resident assessment tool used to identify resident cognitive, physical abilities and needs) assessment dated [DATE], the MDS assessment indicated, Resident 114's Brief Interview for Mental Status (BIMS-screening tool used to assess resident cognition status on a scale of 015 [0-6 severe cognitive deficit, 7-12 moderate cognitive deficit, 13-15 no cognitive deficit) assessment score was 15 out of 15 which indicated Resident 114 had no cognitive deficit. During a review of Resident 114's Medication Administration Record (MAR), dated 3/6/25, the MAR indicated, Resident 114 was prescribed Apixaban Oral Tablet 2.5 MG (unit of measure) . two times daily for DVT prophylaxis (to prevent blood clots) . During a concurrent interview and record review on 3/6/25 at 1:30 p.m. with Licensed Vocational Nurse (LVN) 4, all of Resident 114's active Care Plans (CP), dated 3/6/25 were reviewed. The CP indicated, a CP for anticoagulants was not created. LVN 4 stated, a CP was required for all residents taking anticoagulants and the care plan should include what to monitor while resident is receiving anticoagulants. During an interview on 3/6/25 at 2:57 p.m. with the Director of Nurses (DON), the DON stated, Resident 114 did not have an anticoagulant care plan. Resident should have had a care plan to monitor for adverse reactions such bruising, bleeding, or light headedness. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's policy and procedure (P&P), titled Resident Participation - Assessment Care Plans dated 2001, indicated, .Resident assessments are begun on the first day of admission . any specialized services to be provided . reflects currently recognized standards of practice for problem areas and conditions .

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48739 Based on observation, interview, and record review, the facility failed to meet professional standards of practice for two of seven sampled residents (Residents 52 and 113) when: 1. Resident 52's tube feeding bag (TF - a liquid form of nutrition that is carried through your body through a flexible tube) was not labeled with the date it was hung (set up for administration). 2. Resident 113's TF bag was not labeled with the time the TF bag was hung. These failures had the potential to result in Residents 52 and 113 to receive nutrition that was outdated or expired and put them at risk of food borne illness (any illness resulting from eating contaminated/spoiled foods). Findings: During an observation on [DATE] at 9:35 a.m. in Resident 52's room, Resident 52 was dressed, lying in bed asleep with her head elevated. Resident 52 had a TF attached to a feeding pump (a machine that delivers specific amount of fluids per hour of nutrition) that was not administering TF to Resident 52. Resident 52's TF bag had no date listed indicating when the TF was hung, and the feeding pump was set to paused. During a concurrent observation and interview on [DATE] at 9:37 a.m. with Licensed Vocational Nurse (LVN) 6 in Resident 52's room, Resident 52's TF bag had no date listed. LVN 6 stated the TF bag should have been dated when it was hung. LVN 6 stated the TF bag needed to be changed every 24 hours. LVN 6 stated the TF bag needed a date in order to see when it was last changed. LVN 6 stated if there was no date on the bag, Resident 6 could have received a feeding that had gone bad from being in the bag too long. During a review of Resident 52's Admission Record (AR - a summary of information regarding a patient which includes patient identification, past medical history, insurance status, care providers, family contact information and other pertinent information), dated [DATE], the AR indicated, Resident 52 was admitted to the facility from a hospital on [DATE] with diagnoses of acute respiratory failure (a serious condition that occurs when the lungs cannot get enough oxygen into the blood or remove enough carbon dioxide [a waste gas] from the blood), subarachnoid hemorrhage (bleeding in the space between the brain and the membrane that covers it), Congestive heart failure (CHF-a heart disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling), and dysphagia (difficulty swallowing). During a review of Resident 52's Minimum Data Set (MDS - a resident assessment tool used to identify cognitive [mental processes] and physical functional level assessment), dated [DATE], the MDS section C indicated, Resident 52 had a Brief Interview for Mental Status (BIMS - a test given by medical professionals to determine cognitive (involving the process of thinking, learning and understanding) understanding on a scale of ,d+[DATE]) score of zero (a score of ,d+[DATE] suggests severe cognitive impairment, ,d+[DATE] suggests moderately impaired, ,d+[DATE] suggests cognitively intact), which suggested Resident 52 was severely cognitively impaired. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 52's Order Summary Report, dated [DATE], the Order Summary Report indicated, . Enteral Feed Order [tube feeding] in the evening related to DYSPHAGIA, OROPHARYNGEAL PHASE (the middle part of the throat, behind the mouth) . Enteral: (Feeding Brand Name) at 50 milliliters per hour (mL/HR - unit of measurement) x [every] 16 hours (800ml total) via G-Tube (a surgical opening fitted with a device to allow feedings to be administered directly to the stomach). Start Feeding . at 1700 [5:00 pm]. Continue infusion until complete . During an observation on [DATE] at 10:10 a.m. in Resident 113's room, Resident 113 was dressed, lying on his back, head elevated with his arms bent up toward his chest. Resident 113's TF was infusing at a rate of 40ml/HR. Resident 113's TF bag had no label with the time it was hung. During a review of Resident 113's AR, dated [DATE], the AR indicated, Resident 113 was admitted to the facility from a hospital on [DATE] with diagnoses of chronic respiratory failure (a serious condition that occurs when the lungs cannot get enough oxygen into the blood or remove enough carbon dioxide [a waste gas] from the blood), intracranial hemorrhage (bleeding in and around the brain), Tracheostomy (a surgical opening in the windpipe to allow air and oxygen reach the lungs), and transient ischemic attack (TIA - a short period of symptoms similar to those of a stroke, caused by a brief blockage of blood flow to the brain). During a review of Resident 113's MDS, dated [DATE], the MDS section C indicated, Resident 113 had a BIMS score of zero, which suggested Resident 113 was severely cognitively impaired. During a review of Resident 113's Order Summary Report, dated [DATE], the Order Summary Report indicated, . enteral feed order in the evening . tube feeding [tube feeding brand name] at 40 ml/HR x 20hrs . Start Feeding . at 1700 until total volume is met . During an interview on [DATE] at 9:29 a.m. with LVN 7, LVN 7 stated feeding tube and fluid bags should have been changed every night and the bags should have had a label with the date and time they were changed. LVN 7 stated staff needed to know when the TF was hung and if the infusion was completed at the ordered time. LVN 7 stated most tube feedings were given over 20 hours. LVN 7 stated the TF bag could have been changed at any time and having the date and time it was hung helped staff know if the amount infused within a certain time was correct for the resident. During an interview on [DATE] at 4:33 p.m. with the Director of Nursing (DON), the DON stated the TF bag should have been dated and timed when it was hung. The DON stated labeling the TF bag was a safe practice and it was a guideline set by the manufacture. The DON stated the nurses have 48 hours to give the tube feeding before it needed to be changed out. The DON stated the tube feeding consistency could have changed if it was left in the bag too long. The DON stated staff would be giving food to the resident that had gone bad. The DON stated labeling tube feeding with dates and times would also be considered an infection prevention practice which would prevent the resident from getting a food borne illness (any illness resulting from eating contaminated or spoiled foods). During a review of the facility's policy and procedure (P&P) titled, Enteral Nutrition, dated ,d+[DATE], the P&P indicated, . adequate nutritional support through enteral nutrition is provided to residents as ordered . the nurse confirms that orders for enteral nutrition are complete . administration method . volume and rate of administration . instructions for flushing (solution, volume, frequency, timing and 24-hour volume) .

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observe each nurse aide's job performance and give regular training. 49949 Based on observation, interview and record review the facility failed to ensure three of the five sampled Certified Nursing Assistant's (CNA) received nurse aide performance evaluation (a formal assessment of a nurse aide's job performance, covering areas like clinical competence, communication, teamwork, and professionalism, to identify strengths and areas for improvement) every 12 months. This failure resulted in CNAs not getting their performance check and had the potential for weak areas to not be identified and improved. Finding: During a concurrent interview and record review on 3/6/25 at 12:00 p.m. with the Director of Staff Development (DSD), CNA 4's annual performance evaluation was reviewed. The DSD stated, I don't see one done for the year of 2024. The DSD stated CNA 4 should had one done in 2024. The DSD stated CNA 4 last in-service infection control, communication and behavior health training were done on 12/18/23. The DSD stated CNA 4 should have had the trainings completed annually. During a concurrent interview and record review on 3/6/25 at 12: 15 p.m. with the DSD, CNA 5's annual evaluation was reviewed. The DSD stated CNA 5's annual evaluation was last done on 5/11/23. The DSD stated it should have been done on 4/11/24 and it was not. The DSD stated CNA 5 skills competency check was done on 8/4/23 and should have been done competed annually. During a concurrent interview and record review on 3/6/25 at 12:30 p.m. with the DSD, CNA 6's annual evaluation was reviewed. The DSD stated CNA 6 did not have one done for the year 2024 and should had one done on 11/28/24. During an interview on 3/6/25 at 12:30 p.m. with the DSD, the DSD stated, in- services (staff training) are done twice a month and attempted three times. The DSD stated, It is the DSD responsibility to ensure the staff does their annual in-services. The DSD stated, It is important so they can be updated on the resident's need and to better provide care for the residents. The DSD stated annual in-services and training were good refresher for training with new ideas. The DSD stated, not doing annual training would affect the CNA's certification and the training was needed to provide better care for the residents. The DSD stated annual performance training and evaluations could help CNA's address issues or concerns with their skills. The DSD stated, The training should be done annually and as needed depending on the needs of the facility. The DSD stated the CNA's evaluation was done annually to see the growth or decline. The DSD stated Not doing annual performance evaluation, the facility won't see the areas the staff needs improvement in. During an interview on 3/7/25 at 12:57 p.m. with the Director of Nursing (DON), the DON stated, Staff should be getting annually evaluation for job performance and competency. The DON stated, We are not following their performing, not adhering to competency skills check, identify weakness and performance. The DON stated, we would not identify areas that would need improvement, and we would not be able to celebrate growth, strength professional development. (continued on next page)

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 03/07/25 at 1:16 p.m. with the Administrator (ADM), the ADM stated, The expectation is annual evaluation for skills competency and performance for the feedback. The ADM stated, There is potential for the staff to not meet their requirements. The ADM stated We should ensure the staff are competent. And we should do it through skills check and performance evaluation. The ADM stated without the training performance evaluation the standard of care would not be provided for residents. During a review of the facility's policy and procedure titled, Staffing, Sufficient and Competent Nursing, dated 2011 the P&P indicated, Competency requirements and training for nursing staff are restabilized and monitored by nursing leadership with input from the medication director to ensure that: . gaps in education are identified and addressed .

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48430 Based on interview, and record review, the facility failed to prevent residents from receiving unnecessary medications for three out of seven sampled residents (Residents 8, 38, and 126) when: 1.Resident 8 and 126's did not have liver function test labs (LFT- blood tests that measure how well your liver is functioning) completed or monitored while taking valproic acid (a medication used to treat seizure disorders [sudden burst of electrical activity in the brain], certain psychiatric conditions [a wide range of conditions that affect a person's thoughts, emotions and behavior]). These failures resulted in the status of Resident 8 and 126's liver function being unknown and had the potential to cause serious negative effects including toxic levels of valproic acid leading to increased sedation (a state of calmness, relaxation or sleepiness), confusion, seizures, tremors, and liver failure which may become life threatening. 2.Resident 38 was administered oxycodone (opioid pain killer)-acetaminophen (combined pain medication use to treat moderate (pain scale [a zero to 10 scale where zero is no pain progressing to 10 being the most pain imaginable] level 4-6) to severe (pain level 7-10 pain) 10-325 mg (milligram-unit dose of measurement) no pain and for mild pain (level is pain level 1-3). This failure resulted in Resident 38 getting unnecessary medication for mild pain and resulting in medication error. Findings: 1.Resident 8 During a review of Resident 8's Admission Record (AR- document containing resident demographic information and medical diagnosis) dated 3/05/25, the AR indicated, Resident 8 was admitted to the facility on [DATE] with diagnoses of unspecified mood affective disorder (mental health condition that primarily affects your emotional state), bipolar disorder (mental health condition that causes extreme mood swings), anxiety disorder (intense, excessive, and persistent worry and fear about everyday situations), major depressive disorder (mental health disorder characterized by persistently depressed mood or loss of interest in activities) and seizures. During a review of Resident 8's Minimum Data Set (MDSC - a resident assessment tool used to identify cognitive [mental processes] and physical functional level assessment), section C dated12/12/24, the MDSC indicated, Resident 8 had a Brief Interview for Mental Status (BIMS - a test given by medical professionals to determine cognitive understanding on a scale of 1-15) score of 15 (a score of 0-7 suggests severe cognitive impairment, 8-12 suggests moderately impaired, 13-15 suggests cognitively intact) indicating, Resident 8 was cognitively intact. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 8's Order Summary Report (OSR) dated 3/05/25, the OSR indicated, .[trade name for valproic acid] Tablet Delayed Release 500MG (mg-milligram, a unit of measure) . Give 3 tablets by mouth relate to OTHER SEIZURES . Start Date . 09/27/2024 . [lab test orders] CBC (complete blood count-a blood test), CMP (comprehensive metabolic panel-a blood test), TSH (thyroid stimulating hormone-a hormone made by the brain that tells the thyroid [a small gland in the neck] to make other hormones that control energy), Lipid Panel (labs that measure fats in the blood, HgbA1C (hemoglobin a1c-measures the average amount of sugar in your blood over the past three months), Vit D (vitamin d-an essential nutrient that helps support a healthy immune response) . The OSR did not indicate any lab test orders to monitor LFTs. During an interview on 3/05/25 at 10:58 a.m. with Licensed Vocational Nurse (LVN) 8, LVN 8 stated valproic acid levels should be done every six months. LVN 8 stated, if LFT's were not monitored, toxic levels of valproic acid could have occurred that could have led to side effects such as diaphoresis, insomnia, seizures, and tremors. During a concurrent interview and record review on 3/05/25 at 11:37 a.m. with the facility's Consultant Pharmacist (CP), Resident 8's Lab Results Report (LRR) dated 8/20/24 to present were reviewed. The LRR did not indicate LFT labs were drawn. The CP stated, he did not see LFT lab results documented on the LRR and Resident 8 should have had an LFT lab ordered. The CP stated, he recommended an LFT to be done around the first month of starting valproic acid. The CP stated, if labs were not done, there could have been a rise in liver enzymes (compounds in the liver that speed up chemical reactions in the body) and had the potential for liver damage overtime. The CP stated, that no orders, past or present, had been given to draw LFTs. During and interview on 3/07/25 at 10:23 a.m. with the Director of Nursing (DON), the DON stated, she expected staff to monitor psychotropic medications (medications that affect the brain) labs for toxicity and other adverse effects. The DON stated, when the CP recommended lab draws, staff should have acted on the recommendation. The CP stated, if labs were not monitored, toxic levels of valproic acid could have occurred, potentially leading to the resident's death. During a review of the CP's Medication Regimen Review (MRR) dated 3/1/25 and 3/7/25, the MRR indicated, .the resident is receiving [brand name for valproic acid], which ay cause blood dyscrasias and impair liver function, especially early in therapy .please consider monitoring .LFTs every six months . During a review of Resident 8's Care Plan (CP) dated 4/26/25, the CP indicated, .Resident taking [brand name for valproic acid] Tablet Delayed Release 500mg for Seizure . the resident has seizure disorder . Obtain and monitor lab/diagnostic work as ordered . Report results to Physician and follow up as indicated . During a review of the facility's policy and procedure (P&P) titled, Psychotropic Medication Use dated 2001, the P&P indicated, .Psychotropic medication management includes: . adequate monitoring for efficacy and adverse consequences . residents receiving psychotropic medication are monitored for adverse consequences . (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the Professional Reference (PR) found on https://www.accessdata.fda.gov/drugsatfda_docs/label/2011/018723s037lbl.pdftitled, Depakote (divalproex sodium) Tablets dated 10/07/2011, the PR indicated, .WARNINGS: LIFE THREATENING ADVERSE REACTIONS . Hepatotoxicity (a condition characterized by damage to the liver cause by chemicals), including fatalities, usually during the first 6 months of treatment . Monitor patients closely, and perform liver function tests prior to therapy and at frequent intervals thereafter . During a review of Resident 126's AR dated 3/05/25, the AR indicated, Resident 126 was admitted to the facility on [DATE] with diagnoses of schizophrenia (a mental condition that affects a person's ability to think, feel, and behave clearly), hypothyroidism (condition in which the thyroid gland doesn't produce enough thyroid hormone), essential hypertension (high blood pressure that is not due to another medical condition) and unspecified convulsions (rapid, involuntary muscle contractions that cause uncontrollable shaking and limb movement). During a review of Resident 126's MDSC dated 8/15/24, the MDSC indicated, Resident 126 had a BIMS score of 99 indicating Resident 126 was cognitively impaired. During a review of Resident 126's OSR dated 3/05/25, the OSR indicated, . [trade name for valproic acid] Tablet Delayed Release 500MG . Give 1 tablets by mouth two times a day related SCHIZOPHRENIA . Start Date .08/16/2024 . The OSR did not indicate any orders to monitor LFTs. During a concurrent interview and record review on 3/05/25 at 2:27 p.m. with the facility's CP, Resident's 126's LRR dated 08/21/24 to present were reviewed. The LRR did not indicate LFT labs were drawn. The CP stated, he could not find LFT labs ordered. The CP stated, a baseline LFT should have been ordered. The CP stated, it was important to ensure LFTs were monitored to ensure liver damage did not happen. The CP stated, liver damage from valproic acid could have resulted in jaundice (a condition where the skin and eyes become yellow due to liver damage), change in bowel habits, and shaking hands. During an interview on 3/07/25 at 10:23 a.m. with the DON, the DON stated, she expected staff to monitor psychotropic medications (medications that affect the brain) labs for toxicity and other adverse effects. The DON stated, when the CP recommended lab draws , staff should have acted on the recommendation. The DON stated, if labs were not monitored, toxic levels of valproic acid could have occurred, potentially leading to the resident's death. During a review of the CP's MRR dated 3/1/25 and 3/7/25, the MRR indicated, .New Start [brand name for valproic acid] 8/2024 .triglycerides [fats in the blood] 433 mg/dl (mg/dl- milligrams per deciliter [a unit of measure])-high .can be due to antipsychotic use, continue to monitor and consider lipid therapy if appropriate . During a review of the facility's Progress Notes (PN) dated 8/19/24, the PN indicated, .Pharmacy: Pharmerica-Fresno .Yes .labs were ordered [specific labs were not listed] . During an interview on 7/07/25 at 10:53 a.m. with LVN 9, LVN 9 stated, no follow up LFT labs had been ordered for Resident 126. LVN 9 stated, it was important to monitor Resident 126's LFTs while on valproic acid because the medication could have caused liver damage. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 126's CP dated 1/03/25, the CP indicated, .Medical Diagnosis: schizophrenia, unspecified . Medication: [brand name for valproic acid] . At risk for adverse drug reaction . monitor/report labs as ordered by Physician .ammonia levels (a byproduct of liver metabolism that can be toxic in high levels). During a review of the facility's policy and procedure (P&P) titled, Psychotropic Medication Use dated 2001, the P&P indicated, . Psychotropic medication management includes: .adequate monitoring for efficacy and adverse consequences . residents receiving psychotropic medication are monitored for adverse consequences . During a review of the Professional Reference (PR) found on https://www.accessdata.fda.gov/drugsatfda_docs/label/2011/018723s037lbl.pdftitled, Depakote (divalproex sodium) Tablets dated 10/07/2011, the PR indicated, .WARNINGS: LIFE THREATENING ADVERSE REACTIONS . Hepatotoxicity (a condition characterized by damage to the liver cause by chemicals), including fatalities, usually during the first 6 months of treatment . Monitor patients closely, and perform liver function tests prior to therapy and at frequent intervals thereafter . 49949 2. During a review of Resident 38's Admission Record (AR- document containing resident demographic information and medical diagnosis) dated 3/5/25, the AR indicated, Resident 38 was admitted to the facility on [DATE]. Resident 38 's diagnosis included, congestive heart failure (CHF- a condition where the heart muscle is weakened and cannot pump blood effectively), diabetes mellitus (DM- a chronic metabolic disorder characterized by high blood sugar (glucose) levels), chronic pain, chronic obstructive pulmonary disease (COPD- a group of lung diseases that cause airflow obstruction and breathing difficulties), anxiety, bipolar disorder (chronic mental health condition characterized by significant and persistent shifts in mood, energy, and activity levels) and dysphagia (difficulty swallowing). During a review of Resident MDSC dated 12/17/24, the MDSC indicated, Resident 38 BIMS score of 13 indicating Resident 38 was moderately cognitively impaired. During a review of Resident 38's Medication Administration Record (MAR-a standardized record that organizes essential information about a resident and their prescribed medications, dated February 2025, the MAR indicated, Oxycodone-Acetaminophen oral tablet 10-325mg-give 1 tablet by mouth every 4 hours as needed for moderate to severe pain. Do not exceed 3 grams in . 24 hrs. [box 2/3/25] Mon: 3 . [box] pain level: 3 . [box 2/9/25] Sun: 9 . [box] pain level: 0 . During a review of Resident 38's MAR, dated [DATE], the MAR indicated, Oxycodone-Acetaminophen oral tablet 10-325mg-give 1 tablet by mouth every 4 hours as needed for moderate to severe pain. Do not exceed 3 grams . in 24 hrs. [box 3/3/25] Mon: 3 .[box] pain level: 0 . (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 2/5/25 at 11:15 a.m. with License Vocational Nurse (LVN) 1, Resident 38's MAR dated February 2025 and March 2025, was reviewed. The MAR indicated, on 2/3/25, Resident 38 was administered Oxycodone-acetaminophen oral tablet 10-325 for pain of three out of 10 and on 2/9/25 for pain level of zero out of 10. LVN 1 stated, the order for oxycodone-acetaminophen 10-325mg was for moderate to severe pain and should not have been given for mild pain. LVN 1 stated, Resident 38 had 0/10 pain on 2/9/25 and 3/3/25 should not have received any medication. LVN 1 stated on 2/3/25 Resident 38 had 3/10 pain and should have received less invasive drug [acetaminophen] and not oxycodone-acetaminophen. LVN 1 stated it was important to follow the physician order to prevent drug abuse. LVN 1 stated, We [nurses] should be following the [physician] order. LVN 1 stated, giving oxycodone-acetaminophen for 0-3 pain was considered a medication error and we should have followed the physician order to prevent medication errors. During an interview on 3/7/25 at 12:22 p.m. with the Director of Nursing (DON), the DON stated, nurses should have followed the physician order. The DON stated, nurses did not give the appropriate medication for the pain level base on the MAR. The DON stated nurse should have followed the physician order and given Resident 38 medication based what was written. The DON stated, the unit managers and assistance director of nursing should have checked to make sure the physician order were being followed. During review of the facility's policy and procedure (P&P) titled, Administering Medication dated April 2019, the P&P indicated, Medications are administered in a safe and timely manner, and as prescribed . 4. Medication are administered in accordance with prescriber orders, including any required time frame . During a review of the facility's policy and procedure (P&P) titled, Pain Assessment and Management, dated October 2022, the P&P indicated, The purpose of this procedure are to help the staff identify pain in the resident, and to develop interventions that are consistent with the resident's goals and needs and that address the underlying cause of pain .4 standardized pain assessment tool, as indicated per facility protocol; and .assess pain using a consistent approach and a standardized pain assessment instrument appropriate to the resident's cognitive level .

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51134 Based on observation, interview, and record review, the facility failed to ensure the medication error rate was less than five percent when the facility ' s medication error rate was 14.81 percent. There were 27 opportunities for errors and four medication errors occurred with two of four sampled residents (Residents 25 and 85) when: 1. Resident 25 was administered an fluticasone propionate and salmeterol inhalation (medication that is inhaled and helps reduce swelling in the airways) and did not rinse mouth after use as indicated in the prescriber order. 2. Resident 85 was administered one Bumetanide tablet (medication that can treat fluid retention and high blood pressure [force exerted by blood on the walls of the arteries as it is pumped by the heart throughout the body]) at 9:32 a.m. when it was scheduled to be administered at 8:00 a.m. (over an hour past the administration time). 3. Resident 85 was administered Carvedilol (medication to treat heart failure [condition in which the heart cannot pump enough blood to all parts of the body] and high blood pressure) without food as indicated in the prescriber order. 4. Resident 85 was administered a nutritional supplement (powder medication mixed in water used to support wound healing and build lean body mass) in an unmeasured amount of liquid when the prescriber order indicated to mix in four ounces (unit of weight measurement) of water. These failures resulted in medication errors (observed or identified preparation or administration of medications not in accordance with prescriber orders, manufacturer specifications and accepted professional standards) and had the potential to result in adverse drug reactions and ineffective action of the medications for Residents 25 and 85. Findings: 1. During an observation on 3/5/25 at 8:19 a.m. in Resident 25 ' s room, Licensed Vocational Nurse (LVN) 2 was administering Resident 25 her morning medications. LVN 2 first administered by mouth medications and once completed, proceeded to hand Resident 25 the fluticasone propionate and salmeterol inhalation and Resident 25 administered the medication to herself. Once Resident 25 completed the self-administration of fluticasone propionate and salmeterol inhalation, Resident 25 did not rinse out her mouth. Once Resident 25 completed self-administering the medication, LVN 2 did not instruct Resident 25 to rinse her mouth. During a review of Resident 25 ' s Admission Record (AR) dated 3/5/25, the AR indicated Resident 25 was admitted on [DATE]. The AR indicated, . Diagnosis Information . Chronic Obstructive pulmonary disease [COPD- a chronic lung disease causing difficulty in breathing] . sleep apnea [a sleep disorder in which breathing repeatedly stops and starts] . mild persistent asthma [experience symptoms, such as wheezing, coughing, chest tightness and shortness of breath, more than twice per week but not as frequently as once per day] . (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 25 ' s Medication Order Details, (undated), the Medication Order Details indicated, . [fluticasone propionate and salmeterol] Inhalation Aerosol Powder Breath Activated . 1 puff inhale orally two times a day . Rinse mouth after each use . During an interview on 3/5/25 at 2:11 p.m. with LVN 2, LVN 2 stated Resident 25 did not rinse her mouth after using the inhaler. LVN 2 stated if a resident did not rinse their mouth after using an inhaler, this could leave white patches in the resident ' s mouth that could lead to a respiratory tract infection. 2. During an observation on 3/5/25 at 9:32 a.m. LVN 2 administered one Bumetanide medication to Resident 85. During a review of Resident 25 ' s Admission Record (AR) dated 3/5/25, the AR indicated Resident 85 was admitted on [DATE]. The AR indicated The AR indicated, . Diagnosis Information: . unspecified diastolic (Congestive) heart failure [CHF-a heart disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling] . morbid obesity [severe form of obesity characterized by a significantly excessive body weight] .chronic ulcer [a wound that fails to heal within the expected time frame due to underlying issues such as poor circulation, pressure or other health conditions] . essential (primary) hypertension [high blood pressure that develops over time and has no clear cause] . During a review of Resident 85 ' s Medication Order Details, (undated), the Medication Order Details indicated, [Bumetanide] oral tablet 1 mg [milligram - a unit of measure]. Give 1mg by mouth in the morning for edema [swelling caused by an accumulation of excess fluid in the body ' s tissue]. The Medication Order Details indicated, Bumex is to be administered at [8:00]. During an interview on 3/5/25 at 2:20 p.m. with LVN 2, LVN 2 stated Bumetanide was administered over an hour late. LVN 2 stated it is important to administer medications at or around the ordered time to ensure the medication is more effective. 3. During an observation on 3/5/25 at 9:32 a.m. in Resident 85 ' s room, LVN 2 gave Resident 85 a cup full of medications that included Carvedilol. Resident 85 self-administered the cup full of medication. Resident 85 was not eating and there was no food in Resident 85 ' s room. During a review of Resident 85 ' s Prescriber Order dated 5/25/23, the Prescriber order indicated, Carvedilol oral tablet 6.25 mg . Give with food . During an interview on 3/7/25 at 1:11 p.m. with LVN 3, LVN 3 stated if a medication is ordered to be given with food and is not it can cause gastrointestinal (relating to the stomach and intestines) upset. During an interview on 3/7/25 at 1:51p.m. with LVN 2, LVN 2 stated Carvedilol was not administered with food. LVN 2 stated it is important to administer medication with food when ordered to prevent the resident from having an upset stomach. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. During an observation on 3/5/25 at 9:32 a.m. in Resident 85 ' s room, LVN 2 administered medications to Resident 85. LVN 2 opened the nutritional supplement packet and mixed the packet into the resident ' s bottle of water. LVN 2 did not measure the fluid to be mixed with the nutritional supplement packet. During a review of Resident 85 ' s Prescriber Order dated 9/3/24, the Prescriber Order indicated, . Order summary: [nutritional supplement] two times a day for wound management 1 packet [nutritional supplement] mixed with 4 [ounces] (120[milliliters]) water BID [twice a day] . During an interview on 3/5/25 at 2:27 p.m. with LVN 2, LVN 2 stated the order for Resident 85 ' s nutritional supplement was not followed when the water was not measured to match the order of four ounces. LVN 2 stated it is important to mix medication in the correct amount of liquid because if more liquid is used than is ordered, the medication could be less effective. During an interview on 3/7/25 at 9:15 a.m. with the Director of Nursing, the DON stated the expectation for nurses during medication administration is for nurses to follow the policy and procedure on medication administration that includes verifying orders. The DON stated if medication orders were not followed it could be a safety risk. During a review of the facility ' s policy and procedure (P&P) titled, Administering Medications, dated 2001, the P&P indicated, . 4. Medications are administered in accordance with prescriber orders, including any required time frame . The P&P indicated, . 7. Medications are administered within one (1) hour of their prescribed time, unless otherwise specified (for example, before and after meal orders) . 10. The individual administering the medication checks the label THREE (3) times to verify the right resident, right medication, right dosage, right time and right method (route) of administration before giving the medication . During a review of the job description Charge Nurse dated 2003, the job description indicated, .Drug Administration Functions: Prepare and administer medications as ordered by the physician .

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51134 Based on observations, interview, and record review, the facility failed to properly store and label medications in two of six medication carts when: 1. Eight of fifteen liquid bottled medications did not have an open date in the long-term wing medication cart. Seven of these nine medications were for Residents 1, 25, 34, 62 and 100. This failure had the potential to decrease medication potency that could compromise the therapeutic effectiveness of stored medications 2. Five of 11 eye drop bottles did not have patient labels for Residents 1, 62, and 94 in the long-term wing medication cart. This failure had the potential to result in misidentification of a medication, patient safety risks, and incorrect dosage. 3. One of six medication carts had eye drop medication for three of three residents (residents 76, 115, and 145), that were not labeled with resident name or date the medication was opened. This failure had the potential for residents to receive other residents' medications and/or expired medication that could lead to resident harm. Findings: 1. During an observation on [DATE] at 2:28 p.m. with Licensed Vocational Nurse (LVN) 2, four medication carts were checked for written open dates and expiration dates. In one of four medication carts, eight liquid medication bottles, including one multiuse (used for multiple residents) bottle of Acetaminophen (medication used to relieve mild or chronic pain and reduce fevers) 160 milligram [mg- unit of measure] / 5 milliliter [mL- unit of measure], four bottles of Lactulose (medication used to treat constipation and liver disease) and one bottle of Nystatin (an antibiotic used to treat fungal infections) 100,000 unit/ml bottled medications, had been opened with no open date written on the bottle. During a review of Resident 1 ' s Order Details dated [DATE], the Order Details indicated, Order Summary: Nystatin Mouth/Throat Suspension 10000UNIT/ML (Nystatin (Mouth-Throat). Give 5 ml by mouth every 6 hours for Thrush for 10 days swish and swallow. During a review of Resident 34 ' s Order Details dated [DATE], the Order Details indicated, Order summary: Lactulose Oral Solution 10GM [gram - a metric unit of measurement]/15ML [milliliter - unit of measure that is one thousandth of a liter] (Lactulose). Give 30 mL by mouth every 24 hours as needed for constipation one time a day. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 62 ' s Order Details dated [DATE], the Order Details indicated, Order Summary: Lactulose Encephalopathy Oral Solution 10 GM/15ML . Give 30 ml by mouth every 72 hours as needed for constipation. During a review of Resident 100 ' s Order Details dated [DATE], the Order Details indicated, Order Summary: Lactulose Oral Solution 20 GM/30ML (Lactulose). Give 30 ml by mouth three times a day for bowel regularity. Mix with ,d+[DATE] oz of water or juice/ Hold for loose watery stool. During an interview on [DATE] at 2:51 p.m. with Licensed Vocational Nurse (LVN) 2, LVN 2 stated it was important to put open date on a multiuse medication bottle to make sure a nurse was not administering an expired medication. LVN 2 stated some medications have a shorter expiration date when opened, therefore it is important to put open date on the medication. 2. During an observation on [DATE] at 3:04 p.m. at the long-term wing medication cart, five of 11 eye medications, including four bottles of artificial tears (eye drops used to relieve eye dryness and soreness) and one tube of eye lubricating ointment, with no patient label on the medication bottle for Resident 1, Resident 25, Resident 34, and Resident 94. During a review of Resident 62 ' s Order Details dated [DATE], the Order Details indicated, Order Summary: Polvinyl Alcohol [artificial tears] ophthalmic solution 1.4% . Instill 1 drop in both eyes two times a day for dry eyes. During a review of Resident 94 ' s Order Details dated [DATE], the Order Details indicated, Order Summary: Artificial Tears [lubricating eye drops used to relieve dryness and irritation] Ophthalmic [eye] Solution 0XXX, d+[DATE]XXX,d+[DATE]% . Instill 1 drop in both eyes three times a day for [complaints of] dry eyes 1 [drop] each eye. During an interview on [DATE] at 3:07 p.m. with LVN 2, LVN 2 stated it was important to put a patient label on an eye medication bottle and not just the box, just in case the bottle gets separated from the box. LVN 2 stated it was important to make sure there is a patient label on the bottle to ensure correct medication is being given to the right resident. During an interview on [DATE] at 3:17 p.m. with LVN 3, LVN 3 stated all medications that are opened need to be labeled with an open date. LVN 3 stated it was important to have medication patient label on medication just in case resident moves rooms. During an interview on [DATE] at 9:15 a.m. with the Director of Nursing (DON), the DON stated all medications that are opened should have an open date written on them. The DON stated for eye medication, if the bottle is out of the box and on its own the eye medication should be thrown away immediately and replaced. The DON stated it is important to label medications so the nurse administering the medication can identify which resident it is for. The DON stated if medications do not have a resident label and/or do not have an open date this could be a safety issue. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility ' s policy and procedure (P&P) titled Medication Labeling and Storage dated 2001, the P&P indicated, .Medication Labeling . 2. The medication label includes, at a minimum: a. medication name (generic and/or brand); b. prescribed dose; c. strength; d. expiration date, when applicable; e. resident ' s name; f. route of administration; and g. appropriate instructions and precautions . 5. Multi-dose vials that have been opened or accessed ([example] needle punctured) are dated and discarded within 28 days unless the manufacturer specifies a shorter or longer date for the open vial . 41608 3. During a concurrent observation and interview on [DATE] at 3:15 p.m. with Licensed Vocational Nurse (LVN) 4, in nurse station three, one of six medication carts had three of three open bottles of eye drop medications for three of three residents (Resident 76, 115, and 145), that were not labeled with resident information or a date the bottle was opened. Three of three medication boxes were labeled, but the bottles of medication inside were not labeled. LVN 4 stated, the individual medication bottles need to be labeled with resident information. LVN 4 stated, if the box to the medication was lost, the unlabeled medication bottle could be given to the wrong resident and cause unwanted side effects. During an interview on [DATE] at 3:25 p.m. with the Director of Nurses (DON), the DON stated she expects the staff to label both the box and bottle of medications. The DON stated if the medications are not labeled with resident name and date the bottle was opened, residents could receive the wrong medication and/or an expired medication. The DON stated, receiving a wrong or expired medication could cause an allergic reaction or not be as effective if the medication has expired. During an interview on [DATE] at 9:40 a.m. with Resident 76, Resident 76 stated she takes a lot of medicine, . she does not know what all of it is, she depends on the nurse to know what it is . During a review of Resident 76's Admission Record (AR), dated [DATE], the AR indicated, Resident 76 was admitted on [DATE] from a hospital (with diagnosis of Heart Failure (HF), Diabetes Mellitus (DM-a condition where your body does not make enough insulin), Major Depressive Disorder (a mood disorder that causes sadness, and loss of interest), Bilateral Retinoschisis (a condition that happens when your retina-[the light-sensitive tissue lining the back of your eye that converts light into signals and sends them to the brain for processing, allowing you to see], divides into two or more layers) and Macular Degeneration (an eye disease that causes gradual loss of vision in the center of the eye. During a review of Resident 76's Minimum Data Set (MDS-a resident assessment tool used to identify resident cognitive, physical abilities and needs) assessment dated [DATE], the MDS assessment indicated, Resident 76's Brief Interview for Mental Status (BIMS-screening tool used to assess resident cognition status on a ,d+[DATE] scale-[,d+[DATE] severe cognitive deficit, ,d+[DATE] moderate cognitive deficit, ,d+[DATE] no cognitive deficit) assessment score was 0 out of 15 which indicated Resident 76 had severe cognitive deficits. During a review of Resident 76's Medication Administration Record (MAR), dated [DATE], the MAR indicated, Resident 76 had a medication order for Polyvinyl Alcohol-Povidone Ophthalmic Solution 0XXX, d+[DATE].6%, instill one drop in both eyes as needed every six hours for dry eyes. Start date [DATE] at 5:15 p.m (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on [DATE] at 10:00 a.m. with Resident 115, Resident 115 stated she took eye drops for her eyes, they are always dry and scratchy. Resident 115 stated she does not know what they are called, she asks the nurse for them, and she/he brings them. Resident 115 stated she never looked on the bottle to see if it was her name on the bottle, she assumed the nurse would not bring her someone else's medicine. During a review of Resident 115's AR dated [DATE], the AR indicated, Resident 115 was admitted from a hospital on [DATE] with the diagnosis of Sequelae (long term affects) of Cerebral (brain) Infarction (Stroke - when blood flow is interrupted), hemiplegia (paralysis on one side of the body), hemiparesis (weakness on one side of the body, often affecting the arm, leg, face, or hand, making it difficult to perform everyday tasks), and chronic pain. During a review of Resident 115's MDS assessment dated [DATE], the MDS assessment indicated, Resident 115's BIMS assessment score was 10 out of 15 which indicated Resident 115 had moderate cognitive deficits. During a review of Resident 115's MAR, dated [DATE], the MAR indicated, Resident 115 had a medication order for Lubricant Eye Drops Ophthalmic Solution (Carboxymethylcellulose Sodium), instill one drop in both eyes twice daily for dry eyes. Start date [DATE] at 9:00 a.m. During an interview on [DATE] at 4:10 p.m. with Resident 145, Resident 145 stated, she would not know if the eye medication that was being given to her was hers unless it had a label with her name on it. Resident 145 stated, she would be afraid of taking another resident's eye medication because it could possibly blind her. During a review of Resident 145's AR dated [DATE], the AR indicated, Resident 76 was admitted from a hospital on [DATE] with the diagnosis of history of falls, difficulty walking, chronic kidney disease, anxiety (feeling of fear or dread), disorder, and dry eye syndrome (a condition where the eyes do not produce enough tears or tears of poor quality, resulting in discomfort, irritation, and potential vision problems). During a review of Resident 145's MDS assessment dated [DATE], the MDS assessment indicated, Resident 145's BIMS assessment score was 15 out of 15 which indicated Resident 145 had no cognitive deficits. During a review of Resident 145's MAR, dated [DATE], the MAR indicated, Resident 145 had a medication order for Polyvinyl Alcohol-Povidone Ophthalmic Solution 0XXX,d+[DATE].6%, instill one drop in both eyes as needed every 8 hours for dry eyes. Start date [DATE] at 8:15 p.m. During a review of the facility's policy and procedure (P&P) titled, Medication Labeling and Storage date , d+[DATE], the P&P indicated, . nursing staff sis responsible for maintaining medication storage . in a clean, safe, and sanitary manner . labeling of medications and biologicals dispensed by the pharmacy is consistent with applicable federal and state requirements and currently accepted pharmaceutical practices . the medication label includes, at a minimum: . expiration date . resident's name .

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F 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide routine and 24-hour emergency dental care for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51134 Based on observation, interview, and record review, the facility failed to maintain routine dental services to meet the needs each for one of two residents when Resident 76 had treatment recommendations for a bone spur (an abnormal bony growth that forms on or around joints or along the edges of bones) removal and a new full set of dentures (a removable plate or frame holding one or more artificial teeth) and no action taken by the facility since 9/15/23, leaving the resident without dental service intervention for 17 months and three weeks. These failures resulted in Resident 76 wearing dentures that did not fit properly and caused her pain had the potential to result in poor oral health, difficulty eating and speaking, and decreased quality of life that could lead to depression (a mood disorder that causes a persistent feeling of sadness and loss of interest) and anxiety (a mental health disorder characterized by feelings of worry, anxiety, or fear that are strong enough to interfere with one ' s daily activities). Findings: During a concurrent observation and interview on 3/3/25 at 9:25 a.m. with Resident 76 in Resident 76 ' s room, Resident 76 was observed sitting upright, awake in bed on her tablet with bedside table across her bed with drinks and snacks. Resident 76 stated, I have dentures, but they don ' t fit right. This is my second set [of dentures]. Resident 76 stated I have a bone sticking out on the bottom right row of my mouth and because of this the dentures are uncomfortable to wear and cause pain. Resident 76 stated the dentures were uncomfortable and did not fit right and staff had been informed. Resident 76 stated not wearing the dentures had not affected her diet or contributed to weight loss but, I have to be careful when eating some hard foods like chips. During an interview on 3/6/25 at 8:38 a.m. with Resident 76, Resident 76 stated she would prefer to wear dentures and would love to have a beautiful smile. Resident 76 stated, right now I prefer not to wear my dentures because they hurt. Resident 76 stated, I think if I could wear dentures it will make me feel better about myself. During a review of Resident 76 ' s Admission Record (AR) dated 3/6/25, the AR indicated the resident was initially admitted on [DATE] and readmitted on [DATE]. The AR indicated Resident 76 is her own Responsible Party (RP- healthcare decision maker). The AR indicated, .Diagnosis Information . Major Depressive . anxiety disorder . During a review of Resident 76 ' s Care Plan (CP) dated 12/8/24, the CP indicated, Focus: Resident has dental appliance - removable dentures. At risk for gum irritation and difficulty chewing. Date initiated: 12/18/2024 . Interventions/Tasks: Monitor/document/report to MD [Medical Director] PRN [as needed] s/sx [signs and symptoms] of oral/dental problems needing attention: Pain (gums, toothache, palate [roof of the mouth]) . Date initiated:12/18/2024 . Refer to dentist as needed. Date initiated: 12/18/2024 . (continued on next page)

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F 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of dental note from [contracted dental office], dated 7/7/23, the dental note indicated, . Initial done . Bone spur on lower right, pt [patient] cannot wear F2 [upper and lower dentures]. Need to remove bone spur . The dental note indicated, . [Treatment] Recommendations: . removal of bone spur . During a review of dental note from [contracted dental office], dated 7/14/23, the dental note indicated, . Evaluation. Pt has a bone spur area [number] 29 [number location of tooth] [through] 30 [number location of tooth]. Per pt it causes pain and is unable to wear F2 . During a review of dental note from the [contracted dental office], dated 9/15/23, the dental note indicated, . [evaluation] [with] x-ray [a photographic or digital image of the internal composition of something] only . Treatment in progress: NOA [notice of insurance authorization] pending . During a review of Social Service Note dated 7/10/23, the Social Service Note indicated, .Resident was seen by the Dentist on 7/7/23. Please refer to notes reflecting visit under DOCUMENTS Tab/PHYSICIAN CONSULTATIONS . During a review of Social Service Note dated 7/17/23, the Social Service Note indicated, .Resident was seen by the Dentist on 7/14/23. Please refer to notes reflecting visit under DOCUMENTS Tab/PHYSICIAN CONSULTATIONS . During a review of Social Service Note dated 9/18/23, the Social Service Note indicated, .Resident was seen by the Dentist on 9/15/23. Please refer to notes reflecting visit under DOCUMENTS Tab/PHYSICIAN . During a review of Social Service Note dated 3/6/23, the Social Service Note indicated, Writer spoke with [dental office employee] from [the contracted dental office] regarding the status of resident ' s recommendations from Dentist of removal of bone spur [due to] dentures not fitting well. Per [dental office employee] stated, they had the resident as discharged as of December 2024. [Dental office employee] was sent via email current facesheet and has scheduled the resident to be seen by the dentist on 3/10/25. Resident made aware and satisfied . During an interview on 3/6/25 at 11:55 a.m. with the Social Services Director (SSD), the SSD stated when he spoke with dental healthcare in the morning, Resident 76 was discharged on their census since December 2024 due to an acute hospital visit and was not readmitted to their services upon Resident 76 ' s return to the facility. The SSD stated every month a census is sent to dental services before they are to come in and perform their monthly evaluations on residents and dental services had received a facility census for January 2025 and February 2025. The SSD stated the individual in the facility to coordinate care between dental services and the resident would be social services. The SSD stated, I should have reviewed dental notes and followed up on resident care. The SSD stated he is responsible for reviewing the dental notes for residents when they are made and when they are uploaded. During an interview on 3/6/24 at 4:52 p.m. with the Director of Nursing (DON), the DON stated, even if a resident is their own RP, the facility should be the [NAME] to coordinate dental services with a resident. The DON stated the SSD should have stepped in to coordinate services between the resident and dental care services. (continued on next page)

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F 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/7/25 at 9:15 a.m. with the DON, the DON stated if dental issues or getting dentures for a resident are not addressed, it may affect how a resident feels about themselves. During a review of the facility ' s policy and procedure (P&P) titled Dental Services dated 2001, the P&P indicated, .6. Social services representatives will assist residents with their appointments, transportation arrangements, and for reimbursement of dental services under the state plan, if eligible . 10. If dentures are damaged or lost, residents will be referred for dental services within 3 days. If the referral is not made within 3 days, documentation will be provided regarding what is being done to ensure that the resident is able to eat and drink adequately while awaiting the dental services; and the reason for the delay . During a review of the job description Director of Social Services dated 2003, the Director of Social Services indicated, .Administrative Functions: . Coordinate social service activities with other departments as necessary. Work with the facility ' s consultants as necessary and implement recommended changes as required .

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. 51271 Based on observation, interview and record review, the facility failed to ensure two out of twenty-three kitchen staff (KS 1 and 2) had appropriate competencies and skill sets to safely and effectively carry out the functions of food and nutrition services when: 1. KS 1 used a #12 scoop (1/3 cup, 2.67 ounces) to portion chopped meat when the menu did not indicate portion sizes for chopped meat; and 2. KS 2 did not use the correct portion size when preparing tuna and egg salad sandwiches. These failures had the potential to result in residents receiving inadequate protein which could result in frailty (decreased energy), weight loss, delayed wound healing, loss of muscle, and increased risk of fractures (broken bones). Findings: 1. During an observation of the lunch meal service on 3/4/25 at 12:37 p.m. KS 1 was plating chopped hamburger for residents on prescribed chopped diets. Hamburger patties were pre-chopped and paced in a container on the steam table prior to the start of meal service. Hamburger pieces were approximately 1/2 inch in size. KS 1 used a full #12 scoop to portion chopped hamburger meat for Residents 107, 34, 74, and 26. During an interview on 3/4/25 at 1:30 p.m. with KS 1 at the completion of the lunch meal service, KS 1 stated a full #12 scoop was used for regular portion sizes. For residents with ordered small portion sizes a #12 scoop should be used and filled up halfway. KS 1 stated she had been employed at the facility for eight years. During a review of the lunch spreadsheet titled, Daily Spreadsheet dated 3/4/25 the spreadsheet indicated, food portion sizes for mechanical soft (easily chewable) and puree (blended smooth) diets but did not indicate portion sizes for a chopped diet. During a review of the facilities document titled, Resident Alert Tally Report dated 3/5/25, the report indicated, Resident 107, 34, 74 and 26 required chopped meat, regular portion sizes. During an interview on 3/4/25 at 4:48 p.m. with Registered Dietitian (RD), RD stated it was her expectation for staff to follow all recipes and portions. During an interview on 3/5/25 at 11:14 a.m. with Dietary Services Supervisor (DSS), the DSS stated the regular chopped hamburger portion size amount should have been 3 ounces for the patty. DSS stated a #12 scoop would have been an appropriate portion for residents with ordered small portions, but not for residents with regular portion size. (continued on next page)

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 3/5/25 at 11:15 a.m. with the DSS, the facilities policy and procedure (P&P) titled, Portion Control, dated 8/1/23 was reviewed. The P&P indicated, Food and nutrition services staff would receive training on proper portion sizes at regular intervals . #12 scoop equaled 2.67 ounces or 1/3 cup . #10 scoop equaled 3 1/4 ounces. DSS stated a #12 scoop equaled a 2.67-ounce portion and the #10 scoop would have been 3 1/4 ounces. DSS stated the #10 scoop should have been used when KS 1 portioned out the chopped hamburger during meal service. DSS stated he did not have any competency evaluations (knowledge skills checks) for KS 1. During an interview on 3/5/25 at 3:35 p.m. with RD, the RD stated she reviewed and approved the facility menu. RD stated that it was possible to add a column on the menu spreadsheet to indicate portions required for chopped diets. RD stated regular chopped diets required the same portion amounts as regular diets. RD stated it was important for the serving size of regular chopped foods to be accurate and the same as regular diets. To ensure the portions were accurate, RD stated it was her expectation of staff to get a whole hamburger patty (regular portion), chop it and plate immediately during meal service. RD stated that was how she trained staff to prepare chopped diets. RD stated she did not have a copy of the training in-service. RD stated she believed there were training issues among kitchen staff. During a review of KS 1 personnel file, there was no job competency. During an interview with DSS on 3/5/25 at 3:59 p.m. the DSS stated there was no job competency completed for KS 1. 2. During an observation on 3/3/25 at 4:07 p.m. in the kitchen, KS 2 was putting prepared sandwiches away (three egg salad, two tuna). KS 2 stated she made them ahead of time for residents that may request them for dinner. KS 2 stated she used a plastic spoon to scoop and measure out how much tuna and egg salad to put on the bread. KS 2 stated she placed 1-2 plastic spoonful's per sandwich. During an interview on 3/4/25 at 9:35 a.m. with DSS. The DSS stated KS 2 had come to him and asked how much filling should be added when tuna and egg sandwiches were prepared. The DSS stated he in-serviced KS 2 on how to properly make sandwiches. The recipes were printed out and hung for kitchen staff reference. The DSS stated a #8 scoop (1/2 cup) should be used to fill sandwiches. The expectation was kitchen staff would scoop it off and measure when sandwiches were prepared. The DSS stated the sandwiches that were prepared by KS 2 the day before were remade. During an interview on 3/4/25 at 4:48 p.m. with RD, RD stated it was her expectation of staff to follow recipes and portions when preparing food. During a review of the facilities policy and procedure (P&P) titled, Portion Control dated 8/1/2023, the P&P indicated, #8 scoop is equal to 1/2 cup or four ounces . scoops should be leveled off (not overflowing) for the most accurate portion size . portions that are too small result in the individual not receiving the nutrients needed . Food and nutrition service staff will receive training on proper portion sizes at regular intervals . During a review of a dietary department in-service sign in sheet titled Meal service, tray line, following correct portion sizes according to spreadsheet, dated 8/15/24 indicated KS 2 had not received the provided training along with six other dietary department staff. (continued on next page)

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of KS 2 personnel file, there was no job competency. During an interview with DSS on 3/5/25 at 11:14 a.m. DSS stated there was no job competency completed for KS 2. During a review of the facilities policy and procedure (P& P) titled Evaluating Food and Nutrition Services and Clinical Nutrition Personnel, dated 2023, the P&P indicated, The director of food and nutrition services will complete periodic written evaluations for department staff . clinical staff should be evaluated using competency based assessment . the registered dietitian nutritionist should evaluate nutrition support staff . the employee competency checklist will be completed at the end of 30/60/90 days and periodically as needed .

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49949 51271 Based on observation, interview, and record review the facility failed to ensure food was stored, prepared and distributed in accordance with professional standards when: 1. Kitchen staff (KS 3) did not monitor had not recorded the temperature during the cooling process after preparing tuna salad that was at ambient temperature (room temperature) ; 2. Kitchen staff (KS 4) did not wear a beard net while preparing resident juice cups nor did kitchen staff (KS 5) wear a beard net while putting away equipment and wiping down surfaces; 3. Two robot coupes were stored wet with water inside, pooled on bottom and condensation on the lid; 4. A black serving scoop was stored inside a dry storage bin containing thickener; and 5. A box containing hash brown potatoes was on the floor inside the walk-in freezer. The facility's failure to maintain professional standards for food service safety had the potential to expose highly susceptible residents who received food from the kitchen to foodborne illness (an illness that occurs when you eat or drink something contaminated with harmful bacteria, viruses, toxins, or chemicals) due to cross-contamination (bacteria unintentionally transferred from one substance or object to another, with harmful effect). 6.A box of yellow crackers was not labeled with resident name and open dated. This failure had the potential for unlabeled food items to be given to the wrong residents and undated food to be served to residents after they had expired which had the potential to cause foodborne illness (an illness caused by consuming contaminated food or beverages and cross-contamination (the transfer of harmful bacteria from one person, object, or place to another). Findings: 1. During an interview on [DATE] at 10:27 a.m. with KS 3, KS 3 stated she had prepared tuna salad that morning around 9:30 a.m. KS 3 stated she had gotten the tuna from the dry storage room and the mayo from the fridge. KS 3 stated the prepared tuna salad would be used for sandwiches. KS 3 stated once she had completed making the tuna salad, she would label and date with todays and the use- by date. KS 3 stated she does not take temperature of the food/tuna after making it. KS 3 stated she would just put it in the refrigerator. During an observation on [DATE] at 10:45 a.m. the tuna salad in refrigerator, dated [DATE] and use-by [DATE], had a recorded temperature of temp 47.1 degrees Fahrenheit (F- temperature scale). (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on [DATE] at 1:17 p.m. the tuna salad in refrigerator, dated [DATE] use by [DATE], had a recorded temp of 43.6 degrees F. During an interview on [DATE] at 4:48 p.m. with Registered Dietitian (RD), RD stated it was her expectation of staff to follow the cool down process for the ambient and the time frame to get it cool. During an interview with Dietary Services Supervisor (DSS) on [DATE] at 9:20 a.m. the DSS stated with small cans of tuna, it had not been the expectation for staff to monitor or check temperatures. DSS stated that he was now trying to put small tuna cans in the refrigerator prior to making the tuna salad. During a review of the facilities policy and procedure (P&P) titled, Food Receiving and Storage, dated , d+[DATE], indicated, Danger zone means temperatures above 41 degrees Fahrenheit and below 135 degrees Fahrenheit that allow the rapid growth of pathogenic microorganisms that can cause foodborne illness. Potentially Hazardous Foods (PHF) or Time/Temperature Control for Safety (TCS) foods held in the danger zone for more than four hours (if being prepared from ingredients at ambient temperature) or six hours (if cooked and cooked) may cause a foodborne illness outbreak if consumed. During a review of the facilities policy and procedure (P&P) titled, Food Preparation and Service, dated , d+[DATE], indicated, If time is used in place of temperature as a means of ensuring food safety, the amount of time potentially hazardous foods are held out of temperature control is tracked and foods are discarded accordingly . Proper hot and cold temperatures are maintained during food distribution and service. Foods that are held in the temperature danger zone are discarded after four hours. During a review of professional reference titled, Food and Drug Administration (FDA) Food Code 2022, section ,d+[DATE].14 Cooling, Time/Temperature control for Safety Food shall be cooled within 4 hours to 5 degrees Celsius (41 degrees F) or less if prepared from ingredients at ambient temperature, such as . canned tuna . 2. During a concurrent observation and interview on [DATE] at 11:14 a.m. with DSS in the kitchen, KS 4 poured juice into cups for the tray line. KS 4 wore a surgical mask, but the facial hair on the sides and below the mask hung out, uncovered. KS 5 was putting away equipment and wiping down surfaces. He had a fully trimmed beard and was only wearing a surgical mask. Although his beard was short, it was still uncovered on the sides and neck area. DSS stated the expectation was beards should be covered with a beard net. DSS at that moment had KS 4 and 5 don beard nets. During a review of the facilities policy and procedure (P&P) titled, Food Preparation and Service, dated , d+[DATE], the P&P indicated, Food and nutrition service staff wear hair restraints (hair net, hat, beard restraint, etc) so that hair does not contact food . 3. During an observation on [DATE] at 8:58 a.m. during initial kitchen tour, two of two facility robot coupes (food processor equipment) were stored on their bases, indicating they were ready for use. Both robot coupes were wet, with water pooled at the bottom, and one lid had condensation on it. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Horizon Health & Subacute Center	3034 E Herndon Fresno, CA 93720

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on [DATE] at 4:48 p.m. with RD, the RD stated it was her expectation kitchen equipment would be air dried, and equipment should not be nested (arrange or fit, typically smaller ones inside larger ones) wet. During a review of the facilities policy and procedure (P&P) titled, Sanitization, dated ,d+[DATE], the P&P indicated, Food preparation equipment and utensils that are manually washed are allowed to air dry whenever practical . 4.During a concurrent observation and interview on [DATE] at 8:58 a.m. with DSS during the initial kitchen tour, a large rolling bin containing thickener had a black scoop inside. The lid was left open. The DSS stated the scoop should not be stored inside the bin. During an interview on [DATE] at 4:48 p.m. with RD, the RD stated it was her expectation that scoops were not stored in products of food. During a review of professional reference titled, FDA Food Code 2022, section ,d+[DATE].12, In-Use Utensils, Between-Use Storage, During pauses in food preparation or dispensing, Food preparation and dispensing utensils shall be stored: b) in in food that is not time/temperature control for food safety with their handles above the top of the food within containers or equipment that can be closed, such as bins of sugar, . 5. During an observation on [DATE] at 8:58 a.m. during initial kitchen tour a box containing potatoes was on the floor inside the deep freezer. During an interview on [DATE] at 9:05 a.m. with DSS stated the facility had not received any food shipments that morning. The DSS also stated boxes should not have been stored on the floor. During a review of professional reference titled, FDA Food Code 2022, section ,d+[DATE].11 Storage of Food, Food shall be protected from contamination by storing the food: (3) At least 15 cm (6 inches) above the floor. 6. During a review of Resident 98's Admission Record (AR- document containing resident demographic information and medical diagnosis) dated [DATE], the AR indicated, Resident 98 was admitted to the facility on [DATE]. The AR indicated, Resident 98 had diagnoses of difficulty in walking, history of falling, weakness, hypertension (high blood pressure), hyperlipidemia (a condition characterized by elevated levels of lipids (fats) in the blood, such as cholesterol and triglycerides), pain, and constipation. During a review of Resident 98's Minimum Data Set (MDS - a resident assessment tool used to identify cognitive [mental processes] and physical functional level assessment), dated [DATE] the MDS, indicated, Resident 98 had a Brief Interview for Mental Status (BIMS - a test given by medical professionals to determine cognitive understanding on a scale of ,d+[DATE]) score of 12 (a score of ,d+[DATE] suggests severe cognitive impairment, ,d+[DATE] suggests moderately impaired, ,d+[DATE] suggests cognitively intact) indicating Resident 98 was moderately impaired. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation and interview on [DATE] at 9:25 a.m. in Resident 98's room, an opened box of yellow crackers snack was on Resident 98's nightstand. The open box of snack had no resident name listed on the box and had no opened date labeled. Resident 98 stated her family member brought the snack for her. Resident 98 stated it should have been tossed in the garbage can. Resident 98 stated her family member brought the yellow crackers over three months ago. Resident 98 stated she would like it thrown away and the staff should have thrown it away. During an observation and interview on [DATE] at 11:52 a.m. with Certified Nursing Assistant (CNA) 1, CNA 1 stated, the nurses were responsible to check snacks to make sure it was within resident's physician ordered diet. CNA 1 stated CNA's were responsible for labeling the residents name, received and opened date on snack items. CNA 1 stated it was important to label the snack items to make sure the items were not expired and given to wrong residents. CNA 1 stated, residents could have experienced nausea, vomiting or become sick from consuming expired foods. CNA 1 stated snacks without resident names could have been given to the wrong residents and caused cross-contamination and sickness. CNA 1 stated she was not sure when the last in-service (training) was done at the facility for food brought from home. During an interview on [DATE] at 2:59 p.m. with License Vocation Nurse (LVN), LVN 1 stated, The nurses were responsible to make sure it is ok and within their [residents] diet. LVN 1 stated If it is [snack items] at the bedside, we need to make sure was dated with an open date, their name and room number. LVN 1 stated, it was important to label food items with open date, name and room number to prevent infections. LVN 1 stated, snack items could have been expired or given to the wrong residents. LVN 1 stated residents could have experienced a stomachache, diarrhea, vomiting and nausea when food items were not labeled properly. LVN 1 stated The CNA should be checking bedside and making sure nothing is there and left out. LVN 1 stated, We all should be checking to make sure residents [snack items] be labeled with resident's name and received date. During an interview on [DATE] at 12:37 p.m. with the Director of Nursing (DON), the DON stated, food brought in by family member should be clearly distinguished between facility and should be labeled with patient's room number and name opened date. The DON stated, We all are responsible for it. The DON stated it was important to label food items with resident name to prevent confusion among residents. The DON stated labeling items could prevent residents from consuming expired food. The DON stated residents could have gotten sick or food poisoning from consuming expired food. The DON stated, we did not follow the facility policy and procedure titled, Foods brought by family/visitors. During a review of the facility's policy and procedure (P&P) titled, Foods brought by family/Visitors dated , d+[DATE], the P&P indicated, Food brought by family/visitors that is left with the resident to consume later is labeled and stored in a manner that it is clearly distinguishable .

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48430 Based on observation, interview and record review, the facility failed to ensure accurate and complete medical records in accordance with professional standards of practices were maintained for seven of twelve sampled residents (Residents 15, 16, 33, 45, 52, 106, and 126), when the Physician Orders for Life-Sustaining Treatment (POLST- a form that contains written medical orders for healthcare professionals regarding specific medical treatments that can or cannot be done at the end-of life) were not accurate and complete. This failure had the potential for Resident 15, 16, 33, 45, 52, 106, and 126's decisions regarding treatment options and end of life wishes to not be honored. Findings: During a review of Resident 15's Physician Orders for Life Sustaining Treatment (POLST-is a medical order that helps give people with serious illness more control over their care during a medical emergency) dated [DATE], the POLST indicated, . Date Form Prepared . (no date written) . During a concurrent interview and record review on [DATE] at 3:07 p.m. with the Admissions Nurse (AN), Resident 15's POLST, dated [DATE] was reviewed. The POLST indicated, a preparation date was not filled. The AN stated, Resident 15's POLST was missing a preparation date. The AN stated, she was responsible for filling out a new resident's POLST form. The AN stated, POLST forms needed to be completed in full, including preparation dates, for the form to be considered valid doctor's orders. The AN stated, POLST's should have been accurate and up to date. The AN stated, if a POLST was not accurate or up to date, it was incomplete, and potentially staff might not now know what to do in an emergency. During a concurrent interview and record review on [DATE] at 3:42 p.m. with the Minimum Data Set Nurse (MDSN), Resident 15's POLST, dated [DATE] was reviewed. The POLST indicated, a preparation date was not filled. The MDSN stated, the preparation date for Resident 15's POLST was missing. The MDSN stated, she took responsibility for completing a resident's Minimum Data Set (MDS-a standardized assessment tool measuring health status in nursing home residents). The MDSN stated, the AN was responsible for filling out and completing the POLST. The MDSN stated, when the AN completed the POLST, medical records audited it to ensure everything was filled out completely. The MDSN stated, once medical records reviewed the completed POLST, she completed the resident's MDS. The MDSN stated, a POLST was considered a doctor's orders. the MDS stated, for a POLST to be valid it must have, a doctor's signature, the resident's signature or the responsible party (RP), and all boxes filled out and dated, including the dates when it was prepared and signed. The MDSN stated, if there was no preparation date, the POLST form would have been considered invalid, and the resident's decision regarding treatment options and end of life wishes would not have been honored. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 15's AR (AR - a summary of information regarding a patient which includes patient identification, past medical history, insurance status, care providers, family contact information and other pertinent information), dated [DATE], the AR indicated, Resident 15 was admitted to the facility on [DATE]. Resident 15 had diagnoses of schizoaffective disorder (a mental condition that causes mood problems, hallucinations [seeing or hearing things that are not there] delusions [false belief]), chronic pulmonary obstructive disease (a lung disease that makes it hard to breath), hypothyroidism (a condition where the thyroid [a small gland in the body] does not make enough hormones), chronic viral hepatitis c (a long term liver infection caused by a virus[a microscopic organism that causes disease]), insomnia (unable to sleep), other chronic pain, gastro-esophageal reflux disease without esophagitis (a condition where stomach acid flows up the throat causing heartburn [a burning feeling in the chest] without inflammation, constipation (difficulty having bowel movements), and nicotine dependance (an addiction to nicotine [an addictive chemical usually found in tobacco). During a review of Resident 15's Minimum Data Set (MDS-a standardized assessment tool measuring health status in nursing home residents) dated [DATE], the MDS section C indicated, Resident 15 had a score of 15, which suggested Resident 15's cognitive functions (a person's ability to think, learn, and reason) was intact. During a review of Resident 15's POLST dated [DATE], the POLST indicated, .Full Treatment-primary goal of prolonging life by all medically effective means . [cross checked] Patient (Patient Has Capacity) . [Resident 15's signature present] . During an observation on [DATE] at 9:21 a.m. in Resident 16's room, Resident 16 was asleep in bed, turned to his right side, right and left hand contracted. Resident 16's tracheostomy (a surgical opening in the windpipe to allow air and oxygen reach the lungs) site was observed with a clean dressing. During a review of Resident 16's AR dated [DATE], the AR indicated, Resident 16 was admitted to the facility from a hospital on [DATE] with diagnoses of chronic respiratory failure (a serious condition that occurs when the lungs cannot get enough oxygen into the blood or remove enough carbon dioxide [a waste gas] from the blood), anoxic brain damage (brain damage due to a complete lack of oxygen to the brain), tracheostomy (a surgical opening in the windpipe to allow air and oxygen reach the lungs), and persistent vegetative state (when a person is awake, but shows no signs of awareness). During a concurrent interview and record review on [DATE] at 3:42 p.m. with the MDSN, Resident 16's POLST, (undated) was reviewed. The POLST indicated, it was missing the date it was prepared. The MDSN stated Resident 16's POLST was missing the date the POLST was prepared. The MDSN stated the POLST guided care for the resident in an emergency or if something happened to the resident. The MDSN stated the POLST informed staff whether to do cardiopulmonary resuscitation (CPR - an emergency lifesaving procedure performed when the heart stops beating or the person stops breathing), intubate (to place a flexible plastic tube into the windpipe to keep it open), if the resident wanted long term nutrition and whether to put the resident on a ventilator (a machine or device used medically to support or replace the breathing of a person) or not. The MDSN stated the date the POLST was prepared should have been filled in. The MDSN stated Resident 16's POLST was incomplete because it was missing the date. The MDSN stated she did not work on the floor with residents and did not know if the POLST was sent with residents when they were sent out of the facility. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on [DATE] at 11:16 a.m. in Resident 33's room, Resident 33 was in bed with her eyes open but did not respond when spoken to. Resident 33's tracheostomy (a surgical opening in the windpipe to allow air and oxygen reach the lungs) site was covered with a clean dressing. During a review of Resident 33's AR, dated [DATE], the AR indicated, Resident 33 was readmitted to the facility from a hospital on [DATE] with an initial admitted [DATE] and an original admitted [DATE]. Resident 33 had diagnoses of chronic respiratory failure, injury of the head, seizure (a burst of uncontrolled electrical activity between brain cells that causes temporary abnormalities in muscle tone or movements, behaviors, sensations or states of awareness), and dysphagia (difficulty swallowing). During a review of Resident 33's MDS, dated [DATE], the MDS section C indicated Resident 33 had a score of zero, which suggested Resident 33 was severely cognitively impaired. During a review of Resident 33's Order Summary Report, dated [DATE], the Order Summary Report indicated, . Code Status - Do Not Resuscitate (DNR) . During a concurrent interview and record review on [DATE] at 3:42 p.m. with the MDSN, Resident 33's POLST, (undated) was reviewed. The POLST indicated, . Date Form Prepared . was undated and section D . Information and Signatures . Signature of Physician/Nurse Practitioner/Physician Assistant (physician/NP/PA) . Date . was undated. The MDSN stated Resident 33's POLST was not complete. The MDSN stated nursing staff would need to review the latest POLST on file to see what treatment to give Resident 33 during an emergency. During an observation on [DATE] at 11:28 a.m. in Resident 45's room, Resident 45 was in bed on his back leaning to the right with right and left hands contracted. A clean dressing was observed over Resident 45's tracheostomy site. During a review of Resident 45's AR, dated [DATE], the AR indicated. Resident 45 was admitted to the facility from a hospital on [DATE] with initial admission on [DATE]. Resident 45 was admitted with diagnoses of chronic respiratory failure, anoxic brain damage, tracheostomy, dependence on respirator (ventilator - a machine or device used medically to support or replace the breathing of a person), and persistent vegetative state (when a person is awake, but shows no signs of awareness). During a review of Resident 45's Order Summary Report, dated [DATE], the Order Summary Report indicated, . Code Status - FULL CODE . During a concurrent interview and record review on [DATE] at 3:50 p.m. with the MDSN, Resident 45's POLST, (undated) was reviewed. The POLST indicated, the date completed was not filled in. The MDSN stated the POLST is a Physician's order and should have been dated when it was completed. The MDSN stated the POLST was not considered completed and not a valid order if the date completed was not filled in. During an observation on [DATE] at 9:35 a.m. in Resident 52's room, Resident 52 was dressed, lying in bed asleep with her tracheostomy site covered with a clean dressing. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 52's AR, dated [DATE], the AR indicated, Resident 52 was admitted to the facility from a hospital on [DATE] with diagnoses of acute respiratory failure, subarachnoid hemorrhage (bleeding in the space between the brain and the membrane that covers it), Congestive heart failure (CHF-a heart disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling), and dysphagia. During a review of Resident 52's MDS, dated [DATE], the MDS section C indicated, Resident 52 had a score of zero, which suggested Resident 52 was severely cognitively impaired. During a review of Resident 52's Order Summary Report, dated [DATE], the Order Summary Report indicated, . code status - Do Not Resuscitate [DNR- a medical order written by a doctor to instruct health care providers NOT to do CPR if breathing stops or the heart stops beating]) . During a concurrent interview and record review on [DATE] at 3:50 p.m. with the MDSN Resident 52's POLST, (undated), was reviewed. The POLST indicated, . date form prepared . was not completed, and section . B . Medical Interventions . Full Treatment - primary goal of prolonging life by all medically effective means . Selective Treatment - goal of treating medical conditions while avoiding burdensome measures . Comfort-Focused Treatment - primary goal of maximizing comfort . was not complete. The MDSN stated Resident 52's POLST was missing the date it was prepared and section B should have been filled in. The MDSN stated Resident 52's POLST helped guide care for Resident 52 so staff would have known what treatment to give Resident 52, if she or her RP wanted only comfort focused treatment. The MDSN stated Resident 52's POLST was not complete. The MDSN stated the nurse who completed Resident 52's POLST should have made sure it was filled in. The MDSN stated Resident 52's POLST should have been reviewed in Resident 52's care conference. The MDSN stated all sections of a resident's POLST should have been completed in order for the POLST to be complete and valid. During a review of Resident 106's POLST dated [DATE], the POLST indicated, . Date Form Prepared . (no date written) .Full Treatment-primary goal of prolonging life by all medically effective means . [cross checked] Patient (Patient Has Capacity) . [Resident 106's signature present] . During a concurrent interview and record review on [DATE] at 3:07 p.m. with the AN, Resident 106's POLST, dated [DATE] was reviewed. The POLST indicated, a preparation date was not filled. The AN stated, Resident 106's POLST was missing a preparation date. The AN stated, she was responsible for filling out a new resident's POLST form. The AN stated, POLST forms needed to be completed in full, including preparation dates, form it to be considered valid doctor's orders. The AN stated, POLST's should have been accurate and up to date. The AN stated, if a POLST was not accurate or up to date, it was incomplete, and potentially staff might now know what to do in an emergency. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on [DATE] at 3:42 p.m. with the MDSN, Resident 106's POLST, dated [DATE] was reviewed. The POLST indicated, preparation date was not filled. The MDSN stated, the preparation date for Resident 106's POSLT was missing. The MDSN stated, she took responsibility for completing a resident's MDS. The MDSN stated, the AN was responsible for filling out and completing the POLST. The MDSN stated, when the AN complete the POLST, medical records audited it to ensure everything was filled out completely. The MDSN stated, once medical records reviewed the completed POLST, she completed the resident's MDS. The MDSN stated, a POLST was considered a doctor's orders. the MDS stated, for a POLST to be valid, a doctor's signature, the resident's signature or the responsible party (RP), and all boxes filled out and dated, including the dates when it was prepared and signed, were required. The MDSN stated, if there was no preparation date, the POLST form would have been considered invalid, and the resident's decision regarding treatment options and end of life wishes would not have been honored. During a review of Resident 106's AR, dated [DATE], the AR indicated, Resident 106 was admitted to the facility on [DATE]. Resident 106 had diagnoses of schizoaffective disorder, anxiety disorder (Intense, excessive, and persistent worry and fear about everyday situations), major depressive disorder (persistent depressed moods or loss of interest in activities), Type 2 Diabetes Mellitus (a disease in which your blood glucose, or blood sugar, levels are too high), and nicotine dependence. During a review of Resident 106's MDS dated [DATE], the MDS section C indicated, Resident 106 had a score of 15, which suggested Resident 106 cognitive functions was intact. During a concurrent interview and record review on [DATE] at 3:07 p.m. with the AN, Resident 126 POLST, dated [DATE] was reviewed. The POLST indicated, a preparation date was not filled. The AN stated, she was responsible for filling out a new resident's POLST form. The AN stated, Resident 126's POLST was missing a preparation date. The AN stated, POLST forms needed to be completed in full, including preparation dates, form it to be considered valid doctor's orders. The AN stated, POLSTs should have been accurate and up to date. The AN stated, if a POLST was not accurate or up to date, it was incomplete, and potentially staff might now know what to do in an emergency. During a concurrent interview and record review on [DATE] at 3:42 p.m. with the MDSN, Resident 126's POLST, dated [DATE] was reviewed. The POLST indicated, a preparation date was not filled. The MDSN stated, the preparation date for Resident 126's POSLT was missing. The MDSN stated, she took responsibility for completing a resident's Minimum Data Set (MDS-a standardized assessment tool measuring health status in nursing home residents). The MDSN stated, the AN was responsible for filling out and completing the POLST. The MDSN stated, when the AN complete the POLST, medical records audited it to ensure everything was filled out completely. The MDSN stated, once medical records reviewed the completed POLST, she completed the resident's MDS. The MDSN stated, a POLST was considered a doctor's orders. the MDS stated, for a POLST to be valid, a doctor's signature, the resident's signature or the responsible party (RP), and all boxes filled out and dated, including the dates when it was prepared and signed, were required. The MDSN stated, if there was no preparation date, the POLST form would have been considered invalid, and the resident's decision regarding treatment options and end of life wishes would not have been honored. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 126 AR, dated [DATE], the AR indicated Resident 126 was admitted to the facility on [DATE]. Resident 126 had diagnoses schizophrenia (mental illness that affects how a person thinks, feels, and behaves), hypothyroidism, unspecified convulsions (rapid, involuntary muscle contractions that cause uncontrollable shaking and limb movement), and prediabetes (a condition where blood sugars are higher than normal). During a review of Resident 126's MDS dated [DATE], the MDS section C indicated Resident 126 had a score of 99, which suggested Resident 126 cognitive functions was impaired. During a review of Resident 126 POLST dated [DATE], the POLST indicated, .Full Treatment-primary goal of prolonging life by all medically effective means . During an interview on [DATE] at 9:29 a.m. with Licensed Vocational Nurse (LVN) 7, LVN 7 stated resident's POLST's were important. LVN 7 stated if a resident started coding (stopped breathing/heart stopped beating), nurses would have looked at the resident's POLST first to see what care to give. LVN 7 stated if a resident was in the hospital for approximately one week, the facility would have needed a new POLST completed. LVN 7 stated a resident's POLST would have been the first paperwork that needed to be signed by the resident or responsible party (RP). LVN 7 stated the facility would have requested a POLST the first day the resident was brought to the facility. LVN 7 stated nurses would have sent a copy of the resident's POLST with the resident if the resident was sent out of the facility or went to another station in the facility. LVN 7 stated the nurse would have printed out two copies, one would go to the Emergency Medical Technician (EMT - a medical professional that provides emergency medical services) and one for the receiving facility. LVN 7 stated the POLST was not considered complete if it was not dated and signed. LVN 7 stated nurses would have looked at the most recent POLST for the resident, so the POLST needed to have the date it was prepared. LVN 7 stated the resident's RP could have changed their mind on the resident's code status, so the date prepared needed to be filled in. LVN 7 stated nurses would have needed to perform a full code on the resident if the resident did not have a completed POLST. LVN 7 stated a completed POLST was very important, so nurses were not guessing on what care to provide to the resident. LVN 7 stated staff could have wasted time during an emergency situation figuring out if a resident was a DNR or full code. LVN 7 stated the resident's RP and physician signature should have been dated. LVN 7 stated the POLST was not valid if it was incomplete. During an interview on [DATE] at 4:33 p.m. with the Director of Nursing (DON), the DON stated a resident's POLST should have been dated when it was prepared and discussed with the resident. The DON stated a resident's POLST was important as it gave instruction and direction for resident care and wishes during an emergency. The DON stated if the POLST was not dated, it was considered incomplete and invalid. The DON stated if the resident was a DNR and their POLST was incomplete, staff would do a full code on the resident. The DON stated if the resident was discharged and returned to the facility, staff would complete a new POLST. The DON stated nurses knew to use the latest POLST in the system. The DON stated if the resident's POLST was not completed, there was a risk of going against the resident or RP's wishes for life sustaining treatment. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's policy and procedure (P&P) titled, Advanced Directives, dated ,d+[DATE], the P&P indicated, . completion of the POLST (Physician Orders for Life-Sustaining Treatment) form is voluntary and not required. The state-appointed conservator must respect any wishes expressed in a . POLST . if a DNR (Do Not Resuscitate) or POLST has not been signed by the conservator, all LPS ([NAME]-Petris-Short) conservatees will be treated as Full Code (full support which includes cardiopulmonary resuscitation [CPR], if the patient has no heartbeat and is not breathing) . 48739

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Horizon Health & Subacute Center	3034 E Herndon Fresno, CA 93720

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48739 Based on observation, interview, and record review, the facility failed to establish and maintain an effective infection prevention and control program when: 1. When Resident 16's handheld nebulizer (a flexible tube that fits into a small, handheld machine that turns liquid medicine into a mist and resident inhale the mist through the mouthpiece for delivery of medication) tubing was on the floor. 2. The washing machine had a white substance buildup on and below the front-loading door and on the handle of the front-loading door. These failures placed residents at risk for cross-contamination (the process when germs are unintentionally transferred from one substance or object to another, which causes a harmful effect) and infection (an invasion of the body by germs that cause disease). 3. One of one Licensed Vocational Nurses (LVN) 1, did not properly clean and disinfect a glucometer (a glucose (sugar) meter, a medical device for determining the approximate concentration of glucose in the blood) after use on Resident 80. This failure had the potential to result in the spread and transmission of communicable (infectious disease - a condition that can be transmitted from one person to another through various means including direct contact and indirect contact) diseases and infections. Findings: 1. During an observation on 3/03/25 at 9:21 a.m. in Resident 16's room, Resident 16 was asleep in bed, turned to his right side with his right and left hand contracted (a permanent tightening of the muscles, tendons, skin and nearby tissue, that causes the joints to shorten and become very stiff). Resident 16 had a tracheostomy (a surgical opening in the windpipe to allow air and oxygen reach the lungs). A nebulizer that was in Resident 16's bedside dresser drawer was not in use with part of the tubing on the floor and not placed in a bag that was on the bedside dresser. During a review of Resident 16's Admission Record (AR - a summary of information regarding a patient which includes patient identification, past medical history, insurance status, care providers, family contact information and other pertinent information), dated 3/5/25, the AR indicated, Resident 16 was admitted to the facility from a hospital on 3/21/11 with diagnoses of chronic respiratory failure (a serious condition that occurs when the lungs cannot get enough oxygen into the blood or remove enough carbon dioxide [a waste gas] from the blood), anoxic brain damage anoxic brain damage (brain damage due to a complete lack of oxygen to the brain), tracheostomy (a surgical opening in the windpipe to allow air and oxygen reach the lungs), and persistent vegetative state (when a person is awake, but shows no signs of awareness). (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a concurrent observation and interview on 3/03/25 at 9:47 a.m. with Licensed Vocational Nurse (LVN) 6 in Resident 16's room, Resident 16's nebulizer tubing was on the floor. LVN 6 stated Resident 16's nebulizer tubing should not have been on the floor. LVN 6 stated the tubing should have been wrapped up and placed in a bag when not in use. LVN 6 stated there was a risk of cross-contamination to the resident. During an interview on 3/05/25 at 10:28 a.m. with the Restorative Nursing Assistant (RNA), the RNA stated Resident 16's nebulizer tubing should not have been touching floor. The RNA stated the tubing should have been in a bag, and the nebulizer machine should have been in Resident 16's bed side drawer when not in use. The RNA stated the nurses put the tubing and machine away after use. The RNA stated if the tubing was on the floor, it was an infection control problem and put Resident 16 at risk for cross-contamination. During an interview on 3/06/25 at 4:33 p.m. with the Director of Nursing (DON), the DON stated Resident 16's nebulizer tubing should not have been on the floor. The DON stated the tubing should have been put in a bag and dated. The DON stated if the tubing was on the floor, the nurse should have changed the tubing immediately. The DON stated it was a risk of infection to resident. During an interview on 3/05/25 at 3:25 p.m. with the Infection Preventionist (IP) the IP stated nebulizer tubing should not have been on floor, it should have been stored in a bag when not in use. The IP stated the tubing could have gotten dirty and the resident could have caught an infection. The IP stated having the tubing put in a bag was for infection control. The IP stated staff should have discarded the tubing, got a new tubing, and stored the tubing properly. During a review of the facility's job description document titled, Certified Nursing Assistant, dated 2023, the document indicated, . keep excess supplies and equipment off the floor. Store in designated areas . During a review of the facility's policy and procedure (P&P) titled, Administering Medications through a Small Volume (Handheld) Nebulizer, dated 10/2010, the P&P indicated . rinse and disinfect the nebulizer equipment according to facility protocol . when equipment is completely dry, store in a plastic bag with the resident's name and the date on it . During a review of the facility's P&P titled, Infection Prevention and Control Program, dated 10/2017, the P&P indicated . the goals of the facility Infection Prevention and Control Program are to . implement control measures and decrease opportunities for cross contamination . staff and resident education focuses on risk of infection and practices to decrease risk . 2. During an observation and interview on 3/06/25 at 10:00 a.m. with Laundry staff (LND) 1 in the laundry room, the washing machines had a white substance buildup around and below the front-loading door of the machine and on the back tubes of the machine. LND 1 stated she did not know what the white substance was, but did not think it would have gotten on resident's clothes. LND 1 stated she did not know when the washers were serviced. LND 1 stated the washer had been fixed but water leaked at times. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 3/06/25 at 11:21 a.m. with the Maintenance Director (MD), the MD stated he was not sure who did the washing machine cleaning. The MD stated he would check on washing machine logs and the last maintenance of the machines. The MD stated cleaning the washing machines was important due to infection control. The MD stated it was possible for cross contamination if the machines were not clean. No maintenance logs were presented for the washing machines by the end of the survey. During an interview on 3/06/25 at 2:51 p.m. with the IP, the IP stated a buildup on the front of the washing machine was considered dirty. The IP stated dirty washing machines should have been kept cleaned. The IP stated there was the possibility for cross-contamination and infection risk if the buildup got on resident's clothes. During an interview on 3/06/25 at 4:27 p.m. with the Housekeeping Director (HD), the HD stated the maintenance department was responsible for cleaning washing machines. The HD stated there was a possibility for cross contamination if the substance buildup got on resident's clothes. The HD stated his staff would dry the wet area on the front of the machine when they saw it leaking. The HD stated it could be an infection control issue if staff were not cleaning behind the washing machines. During a review of the facility's job duties document titled, Maintenance Supervisor, dated 2023, indicated, . assist in the orientation and training of maintenance personnel . ensure that personnel follow the manufacturer's guidelines when servicing equipment . ensure that . repairing of facility equipment is accomplished win accordance with established policies . During a review of the facility's job duties document titled Laundry Supervisor, dated 2023, the document indicated, . conduct daily inspections of assigned work areas to assure cleanliness and sanitary conditions are maintained . During a review of the facility document titled, Maintenance, (undated), the document indicated . end of day . clean the wash drum, door glass, and door gasket of residual detergent and all foreign matter . clean the machine's exposed surfaces with all-purpose cleaner . 51134 3. During an observation on 3/5/25 at 11:24 a.m. outside of Resident 80's room, LVN 1 gathered supplies to collect Resident 80's blood glucose (level of sugar in the bloodstream) level. LVN 1 placed a glucometer, lancet (small medical instrument used to obtain a small blood sample through a finger stick), and alcohol wipe on a paper plate. LVN 1 entered Resident 80's room holding the paper plate, placed the paper plate on top of the resident's bed sheet and prepped to obtain a blood glucose reading. LVN 1 wiped Resident 80's right index finger with an alcohol wipe, waited to dry, grabbed the glucometer and inserted a strip into glucometer. LVN 1 then grabbed the lancet, poked the resident's right index finger, wiped a drop of blood and placed the strip that was inserted in the glucometer to the second drop of blood on Resident 80's finger. Once blood was collected, LVN 1 put the glucometer placed back on top of paper plate to await results. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an observation on 3/5/25 at 11:30 a.m. LVN 1 exited Resident 80's room and returned to the medication cart. LVN 1 placed the used glucometer on top of the medication cart, disposed of old gloves, hand sanitized and placed new gloves. LVN 1 cleaned the glucometer with a bleach wipe, wiping the glucometer front to back for one minute. LVN 1 then placed the wet glucometer directly on top of the medication cart and left it to dry. After three minutes of drying, LVN 1 placed the glucometer into the medication cart. During an interview on 3/5/25 at 11:42 a.m. with LVN 1, LVN 1 stated after using a glucometer on a resident, I clean [the glucometer] for about 1 minute front and back and let it sit to dry for three minutes. LVN 1 stated the glucometer machine would not be cleaned again prior to being used on the next resident because it was cleaned before being placed back into the medication cart. During an interview on 3/5/25 at 11:47 a.m. with LVN 2, LVN 2 stated she would use a bleach wipe to clean a glucometer. LVN 2 stated she would first wipe the front and back of the glucometer, then the glucometer is wrapped in a wipe and kept there for four minutes. LVN 2 stated after four minutes, she would let the glucometer dry for five minutes then place in the medication cart. During an interview on 3/5/25 at 12:04 p.m. with LVN 4, LVN 4 stated to clean a glucometer, first the glucometer was wiped down with a bleach wipe. LVN 4 stated once the glucometer is wiped down, the glucometer was wrapped in a bleach wipe for five minutes. LVN 4 stated once this is done, the glucometer was left to dry for three minutes and then placed into the medication cart. LVN 4 stated it is important to clean and disinfect the glucometer after resident use to prevent the spread of infection. During an interview on 3/5/25 at 12:06 p.m. with LVN 5, LVN 5 stated to clean a glucometer the first step was to use a bleach wipe to wipe the glucometer. LVN 5 stated once the glucometer was wiped down, the glucometer was wrapped in a bleach wipe for five minutes. LVN 5 stated after this, the glucometer would sit to dry for three minutes. LVN 5 stated it was important to clean and disinfect the glucometer after resident use to kill pathogens (a bacterium, virus, or other microorganism that can cause disease). LVN 5 stated if the glucometer is not cleaned and disinfected it could lead to blood borne pathogens (infectious microorganisms that are present in blood and can cause disease) being spread from resident to resident. During an interview on 3/6/24 at 3:46 p.m. with the Infection Preventionist (IP), the IP stated to clean and disinfect a glucometer, the process was to first wipe the glucometer front and back with a bleach wipe. The IP stated the next step was to wrap the glucometer with a new bleach wipe. The IP stated the dwell time (the amount of time a disinfectant needs to remain visibly wet on a surface to effectively kill germs, viruses and bacteria) depended on the manufacturer guideline of the product being used. The IP stated once the dwell time was complete, then let the glucometer air dry and once completely dry will put the machine away (back into the medication cart). The IP stated if the glucometer is not cleaned and disinfected properly it could spread infection from one resident to another. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 3/6/25 at 4:52 p.m. with the Director of Nursing (DON), the DON stated to clean the glucometer, the process was to start by cleaning all sides with a bleach wipe. The DON stated once this was done, then disinfect the glucometer by leaving the glucometer wrapped in a bleach wipe for three minutes. The DON stated after this was complete, let the glucometer completely air dry and return to the medication cart. The DON stated it was important to clean and disinfect the glucometer to prevent infection. During a review of Resident 80's ARdated 3/5/25, the AR indicated, Resident 80 was admitted to the facility on [DATE] with Type 2 Diabetes Mellitus (a chronic condition causing high blood sugar levels). During a review of the facility's policy and procedure (P&P) titled, Obtaining a Fingerstick Glucose Level, dated 2001, the P&P indicated, .3. Always ensure that blood glucose meters intended for reuse are cleaned and disinfected between resident uses .18. Clean and disinfect reusable equipment between uses according to the manufacturer's instructions and current infection control standards of practice . During a review of the manufacturer guideline for the glucometer titled, [Brand Name] Blood Glucose Monitoring System, (undated), the manufacturer guideline indicated, .Cleaning and Disinfecting Your Meter and Lancing Device . 4. To disinfect your meter, clean the meter with one of the validated disinfecting wipes listed below . [Bleach Wipe] Disinfecting, Deodorizing, Cleaning Wipes with Alcohol . Wipe all external areas of the meter including both front and back surfaces until visibly clean . Allow the surface of the meter to remain wet at room temperature for the contact time listed on the wipe's directions for use . During a review of the manufacturer guideline, Healthcare Cleaning and Disinfectant Wipes, (undated) for [Brand Name] Bleach Wipes contact times. Contact time for disinfectant is the amount of time a surface must remain wet with the product to achieve disinfection The manufacturer guideline indicated, . Kills Clostridium difficile [a bacterium that can infect the intestines and cause diarrhea] spores [single cells that are main reproductive units for fungi] in 3 minutes and Candida auris [a species of fungus that grows as yeast] in 2 minutes .

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49949 Based on observation, interview and record review, the facility failed to ensure one of six sampled residents (Resident 35) area was maintained a safe, functional, sanitary and comfortable environment for residents staff and the public when, Resident 35's room had a bag of adult diapers, multiple t-shirts, sweaters and jackets stacked on top of a walker and wheelchair at the foot of the hospital bed, blocking access to the window. These failures had the potential to cause injuries, falls and a fire safety hazard for Resident 35 and her roommate. Findings: During a review of Resident 35's Admission Record (AR- document containing resident demographic information and medical diagnosis) dated 3/6/25 the AR indicated, Resident 35 was admitted to the facility on [DATE]. Resident 35's diagnosis included, chronic kidney disease (a long-term condition where the kidneys gradually lose their ability to filter waste products and excess fluid from the blood), pain, hypertension (high blood pressure), anxiety, depressive disorder (a common mental health condition characterized by persistent feelings of sadness, hopelessness, and loss of interest or pleasure in activities) and hyperlipidemia (abnormally high levels of lipids (fats) in the blood). During a review of Resident 35's Minimum Data Set (MDS - a resident assessment tool used to identify cognitive [mental processes] and physical functional level assessment), dated 2/18/25 the MDS, indicated, Resident 35 had a Brief Interview for Mental Status (BIMS - a test given by medical professionals to determine cognitive understanding on a scale of 1-15) score of 10 (a score of 0-7 suggests severe cognitive impairment, 8-12 suggests moderately impaired, 13-15 suggests cognitively intact) indicating Resident 35 cognition was moderately impaired. During an observation and interview on 3/3/25 at 10:07 a.m. in Resident 35's room, there were four shirts hanging on a doorknob, four loose adult diapers, a bag of adult diapers, men and women t-shirts, sweaters and jackets were stacked on top of a walker and wheelchair at the foot of the hospital bed, blocking access to the window. Resident 35 stated she has been a resident at the facility for more than seven years. During an interview on 3/05/25 at 12:09 p.m., the Director of Social Services (DSS) stated Resident 35's family member brought clothing and personal items for her. The DSS stated Resident 53 had issues with hoarding (accumulation of items) and the facility tried to assist her. The DSS stated all staff members were responsible to help keep the area free from clutter. The DSS stated the Certified Nursing Assistant's (CNA) and nurses should have help organized the clothes during personal care. The DSS stated, Resident 35's personal area should be cleaned, clear and organized for everyone's safety. The DSS stated, the cluttered area was a safety risk, and residents were at risk for falls. The DSS stated, the cluttered area was blocking a clear path and was a fire hazard. The DSS stated the clothes could have contained mold. The DSS stated it was not a home-like environment because the room was cluttered. (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/5/25 at 12:25 p.m. with CNA 4, CNA 4 stated CNAs were responsible for organizing and making sure Resident 53's room was cleaned and organized. CNA 4 stated Resident 35 could have fallen due to the area not having a clear pathway for her to walk. CNA 4 stated the foot of the bed should have been cleaned and cleared. NA 4 stated it was not a home-like environment. During an interview on 3/5/25 at 2:47 p.m. with License Vocational Nurse (LVN) 1, LVN 1 stated Resident 35 cluttered area had been ongoing for awhile. LVN 1 stated all staff were responsible to keep the area cleaned and free from clutter. LVN 1 stated Resident 35 loved clothes and staff tried to organize her clothing, but her closet was full. LVN 1 stated, Resident 35, roommate and staff could have fallen from the cluttered area. LVN 1 stated the foot of the bed should have been cleared because it was a fire safety hazard. During a concurrent interview and record review on 3/7/25 at 12:28 p.m. with the Director of Nursing (DON), the facility policy and procedure (P&P) titled, Homelike Environment, dated February 2021 was reviewed. The P&P indicated, The facility staff and management maximize, to the extent possible, the characteristic of the facility that reflect a personalized, homelike setting. These characteristics include . a. clean, sanitary and orderly environment. The DON stated the facility staff should have followed the P&P but didn't. The DON stated, There should be a clear pathway to the restroom, and it is everyone's responsibility to ensure it is safe and clean. The DON stated Resident 35's area was not cleaned and clutter free. The DON stated, Resident 35's area should have been clean and orderly environment. The DON stated Resident 35, and her roommate were at risk of falling. The DON stated the cluttered area was a safety concern and in the event of disaster it would have made it difficult to get to the residents. The DON stated the cluttered area could have caused injures and harm.