STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055201	A. Building B. Wing	04/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oak Grove Post Acute	4545 Shelley Court Stockton, CA 95207

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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 - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to provide food storage and preparation, as well as maintain kitchen equipment and food contact surfaces in accordance with professional standards for food safety for the 102 residents who ate facility prepared meals when:1) Kitchen walls, ceiling vent area, and floor were observed with chips in the paint, drywall, and tiles;2) The can opener, red cutting board, and 2 fry pans were observed worn and damaged;3) Food items (sausage patties and container of rice) were found stored but exposed to air; and4) The resident refrigerator in the center nursing hallway had five days of temperatures logged above the safe food range without intervention, and the north resident refrigerator was observed with ice buildup covering the freezer.These failures had the potential to put residents at risk for foodborne illnesses.Findings: 1. During an observation on 4/6/26, at 8:39 AM, during the initial kitchen tour, the walls in the kitchen were noted to have chipped paint. The floor tiles in the kitchen by the refrigerators were noted to be broken with missing sections. During an interview on 4/6/26, at 9:08 AM, with the Maintenance Director (MD), the MD concurred and stated that the facility had discussed the need for replacing lights, repainting the kitchen, and as well as replacing some tiles. During a concurrent observation and interview on 4/8/26, at 10:33 AM, with the Food Service Director (FSD), two stains surrounding the two ceiling vents over the food preparation area were observed. The ceiling drywall had gouges in it and the paint was noted to be chipped and cracked. The vent at the center of kitchen had a white, approximately 4-inch long item hanging from it. The FSD confirmed the observations and stated the facility had previously had water leaks and that the item hanging may be old caulking. A review of the facility's policy and procedure titled, Maintenance Service, revised 12/09, indicated, .Functions of maintenance personnel include, but are not limited to: a. Maintaining the building in compliance with current federal, state, and local laws, regulations, and guidelines. b. Maintaining the building in good repair and free from hazards.d. Maintaining the heat/cooling system, plumbing fixtures, wiring, etc., in good working order. A review of the United States (US) FDA (Food and Drug Administration) 2022 Food Code, section 6-501.11 on Repairing, indicated, .physical facilities shall be maintained in good repair . (https://www.fda.gov/food/fda-food-code/food-code-2022) A review of the USFDA 2022 Food Code, section 4-202.16 on Nonfood-Contact Surfaces, indicated, .Nonfood-contact surfaces shall be free of unnecessary ledges, projections, and crevices, and designed and constructed to allow easy cleaning and to facilitate maintenance. Hard-to-clean areas (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	could result in the attraction and harborage of insects and rodents and allow the growth of foodborne pathogenic microorganisms . (https://www.fda.gov/food/fda-food-code/food-code-2022) A review of the USFDA 2022 Food Code, section 6-201.11 on Floors, Walls, and Ceilings, indicated, . floors, floor coverings, walls, wall coverings, and ceilings shall be designed, constructed, and installed so they are smooth and easily cleanable . (https://www.fda.gov/food/fda-food-code/food-code-2022) 2. During a concurrent observation and interview on 4/6/26, at 8:54 AM, with the FSD, a can opener was observed with the blade discolored, and a brownish area along the cutting surface appearing as worn metal. The FSD confirmed the observation and stated that the blade needed to be replaced. A review of the USFDA 2022 Food Code, section 4-501.11 on Good Repair and Proper Adjustment, indicated, .(A) EQUIPMENT shall be maintained in a state of repair and condition . (C) Cutting or piercing parts of can openers shall be kept sharp to minimize the creation of metal fragments that can contaminate food when the container is opened. The cutting or piercing parts of can openers may accumulate metal fragments that could lead to food containing foreign objects and, possibly, result in consumer injury . (https://www.fda.gov/food/fda-food-code/food-code-2022) During a concurrent observation and interview on 4/6/26, at 9:55 AM, with the FSD, a red cutting board (used for preparing beef) was observed in the kitchen food preparation area with deep gouges. The FSD concurred that the cutting board was worn and should have been replaced. A review of the USFDA 2022 Food Code, section 4-501.12 on Cutting Surface, indicated, .Surfaces such as cutting blocks and boards that are subject to scratching and scoring shall be resurfaced if they can no longer be effectively cleaned and sanitized, or discarded if they are not capable of being resurfaced. Cutting surfaces such as cutting boards and blocks that become scratched and scored may be difficult to clean and sanitize. As a result, pathogenic microorganisms transmissible through food may build up or accumulate. These microorganisms may be transferred to foods that are prepared on such surfaces . During an observation and interview on 4/6/26, at 10:04 AM, with the FSD, two fry pans were observed with dark buildup and discoloration of up to three inches covering the sides of the pans. A saucepan was also observed stored in this cook's preparation area, that was worn and had deep pitting in the metal. The FSD confirmed the observations and stated they should not be used as it was not good for the health of the residents as the scratches could contain bacteria. A review of the USFDA 2022 Food Code, section 4-202.11 on Food-Contact Surfaces, indicated, .(A) Multiuse food-contact surfaces shall be: (1) Smooth; (2) Free of breaks, open seams, cracks, chips, inclusions, pits, and similar imperfections; (3) Free of sharp internal angles, corners, and crevices; (4) Finished to have smooth welds and joints; . Food contact surfaces that do not meet these requirements provide a potential harbor for foodborne pathogenic organisms. Surfaces which have imperfections such as cracks, chips, or pits allow microorganisms to attach and form biofilms. Once established, these biofilms can release pathogens to food. Biofilms are highly resistant to cleaning and sanitizing efforts . (https://www.fda.gov/food/fda-food-code/food-code-2022) A review of the facility's policy and procedure titled, Equipment, revised 9/17, indicated, .All food service equipment will be clean, sanitary, and in proper working order.All equipment will be routinely cleaned and maintained in accordance with manufacturer's directions and training materials.The (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Dining Services Director will submit requests for maintenance or repair to the Administrator and/or Maintenance Director as needed. 3. During a concurrent observation and interview on 4/6/26, at 9:47 AM, with the FSD, during the initial kitchen tour, a box of sausages was observed in the freezer with the plastic covering left open and the contents exposed to the air. During a subsequent interview with the FSD on 4/6/26/ at 9:55 AM, the FSD confirmed that the plastic bag had been left open and stated it should have been tightly closed before the sausage was returned to the box. During a concurrent observation and interview on 4/6/26, at 10:17 AM, a small steam table pan of rice covered with foil was observed in the reach in refrigerator with a punctured hole on the foil, exposing the rice to the air. The FSD confirmed the observation. The FSD stated the rice should have been discarded. A review of the facility's policy and procedure titled, Food Storage: Cold Foods, revised 2/23, indicated, .All Time/Temperature Control for Safety (TCS) foods, frozen, and refrigerated, will be appropriately stored in accordance with guidelines of the FDA Food Code.All foods will be stored wrapped or in covered containers, labeled and dated, and arranged in a manner to prevent cross contamination. A review of the USFDA 2022 Food Code, section 3-302.11 Packaged and Unpackaged Food -Separation, Packaging, and Segregation, 1/18/23 version, indicated, . Food shall be protected from cross contamination by .storing the food in packages, covered containers, or wrappings . (https://www.fda.gov/food/fda-food-code/food-code-2022) 4. During a concurrent interview and record review on 4/7/26, at 2:48 PM, at the Center Nurse's station, with Licensed Nurse (LN) 1, LN 1 confirmed that the temperature log showed a temperature ranging from 38 degrees F (degrees Fahrenheit, a unit of measurement) to 48 degrees F for the Resident refrigerator in the center hall nurse's station. A temperature of 48 degrees F was entered on the morning shift log for the dates of April 1, 2, and 3 of 2026 and a temperature of 42 degrees F on the morning shifts for both April 6 and 7 of 2026. The temperature log document indicated that the expected temperature should be below 40 degrees F for the refrigerator and below 0 degrees F for the freezer. The log did not indicate any actions were taken due to the high temperature of the refrigerator on those dates. During an interview on 4/7/26, at 2:37 PM, with LN 2, LN 2 stated that the nurse on duty each shift is responsible for logging the temperature of the refrigerator, and if there was an issue with the refrigerator, the nurse would create a work order in the computer to notify the maintenance staff. During a concurrent observation and interview on 4/7/26, at 2:46 PM, with the Maintenance Director (MD) at the Center nurse's station, the MD stated he had not been informed that the refrigerator was not at the correct temperature range. During a concurrent observation and interview on 4/7/26, at 2:56 PM, with the MD at the north nurse's station refrigerator, ice buildup was observed on the freezer compartment. The MD stated he had not been informed about it. The MD stated that the issue should have been reported in their computer system to create a work order. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 4/8/26, at 4:12 PM, with the FSD, the FSD stated the resident refrigerator should be below 40 degrees F, as being over that temperature would be a food safety issue. During an interview on 4/9/26, at 9:19 AM, with the Assistant Director of Nursing (ADON), the ADON stated that she expected the nurses to report if the refrigerator was not properly working to the maintenance. The ADON stated that the nurses must notify maintenance if the temperature of the refrigerator was high or incorrect. The ADON stated that if the temperature was not within the acceptable range which is below 40 degrees F, the food could spoil and cause the residents to have stomach issues. A review of the facility's policy and procedure titled, Food Brought by Family/Visitors, revised 3/8/24, indicated, .Refrigerator/freezer for storage of foods brought in by visitors will be properly maintained and.Have temperature monitored daily for refrigeration <41 [less than forty one] deg F [degrees Fahrenheit] and freezer ≤ 0 [less than or equal to zero] degrees F. A review of the USFDA 2022 Food Code, section 3-501.16 on Time/Temperature Control for Safety Food, Hot and Cold Holding, indicated, .Bacterial growth and/or toxin production can occur if time/temperature control for safety food remains in the temperature Danger Zone of . (41 degrees F to 135 degrees F) too long .

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Dispose of garbage and refuse properly. Based on observation, interview, and record review, the facility failed to ensure a garbage dumpster lid was maintained to properly cover the contents and preventing the harborage and feeding of pests in one of two facility dumpsters.This deficient practice had the potential of disease spreading among residents and visitors by vermin and pest infestation for a census of 109.Findings: During an observation on 4/6/26 at 10:08 AM, two outdoor garbage dumpsters were observed with one bin noted to not be fully closed. During a concurrent observation and interview on 4/8/26, at 4:27 PM, with the Dietary Manager (DM), the outdoor garbage dumpster was observed with an opening in between the lids and was not tightly closed. A two inches gap in-between the lids was also observed. The DM stated that the opening would allow pests to get inside of the garbage dumpster. During a review of the facility's policy and procedure titled, Dispose of Garbage and Refuse, revised 2/25, indicated, .All garbage and refuse will be collected and disposed of in a safe and efficient manner.The Dining Services Director will ensure that:.Appropriate lids are provided for all containers.All trash will be properly disposed of in external receptacles (dumpsters) with lids covered when not in use. Review of the US Food Code 2022, section 501.116 on Cleaning Receptacles, indicated Proper storage and disposal of garbage and refuse are necessary to minimize the development of odors, prevent such waste from becoming an attractant and harborage or breeding place for insects and rodents, and prevent the soiling of food preparation and food service areas. All containers must be maintained in good repair and cleaned as necessary in order to store garbage and refuse under sanitary conditions as well as to prevent the breeding of flies. Outside receptacles must be constructed with tight-fitting lids or covers to prevent the scattering of the garbage or refuse by birds, the breeding of flies, or the entry of rodents. (https://www.fda.gov/food/fda-food-code/food-code-2022)

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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. Based on observation, interview, and record review the facility failed to implement a comprehensive care plan (a list of resident specific problems, goals, and interventions) for five of 32 sampled residents (Resident 1, Resident 15, Resident 54, and Resident 123), when:1. Resident 1's Physician was not notified when Resident 1's arteriovenous (AV) fistula (a surgically created connection of an artery directly to a vein allowing high blood flow during hemodialysis (HD), a life-saving treatment that acts as an artificial kidney that removes waste and extra fluid from the blood and regulates blood pressure) was negative for thrill (vibration) and bruit (buzzing or swoosh sound) indicating a blockage or failure.2. Resident 15 was receiving oxygen without a physician's order.3. Resident 15 and Resident 54 did not receive one to one activities at least once a week.4. An Enhanced Barrier Precautions care plan was not developed for Resident 123. These failures had the potential to negatively affect the health and well being of Resident 1, Resident 15, Resident 54, and Resident 123.Findngs: 1. A review of Resident 1's admission Record, indicated Resident 1 was admitted to the facility with diagnoses that included but not limited to hypertension (a chronic condition where the force of blood pushing against artery walls is consistently too high, forcing the heart to work harder), chronic kidney disease (a long term, irreversible loss of kidney function where the kidney cannot effectively filter waste and excess water from the blood), and dependance on renal (kidney) dialysis. A review of Resident 1's AV fistula for dialysis care plan dated 1/13/26, the care plan indicated, .Monitor skin condition around catheter insertion site and report to physician as indicated. During a concurrent interview and record review on 4/9/26, at 9:40 a.m., with the Director of Nursing (DON), Resident 1's MEDICATION ADMINISTRATION RECORD dated March 2026 was reviewed. The DON verified on dates 3/14, 3/24, 3/25, 3/26, 3/27, 3/28, and 3/31 licensed nursing staff documented negative for thrill and bruit (the nurse performed a physical exam and did not feel a thrill (vibration) or bruit (buzzing or swishing sound) over a blood vessel indicating a blockage or failure). The DON also verified that a change of condition assessment or informing the physician was not done. The DON stated it was her expectation of licensed nursing staff to notify the MD of the change in condition. The DON further stated this placed Resident 1 at risk of missing hemodialysis. 2.A review of Resident 15's, admission Record indicated Resident 15 was admitted to the facility with diagnoses that included but not limited to traumatic brain injury, schizophrenia (chronic brain disorder that causes people to lose touch with reality, making it difficult to distinguish what is real from what is not), and insomnia (chronic inability to get enough sleep). During an observation on 4/7/26, at 12:30 p.m., Resident 15 was observed laying in bed with oxygen running through a nasal cannula (a lightweight, flexible plastic tube with two small prongs that sit just inside the nostrils to deliver extra oxygen). During a concurrent interview and record review on 4/7/26, at 12:35 p.m., with the Assistant Director of Nursing (ADON), Resident 15's at risk for myocardial infarction (when blood flow, carrying essential oxygen, is suddenly blocked from reaching a part of the heart muscle) care plan dated 12/22/25, and Resident 15's Order Summary Report dated 4/7/26, was reviewed. The ADON verified Resident 15's care plan indicated to apply oxygen as ordered and the ADON also verified Resident 15's order summary did not have an order for oxygen. (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 concurrent observation and interview on 4/7/26, at 12:40 p.m., with the ADON, Resident 15 was observed receiving oxygen via nasal cannula and the ADON verified the care plan was not followed. The ADON stated the care plan was not followed, and the order should have been in place so the use of oxygen can be monitored by nursing staff. The ADON further stated Resident 15 was at risk for unnecessary side effects of supplemental oxygen use if the supplemental oxygen was not indicated such as tachycardia (abnormally fast heartbeat) and headache. 3. A review of Resident 15's activity care plan dated 5/5/25, indicated, .the resident needs 1 to 1 bedside/in-room visits and activities if unable to attend out of room events. A review of Resident 15's, Participation Record dated March 2026, indicated Resident 15 did not participate in group activity and between 3/11/26 to 3/17/26, Resident 15 did not receive one to one activities. A review of Resident 54's admission Record, indicated Resident 54 was admitted to the facility with diagnoses that included but not limited to adult failure to thrive (rapid or gradual decline in an older person's physical, mental, or social functioning, often characterized by unexplained weight loss, poor appetite, exhaustion, and loss of independence), delusional disorders (mental health condition where a person holds a firm, unshakable belief in something that is untrue, despite clear evidence to the contrary), and insomnia. During an interview on 4/7/26, at 8:25 a.m., with Resident 54, Resident 54 stated she used to get one to one visits from activities once or twice a week, but last couple of weeks the one to one visits have stopped and she no longer gets visited. Resident 54 further stated she was a little sad about it and she used to look forward to one to one activity visits since she was bedbound. A review of Resident 54's activity care plan dated 1/4/26, indicated, .one to one room visits 1-3x per week.the residents preferred activities are writing, conversing. During a concurrent interview and review with the assistant director of activities (ADA) Resident 54's, Participation Record dated March 2026, was reviewed the ADA verified the record indicated between 3/19/26, to 3/29/26, Resident 54 did not receive a one to one visit or activity. The ADA stated Resident 54 only participates in one to one activities. The ADA further stated if residents did not receive one to one activities when unable to attend group activity, it can negatively impact resident's mood and potentially experience loneliness. A review of the facility's policy and procedure (P&P) titled, Individual Activities and Room Visit Program dated 6/2018, indicated, .Individual activities will be provided for those residents whose situations or conditions prevent participation in other types of activities , and for those residents who do not wish to attend group activities.individualized activities offered are reflective of the resident's activity interests, as identified in the Activity Assessment, progress notes, and the resident's Comprehensive Care Plan.It is recommended that residents with in-room activity programs receive, at a minimum, three in-room visits per week. 4. During a review of Resident 123's admission RECORD dated 4/7/26, the record indicated, Resident 123 was admitted to the facility with diagnoses that included but not limited to Sepsis (a life-threatening medical emergency caused by the body's extreme, dysfunctional response to an infection, leading to tissue damage and organ failure), bacteremia (the presence of bacteria in the bloodstream) and bell's palsy (a sudden, temporary weakness or paralysis of facial muscles caused (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	by inflammation of the 7th cranial nerve, typically affecting one side of the face). A review of Resident 123's record titled Order Listing Report with a revision date of 3/27/2026, indicated an order of Enhanced Barrier Precautions (EBP) [an infection control intervention designed to reduce the spread of multidrug-resistant organisms (MDROs)] r/t IV-PICC (Peripherally Inserted Central Catheter is a thin, flexible tube inserted into an upper arm vein and guided to a large vein near the heart. It provides long-term IV access (weeks to months) for medications, fluids, nutrition, or blood sampling, avoiding repeated needle sticks). During a concurrent interview and record review with the IP (Infection Preventionist) on 4/8/26 at 2:48 p.m., the IP confirmed there was no care plan for Enhanced Barrier Precautions for Resident 123. The IP stated Resident 123 is on EBP for PICC line. The IP further stated there should have been a care plan for EBP. The IP stated there was a risk for delay in care and delay in precautions due to not having a care plan. The IP stated it was very important to have a care plan to properly care for the resident. During an interview with the DON (Director of Nursing) on 4/9/26 at 10:41 a.m., the DON stated there should be a care plan for a resident on EBP. The DON confirmed there was a risk of infection spreading to other staff, visitors and other residents. The DON stated it was important to make care plan to prevent the spread of infection. A review of the facility policy and procedure (P&P) titled CARE PLAN COMPREHENSIVE, dated 8/25/2021, indicated, .Incorporate identified problem area, b. Incorporate risk and contributing factors associated with identified problems.Identify professional services that are responsible for each element of care.Reflect currently recognized professional standards of practice for problem areas and conditions.The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being.The resident's goals for admission and desired outcomes.the reductions of factors leading to preventable readmissions.Assessments of residents are ongoing and care plans are reviewed and revised as information about the resident and the resident's condition change.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. Based on observation, interview, and record review, the facility failed to provide appropriate care and services to four of eight sampled residents (Resident 92, Resident 107, Resident 63, and Resident 95) during medication administration when:1. The first drop of blood sample for glucose level reading for Resident 92, Resident 107, and Resident 63 was not discarded before a sample was obtained on 4/6/26;2. Several crushed and liquid medications in plastic medication cups for gastrostomy tube (GT-also referred to as enteral feeding/tube feeding-a tube inserted through the abdomen directly into the stomach to deliver nutrition, fluids, and medications when swallowing is not possible or safe) medication administration for Resident 95 were left at the bedside table unattended and unsupervised on 4/9/26; and,3. Resident 95's GT placement (the placement of a feeding tube directly into the stomach) and residual (the amount of fluid/contents that are in the stomach) were not checked before medication administration per physician's order on 4/9/26. These failures had the potential for inaccurate glucose level readings that could affect the dosage of insulin administered for Resident 92, Resident 107, and Resident 63 leading to possible adverse (undesirable or harmful) outcome, potential for drug misuse and/or drug diversion, and potential for Resident 95 aspirating (when food or fluid enters the airway of lungs by accident) which could lead to lung problems such as pneumonia (a lung infection) and possibly result in death.Findings:1a. During a review of Resident 92's admission RECORD, dated 4/9/26, the record indicated, Resident 92 was admitted to the facility with diagnoses including type 2 diabetes mellitus (this happens when the body cannot use insulin correctly and sugar builds up in the blood. Insulin is a hormone produced by the pancreas that regulates blood sugar (glucose) levels by allowing cells to absorb glucose for energy).During a review of Resident 92's Order Summary Report, active physician's orders as of 4/9/26, the order indicated, .Check finger stick blood sugar before meals and at bedtime before administering insulin.During a medication administration observation on 4/8/26, at 7:22 a.m. at the South Unit outside Resident 92's room, Licensed Nurse (LN) 4 prepared supplies to obtain Resident 92's fingerstick blood sugar (FSBS) level reading. The supplies including glucometer (a small, portable, battery-powered device used to measure the concentration of sugar (glucose) in a small sample of blood), lancet (used to make punctures, such as fingerstick, to obtain small blood specimens), test-strip (a band/piece/strip of paper or other material used for biological testing such as blood sugar), and an alcohol pad (a fast-acting antiseptic to sterilize skin before injections, blood draws, or glucose monitoring) were on a tray and LN 4 brought the tray into Resident 92's room to obtain a blood sample. LN 4 took the alcohol pad and cleaned Resident 92's fingertip, took the lancet and pricked her sanitized fingertip, a drop of blood sample appeared, placed the test-strip into the glucometer and with the test-strip, LN 4 collected the sample. LN 4 did not wipe off the first drop of blood before collecting a sample.1b. During a review of Resident 107's admission RECORD, dated 4/9/26, the record indicated, Resident 107 was admitted to the facility with diagnoses including type 2 diabetes mellitus.During a review of Resident 107's Order Summary Report, active physician's orders as of 4/9/26, the order indicated, .Notify MD [Doctor of Medicine] if FSBS <60 or >400 [< less than or > greater than].During a medication administration on 4/8/26, at 7:32 a.m. at the South Unit outside Resident 107's room, LN 4 prepared supplies to obtain Resident 107's FSBS level reading. The supplies including glucometer, lancet, test-strip, and an alcohol pad were on a tray and LN 4 brought the tray into Resident 107's room to obtain a blood sample. LN 4 took the alcohol pad and cleaned Resident 107's fingertip, took the lancet and pricked her sanitized fingertip, a drop of blood sample appeared, placed the test-strip into the glucometer and with the test-strip, LN 4 collected the sample. LN 4 did not wipe off the first drop of blood before collecting a sample.1c. During a review of Resident 63's admission RECORD, dated 4/9/26, the record indicated, Resident 63 was admitted to the facility with diagnoses including type 2 diabetes mellitus.During a review or Resident 63's Order Summary Report, active physician's orders as of 4/9/26, the order indicated, .Blood sugar checks before meals and at bedtime.During a (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	medication administration on 4/8/26, at 7:48 a.m. at the South Unit outside Resident 63's room, LN 4 prepared supplies to obtain Resident 63's FSBS level reading. The supplies including glucometer, lancet, test-strip, and an alcohol pad were on a tray and LN 4 brought the tray into Resident 63's room to obtain a blood sample. LN 4 took the alcohol pad and cleaned Resident 63's fingertip, took the lancet and pricked her sanitized fingertip, a drop of blood sample appeared, placed the test-strip into the glucometer and with the test-strip, LN 4 collected the sample. LN 4 did not wipe off the first drop of blood before collecting a sample.During a subsequent interview on 4/8/26, at 7:48 a.m. with LN 4, LN 4 stated that when collecting blood sample for glucose level reading was to wipe off the first blood sample then collect the next drop of blood. LN 4 stated he did not wipe off the initial drop of blood when obtaining the FSBS for Resident 92, Resident 107, and Resident 63. LN 4 stated he should have wiped off the first drop of blood because it may have registered an inaccurate reading.During an interview on 4/9/26, at 12:23 p.m. with the Infection Preventionist (IP), the IP stated when taking blood sample for FSBS, the LN was to wipe off the initial sample then collect the second drop of blood. The IP stated this practice would ensure to collect uncontaminated blood samples with whatever contaminants were present on the surface of the skin. The IP stated this method would have more accurate blood glucose readings.During a review of the facility's Procedure titled, Obtaining a Fingerstick Glucose Level, revised October 2011, the procedure indicated, .The purpose of this procedure is to obtain a blood sample to determine the resident's blood glucose level.Obtain a blood sample by using a sterile lancet.Discard the first drop of blood if alcohol is used to clean the fingertip because alcohol may alter the results.2. During a review of Resident 95's admission RECORD, dated 4/9/26, the record indicated, Resident 95 was admitted to the facility with diagnoses including dysphagia (difficulty swallowing), cerebral infarction (also known as stroke-occurs when blood flow to the brain is blocked), and encounter for attention to gastrostomy.During a review of Resident 95'a Minimum Data Set (MDS-a federally mandated resident assessment tool), dated 1/2/26, the MDS revealed Resident 95's Brief Interview for Mental Status (BIMS-a tool to assess mental functioning) score was entered 3 indicating severe problems with thinking and memory. The MDS also revealed that Resident 95 had a feeding tube while as a resident in the facility.During a review of Resident 95's Order Summary Report, active physician's orders as of 4/9/26, the order indicated the medications as followed, .Prostat [a dietary supplement] one time a day.BusPIRone HCL [treats anxiety disorders] Tablet 5 MG [milligram, unit of measurement] Give 1 tablet.Carvedilol [treats high blood pressure] Tablet 6.25 MG Give 1 tablet.Cholecalciferol [dietary supplement to treat vitamin D deficiency] Tablet 1000 UNIT [amount of drug in a single dose] Give 1 tablet.Docusate Sodium [treats constipation] Tablet 100 MG Give 1 tablet.levETIRAcetam [use to help control certain types of seizures] Solution 500 MG/5ML [milliliter, unit of measurement] Give 10 ml.Lisinopril [treats high blood pressure] Tablet 10 MG Give 1 tablet.Omeprazole [treats acid reflux] Oral Capsule 20 MG Give 1 capsule.Phenytoin [treats and prevents seizures] Oral Suspension 100 MG/4ML Give 4 ml.Valproic Acid Solution 250 MG/5ML give 5 ml [treats and prevents seizures].During a medication administration observation on 4/9/26, at 7:50 a.m. in the North Unit outside Resident 95's room, LN 5 prepared each medication, crushed each tablet and placed it in separate plastic medicine cup, poured each solution (liquid medications) into different medicine cup, and opened the capsule and poured the contents into the medicine cup. LN 5 then added 5 ml of water into each solid medication to dilute it. LN 5 brought all the medicine cups into Resident 95's room and placed them on the bedside table. LN 5 had indicated that she forgot a towel to use during administering the medications through the GT. LN 5 left Resident 95's room and the medications on the bedside table were unattended and unsupervised. There were no other licensed nurses when LN 5 left the room.During a subsequent interview on 4/9/26, at 7:50 a.m. with LN 5, LN 5 confirmed she left the room to get a towel and left the medications at the bedside table. LN 5 stated she should not have left the room and the medications at the bedside table and should have gathered all her supplies prior to preparing her medications. LN 5 also stated that leaving medications unattended and unsupervised would increase (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the risk for someone taking the medications and/or potential for medication misuse.During an interview on 4/9/26, at 10 a.m. with the Pharmacy Consultant (PC), the PC stated that medications should not have been left at the bedside unattended. The PC also stated the risk for medications at the bedside and unsupervised had the potential to be taken, hidden, thrown away, or taken by another resident or staff member.During an interview on 4/9/26, at 12:29 p.m. with the Director of Nursing (DON), the DON stated medications should never be left unattended to ensure the intended resident should be the one receiving the medications and no one else.During a review of the facility's Policy titled, Administering Medications, revised April 2019, the policy indicated, .Medications are administered in a safe and timely manner, and as prescribed.Only persons licensed or permitted by this state to prepare, administer and document the administration of medications may do so.3. During a review of Resident 95's Order Summary Report, active physician's orders as of 4/9/26, the order indicated, .Enteral Feed Order every shift Check GT for proper placement before giving medications, feedings and/or flushes [introducing with water through the tube after each feeding and before and after giving medicines]. The report also indicated, .Enteral Feed Order every shift Check residual before feeding.During a review of Resident 95's Care Plan Report (a form where you can summarize a person's health conditions, specific care needs, and current treatments), dated 3/19/26, the report indicated, .Resident has an enteral feeding tube.check patency, placement of tube and gastric contents/residual volume, as ordered.During a medication administration observation on 4/9/26, at 7:50 a.m. in the North Unit outside Resident 95's room, LN 5 prepared ten medications and placed each medicine in separate plastic medicine cups. LN 5 diluted the crushed medicines with 5 ml water and took all the medications in Resident 95's room and placed them on the bedside table. When LN 5 came back to the room, she started administering the medications after flushing the GT with water, took one medicine cup and poured it into the syringe, took plunger of the syringe and pushed the medicine into the GT while Resident 95 was trying to spit at LN 5 and the Certified Nurse Assistant. LN 5 indicated Resident 95 was not cooperating with medication administration during that time.During a subsequent interview on 4/9/26, at 7:50 a.m. with LN 5, LN 5 confirmed she did not check the GT for placement before medication administration by auscultation (listening to a sound in the stomach when air is introduced through a syringe) or by checking the residual. LN 5 stated she should have checked for placement first to make sure the GT was in the correct place and it was not dislodged. LN 5 further stated Resident 95 was at risk for medications going to the wrong place and at risk for aspiration. LN 5 also stated she did not check the residual prior to flushing and medication administration. LN 5 further stated Resident 95 could potentially be at risk for fluid overload.During an interview on 4/9/26, at 12:55 p.m. with the DON, the DON stated Nurses needed to check for GT placement by listening with stethoscope (a tool to listen to body sounds such as the stomach) or checking residual because it was important for the medications to be going in the right place.During a review of the facility's Policy & Procedure (P&P) titled, ENTERAL TUBE MEDICATION ADMINISTRATION, effective date August 2014, the P&P indicated, .The facility assures the safe and effective administration of enteral formulas and medications via enteral tubes.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on observation, interview, and record review, the facility failed to ensure two out of 32 sampled residents (Resident 49 and Resident 85) were assisted with nail care as part of the Activities of Daily Living (ADLs- normal daily functions required to meet basic needs) when Resident 49 and Resident 85 had long fingernails. This failure had the potential for Resident 49 and Resident 85 to sustain skin injury and/or to acquire an infection, and not achieve the highest practicable well-being.Findings:During a concurrent observation and interview on 4/7/26 at 8:52 a.m. with CNA 4, in Resident 49's room, CNA 4 confirmed that Resident 49 had long fingernails with green substance underneath the fingernails. CNA 4 stated Resident 49's fingernails should have been trimmed short. CNA 4 stated she had trimmed Resident 49's fingernails in the past. CNA 4 further stated Resident 49 could hurt herself by scratching herself with long fingernails.During a review of Resident 49's admission Record, the record indicated Resident 49 was admitted to the facility with diagnoses that included senile degeneration of brain (a progressive, age-related neurological decline), vascular dementia (a progressive decline in thinking, memory, and behavior caused by impaired blood flow to the brain, often following strokes or chronic vascular damage), age-related nuclear cataract (a common, slow-progressing clouding of the eye's central lens (nucleus) caused by protein hardening), contracture (the permanent, painful tightening of muscles, tendons, skin, or tissues, causing rigid joint deformities and reduced motion) of right hand and contracture of left hand.Review of Resident 49's Care Plan, initiated on 3/10/20, indicated, Focus.Resident has PHYSICAL FUNCTIONING DEFICIT related to [history] of cerebral infarction.limited mobility.requires physical staff assistance in ADLs.Goal .Physical functioning comfort will be maintained .Interventions.Inspect skin with care .Provide assistance in ADL.Review of Resident 49's Care Plan, initiated on 7/8/22, indicated, Focus.risk for DECLINE IN ADL FUNCTION/SELF CARE DEFICIT .Goal .Overall comfort in ADL activities/functional abilities will be maintained .Interventions.Use consistent routines and allow adequate time for [resident] to complete tasks.A review of Resident 49's Minimum Data Set (MDS- a federally mandated resident assessment tool) Functional Abilities, dated 3/18/26, indicated Resident 49 dependent with toileting hygiene, shower/bathing, upper and lower body dressing, putting on/taking off footwear and personal hygiene.Review of Resident 49's Physician Order dated 6/26/25, indicated, Podiatry, Dental and Ophthalmology Consult and treatment as needed for [resident] health and comfort. During an observation and interview on 4/6/26 at 12:23 a.m. with Resident 85, in Resident 85's room, Resident 85 had long fingernails. Resident 85 stated he would like to have short fingernails.During a concurrent observation and interview on 4/6/26 at 12:26 a.m. with Certified Nurse Assistant (CNA) 3, in Resident 85's room, CNA 3 confirmed that Resident 85 had long fingernails. CNA 3 stated she did not know when the last time was Resident 85 had his nails trimmed short. CNA 3 stated Resident 85 should have had his fingernails trimmed. CNA 3 stated Resident 85 could get skin tears by scratching himself with long fingernails. CNA 3 stated after she trimmed a resident's nails short, she would notify a Licensed Nurse (LN).During a review of Resident 85's admission Record, the record indicated Resident 85 was admitted to the facility with diagnoses that included disorder of urea cycle metabolism (a group of rare disorders where the body cannot break down ammonia, causing a toxic buildup that can affect brain and liver), Todd's paralysis (temporary weakness or paralysis of one side of the body or a specific limb, lasting from 30 minutes to 36 hours average 15 hours following a seizure), type 2 diabetes mellitus (a chronic metabolic condition where the body resists insulin or fails to produce enough, causing high blood sugar. It is characterized by symptoms like increased thirst, frequent urination, fatigue, and blurred vision), hepatic failure (a critical condition where the liver loses function rapidly [acute] or progressively [chronic], causing toxins to build up, impaired clotting, and potential multi-organ failure), primary osteoarthritis (a chronic, non-inflammatory joint disease caused by the breakdown of cartilage due to age and mechanical stress, rather than injury. It typically causes pain, stiffness, and reduced mobility in the hands) right (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	hand and primary osteoarthritis left hand.Review of Resident 85's Care Plan, initiated on 9/29/22, indicated, Focus.risk for DECLINE IN ADLS/SELF CARE DEFICIT .Goal .Resident will participate as able in ADL's and have all basic self care needs met at all times .Interventions.Assist resident with activities he is unable to perform independently.Assure that all tasks are done up to facility standards.Encourage resident to do as much self care as possible .A review of Resident 85's MDS Functional Abilities and Goals, dated 3/13/26, indicated Resident 85 required substantial/maximal assistance with upper and lower body dressing, and personal hygiene.Review of Resident 85's Physician Order dated 6/28/24, indicated, May Cut Nail one time a day every 4 weeks on [Sunday] .Review of Resident 85's Physician Order dated 6/28/24, indicated, May see podiatrist with follow-up treatment as indicated.During an interview on 4/7/26 at 4:14 p.m. CNA 5 stated she made sure residents had short and clean nails during ADL care. CNA 5 stated in the past she had clipped residents' nails with the approval of a LN. CNA 5 further stated residents who had diabetes had their nails cut by the podiatrist (is a medical specialist focused on diagnosing, treating, and preventing conditions affecting the foot, ankle, and lower leg). During a concurrent interview and record review on 4/8/26 at 9:56 a.m. LN 2 stated CNA and LN were both responsible for trimming residents' fingernails. LN 2 stated the CNA would notify the LN after completing nailcare on a resident. LN 2 stated nailcare that was done by CNA was documented in a resident's medical records in the progress note section. LN 2 stated there was no documentation indicating Resident 49 and Resident 85's nails were clipped short. LN 2 stated resident with long fingernails could scratch themselves and get a skin tear which could lead to an infection.During a concurrent interview and record review on 4/8/26 at 11:13 a.m. with the Assistant Director of Nursing (ADON), the ADON stated the expectation was to have residents have their nails short and clean. The ADON stated residents with long fingernails could have pain and get an infection by scratching themselves.During a concurrent interview and record review on 4/8/26 at 3:45 p.m., LN 8 stated both CNA and LN are responsible to keep residents' fingernails trimmed short and clean. LN 8 stated a podiatrist visited the facility every three months and trimmed nails for residents who had diabetes. LN 8 stated there was no documentation that nail care was provided for Resident 49 and Resident 85 in the last 30 days. LN 8 further stated there was no documentation for a podiatry visit for Resident 49 and Resident 85 from 1/26 to 3/26.During an interview on 4/9/26 at 9:29 a.m., LN 5 stated Resident 49 was not diabetic, and a CNA or LN should have clipped Resident 49's fingernails. LN 5 stated Resident 85 had an order to be seen by a podiatrist. LN 5 stated she had not seen a podiatrist do nail care to Resident 85 in a long time. LN 5 stated Residents could get bacteria under their long fingernails, get an infection or residents could scratch themselves and create an open wound.During an interview on 4/9/26 at 11:51 a.m. with the Administrator (ADM), the ADM stated the facility should have called a podiatrist for nail care for a resident who is diabetic and has thick nails. The ADM stated the LN could have also trimmed residents' nails short. The ADM further stated long finger nails have a risk of an infection and residents' fingernails should have been trimmed on a routine.A review of the facility's policy and procedures (P&P) titled, Fingernails/Toenails, Care of, revised 2/2018, the P&P indicated, .The purposes of this procedure are to clean the nail bed, to keep nails trimmed, and to prevent infections.Nail care includes daily cleaning and regular trimming.Proper nail care can aid in the prevention of skin problems around the nail bed.Trimmed and smooth nails prevent the resident from accidently scratching and injuring his or her skin.Stop and report to the nurse supervisor if there is evidence of ingrown nails, infections, pain, or if nails are too hard or too thick to cut with ease.The following information should be recorded in the resident's medical record: 1.The date and time that nail care was given.2.The name and title of the individual(s) who administered the nail care.A review of the facility's policy and procedures (P&P) titled, Activities of Daily Living (ADLs), Supporting, revised 3/2018, the P&P indicated, .Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene .

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure safe medication storage practices in the medication rooms and medication refrigerators for a resident census of 109, when:1. North station medication room stored four (4) outdated intravenous (IV) fluid bags of antibiotics (medications used to treat infections) in the medication refrigerator together with other active medications;2. An unauthorized facility staff was in the North station medication room unaccompanied by a licensed nurse;3. South station medication room [ROOM NUMBER] stored multiple enteral feedings in bottles and cartoons and five (5) emergency medication kits (e-kits, portable collection of essential prescription medicines designed to provide immediate care during crisis) with no daily log to document and monitor the temperature of the medication room;4. An e-kit stored in South station medication room [ROOM NUMBER] containing mostly antibiotic oral medications (to treat infections) sealed with a yellow tag (indicates the e-kit was opened and a medication was pulled out for emergency use) was not replaced in a timely manner;5. South station medication room [ROOM NUMBER] stored active medications in the medication refrigerator with extensive frost built up and had days where the temperature was out of range per facility guidelines;6. The medication refrigerator in South station medication room [ROOM NUMBER] stored two (2) bottles of medications without a readable label and one of the medication bottles had a handwritten label; and,7. South station medication room [ROOM NUMBER] stored a pharmaceutical waste container without a seal and had disposed/discarded medications that were recognizable and retrievable by hand.These failures could contribute to unsafe medication use, medication error, risk of residents receiving medications that were contaminated, spoiled, expired or reduced potency, and the potential for medication misuse and/or drug diversion (when individuals steal controlled substances-highly regulated medications-for recreational use).Findings: 1. During a concurrent medication storage observation and interview on 4/6/26, at 8:40 a.m. with License Nurse (LN) 9 in the North station medication room, there were four expired IV antibiotic bags stored in the medication refrigerator with other active medications. Two of the IV fluid antibiotic bags had an expiration date of 3/23/26 and the other two IV fluid antibiotic bags had an expiration date of 3/29/26. LN 9 confirmed that the individual whom the IV antibiotics were prescribed for was still a current resident in the facility. LN 9 stated that the expired IV antibiotics should not be used and should have been taken away from the active medications and should have been discarded. LN 9 also stated there could be a potential risk for accidental use of expired IV antibiotics that may not have been good to use or may not have been effective and would not treat the infection and could have resulted in harm to the resident. During an interview on 4/6/26, at 11:10 a.m. with the Director of Nursing (DON), the DON stated that expired medications still stored with the active medications had the potential for being administered to the residents. During a phone interview on 4/9/26, at 9:49 a.m. with the Pharmacy consultant (PC), the PC stated that expired medications still stored with the active medications had an increased risk for staff grabbing it and could potentially be used and may have caused harm to the residents. During a review of the facility's Policy and Procedure (P&P) titled, MEDICATION STORAGE IN THE FACILITY, revised 1/25, the P&P indicated, .Medications and biologicals are stored safely, securely, (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	and properly following manufacturer's recommendations or those of the supplier.Outdated, contaminated, or deteriorated medications and those in containers that are cracked, soiled, or without secure closures are immediately removed from stock, disposed of according to procedures for medication disposal, and reordered from the pharmacy if a current order exists. 2. During a concurrent medication storage observation and interview on 4/6/26, at 8:40 a.m. with LN 9 and the Central Supply (CS) staff in the North station medication room LN 9 knocked on the door and the CS staff opened the medication room. Upon entering the medication room, the CS staff was found to be alone and there was no licensed nurse with him. The medication room stored multiple active overflow medications on open shelves that were prescribed for the residents in the North Unit and for the residents in the Center Unit. The CS staff explained that the licensed nurse usually gave the key to him so he could replenish supplies and over-the-counter medications. The CS staff stated he usually was in the medication room by himself and unaccompanied by a licensed nurse. The CS staff also stated that he replenished all supplies and over-the-counter medications in every medication room with no licensed nurse with him. LN 9 confirmed the CS staff was in the medication room by himself. LN 9 stated that the CS staff should not be by himself and should have been accompanied by a licensed nurse. LN 9 further stated that only licensed nurses were allowed in the medication room and other personnel such as the CS staff should be accompanied. During an interview on 4/6/26, at 9:02 a.m. with the CS staff, the CS staff explained that he asked for the keys to the medication rooms from the licensed nurse on duty to refill over-the-counter medications and other supplies. The CS staff stated that he had always refilled the medication rooms this way and he also stated that he checked medication rooms twice a week. During an interview on 4/6/26, at 9:20 a.m. with the Assistant Director of Nursing (ADON), the ADON stated only authorized licensed nurses such as the LNs, DON, ADON, and treatment licensed nurses have access to all the medication rooms and all other unauthorized personnel such as the housekeepers including the central supply staff members should be accompanied by licensed staff when entering the medication room. During an interview on 4/6/26, at 11:10 a.m. with the DON, the DON stated non-nursing personnel other than the licensed staff should be accompanied by an authorized licensed nurse when entering the medication room. The DON stated unauthorized personnel should not be in the medication room without a licensed nurse to prevent the risk for misuse and/or drug diversion of prescribed medications and/or over-the-counter medications. During a phone interview on 4/9/26, at 9:49 a.m. with the PC, the PC stated she would have expected the licensed nurses to stay with the non-nursing staff going into the medication rooms. The PC also stated there would be an increased risk for non-authorized personnel to take something from the medication room when the licensed nurse is not present. The risk for misuse and/or drug diversion could potentially happen. During a review of the facility's Policy & Procedure (P&P) titled, MEDICATION STORAGE IN THE FACILITY, revised 1/25, the P&P indicated, .Medications and biologicals are stored safely, securely, and properly following manufacturer's recommendations or those of the supplier. The medication supply is accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized.Only licensed nurses, pharmacy personnel, and those lawfully authorized are allowed access to medications, Medication rooms, carts, and medication supplies are locked or attended by persons with authorized access. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. During a concurrent medication storage observation and interview on 4/6/26, at 9:20 a.m. with the ADON in the South station medication room [ROOM NUMBER], multiple enteral feeding nutrition (nutrition administered directly into the stomach through a tube) in bottles and in cartoons together with active overflow medications prescribed for residents in the South Unit were stored. There were also five e-kits sealed with red tags and one e-kit sealed with yellow tag stored in this medication room. The ADON confirmed the thermometer in the medication room registered a temperature of 72ˆ (degrees Fahrenheit-unit of measurement). The ADON also confirmed that there was no temperature log to monitor and document the registered temperatures in the medication room on a daily basis. The ADON also confirmed the medication room stored multiple enteral nutrition, overflow medications, and e-kits. The ADON stated unregulated temperatures in the medication room had the potential to spoil the enteral nutrition and may potentially affect the potency of the overflow medications and the medications or supplies stored in the e-kits. During an interview on 4/6/26, at 11:10 a.m. with the DON, the DON stated that temperatures in all medication rooms should be monitored and logged on a daily basis and should be maintained in the correct temperature range as indicated on the log guidelines to prevent the spoilage of the enteral nutrition by heat. The DON also stated that the enteral nutrition should be stored at room temperature. The DON further stated that the medications along with the medications in the e-kit should be stored in the same way. During a phone interview on 4/9/26, at 9:49 a.m. with the PC, the PC stated that medications stored in a medication room with unregulated temperature with no method of monitoring could potentially affect the stability of the medication if temperatures were not in the proper range. During a review of the facility's Policy & Procedure (P&P) titled, MEDICATION STORAGE IN THE FACILITY, revised 1/25, the P&P indicated, .Medications and biologicals are stored safely, securely, and properly following manufacturer's recommendations or those of the supplier.Medications requiring storage at room temperature are kept at temperatures ranging from 15ˆ [degrees centigrade-unit of measurement] (59ˆ) to 30ˆ (86ˆ). 4. During a concurrent medication storage observation and interview on 4/6/26, at 9:20 a.m. with the ADON in the South station medication room [ROOM NUMBER], an e-kit sealed with a yellow tag was stored in the medication room. The ADON explained an e-kit sealed with a yellow tag would indicate that the e-kit was opened and a medication was taken out and administered to a resident who was in immediate need, such as an antibiotic. The ADON also explained that any medication taken out from the e-kit should be logged out and documented on the form provided and kept inside the e-kit for the pharmacist to know which medication was taken out for replacement. The ADON confirmed the antibiotic was removed from the e-kit on 3/28/26. The ADON stated the e-kit should have been replaced immediately within 72 hours. The ADON confirmed the e-kit was not replaced within 72 hours. During an interview on 4/6/26, at 11:10 a.m. with the DON, the DON stated open e-kits should be replaced within 24 hours, a day or two days. The DON also stated the pharmacy should have been called to let them know an e-kit was opened and needed to be replaced. During a phone interview on 4/9/26, at 9:49 a.m. with the PC, the PC stated e-kits with yellow tags should be replaced within 72 hours of opening. During a review of the facility's Policy & Procedures (P&P) titled, MEDICATION ORDERING AND (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	RECEIVING FROM PHARMACY, revised 1/25, the P&P indicated, .An emergency supply of medications including emergency drugs, antibiotics, controlled substances.is supplied by the provider pharmacy in limited quantities in portable, sealed containers that are in compliance with applicable state regulations.After removing the medication, complete the emergency e-kit slip and re-seal the emergency supply.As soon as possible, the nurse records the medication use on the medication order form and notifies the pharmacy for replacement of the emergency drug supply.If exchanging kits, the used sealed kits are replaced with the new sealed kits within 72 hours of opening. 5. During a concurrent observation and interview on 4/6/26, at 9:30 a.m., with the Assistant Director of Nursing (ADON), the ADON verified the South medication room [ROOM NUMBER]'s medication refrigerator was noted with extensive frost built up and the temperature's recorded were out of range per facility guidelines on 4/1/26, 4/2/26, 4/3/26, and 4/6/26 during the AM shift. The ADON stated maintenance should have been made aware of the refrigerator temperatures being out of range and the ice build up. The ADON further stated the refrigerator temperature out of range may cause the medication stored to lose effectiveness. During an interview on 4/6/26, at 11:55 a.m., with the Director of Nursing (DON), the DON stated it was her expectation for licensed nursing staff to notify maintenance regarding ice build up in the medication refrigerators, and that ice build up will affect the temperature in the medication refrigerator. During an interview on 4/9/26, at 9:49 a.m., with the Pharmacist Consultant (PC) the PC stated there should have not been ice buildup in the medication refrigerator and if the medication refrigerator was not within range per guidelines the stability of the medication could potentially be affected. A review of the facility's policy and procedure (P&P) titled, MEDICATION STORAGE IN THE FACILITY revision date 1/25, the P&P Indicated, .Medications and biologicals are stored safely, securely, and properly.Medication storage conditions are monitored on a routine basis and corrective action taken if problems are identified . 6. During a concurrent observation and interview on 4/6/26, at 9:30 a.m., with the Assistant Director of Nursing (ADON), the ADON verified South medication room [ROOM NUMBER]'s medication refrigerator stored 2 bottles of medications without a readable label and one of the medication bottles had a handwritten label. During an interview on 4/6/26, at 11:55 a.m., with the Director of Nursing (DON), the DON stated it was her expectation for licensed nursing staff to notify the pharmacy if a medication label was not readable and not to hand write on the medication labels. The [NAME] further stated that stored medication without a readable label placed residents at risk of a medication error. During an interview on 4/9/26, at 9:49 a.m., with the PC, the PC stated if a medication label was not readable medication should have been removed and pharmacy notified to replace the medication. The PC further stated staff should not be hand writing on the medication labels. A review of the facility's policy and procedure (P&P) titled, MEDICATION STORAGE IN THE FACILITY revision date 1/25, the P&P Indicated, .Refrigerated medications are kept in closed and labeled containers.Outdated, contaminated, or deteriorated medications and those in containers cracked, soiled, or without secure closures are immediately removed from stock, disposed of according to procedures for medication disposal, and reordered from pharmacy if a current order exists. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	7. During a concurrent observation and interview on 4/6/26, at 9:30 a.m., with the Assistant Director of Nursing (ADON), the ADON verified the South medication room [ROOM NUMBER] stored a pharmaceutical waste container without a seal and had disposed/discarded medications that were recognizable and retrievable by hand. During an interview on 4/6/26, at 11:55 a.m., with the Director of Nursing (DON), the DON stated it was her expectation for the pharmaceutical waste container to use drug buster (a specialized disposal system designed to securely and safely get rid of unwanted or expired medication, preventing them from being misused or harming the environment) and that medications were at risk of being taken out and used from the pharmaceutical waste container. During an interview on 4/9/26, at 9:49 a.m., with the PC, the PC stated a pharmaceutical waste container should be used with a drug destroyer so that medications cannot be recognizable and there was risk of medications being taken from the pharmaceutical waste container.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observation, interview, and record review, the facility failed to implement appropriate infection prevention and control measures for a census of 109, when:1. Resident 50's oxygen tube (a flexible, lightweight, and typically transparent tube used to deliver supplemental oxygen from a source-like a concentrator-directly to a patient's nostrils or mask) was found on the floor without a date and it was not connected to the oxygen concentrator (a medical device that provides purified oxygen to people with breathing disorders by filtering, compressing, and concentrating ambient air into 90%-95% pure oxygen);2. The Glucometer (a small, portable, battery-powered device used to measure the concentration of sugar (glucose) in a small sample of blood) was not cleaned properly and adequately in between Resident 92, Resident 107, and Resident 63 use; and,3. Personal Protective Equipment (PPE, specialized clothing and gear-such as masks, gloves, gowns, and face shields-designed to create a barrier against infectious materials, blood, and body fluids essential for infection control minimizing the spread of germs) was not utilized for Resident 11 and Resident 123, who were on Enhanced Barrier Precautions (an infection control intervention involving the use of a gown and gloves for high-contact resident care activities to help stop or reduce the spread of germs). These failures in infection prevention and control practices had the potential to contribute to the spread of infection among residents and staff within the facility.Findings: 1. During a review of Resident 50's admission RECORD, the record indicated Resident 50 was admitted to the facility with diagnoses including chronic obstructive pulmonary disease (COPD, a progressive, long-term lung disease that makes breathing difficult by damaging lung tissue and narrowing airways) and malignant neoplasm of other parts of the uterus (cancerous tumor of the uterus that can grow uncontrolled and spread to other parts of the body). During a review of Resident 50's Minimum Data Set (MDS, a resident assessment tool), dated 2/25/26, the MDS revealed a Brief Interview for Mental Status (BIMS) score of 9 out of 15 indicating Resident 50 had moderate problems with thinking and memory. During a review of Resident 50's Order Summary Report, active physician's orders as of 4/9/26, the order indicated, .OXYGEN: O2 [oxygen] 2LPM [liters per minute-unit of measurement] via NC [nasal cannula-a transparent tube with two prongs that rest on the nostrils to deliver oxygen] as needed for SOB [shortness of breath]. During a review of Resident 50's Care Plan Report (a form where you can summarize a person's health conditions, specific care needs, and current treatments), dated 5/2/23, the care plan indicated, .Potential for impaired gas exchange [a disruption of the oxygen and carbon dioxide exchange in the lung tissues] r/t [related to] CHRONIC OBSTRUCTIVE PULMONARY DISEASE.Implement measures to improve respiratory status.O2 per order. During a concurrent observation and interview on 4/6/26, at 12:42 p.m. with Resident 50 in her room and Certified Nursing Assistant (CNA) 2, Resident 50 was in bed and her oxygen tube was on the floor disconnected from the oxygen concentrator that was placed on her right side next to the bed with the power on. The oxygen tube also did not have a date when the tube was replaced or changed. Resident 50 stated she did not have her NC because she did not need oxygen at that time but went on to say that she needed oxygen most of the time because she had shortness of breath at times. CNA 2 entered Resident 50's room to deliver her lunch tray and CNA 2 confirmed Resident 50's oxygen tubing was on the floor disconnected from the concentrator and without a date. CNA 2 also confirmed the oxygen concentrator belonged to Resident 50. CNA 2 stated the oxygen tubing should not be on the (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 107's Care Plan Report, dated 2/24/26, the care plan indicated, .The resident is at risk for s/s of hyperglycemia/hypoglycemia r/t DAIBETES MELLITUS TYPE 2 and insulin dependent. During a medication administration on 4/8/26, at 7:32 a.m. at the South Unit outside Resident 107's room, LN 4 took the same glucometer that he used previously with Resident 92 and placed it on the tray with the other supplies that would be needed to take Resident 107's blood sugar levels. Resident 107's blood sugar reading was 175. LN 4 returned to his medication cart with the used glucometer and other supplies. LN 4 took one wipe of micro-kill one Germicidal Alcohol Wipes and cleaned all surfaces of the glucometer. LN 4 then took another wipe and laid the glucometer on top the wipe until the next use. 2c. During a review of Resident 63's admission RECORD, the record indicated, Resident 63 was admitted to the facility with diagnoses including type 2 diabetes mellitus. During a review or Resident 63's Order Summary Report, active physician's orders as of 4/9/26, the order indicated, .Blood sugar checks before meals and at bedtime. During a review of Resident 63's Care Plan Report, dated 5/27/25, the care plan indicated, .Monitor FSBS [fasting blood sugar] QID [four times a day] before meals and at bedtime. During a medication administration on 4/8/26, at 7:48 a.m. at the South Unit outside Resident 63's room, LN 4 took the same glucometer that he used previously with Resident 107 and placed it on the tray with the other supplies that would be needed to take Resident 63's blood sugar levels. Resident 63's blood sugar reading was 144. LN 4 returned to his medication cart with the used glucometer and other supplies. LN 4 took one wipe of micro-kill one Germicidal Alcohol Wipes and cleaned all surfaces of the glucometer. LN 4 then took another wipe and laid the glucometer on top the wipe until the next use. During a subsequent interview on 4/8/26, at 7:48 a.m. with LN 4, LN 4 stated when cleaning a used glucometer that he would clean first using the germicidal alcohol wipes the facility provided and then take a second wipe to wrap around the glucometer for about 1 minute after each use for Resident 92, Resident 107, and Resident 63. LN 4 stated he did not wrap the glucometer with the wipe but laid it on the wipe. LN 4 explained that the glucometer was not cleaned properly and there could be a possibility that the glucometer was still contaminated and could cause infections between residents. During an interview on 4/9/26, at 12:23 p.m. with the IP, the IP stated the process of cleaning a multi-use glucometer was to clean all surfaces first for 30 seconds with the germicidal alcohol wipes then get a second wipe and wrap that wipe around the glucometer for another 30 seconds to ensure the glucometer was cleaned properly and adequately in between use. During a review of the undated Germicidal Alcohol Wipes cleaning and disinfecting guidelines printed on the container, the cleaning guidelines indicated, .use one or more wipes, as necessary, to wet surface sufficiently and to thoroughly clean the surface. and the disinfecting guidelines indicated, .use one or more wipes, as necessary, to thoroughly wet the surface to be treated. Treated surface must remain visibly wet for one minute to achieve complete disinfection of all pathogens listed on the label.Allow surfaces to air dry. During a review of the undated facility's Administrative Policies titled, Glucometer Cleaning, the (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	policy indicated, .All glucometers will be cleaned and disinfected using [brand] Germicidal wipe, EPA regulated [Environmental Protection Agency; the EPA verifies disinfectants work according to their label directions].All glucometers that will be shared by multiple patients will be thoroughly wiped with disinfectant and allowed to air dry after every use and between every patient.All to air dry before using on next patient.Ensure the meter stays wet for 1 minute and is allowed to dry an additional. 3a. During a review of Resident 11's admission RECORD the record indicated Resident 11 was admitted to the facility with diagnoses including but not limited to Unspecified contact dermatitis (a skin rash caused by an unidentified irritant or allergen. It presents as itching, redness, swelling, or blisters when the skin reacts to an unknown substance), allergic rhinitis (an immune system response to allergens like pollen, dust mites, or pet dander, causing nasal inflammation) and Pressure Ulcer of Sacral Region (back and buttocks area), Stage 3 (a full-thickness tissue loss injury, presenting as a deep crater where subcutaneous fat may be visible, but muscle, tendon, or bone are not exposed). During a review of Resident 11's record titled Order Details, active physician's orders as of 10/10/25, the order indicated, .Enhanced Barrier Precaution [EBP; an infection control intervention designed to reduce the spread of multidrug-resistant organisms]: Stage 3, pressure ulcer to coccyx [the last bone at the bottom (base) of your spine]. During a review of Resident 11's record titled Care Plan Report, dated 9/22/25, the care plan indicated, .Resident requires Enhanced Standard Precautions for High Risk for Infection or Transmission R/T [related to] Stage 3 pressure ulcer to coccyx. During an interview with CNA 6 (Certified Nursing Assistant 6) on 4/8/26, at 9:25 a.m., CNA 6 stated they were not using EBP for Resident 11 as there was no yellow dot by Resident 11's name outside her room. CNA 6 said a yellow dot by the name meant that resident was on EBP. CNA 6 further stated he did not think Resident 11 was on EBP. During a concurrent interview and record review with LN 7 (Licensed Nurse 7) on 4/8/26, at 9:28 a.m., LN 7 confirmed a yellow dot by a resident's name indicated that resident was on precautions. LN 7 confirmed there was no yellow dot by Resident 11's name located outside of Resident 11's room. LN 7 checked Resident 11's medical record and confirmed that Resident 11 required EBP. LN 7 stated not having a yellow dot by the name could lead to staff confusion, and that could be why some of the staff might not be using EBP when caring for Resident 11. During an interview with the IP (Infection Preventionist) on 4/8/26 at 10:07 a.m., the IP confirmed that they use yellow dots by resident's names outside the room when a resident was on EBP. The IP stated if there was not a yellow dot by the residents name, the staff might not use the EBP PPE which would lead to a risk of spreading the infection. The IP stated EBP was very important for protection of residents and staff against infections. 3b. A review of Resident 123's admission RECORD, the record indicated Resident 123 was admitted to the facility with diagnoses that included but not limited to Sepsis (a life-threatening medical emergency caused by the body's extreme, dysfunctional response to an infection, leading to tissue damage and organ failure), bacteremia (the presence of bacteria in the bloodstream), and bell's palsy (a sudden, temporary weakness or paralysis of facial muscles caused by inflammation of the 7th cranial nerve, typically affecting one side of the face). A review of Resident 123's record titled Order Listing Report, with a revision date of 3/27/26, (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	indicated an order of Enhanced Barrier Precautions related to IV-PICC (Peripherally Inserted Central Catheter is a thin, flexible tube inserted into an upper arm vein and guided to a large vein near the heart. It provides long-term IV access (weeks to months) for medications, fluids, nutrition, or blood sampling, avoiding repeated needle sticks). During an interview on 4/6/26 at 10:20 a.m., Resident 123 stated the staff were not using EBP PPE when caring for her. During an interview on 4/6/26, at 10:24 a.m. with LN1 (Licensed Nurse 1), LN 1 stated Resident 123 should be on EBP as she had a PICC line. LN1 confirmed that there was no EBP sign on the door and no EBP PPE supplies outside of Resident 123's room. LN1 explained that this situation increased Resident 123's risk of acquiring additional infections from staff and other residents. During an interview on 4/8/26, at 10:11 a.m. with the IP, the IP confirmed Resident 123 should have had EBP, an EBP sign on the door, a cubby on the door with PPE, and a yellow dot by her name. The IP stated that not having EBP in place put Resident 123 at increased risk of spreading infection and getting infected more. The IP further stated that she expected the use of EBP as it was very important in protection against infections. During an interview on 4/9/26, at 10:41 a.m., with the DON (Director of Nursing), the DON confirmed that a resident with a PICC line should have been on EBP. The DON stated that residents were at risk of acquiring infections from staff, visitors, and other residents when EBP were not implemented. The DON further emphasized the importance of EBP by saying that EBP prevented the transmission of infections. A review of the facility's policy and procedure titled, Enhanced Barrier Precautions, revised 12/24, the policy indicated, .Enhanced barrier precautions apply when. A resident is NOT known to be infected or colonized with any MDRO, has a wound or indwelling medical devices.Indwelling medical devices include central lines, urinary catheters, feeding tubes.EBPs employ targeted gown and glove use in addition to standard precautions during high contact resident care activities when contact precautions do not otherwise apply.Enhanced barrier precautions are in place for the duration of the resident's stay or until resolution of the wound or discontinuation of the indwelling medical device that place that at higher risk.Staff are trained prior to caring for residents on EBPs.Signs are posted on the door or wall outside resident's rooms which communicate the type of precautions and PPE required.

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. Based on staff interview and clinical record review, the facility failed to ensure that 1 of 32 sampled residents (Resident 8) was provided with education regarding the risks and benefits of prescribed psychotropic medications (medications used to treat mental health diagnosis) when the facility administered ordered psychotropic medications without confirming that consent had been obtained by the prescribing physician. This failure had the potential to cause Resident 8 to experience unnecessary side effects and duplicate therapy based on the number of psychotropic medications that had been ordered. Findings:During a record review of Resident 8's admission RECORD, dated 4/9/26, the record indicated that Resident 8 was admitted to the facility with diagnosis that included schizophrenia (a serious, chronic brain disorder that disrupts how a person thinks, feels, and acts, making it difficult to distinguish reality from imagination) and major depressive disorder (a serious mental health condition characterized by persistent, overwhelming sadness, hopelessness, or loss of interest in activities for at least two weeks.) The admission RECORD also indicated that Resident 8 was under conservatorship (a legal arrangement where a judge appoints a responsible person or organization (the conservator) to take care of another adult (the conservatee) who can no longer manage their own personal or financial affairs).During a record review of Resident 8's Minimum Data Set, (MDS - a federally required assessment tool) dated 3/10/26, the MDS revealed a Brief Interview for Mental Status (BIMS - a quick, 0-15-point test used in nursing homes to measure a person's memory and thinking ability) score of 3 (the score indicates a person's level of memory impairment with a score of 0-7 indicating severe impairment, 8-12 indicating moderate impairment, and 13-15 indicating no impairment.)During a record review of Resident 8's Order Summary Report, dated 4/9/26, the report indicated that Resident 8 had the following physician ordered psychotropic medications:fluoxetine (an antidepressant medication used to treat depression) 20 mg (milligram - a unit of measurement) once a day with a start date of 3/4/26lithium 600 mg (a mood stabilizing medication used to treat and reduce intense mood swings) two times a day with a start date of 3/4/26oxcarbazepine 300 mg (a medication used to treat seizures but is may also be used as a mood stabilizer for mental health disorders) two times a day with a start date of 3/4/26. The same medication was discontinued on 3/28/26 and a new order for oxcarbazepine 300 mg three times a day was started.risperidone 3 mg (an antipsychotic medication used to treat schizophrenia) with a start date of 3/5/26 then discontinued on 3/27/26quetiapine 400 mg at bedtime with a start date of 3/4/26During a record review of Resident 8's clinical document titled PSYCHOTROPIC MEDICATION ADMINISTRATION DISCLOSURE (Anti-Depressant), [a form used by skilled nursing facilities to document that the mandated process for ensuring residents or the resident's representative understand the risks, benefits, and alternatives to a psychotropic medication before the medication is initiated or the dose is increased], the document indicated that the NP had not obtained consent for the use of the medication fluoxetine 20mg one time a day from Resident 8's conservator until 3/15/26, and the facility had not confirmed that Resident 8's representative had given consent for the medication until 4/9/26.During a record review of Resident 8's clinical document titled PSYCHOTROPIC MEDICATION ADMINISTRATION DISCLOSURE (Anti-Psychotic), the document indicated that the NP had not obtained consent for the use of the medication lithium 600 mg two times a day from Resident 8's conservator until 4/5/26 and the facility had not confirmed that Resident 8's representative had given consent for the medication until 4/9/26.During a record review of Resident 8's clinical document titled PSYCHOTROPIC MEDICATION ADMINISTRATION DISCLOSURE (Anti-Psychotic), the document indicated the NP had not obtained consent for the use of the medication risperidone 3 mg one time a day from Resident 8's conservator until 3/14/26 and the facility had not confirmed that Resident 8's representative had given consent for the medication until 4/9/26.During a record review of Resident 8's clinical document titled PSYCHOTROPIC MEDICATION ADMINISTRATION DISCLOSURE (Anti-Psychotic), the document indicated the NP had not obtained (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	consent for the use of the medication quetiapine 400 mg one time a day from Resident 8's conservator until 3/14/26 and the facility had not confirmed that Resident 8's representative had given consent for the medication until 4/9/26.There was no indication that a PSYCHOTROPIC MEDICATION ADMINISTRATION DISLOSURE form had been completed for the administration of oxcarbazepine 300mng twice a day.During a record review of Resident 8's clinical document titled MEDICATION ADMINISTRATION RECORD, (MAR) dated 3/1/26 through 3/31/26, the MAR indicated that Resident 8 was administered the following medications during the indicated period without informed consent:fluoxetine 20 mg every day from 3/5/26 through 3/14/26lithium 600 mg twice a day from 3/5/26 through 3/31/26oxcarbazepine 300 mg twice a day from 3/5/26 to 3/27/26 then three times a day from 3/28/26 through 3/31/26risperidone 3 mg at bedtime from 3/5/26 through 3/14/26quetiapine 400 mg at bedtime from 3/5/26 through 3/14/26During a record review of Resident 8's clinical document titled MAR, dated 4/1/26 through 4/30/26, the MAR indicated that Resident 8 was administered the following medication during the indicated period without informed consent:lithium 600 mg twice a day from 4/1/26 through 4/5/26oxcarbazepine 300 mg three a day from 4/1/26 through 4/7/26, held all three doses on 4/8/26 due to hospital stay, then given on 4/9/26 without documented consent.During a review of Resident 8's clinical document titled Visit Type: APP Initial Stabilization, dated 3/31/26, entered by NP 1, indicated that psychotropic medications fluoxetine, mirtazapine, oxcarbazepine, quetiapine and lithium were all to continue to treat Resident 8's diagnosis of schizophrenia and depression but did not indicate that informed consent had been obtained prior to the administration of the listed psychotropic medications.During a review of Resident 8's clinical document titled Visit Type: Follow Up, dated 4/1/26 and entered by Nurse Practitioner (NP) 1 review of the note revealed that there was no documentation that consent had been obtained by NP 1 from Resident 8's representative any the ordered psychotropic medications.During a review of Resident 8's clinical document titled Note Text: Progress Note, dated 4/2/26, entered by NP 2, indicated that the psychotropic medications had been ordered to treat Resident 8's diagnosis of schizophrenia and depression, but did not indicate that informed consent had been obtained prior to the medications being administered.During an interview on 4/8/26 at 11:42 AM with Licensed Nurse (LN) 1, LN 1 stated that informed consent for the use of psychotropic medication was required to be obtained by the MD and then confirmed by the nurse with the resident or the resident's representative that they had given consent to the MD and had agreed to the psychotropic medication order. LN 1 stated this process was to be completed before a psychotropic medication was to be administered. LN 1 stated they use the form titled PSYCHOTROPIC MEDICATION ADMINISTRATION DISCLOSURE to have the prescribing practitioner sign and date that the risks, benefits, and alternatives were discussed, the resident or their representative sign and date when the consent was given, and the nurse speaks to the resident or the representative to confirm that consent was given and then signs and dates the form when that is done. LN 1 stated the form then goes to the medical records department so it can be electronically uploaded into the resident's electronic health record.During a concurrent interview and record review on 4/8/26 at 12:07 PM with the Director of Nurses (DON), the DON reviewed Resident 8's psychotropic medication orders and Resident 8's MAR for March 2026 and April 2026. The DON stated that when psychotropic medications were ordered, the prescribing practitioner was responsible for obtaining consent from the resident or the resident's representative before the facility could administer a medication. The DON confirmed that facility used the form titled PSYCHOTROPIC MEDICATION ADMINISTRASTION DISCLOSURE form to document that the prescribing practitioner obtained consent from the resident or the resident's representative. The DON confirmed that Resident 8 had been administered fluoxetine, lithium, oxcarbazepine, risperidone, and quetiapine in March 2026 and lithium and oxcarbazepine in April 2026 without consent being obtained by the prescribing practitioner or confirmed by the facility. The DON stated that the psychotropic medications should not have been administered without the informed consent being obtained by the prescribing practitioner from the resident or the resident's (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	representative. During a review of the facility's policy and procedure titled Psychotropic Medication Use, dated 7/22, the P&P indicated .Categories of medications which affect brain activity such as.central nervous system medications that are prescribed as a substitute for or an adjunct to a psychotropic medication are monitored and managed as psychotropic medications.Residents (and/or representatives) have the right to decline treatment with psychotropic medications.the staff and physician will review with the resident/representative the risks related to not taking the medication as well as appropriate alternatives.During a review of the facility's undated policy and procedure titled Informed Consent for Psychotropic Drugs, the P&P indicated .It outlines responsibilities for obtaining, verifying, and documenting informed consent to protect resident rights, promote safety, and facilitate appropriate use of these medications for residents with behavioral or psychotic symptoms.Informed Consent: Disclosure of material information (e.g., reasons for use, benefits, risks including black box warnings, alternatives including nonpharmacological approaches) to the resident or their representative/surrogate, allowing them to accept, refuse, or revoke consent. Consent must be obtained prior to initiation or increase.Responsibilities Prescribing Practitioner.obtain informed consent for all psychotropic medications prior to initiation or dose increase.document the discussion, resident/representative's understanding, and consent/refusal in the medical record.Facility Role verify (but not obtain) informed consent; ensure documentation in the medical record.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. Based on observation, interview, and record review, the facility failed to accommodate the needs of 2 of 32 sampled residents (Resident 85 and Resident 96) when, Resident 85 and Resident 96 had a call light (device used to contact staff for assistance) that was not within Resident 85 and Resident 96's reach.This deficient practice placed Resident 85 and Resident 96 at increased risk for unmet care needs, delayed staff response, falls, and potential injury.Findings:During a review of Resident 85's admission Record, the record indicated Resident 85 was admitted to the facility with diagnoses that included disorder of urea cycle metabolism (a group of rare disorders where the body cannot break down ammonia, causing a toxic buildup that can affect brain and liver), Todd's paralysis (temporary weakness or paralysis of one side of the body or a specific limb, lasting from 30 minutes to 36 hours average 15 hours following a seizure), type 2 diabetes mellitus (a chronic metabolic condition where the body resists insulin or fails to produce enough, causing high blood sugar. It is characterized by symptoms like increased thirst, frequent urination, fatigue, and blurred vision), hepatic failure (a critical condition where the liver loses function rapidly [acute] or progressively [chronic], causing toxins to build up, impaired clotting, and potential multi-organ failure), primary osteoarthritis (a chronic, non-inflammatory joint disease caused by the breakdown of cartilage due to age and mechanical stress, rather than injury. It typically causes pain, stiffness, and reduced mobility in the hands) right hand and primary osteoarthritis left hand. During a concurrent observation and interview on 4/6/26 at 12:23 p.m., with Resident 85 in Resident 85's room, Resident 85 was lying in his bed. Resident 85's call light was on the floor next to Resident 85's bed. Resident 85 stated he was thirsty.During a concurrent observation and interview on 4/6/26 at 12:26 p.m., with Certified Nursing Assistant (CNA) 3 in Resident 85's room, CNA 3 confirmed Resident 85's call light was not within reach of Resident 85. CNA 3 stated Resident 85's call light was on the floor in Residents 85's room. CNA 3 stated Resident 85 should have his call light within reach. CNA 3 stated Resident 85 could have fallen from his bed when trying to reach for his call light.Review of Resident 85's Care Plan, initiated on 9/29/22, indicated, Focus.risk for DECLINE IN ADLS/SELF CARE DEFICIT .Goal .Resident will participate as able in ADL's and have all basic self care needs met at all times .Interventions.Assist resident with activities he is unable to perform independently.Keep call light within reach and provide verbal reminders to use call light for staff assistance .During a review of Resident 96's admission Record, the record indicated Resident 96 was admitted to the facility with diagnoses that included hypertensive heart disease with heart failure (occurs when chronic high blood pressure forces the heart to work harder, leading to thickened heart muscles [left ventricular hypertrophy] and weakened function. This often results in fluid buildup [shortness of breath, swelling] and reduced heart efficiency), muscle weakness and hemiplegia and hemiparesis (one-sided body weaknesses caused by brain damage).During a concurrent observation and interview on 4/6/26 at 1:48 p.m., with Resident 96 in Resident 96's room, Resident 96 was lying in her bed. Resident 96's call light was on the floor under Resident 96's bed. Resident 96 stated she could not find her call light.During a concurrent observation and interview on 4/6/26 at 1:50 p.m., with Licensed Nurse (LN) 9 in Resident 96's room, LN 9 confirmed Resident 96's call light was on the floor. LN 9 stated Resident 96 could fall out of her bed when trying to reach for her call light. LN 9 picked the call light from Residents 96's bedroom floor and placed the call light next to Resident 96.Review of Resident 96's Care Plan, initiated on 11/14/23, indicated, Focus.risk for and actual FALLS/INJURY.Goal .Safety measures/new fall interventions will be maintained to prevent or lessen any injury from fall.Interventions.Keep frequently used items within easy reach.Review of Resident 96's Care Plan, initiated on 11/14/23, indicated, Focus.risk for and actual SELF-CARE DEFICIT/DECLINE in ADLS. Goal .Resident will participate as able in ADL's and have all basic self care needs met at all times.Interventions.Keep call light within reach and provide verbal reminder for resident to use call light. During an interview on 4/8/26 at 11:13 a.m., with the Assistant Director of Nursing (ADON), the ADON stated Residents should have their call (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	light within reach. The ADON stated call light is a source of communication between the residents and staff. The ADON stated Residents could fall when trying to reach for their call light. During an interview on 4/9/26 at 11:51 a.m., with the Administrator (ADM), the ADM stated residents should have their call light within reach in case residents need immediate assistance which could be when residents are soiled or when residents are choking.Review of facility's policy and procedure (P&P), titled Answering the Call Light, revised 10/24, the P&P indicated .Ensure that the call light is accessible to the resident when in bed.Review of facility's policy and procedure (P&P), titled Activities of Daily Living (ADLs), Supporting, revised 3/18, the P&P indicated Appropriate care and services will be provided for residents who are unable to carry out ADLs independently.Communication (speech, language, and any functional communication systems) .

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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. Based on interview and record review the facility failed to honor the resident's right to choose for 1 of 32 residents (Resident 27), when the facility failed to honor Resident 27's request for a schedule concerning when their room would be deep cleaned (an intensive, systematic disinfection process-often called terminal cleaning-that goes beyond daily cleaning to eliminate pathogens and prevent Healthcare Associated Infections) and by which housekeeping team member. This failure caused Resident 27 to experience psychosocial distress that included feeling harassed by housekeeping staff.Findings:On 3/30/26 at 3:15 PM the Department received a complaint from Resident 27 regarding concerns over a housekeeping (HSK) employee's continued attempts to enter Resident 27's room and talk about deep cleaning Resident 27's room even though the HSK had been told to not have any direct contact with Resident 27. Resident 27 stated in her complaint that the HSK had confronted her and made her feel uncomfortable and felt the facility was not looking out for her best interested. This reported incident was investigated during the facility's annual recertification with a start date on 4/6/26.A review of Resident 27's admission RECORD, indicated Resident 27 admitted to the facility with diagnosis that included functional quadriplegia (a state of complete immobility, where a patient is unable to move due to extreme frailty or severe disability rather than a direct brain or spinal cord injury).A review of Resident 27's clinical record titled ?Minimum Data Set, (MDS- a standardized, federally mandated assessment tool used to evaluate a resident's functional, medical, psychosocial, and cognitive status) dated 1/16/26 indicated a Brief Interview for Mental Status (BIMS - a standardized assessment tool used to measure a person's cognitive function. A higher score indicates better function. It tests orientation, short-term memory, and attention, with scores of 13-15 indicating intact cognition, 8-12 moderate impairment, and 0-7 severe impairment) score of 15.During an onsite visit from 4/6/26 through 4/9/26, attempts to interview Resident 27 were made on 4/7/26 and 4/8/26. Resident 27 declined both times to be interviewed about the situation stating that the complaints already been discussed.During an interview on 4/7/26 at 4:11 PM with the Social Services Director (SSD), the SSD stated that Resident 27 would only allow certain housekeeping staff members to clean Resident 27's room and that Resident 27 had requested a schedule for when the deep cleaning of the room would occur.During an interview on 4/7/26 at 4:24 PM with the Administrator (ADM), the ADM stated one of the housekeeping team members had been directed to have no direct contact with and to stay out of Resident 27's room at Resident 27's request. The ADM stated that the housekeeping team member ignored that directive and went into Resident 27's room to discuss the request for deep cleaning schedule. During an interview on 4/8/26 at 11:52 AM with the HSK, the HSK stated that she had been notified on 3/16/26 that Resident 27 did not want her to come into her room again and that only two specific housekeepers were allowed to clean Resident 27's area of the room. The HSK stated that after 3/16/27 she did go into Resident 27's room to discuss changing the date of the schedule deep cleaning of the room and when she entered the room, Resident 27 started yelling and screaming at her, even after the HSK attempted to explain why she had come back into the room. The HSK stated that Resident 27 was definitely upset by her presence in the room and that she should have listened when she was told not to go in Resident 27's room again and to send someone else in.During a review of the facility's policy and procedure titled, Resident Rights, dated 12/2021, indicated .Federal and state laws guarantee certain basic rights to all residents of this facility. these rights include the resident's right to.be treated with respect, kindness, and dignity.self-determination.communication with and access to people and services, both inside and outside the facility.be supported by the facility in exercising his or her rights.

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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. Based on observation, interview, and record review, the facility failed to provide a safe and comfortable homelike environment to 4 of 32 sampled residents (Resident 24, Resident 51, Resident 57, and Resident 98) when: 1.Comfortable sounds were not maintained for Resident 24, Resident 57, and Resident 98 when Resident 55 yelled loud; and,2. Resident 24, Resident 51, and Resident 98's drawers were broken.These failures removed Resident 24, Resident 51, Resident 57, and Resident 98's right to a dignified homelike environment, with the potential to result in psychosocial harm.Findings:1.A review of Resident 24's admission RECORD indicated, Resident 24 was admitted to the facility with diagnoses which included anxiety disorder (mental health conditions characterized by excessive, persistent, and uncontrollable fear or worry that interferes with daily life, affecting job performance, schoolwork, and relationships. Symptoms include restlessness, rapid heart rate, fatigue, and muscle tension), and muscle weakness.During a review of Resident 24's Care Plan, initiated on 8/3/24, the record indicated, .Goal: Will verbalize feeling well rested.Interventions. Identify factors that affect sleep.During an interview on 4/7/26, at 8:05 a.m., with Resident 24 in her room, Resident 24 stated Resident 55 yelled loud all the time. Resident 24 stated she could not sleep when Resident 55 yelled. Resident 24 stated staff knew that Resident 55 had been yelling loud for a long time. Resident 24 stated staff closed Resident 24's room door when Resident 24 told staff in the past that Resident 24 couldn't sleep because of the noise made by Resident 55. Resident 24 stated she felt bad for Resident 55's room mates because Resident 55 yelled and threw things on the floor in the past. Resident 24 stated she did not like it when Resident 55 yelled loudly. Resident 24 stated staff had tried to take Resident 55 to his room when Resident 55 yelled loudly and threw things.A review of Resident 57's admission RECORD indicated, Resident 57 was admitted to the facility with diagnoses which included hypertensive heart disease with heart failure (a critical condition where long-term high blood pressure [hypertension] causes the heart muscle to thicken, stiffen, or weaken, resulting in the heart's inability to pump blood efficiently), essential (primary) hypertension, and low back pain.During an interview on 4/7/26, at 8:39 a.m., with Resident 57 in her room, Resident 57 stated she had to wear headphones to cancel noise. Resident 57 stated she was bothered by Resident 55 yelling all the time. Resident 57 stated her sleep got interrupted when Resident 55 yelled. Resident 57 stated the sound from Resident 55 yelling got to her ears and she felt there was no stop to the loud noise. Resident 57 further stated she would feel better if Resident 55 did not yell all the time and her sleep did not get interrupted. Resident 57 stated she did not feel Resident 55 was placed with the correct group of residents because of Resident 55's yelling.A review of Resident 51's admission RECORD indicated, Resident 51 was admitted to the facility with diagnoses which included major depressive disorder (a serious, common mood disorder characterized by at least two weeks of persistent, severe low mood or loss of interest/pleasure in daily activities), venous insufficiency (occurs when leg vein valves become weak or damaged, failing to effectively return blood to the heart, causing blood to pool in the lower legs), and bilateral primary osteoarthritis (a chronic, degenerative joint disease where cartilage breaks down, causing pain, stiffness, and reduced mobility) of hip.During a review of Resident 51's Care Plan, initiated on 12/10/24, the record indicated, .Interventions.Respect preference and explain risk of scattered belongings.During a review of Resident 51's Care Plan, initiated on 9/2/25, the record indicated, .Interventions.Provide a pleasant and quiet environment.A review of Resident 55's admission RECORD indicated, Resident 55 was admitted to the facility with diagnoses which included essential (primary) hypertension, and schizophrenia (a severe, chronic mental disorder characterized by disruptions in thought, perception, and emotion, causing individuals to lose touch with reality).During a review of Resident 55's Care Plan, initiated on 4/6/26, the record indicated, Focus: Resident/Patient exhibits symptoms of psychosis related to .continuous laughter and yelling.Goal.Resident/Patient will demonstrate increased involvement/improved relationships (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	with other residents.Interventions.Create a calm, soothing environment.During a review of Resident 55's Progress Note, dated 4/6/26, the record indicated, .IDT [Interdisciplinary Team: a coordinated group of professionals from various disciplines -medicine, nursing, social work, therapy, who collaborate to create, implement, and evaluate comprehensive care plans. They work together to address a patient's complex physical, functional, and psychosocial needs] met on 4/6/26 to discuss [Resident 55] capacity and active behaviors affecting self and others. MD [Medical Doctor] was in the facility and saw [Resident 55] during rounds. [Resident 55] has a [diagnosis] of schizophrenia and has been laughing out loud, yelling at staff.The physician has assessed the resident's condition and has proposed medical intervention by having him sent to the acute to be seen further by psych.A review of Resident 98's admission RECORD indicated, Resident 98 was admitted to the facility with diagnoses which included major depressive disorder and mild neurocognitive disorder (a stage between normal aging and dementia, involving a noticeable decline in cognitive abilities -memory, language, or thinking) due to known physiological condition without behavioral disturbance.During a review of Resident 98's Care Plan, initiated on 6/13/25, the record indicated, Focus: Resident is at risk for complications related to the use of psychotropic drug.Goal.Resident will have no episodes of verbalizations of sadness.Intervention.Monitor for episodes of verbalizations of sadness.During a review of Resident 98's Care Plan, initiated on 6/17/25, the record indicated, .Interventions.Assess/reassess for triggers if change in mood.Allow time for feelings; provide empathy, encouragement, and reassurance.During an observation on 4/6/26, at 9:53 a.m., observed Resident 55 sitting in his room in his wheelchair and yelling at staff when staff tried to talk to Resident 55. During an observation on 4/6/26, at 9:56 a.m., observed Resident 55 yelled at staff and shut his room door loud.During an interview on 4/6/26, at 9:58 a.m., with Licensed Nurse (LN) 6, LN 6 stated Resident 55 had behavior issues where Resident 55 yelled at staff and threw things on the floor. LN 6 stated it would have been nice if Resident 55 had been moved to another room. LN 6 stated due to Resident 55 yelling loud, Resident 98 was moved to the activity room. LN 6 stated Resident 98 should have been able to stay in his room and not taken to activity room due to Resident 55 yelling. LN 6 stated staff had reminded Resident 55 not to close his room door. LN 6 further stated she felt bad for Resident 98 for being moved to the activities room due to Resident 55 yelling loud.During an interview on 4/6/26, at 10:05 a.m., with Certified Nursing Assistant (CNA) 3, CNA 3 stated she had moved Resident 98 to the activity room after Resident 55 yelled and cussed at Resident 98. CNA 3 stated Resident 55 should have been moved to a separate room. CNA 3 stated she felt other residents did not feel safe when Resident 55 yelled and threw things. CNA 3 further stated it would have been better for Resident 98 to be able to stay in his room. CNA 3 stated Resident 55 had been having behavior issues where Resident 55 had been yelling loud and disturbing rest of the residents almost every day for the last few months. CNA 3 stated when Resident 55 got loud staff reoriented Resident 55 and shut Resident 55's room door with Resident 55 inside his room.During an interview on 4/6/26, at 10:33 a.m., with Resident 98 in the dining room, Resident 98 stated he wanted Resident 55 to stop yelling.During an interview on 4/6/26, at 12:13 p.m., with LN 7, LN 7 stated Resident 55 yelled at other residents most of the time. LN 7 stated sometimes Resident 55 got aggressive with the staff and slammed his room door. LN 7 stated staff took Resident 98 from his room to the activity room when Resident 55 got loud. LN 7 stated Resident 24 had asked LN 7 to close Resident 24's room door in the past when Resident 55 was loud. LN 7 stated she felt bad for Resident 98 due to having Resident 55 as a roommate who yelled, talked loudly and slammed the room door. During a concurrent observation and interview on 4/7/26, at 7:39 a.m., with Housekeeper (HK) 2, the HK 2 confirmed Resident 55 sat in his room in his wheelchair laughed loudly and yelled at staff. HK 2 stated Resident 55 yelled all the time and she felt bad for other residents. HK 2 stated Resident 98 might feel uncomfortable when Resident 55 yelled all the time.During an observation on 4/7/26, at 7:47 a.m., Resident 55 sat outside his room in his wheelchair and laughed loudly.During an interview on 4/7/26, at 8:08 a.m., with LN 2, LN 2 stated when Resident 55 did not like someone Resident 55 yelled and (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	threw things on the floor. LN 2 stated he felt the other residents might feel bad because Resident 55 was yelling loud. During an observation on 4/7/26, at 3:40 p.m., Resident 55 was in his room with his room door closed.During an interview on 4/7/26, at 4:14 p.m., with CNA 5, CNA 5 stated Resident 24 had told CNA 3 many times in the past that Resident 24 could not sleep because Resident 55 was loud. CNA 3 stated she had closed Resident 24's room door to minimize the loud noise made by Resident 55. CNA 3 stated Resident 57 had also told CNA 3 in the past Resident 57 could not sleep because Resident 55 was yelling in the hallways outside Resident 57's room. CNA 3 stated when Resident 55 yelled CNA 3 tried to offer Resident 55 snacks and reorient Resident 55. CNA 3 stated Resident 55 had been yelling and having behavior issues for the last few months. CNA 3 stated when Resident 55 did not get what he wanted then Resident 55 would yell and throw things. CNA 3 stated Resident 98 was taken outside his room when his roommate Resident 55 was being loud. CNA 3 stated she felt bad for Resident 98 as Resident 98 shared room with Resident 55 who yelled and threw things in his room. CNA 3 stated she felt bad that residents sleep was interrupted when Resident 55 yelled.During an interview on 4/8/26, at 11:06 a.m., with the Assistant Director of Nursing (ADON), the ADON stated the expectation was to have a calm homelike environment for the residents. The ADON stated residents could have a headache when they were not able to sleep properly due to Resident 55 yelling. The ADON stated resident could get scared when Resident 55 yelled. The ADON stated staff were expected to redirect Resident 55 when Resident 55 made loud noise. The ADON further stated she felt sad for Resident 98 that Resident 98 could not stay in his room due to loud noise.During a concurrent interview and record review on 4/8/26, at 3:45 p.m., with LN 8, LN 8 stated Resident 55 yelled loudly at staff when Resident 55 did not get what Resident 55 wanted. LN 8 stated staff would move Resident 98 outside his room when Resident 55 got loud. LN 8 stated staff tried to reorient Resident 55 by providing Resident 55 with snacks and activities in Resident 55's room when Resident 55 yelled. LN 8 stated Resident 55 had behaviors of agitation.During an interview on 4/9/26, at 11:51 a.m., with the Administrator, the ADM stated the expectation was to have a comfortable homelike environment for the residents. The ADM stated residents should have been assigned with other compatible residents. The ADM stated when a resident yelled other residents could possibly get irritated and have lack of sleep due to constant noise. The ADM stated sometimes staff offered ear plugs to residents when there is noise. The ADM stated it was not fair for Resident 98 to sit outside his own room when Resident 55 was yelling. The ADM stated Resident 98 could have felt frustrated and upset when Resident 98 was not able to rest due to Resident 55 yelling. The ADM stated the facility was looking for a placement for Resident 55.2.During an observation on 4/6/26, at 9:35 a.m., in Resident 98's room, a bottom drawer was missing the front drawer cover.During a concurrent observation and interview on 4/6/26, at 2:10 p.m., in Resident 51's room, bottom drawer face was missing. Resident 51 stated her room drawer had been broken for a long time. Resident 51 stated she would like her drawers to be fixed.During an observation and interview on 4/7/26, at 8:05 a.m., in Resident 24's room, bottom 2 drawers were broken. The bottom 2 drawers were open and unable to close with Resident 24's personnel belonging in the drawers. Resident 24 stated she could not open and close the bottom drawers to get her personal belongings. Resident 24 confirmed the bottom 2 drawers were not closed all the way.During a concurrent observation and interview on 4/7/26, at 8:08 a.m., with LN 2, LN 2 confirmed Resident 24's room drawers were broken and not closed. LN 2 stated he could see Resident 24's personal belongings. LN 2 stated the drawers should be fixed. LN 2 stated the drawers should be closed all the way. LN 2 stated Resident 24 could get hurt if she had tried to close the bottom 2 drawers.During a concurrent observation and interview on 4/8/26, at 10:15 a.m., with the Maintenance Director (MD), the MD stated the bottom drawer for Resident 51 and Resident 98 was missing the drawer face and the bottom 2 drawers were broken for Resident 24. The MD stated he did not remember when the drawer for Resident 98 was last fixed. The MD stated Resident 98 and staff would not be able to open the drawer with the drawer face missing. The MD stated the bottom two rails that held the drawers for Resident 24 were bent. The MD stated Resident 24, (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. Based on observation, interview, and record review, the facility failed to ensure a resident's right to be free from verbal abuse (using negative words and language that cause harm including demeaning, disrespecting, frightening, and threatening words) for one of thirty-two sampled residents (Resident 68) when Licensed Nurse (LN) 3 and Certified Nurse Assistant (CNA) 1 witnessed a contracted staff (staff who are usually not considered official company employee and are not on the traditional payroll but hired by another company for a specific responsibility) from the housekeeping department who made inappropriate and threatening remarks toward Resident 68 on 3/28/26. This failure had the potential to cause emotional distress and could negatively affect Resident 68's psychosocial well-being.Findings:On 3/29/26, at 10:02 a.m., the Department received a facility reported incident regarding an alleged employee to resident verbal abuse. This reported incident was investigated during the facility's annual recertification with a start date on 4/6/26.During a record review of Resident 68's admission RECORD, dated 4/9/26, the record indicated, Resident 68 was admitted to the facility with diagnoses including absence of right leg above knee, abnormal posture, and muscle weakness.During a record review of Resident 68's Minimum Data Set, (MDS, an assessment tool) dated 1/27/26, the MDS revealed a Brief Interview for Mental Status (BIMS) score of 9 out of 15 indicating Resident 68 had moderate problems with thinking and memory.During a record review of Resident 68's Care Plan Report, (summarizes a person's health conditions, specific care needs, and current treatments for care) dated 1/22/26, the report indicated, Resident 68 presents with lower extremities weakness due to impaired balance affecting functional mobility, and Resident 68 will achieve modified independence (patient can perform task safely and independently) with wheelchair mobility.During a concurrent observation and interview on 4/6/26, at 12:42 p.m. with Resident 68 in the South Unit, Resident 68 was in his wheelchair and wheeling around the facility with his right leg amputated (loss or removal of a body part through surgery) above the knee. Resident 68 stated he was doing well and had no concerns.During a review of Resident 68's clinical record titled, Interdisciplinary Care Conference, dated 3/30/26, the record indicated, .Notified by Primary nurse of contracted staff member spoke inappropriate language towards resident while self-propelling in wheelchair across wet floor that staff member had completed mopping.Explained to staff of not to use inappropriate language towards residents.During a record review of Resident 68's Care Plan Report, dated 3/29/26, the report indicated, .Staff to resident abuse [on] 3/28/26.Resident will indicate and/or staff will observe resident to experience no psycho-social distress.Encourage resident to verbalize feelings.Give support and reassurance.During an interview on 4/9/26, at 7:36 a.m. with Resident 68, Resident 68 stated he did not recall any staff member treating him inappropriately. Resident 68 also stated no one was bothering him and that he felt safe here.During a phone interview on 4/9/26, at 10:18 a.m. with CNA 1, CNA 1 stated that it was during the evening shift and was about to clock out for his lunch when CNA 1 heard the contracted housekeeper (HSK) 1 saying profanity and cursing at Resident 68. CNA 1 stated HSK 1 had indicated Resident 68 to get off the floor because he was going to mop it. CNA 1 stated she heard HSK 1 verbally abusive towards Resident 68.During an interview on 4/9/26, at 10:34 a.m. with the Environmental Services District Manager for Health Care Services Group (EVS DM) together with the Housekeeper Supervisor (HSK), the EVS DM stated that their group oversees all their employees and had gone through extensive hiring processes. The HSK stated that she reviews applicants that would be a potential fit to the needs of the facility. The HSK also stated applicants would go through onboarding orientation and through this orientation a background check and health examination would be executed before hiring. The EVS DM stated this process would ensure that applicants were clear and promote safety among the residents in the facility. The EVS DM stated that she expected all contracted employees hired under their group should respect resident rights and all educational training related to working in a (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	nursing home environment including prevention of any abuse should be observed and any broken practices will be addressed. The HSK stated HSK 1 should have respected resident rights and should have worked well with the facility staff and residents.During an interview on 4/9/26, at 10:49 a.m. with the Administrator (ADM), the ADM stated HSK 1 did not follow the proper process of mopping the floor. The ADM stated the rule was to mop the floor one side at a time and HSK 1 got frustrated when Resident 68 passed through the mopped floor. The ADM stated residents felt unsafe and their rights violated when residents were treated inappropriately. During a phone interview on 4/9/26, at 11:03 a.m. with LN 3, LN 3 stated the incident happened at about 7 pm and just came back from her lunch. LN 3 stated she noticed HSK 1 was mopping the floor and she had commented to HSK to mop half of the floor first and not the entire floor in case of emergency to prevent staff from slipping. LN 3 stated HSK 1 responded aggressively that the floor would dry up quickly. LN 3 explained HSK 1 continued mopping the floor while Resident 68 was in wheelchair wheeling himself on the mopped floor at the South Unit close to the nurses' station. LN 3 continued to explain that she then heard HSK 1 saying to Resident 68 to move his ass and to get off the f*** floor. LN 3 stated she removed Resident 68 from the scene. LN 3 also stated that Resident 68 had indicated he was aware of what had happened. LN 3 further explained that she approached HSK and told him to act professionally and not to talk to residents rudely because this was their home and they have the right to be treated well and not to say profanity. LN 3 stated HSK responded and had indicated that the residents frustrated him and added the residents were lucky this was not a prison and if he was the correctional officer that he would beat them. LN 3 stated the residents have the right to be treated well and to feel safe because this place was their home.During a facility record review titled, Follow-Up Interview with [HSK 1], dated 4/2/26 at 12 p.m., the written statement by HSK 1 indicated, .[HSK 1] was asked whether he understood that speaking aggressively to a patient could be considered abuse. He responded, Yes.[HSK 1] was then asked to confirm whether, in his written statement, he indicated that he aggressively told [Resident 68] to move out of the way, [HSK 1] confirmed that those were his exact words. This written statement by HSK 1 was signed by the ADM and the Director of Nursing (DON).During a review of the facility's Policy & Procedure (P&P) titled, Abuse Prohibition, dated 2/23/21, the P&P indicated, .HealthCare Centers prohibit abuse, mistreatment, neglect, misappropriation of resident property, and exploitation for all residents.Verbal abuse is any use of oral, written, or gestured language that willfully includes disparaging and derogatory terms to patients.Examples of verbal abuse include, but are not limited to: threats of harm, saying things to frighten a patient.

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition Based on observation, interview, and record review the facility failed to assess a change in condition for one of 32 residents (Resident 1) and notify the physician when Resident 1's arteriovenous (AV) fistula (a surgically created connection of an artery directly to a vein allowing high blood flow during hemodialysis (HD), a life-saving treatment that acts as an artificial kidney that removes waste and extra fluid from the blood and regulates blood pressure) was not properly functioning. These failures placed Resident 1 at risk of missing hemodialysis as scheduled.Findings:A review of Resident 1's admission Record, indicated he was admitted to the facility with diagnoses that included but not limited to hypertension (a chronic condition where the force of blood pushing against artery walls is consistently too high, forcing the heart to work harder), chronic kidney disease (a long term, irreversible loss of kidney function where the kidney cannot effectively filter waste and excess water from the blood), and dependance on renal (kidney) dialysis.A concurrent interview and record review on 4/9/26, at 9:40 a.m., with the Director of Nursing (DON), Resident 1's MEDICATION ADMINISTRATION RECORD dated March 2026 was reviewed. The DON verified on dates 3/14, 3/24, 3/25, 3/26, 3/27, 3/28, and 3/31 licensed nursing staff documented negative for thrill and bruit (the nurse performed a physical exam and did not feel a thrill (vibration) or bruit (buzzing or swishing sound) over a blood vessel indicating a blockage or failure). The DON also verified that a change of condition assessment or informing the physician was not done. The DON stated it was her expectation of licensed nursing staff to notify the MD of the change in condition. The DON further stated this placed Resident 1 at risk of missing hemodialysis.A review of the facility's policy and procedure (P&P) titled, Change in Condition: Notification of dated 8/25/21, the P&P indicated, .physicians are informed of changes in condition.a significant change in the Resident's physical. status.A review of the facility's P&P titled, DIALYSIS CARE dated 8/25/21, the P&P indicated, .to provide dialysis care for residents in renal failure and those residents who require ongoing dialysis treatments.AV.Site will be inspected for functionality and sign and symptoms of complications.Nursing Staff will keep the Attending Physician, the resident and the resident's family informed of any change in conditions.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. Based on observation, interview, and record review the facility failed to implement an adequate activities program for two of 32 sampled residents, Resident 15 and Resident 54 when:1.Resident 15 was not provided with one-to-one activities from 3/11/26, to 3/17/26, and2.Resident 54 was not provided with one-to-one activities from 3/19/26, to 3/29/26.These failures had the potential to negatively impact the psychosocial wellbeing of Resident 15 and Resident 54.Findings:1. A review of Resident 15's admission Record indicated Resident 15 was admitted to the facility with diagnoses that included but not limited to traumatic brain injury, schizophrenia (chronic brain disorder that causes people to lose touch with reality, making it difficult to distinguish what is real from what is not), and insomnia (chronic inability to get enough sleep).A review of Resident 15's activity care plan dated 5/5/25, indicated, .the resident needs 1 to 1 bedside/in-room visits and activities if unable to attend out of room events.A review of Resident 15's Participation Record dated March 2026, indicated Resident 15 did not participate in group activity and between 3/11/26 to 3/17/26 Resident 15 did not receive one to one activities.2. A review of Resident 54's admission Record indicated Resident 54 was admitted to the facility with diagnoses that included but not limited to adult failure to thrive (rapid or gradual decline in an older person's physical, mental, or social functioning, often characterized by unexplained weight loss, poor appetite, exhaustion, and loss of independence), delusional disorders (mental health condition where a person holds a firm, unshakable belief in something that is untrue, despite clear evidence to the contrary), and insomnia.During an interview on 4/7/26, at 8:25 a.m., with Resident 54, Resident 54 stated she used to get one to one visits from activities once or twice a week, but since last couple of weeks the one-to-one visits had stopped. Resident 54 stated she was no longer getting activity visits. Resident 54 further stated she was a little sad about it and she used to look forward to one-to-one activity visits since she was bedbound.A review of Resident 54's activity care plan dated 1/4/26, the care plan indicated, .one to one room visits 1-3 x [times] per week.the resident's preferred activities are writing, conversing.During a concurrent interview and record review on 4/8/26 at 10:30 a.m., with the assistant director of activities (ADA) Resident 54's, Participation Record dated March 2026, was reviewed. The ADA verified the record indicated between 3/19/26 to 3/29/26, Resident 54 did not receive a one-to-one visit or attended group activity. The ADA stated Resident 54 only participated in one-to-one activities. The ADA further stated if residents did not receive one to one activities when unable to attend group activity, it could negatively impact resident's mood and potentially resident could experience loneliness.A review of the facility's policy and procedure (P&P) titled, Individual Activities and Room Visit Program dated 6/2018, the P&P indicated, .Individual activities will be provided for those residents whose situations or conditions prevent participation in other types of activities, and for those residents who do not wish to attend group activities.individualized activities offered are reflective of the resident's activity interests, as identified in the Activity Assessment, progress notes, and the resident's Comprehensive Care Plan.It is recommended that residents with in-room activity programs receive, at a minimum, three in-room visits per week.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on observation, interview, and record review the facility failed to implement appropriate respiratory care when Resident 15 received supplemental oxygen without a physician's order.This failure had the potential for Resident 15 to experience adverse side effects of supplemental oxygen use.A review of Resident 15's admission Record indicated Resident 15 was admitted to the facility with diagnoses that included but not limited to traumatic brain injury, schizophrenia (chronic brain disorder that causes people to lose touch with reality, making it difficult to distinguish what is real from what is not), and insomnia (chronic inability to get enough sleep).During an observation on 4/7/26, at 12:30 p.m., Resident 15 was observed lying in bed with oxygen running through a nasal cannula (a lightweight, flexible plastic tube with two small prongs that sit just inside the nostrils to deliver extra oxygen).During a concurrent interview and record review on 4/7/26, at 12:35 p.m., Resident 15's Order Summary Report dated 4/7/26, was reviewed with the Assistant Director of Nursing (ADON). The ADON verified Resident 15's order summary indicated Resident 15 did not have an order for oxygen.During a concurrent observation and interview on 4/7/26, at 12:40 p.m., with the ADON, The ADON confirmed Resident 15 was observed receiving oxygen via nasal cannula without a physician order. The ADON stated physician order should have been in place so the use of oxygen could be monitored by nursing staff. The ADON further stated Resident 15 was at risk for unnecessary side effects of supplemental oxygen use such as such as tachycardia (abnormally fast heartbeat) and headache, if the supplemental oxygen was not indicated.During a review of the facility's policy and procedure (P&P) titled, Oxygen Administration dated 10/2018, The P&P indicated, .Verify that there is a physician's order for this procedure.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. Based on interview and record review the facility failed to ensure one of two sampled residents (Resident 1) who required hemodialysis (HD, a medical treatment that acts as an artificial kidney to filter blood by removing waste products, toxins, and excess fluids) received appropriate care when Resident 1's Physician was not notified when Resident 1's arteriovenous (AV) fistula (a surgically created connection of an artery directly to a vein allowing high blood flow during dialysis) was negative for thrill (vibration) and bruit (buzzing or swoosh sound) indicating a blockage or failure.These failures had the potential to result in Resident 1 to miss hemodialysis due to a malfunction of the AV fistula.A review of Resident 1's admission Record, indicated Resident 1 was admitted to the facility with diagnoses that included but not limited to hypertension (a chronic condition where the force of blood pushing against artery walls is consistently too high, forcing the heart to work harder), chronic kidney disease (a long term, irreversible loss of kidney function where the kidney cannot effectively filter waste and excess water from the blood), and dependance on renal (kidney) dialysis.A review of Resident 1's AV fistula for dialysis care plan dated 1/13/26, the care plan indicated, .Monitor skin condition around catheter insertion site and report to physician as indicated.A concurrent interview and record review on 4/9/26, at 9:40 a.m., with the Director of Nursing (DON), Resident 1's MEDICATION ADMINISTRATION RECORD dated March 2026 was reviewed. The DON verified on dates 3/14, 3/24, 3/25, 3/26, 3/27, 3/28, and 3/31 licensed nursing staff documented negative for thrill and bruit (the nurse performed a physical exam and did not feel a thrill (vibration) or bruit (buzzing or swishing sound) over a blood vessel indicating a blockage or failure). The DON verified that a change of condition assessment was not done when Resident 1's AV fistula was negative for thrill and bruit on 3/14, 3/24, 3/25, 3/26, 3/27, 3/28, and 3/31, and a physician was not notified. The DON stated it was her expectation of licensed nursing staff to notify the physician of Resident 1's change in condition when Resident 1's AV fistula was negative for thrill and bruit. The DON further stated this placed Resident 1 at risk of missing hemodialysis.A review of the facility's policy and procedure (P&P) dated 8/25/21, the P&P indicated, .to provide dialysis care for residents in renal failure and those residents who require ongoing dialysis treatments.AV shunt site will be inspected for functionality and sign and symptoms of complications.Nursing Staff will keep the Attending Physician, the resident and the resident's family informed of any change in conditions .

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to ensure pharmacy services were maintained for a census of 109 when non-narcotic (medications that are not opioids-not addictive) prescription medication destruction records were not co-signed by a licensed nurse in twenty-nine (29) out of twenty-nine (29) pages of destruction records reviewed during a medication room inspection in one of four medication room on 4/6/26.This failure had the potential risk for medication misuse and/or drug diversion (unlawful use of prescription drug by unauthorized individuals) of prescribed medications due to unsafe disposition practices.During a concurrent interview and record review on 4/6/26, at 7:35 a.m. with Licensed Nurse (LN) 10 in South Station Medication room [ROOM NUMBER], the non-narcotic prescription medication destruction records titled, MEDICATION DISPOSITION LOG-NON-CONTROLLED MEDICATIONS FOR FACILITY DESTRUCTION, with various dates on 3/4/26, 3/5/26, 3/8/26, 3/17/26, 3/20/26, 3/26/26, 3/27/26, 4/2/26, 4/4/26, 4/5/26 were reviewed. The twenty-nine pages of non-narcotic destruction records reviewed revealed there were no signatures of licensed nurses who witnessed the destruction of the non-narcotic medications. LN 10 confirmed the non-narcotic destruction records were not co-signed by licensed nurses in all twenty-nine pages of records reviewed. LN 10 stated that licensed nurses should have co-signed the non-narcotic destruction records and there should be two nurses signing the records. LN 10 further stated this practice would allow double verification the non-narcotic medications were destroyed and would prevent the risk for drug diversion and/or misuse of the medications. During an interview on 4/6/26, at 10:35 a.m. with the Director of Nursing (DON), the DON stated the non-narcotic destruction records should be signed by 2 nurses. The DON added without a co-signature, there would be no witnesses to verify the destruction of the medications and the risk for drug diversion could happen.During a review of the facility's Policy & Procedures (P&P) titled, DISPOSAL OF MEDICATIONS AND MEDICATION-RELATED SUPPLIES, revised date January 2025, the P&P indicated, .Discontinued medications and medications left in the facility after a resident's discharge, which do not qualify for return to the pharmacy for credit, are destroyed.Non-controlled medication destruction occurs in the presence of two licensed nurses.The nurse(s) and/or pharmacist witnessing the destruction ensure that the following information is entered on the medication disposition form.Signatures of witnesses.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. Based on observation, interview, and record review, the facility failed to ensure residents were free from significant medication errors (the observed or identified preparation or administration of medications or biologicals which are not in accordance with the prescriber's order, manufacturer's specifications, and accepted professional standards) for one of eight sampled residents (Resident 92) during medication administration when, Resident 92 was administered an insulin (medication used to manage blood sugar levels in people with diabetes, a chronic condition where the body does not produce or use insulin properly leading to high blood sugar levels) that was prescribed for Resident 89 on 4/8/26.This failure resulted in a medication error and had the potential for Resident 92 to experience blood sugar fluctuations of hypoglycemia (when blood sugars are too low) and hyperglycemia (when blood sugars are too high), created a risk of transmitting bloodborne pathogens from one resident to another (bacteria that can cause disease), and increased risk for unsafe medication administration.Findings:During a review of Resident 92's admission RECORD, dated 4/9/26, the record indicated, Resident 92 was admitted to the facility with diagnoses including type 2 diabetes mellitus (DM2, this happens when the body cannot use insulin correctly and sugar builds up in the blood. Insulin is a hormone produced by the pancreas that regulates blood sugar (glucose) levels by allowing cells to absorb glucose for energy).During a review of Resident 92's Order summary Report, active physician's orders as of 4/9/26, the order indicated, .HumaLOG Injection Solution 100 UNIT/ML [UNIT-strength of insulin in ML-milliliter, unit of measurement] (Insulin Lispro) Inject as per sliding scale: If 70 - 120 = 0 units; 121 - 150 = 2 units; 151 - 200 =4 units; 201 - 250 = 6 units; 251 - 300 = 8 units; 301 - 350 = 10 units; 351 - 450 = 14 units; 451 - 500 = 16 units recheck in 2 hours and ok to administer correction dose at that check. > [greater than] 450 after repeat call MD, subcutaneously [SQ, beneath, or under, all the layers of the skin into the layer of fatty tissue] with meals for DM2.During a review of Resident 92's Care Plan Report, dated 6/3/24, the report indicated, .risk for s/s [signs/symptoms] of hypoglycemia [low blood sugar/glucose] / hyperglycemia [high blood sugar/glucose] due to TYPE 2 DIABETES MELLITUS.During a review of Resident 89's admission RECORD, dated 4/9/26, the record indicated, Resident 89 was admitted to the facility with diagnoses including type 2 diabetes mellitus.During a review of Resident 89's Order Summary Report, active physician's orders as of 4/9/26, the order indicated, .HumaLOG Injection Solution 100 UNIT/ML (Insulin Lispro) Inject 7 unit subcutaneously with meals related to TYPE 2 DAIBETES MELLITUS.During a review of Resident 89's Care Plan Report, dated 4/12/23, the report indicated, .risk for s/s of hypoglycemia/hyperglycemia related to DIABETES MELLITUS TYPE 2.Administer insulin as ordered.During a medication observation on 4/8/26, at 7:22 a.m. at the South Unit outside Resident 92's room License Nurse (LN) 4 checked Resident 92's finger stick blood sugar (FSBS) to determine if Resident 92 needed insulin. Resident 92's FSBS reading was 197. LN 4 indicated Resident 92 needed 4 units of insulin as per physician's order. LN 4 took out Resident 92's insulin injector pen that was in a plastic package with the insulin order label on the plastic package. LN 4 took out the injector pen from the plastic package and prepared it to administer the 4 units of insulin to Resident 92. LN 4 administered the insulin to Resident 92. Upon further inspection of the insulin injector pen LN 4 used to administer the insulin to Resident 92, the insulin order label printed on the pen revealed the name of Resident 89 and the dosage order of insulin for Resident 89.During a subsequent interview on 4/8/26, at 7:22 a.m. with LN 4, LN 4 confirmed the insulin injector pen did not have the name of Resident 92 but belonged to Resident 89. LN 4 stated the label on the plastic package and the label on the insulin pen were different and did not match. LN 4 stated the insulin pen had the wrong resident and wrong dosage. LN 4 also stated this practice resulted in medication error and the potential risk for cross contamination.During an interview on 4/9/26, at 10 a.m. with the Pharmacy Consultant (PC), the PC stated it was wrong practice to use someone else's insulin injector pen for another resident because this would lead to medication errors. During an interview on 4/9/26, (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	at 12:39 p.m. with the Director of Nursing (DON), the DON stated that the insulin was the same medication and it was not a medication error and stated that she felt it was more a violation of infection control. The DON later stated the 5 rights of medication administration were not followed when the insulin injector pen was the wrong resident with wrong insulin dose. During a review of the facility's educational training program on medication administration titled, Ensuring The Six Rights of Medication Administration, training given on 1/17/26 and 4/6/26, the training program indicated, .To prevent medication errors, keep in mind the six rights of medication administration each time you prepare to administer a drug: right medication, right dose, right patient, right route, right time, and right documentation.During a review of the facility's guidelines titled, Insulin Administration, revised September 2014, the insulin administration guidelines indicated, .To provide guidelines for the safe administration of insulin to residents with diabetes.The type of insulin, dosage requirements, strength, and method of administration must be verified before administration, to assure that it corresponds with.the physician's order.During a review of the facility's Policy & Procedure (P&P) titled, Administering Medications, revised April 2019, the P&P indicated, .Medications are administered in a safe and timely manner, and as prescribed.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.Insulin pens containing multiple doses of insulin are for single-use only. Changing the needle does not make it safe to use insulin pens for more than one resident .Insulin pens are clearly labeled with the resident's name or other identifying information. Prior to administering insulin with an insulin pen, the Nurse verifies that the correct pen is used for that resident .

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to administer the pneumococcal (a serious bacterial infection that can cause respiratory illness) vaccine and the influenza (or the flu, is a contagious viral infection of the respiratory system that can range from mild to severe, causing symptoms like fever, cough, sore throat, muscle aches, and fatigue) vaccine to one out of five sampled residents (Resident 46) when Resident 46 did not receive the pneumococcal and influenza vaccines. These failures had the potential for Resident 46 to go unvaccinated with the risk for serious health related illness and/or death.Findings:A review of Resident 46's record titled admission RECORD indicated, Resident 46 was admitted to the facility on [DATE], with diagnoses which included Myasthenia Gravis (a chronic autoimmune disorder causing fluctuating weakness in voluntary muscles, commonly affecting eye movements, facial expression, swallowing, and breathing), Moderate Persistent Asthma (a chronic condition characterized by daily symptoms, nightly awakenings more than once a week, and reduced lung function, requiring daily long-term control medication) and Muscle Weakness (a reduced capacity to exert force, often causing a feeling of fatigue, heaviness, or difficulty moving limbs).A review of Resident 46's record, titled Immunization Report, with date range 1/1/25-4/30/26, indicated there was no record of the pneumococcal and influenza vaccination.During a concurrent interview and record review on 4/8/26, at 10:02 a.m., with the Infection Preventionist (IP), the IP confirmed Resident 46 did not receive the pneumococcal and influenza vaccines. The IP stated Resident 46 should have received both the pneumococcal and influenza vaccines. The IP also mentioned that she attempted to reach Resident 46's Responsible Party for vaccine consent but was unable to make contact. The IP mentioned that she was supposed to follow up with the responsible party, but she did not do so.During an interview with the Director of Nursing (DON) on 04/09/26 at 10:41 a.m. the DON expressed that residents are expected to receive all recommended vaccinations promptly following admission to the facility. The DON additionally stated that residents who do not receive their immunizations promptly are at increased risk for illness. According to the DON, vaccinations are very important in preventing the spread of infections. A review of the facility's policy titled, Vaccination of Residents, revised 10/19, indicated, .All residents will be offered vaccines that aid in preventing infectious diseases.Prior to receiving vaccinations, the resident or legal representative will be provided information and education regarding the benefits and potential side effects of the vaccinations.All new residents shall be assessed for current vaccination status upon admission.A review of the facility's policy titled, Pneumococcal Vaccine,, revised 8/25, indicated, . All residents are offered pneumococcal vaccines to aid in preventing pneumonia/pneumococcal infections.Prior to or upon admission, residents are assessed for eligibility to receive the pneumococcal vaccine series, and when indicated, are offered the vaccine series within thirty (30) days of admission to the facility.Routine vaccination consists of the following: a. If the resident has not previously received a dose of PCV13, PCV15, PCV20, or PCV21 or whose vaccination history is unknown: 1 dose of PCV15, 1 dose of PCV20, or 1 dose of PCV21 . Administration of the pneumococcal vaccine is made in accordance with current Advisory Committee on Immunization Practices (ACIP) and Centers for Disease Control and Prevention (CDC) recommendations at the time of the vaccination.A review of the facility's policy titled, Influenza Vaccine,, revised 8/25, indicated, .Between October 1st and March 31st each year, the influenza vaccine is offered to residents and employees.Employees hired or residents admitted between October 1st and March 31st are offered the vaccine within five (5) working days of the employee's job assignment or the residents admission to the facility.Administration of the influenza vaccine is made in accordance with current Advisory Committee on Immunization Practices (ACIP) and Centers for Disease Control and Prevention (CDC) recommendations at the time of the vaccination.Review of the Centers for Disease Control and Prevention (CDC) webpage titled Pneumococcal Vaccination: What Everyone Should Know, dated (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1/20/23, indicated, .Pneumococcal disease is common in young children, but older adults are at greatest risk of serious illness and death .CDC recommends pneumococcal vaccination for all children younger than 5 years old and all adults 65 years or older .Some pneumococcal infections are invasive. Invasive disease means that germs invade parts of the body, such as blood, that are normally free from germs. Invasive disease is usually very serious and can sometimes result in death. Vaccines that help protect against pneumococcal disease work well but cannot prevent all cases . (https://www.cdc.gov/vaccines/vpd/pneumo/public/index.html)Review of the CDC webpage titled Seasonal Flu Vaccine Basics, dated 9/17/24, indicated, .Flu vaccine prevents millions of illnesses and flu-related doctor's visits each year. For example, during 2019-2020,ˆthe last flu seasonˆprior to the COVID-19 pandemic, flu vaccination prevented an estimated 7 million influenza illnesses, 3 million influenza-associated medicalˆvisits, 100,000 influenza-associated hospitalizations, and 7,000 influenza-associated deaths in the United States. During seasons when flu vaccine viruses are similar to circulating flu viruses, flu vaccine has been shown to reduce the risk of having to go to the doctor with flu by 40% to 60% .Influenza (flu) is a potentially serious disease that can lead to hospitalization and sometimes even death. Every flu season is different, and flu can affect people differently, but during typical flu seasons, millions of people get flu, hundreds of thousands of people are hospitalized and thousands to tens of thousands of people die from flu-related causes. Flu can mean a few days of feeling bad and missing work, school, or family events, or it can result in more serious illness.Everyone 6 months and older should get a flu vaccine every season with rare exceptions. Vaccination is particularly important for people who are at higher risk of serious complications from influenza. (https://www.cdc.gov/flu/vaccines/index.html)

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to administer Covid-19 (an infectious respiratory disease caused by the SARS-CoV-2 virus) vaccine to one out of five sampled residents (Resident 46) when Resident 46 did not receive the Covid-19 vaccine.This failure put Resident 46 at risk for serious health related illness and/or death. Findings:A review of Resident 46's record titled admission RECORD indicated, Resident 46 was admitted to the facility on [DATE], with diagnoses which included Myasthenia Gravis (a chronic autoimmune disorder causing fluctuating weakness in voluntary muscles, commonly affecting eye movements, facial expression, swallowing, and breathing), Moderate Persistent Asthma (a chronic condition characterized by daily symptoms, nightly awakenings more than once a week, and reduced lung function, requiring daily long-term control medication) and Muscle Weakness (a reduced capacity to exert force, often causing a feeling of fatigue, heaviness, or difficulty moving limbs).A review of Resident 46's record, titled Immunization Report, with a date range 1/1/25-4/30/26, indicated there was no record of Covid-19 vaccination. During a concurrent interview and record review on 4/8/26, at 10:02 a.m., with the Infection Preventionist (IP), the IP confirmed Resident 46 did not receive the Covid-19 vaccine. The IP stated, Resident 46 should have received the Covid-19 vaccine. The IP also mentioned that she attempted to reach Resident 46's Responsible Party for vaccine consent but was unable to make contact. The IP mentioned that she was supposed to follow up with the responsible party, but she did not do so.During an interview with the Director of Nursing (DON) on 4/9/26 at 10:41 a.m. the DON expressed that residents were expected to receive all recommended vaccinations promptly following admission to the facility. The DON additionally stated that residents who do not receive their immunizations promptly were at increased risk for illness. According to the DON, vaccinations were very important in preventing the spread of infections. A review of an undated facility's policy titled, Coronavirus Disease (COVID-19) - Vaccination of Residents, indicated, . Each resident is offered the COVID-19 vaccine unless the immunization is medically contraindicated or the resident has already been immunized.The COVID-19 vaccine may be offered and provided directly by the LTC [Long Term Care] facility.Vaccine recommendations and schedules are consistent with the Centers for Disease Control Interim Considerations for the Use of COVID-19 Vaccines in the United States.Review of the Centers for Disease Control and Prevention (CDC) webpage titled Staying Up to Date with COVID-19 Vaccines, dated 11/19/25, indicated, .Getting the 2025-2026 COVID-19 vaccine is important because: Protection from the COVID-19 vaccine decreases with time. Immunity after COVID-19 infection decreases with time. COVID-19 vaccines are updated to give you the best protection from the currently circulating strains. Getting the 2025-2026 COVID-19 vaccine is especially important if you: Never received a COVID-19 vaccine. Are ages 65 years and older. Are at high risk for severe COVID-19. Are living in a long-term care facility . (https://www.cdc.gov/covid/vaccines/stay-up-to-date.html)