

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

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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055242	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/07/2026
NAME OF PROVIDER OR SUPPLIER Fairmont Rehabilitation Hospital		STREET ADDRESS, CITY, STATE, ZIP CODE 950 S. Fairmont Avenue Lodi, CA 95240	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 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 maintain sanitary conditions in food handling, storage, and preparation areas for 53 residents who received meals from the kitchen when:1. Debris was present inside the clean utensils drawer;2. Mold was found inside a bag of cherries stored in the refrigerator;3. Cereal container lids were found loose;4. An opened box of iced tea bags in the dry goods area contained a plastic bag with a hole;5. Four spice containers were observed with lids that were open and could not be closed;6. Two large spice containers with screw-top lids were not tightly sealed;7. The casserole scalloped potatoes box was not properly sealed;8. Inconsistent food labeling was observed, including multiple opened liquid seasonings and sweetener that lacked open-by-dates; 9. Wet snack containers were found stacked in a cabinet;10. The food preparation table was found with debris and dust accumulation;11. One cutting board was in use in the kitchen, limiting the ability to properly clean and sanitize between tasks;12. The oven/range was found with significant grease buildup;13. The wall surface directly above the manual dishwashing sink in the kitchen was cracked and chipped; and14. Two pieces of fish were found thawing improperly in a bowl of still water. These failures have the potential to result in cross-contamination and foodborne illness for 53 residents.Findings:1. During a concurrent observation and interview on 5/4/26 at 8:20 AM with the Certified Dietary Manager (CDM), the CDM stated the utensils drawer was last cleaned on 4/30/26. The CDM further stated that the debris found inside the drawer may have originated from the wooden surface above the drawer and indicated there was a risk of cross-contamination. During an interview on 5/6/26 at 11:09 AM with the Registered Dietician (RD), the RD stated the utensils drawer needed repair because it could lead to food contamination During a review of the facility's policy titled, SANITATION, dated 2023, the policy indicated, .All utensils, counters, shelves, and equipment shall be kept clean, maintained in good repair and shall be free from breaks, corrosion, open seam, cracks and chipped areas.2. During a concurrent observation and interview on 5/4/26 at 8:20 AM with the CDM, the CDM was shown a bag of cherries in the refrigerator that contained visible mold. The bag was not labeled with a use-by-date. The CDM stated she would discard the bag because it posed a risk for contamination.During an interview on 5/6/26 at 11:09 AM with the RD, the RD stated that mold inside the cherries bag could cause food poisoning.During a review of the facility's policy titled, LABELING AND DATING OF FOODS dated 2023, the policy indicated, .All food items in the storeroom, refrigerator, and freezer need to be labeled and dated based on established procedures. it further requires that .the individual opening or preparing a food shall be responsible for date marking. and that foods .stored cold greater than 24 hours will be marked with a Use By date. The Use-by date will incorporate the open date.According to the FDA Food Code (2022), Chapter 3, 3-501.18, indicated, .Ready-to-Eat, Time/Temperature Control for Safety Food.shall be discarded if it.is in a container or package that does not bear a date or day. (https://www.fda.gov/food/fda-food-code/food-code-2022)According to the FDA Food Code (2022), Chapter 3, 3-701.11, indicated, .A food that is unsafe, adulterated or not honestly presented.shall be discarded (https://www.fda.gov/food/fda-food-code/food-code-2022)3. During a concurrent observation and interview on 5/4/26 at 8:20 AM with the CDM, the CDM was shown cereal containers (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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: 055242	Facility ID: 055242 If continuation sheet Page 1 of 15

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observation, interview, and record review, the facility failed to promote, maintain, and protect the dignity and privacy for one of eighteen sampled residents (Resident 5) when: 1. Certified Nursing Assistant (CNA) 1 did not fully close the privacy curtain during a bed bath, resulting in Resident 5's body being exposed and visible from the hallway; and, 2. Resident 5's nephrostomy (a thin, flexible tube is inserted through the skin of your lower back directly into your kidney to drain urine) drainage bag (urinary bag) was not covered with a dignity bag (privacy bag). These deficient practices resulted in unnecessary exposure of Resident 5 during care and had the potential for loss of privacy and dignity, and increased psychosocial distress (embarrassment, anxiety and feelings of humiliation). Findings: During a review of Resident 5's clinical record titled, FACE SHEET, dated 5/6/26, the record indicated Resident 5 with diagnoses that included, but were not limited to, hydronephrosis with renal and ureteral calculous obstruction (kidney swelling secondary to kidney stones blocking urine flow) During a review of Resident 5's Minimum Data Set (MDS, an assessment tool) dated 4/30/26 it was indicated that Resident 5 required moderate assistance (a person performs less than half of the effort for each activity while staff provide the remaining assistance) with the bathing task. 1. During a concurrent observation and interview on 5/5/26 at 9:08 AM with Certified Nursing Assistant (CNA) 1, the privacy curtain around Resident 5 was not fully closed during her bed bath leaving Resident 5's body exposed and visible from the hallway. According to CNA 1, the risk of not fully closing the curtain was that Resident 5 was exposed for others to see from the hallway. During an interview on 5/6/26 at 8:48 AM with CNA 1, CNA 1 stated that she did not realize the privacy curtain for Resident 5 was not fully closed during Resident 5's bed bath until after the concurrent observation and interview conducted on 5/5/26 at 9:08 AM. During an interview on 5/5/26 at 9:12 AM with CNA 2, CNA 2 stated that during a bed bath, staff have to ensure that curtains are closed from both sides and that there are no openings that would allow others to see the resident from the hallway because if the curtain was not properly closed, the resident may be exposed, and their dignity may be compromised. During an interview on 5/5/26 at 9:27 AM with the Director of Nursing (DON), the DON stated it was a dignity issue if a resident was exposed during a bed bath due to the privacy curtains not being fully closed. During a review of the facility's undated policy titled, Dignity, the policy indicated .Staff promote, maintain and protect Resident privacy, including bodily privacy during assistance with personal care. 2. During a concurrent observation and interview on 5/5/26 at 1:25 PM with Licensed Nurse (LN) 1, LN 1 confirmed that Resident 5's nephrostomy bag did not have a dignity cover and that it posed a risk to Resident 5's privacy. During an interview on 5/5/26 at 1:48 PM with the Infection Preventionist (IP), the IP stated that it was important to provide a nephrostomy bag privacy cover to protect Resident 5's dignity and privacy. During an interview on 5/5/26 at 1:55 PM with the DON, the DON stated that Resident 5's nephrostomy bag should have a cover to protect her dignity and privacy. During a review of the facility's undated policy titled, Dignity, the policy indicated that .Demeaning practices and standards of care that compromise dignity are prohibited. Staff are expected to promote dignity and assist resident; for example: a. helping the resident keep a urinary catheter bag covered.		

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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 1 of 18 sampled residents (Resident 68) when Resident 68's call light (devices used to contact staff for assistance) was not within his reach. This failure placed Resident 68 at increased risk for unmet care needs, delayed staff response, falls, and increased the potential for accidents or injury. Findings: During a review of Resident 68's clinical record titled, Face Sheet, dated 5/6/26, the record indicated that Resident 68 had diagnoses that included, but were not limited to, need for assistance with personal care, hemiplegia (inability to move one side of the body) and hemiparesis (weakness on one side of the body) following cerebral infarction (stroke, a sudden lack of oxygen to the brain) affecting the right dominant side, muscle weakness, aphasia (a language disorder caused by brain damage most commonly from a stroke that impairs the ability to speak, write, and understand language), and dysphagia (difficulty swallowing, indicating a disruption in the process of moving food or liquid from the mouth to the stomach). A review of Resident 68's undated clinical record titled, Care Plan Report, indicated .Focus: At risk for fall related to muscle weakness .The interventions include: Be sure the call light is within reach and encourage to use it to call for assistance as needed. During a concurrent observation and interview on 5/4/26 at 10:34 AM with Certified Nurse Assistant (CNA) 3, Resident 68's call light was observed. CNA 3 confirmed that Resident 68's call light was off to the left side of the bed. CNA 3 stated that Resident 68's call light should have been placed on his bed or his overbed table and not off the bed. CNA 3 also stated that if Resident 68 needed to call for help, he would have been unable to do so by having his call light off the bed and out of reach. During an interview on 5/4/26 at 12:01 PM with Family Member (FM) 1, FM 1 stated that it was hard for Resident 68 to move his body and that he was not verbal. FM 1 also stated that Resident 68 was right-handed and should have his call light close to his right hand as much as possible. During an interview on 5/4/26 at 2:20 PM with the Infection Preventionist, the IP stated that the call lights should be close to residents or within their reach if they are unable to speak their needs. The IP also stated that if a resident needed something, they would not be able to make their needs be known or get the care they needed by having the call light out of reach. During an interview on 5/5/26 at 3:03 PM with the Director of Staff Development (DSD), the DSD stated that her expectation was for the staff members to place the call light within the reach of the residents. The DSD also stated that residents may get neglected or not have their needs met if the call light was not within reach. The DSD further stated that a resident may not get the help they require in an emergency situation if they are not able to use their call light. During an interview on 5/6/26 at 10:55 AM with the Director of Nursing (DON), the DON stated that her expectation was for the staff members to place the call light within reach for the residents after care had been provided. The DON also stated that having call lights close to the residents and easy for them to use would prevent accidents from occurring. During a review of the facility's undated policy and procedure (P&P) titled, Accommodation of Needs, the P&P indicated, .Our facility's environment and staff behaviors are directed toward assisting the resident in maintaining and/or achieving safe independent functioning, dignity and wellbeing . Staff will arrange .personal items so that they are in easy reach of the resident. During a review of the facility's undated P&P titled, Answering the Call Light, the P&P indicated, .When the resident is in bed or confined to a chair be sure the call light is within easy reach of the resident .Some residents may not be able to use their call light .		

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to organize and participate in resident/family groups in the facility. Based on observation, interview, and record review, the facility failed to act upon the concerns brought forth from the Resident Council (a group of residents that meet and discuss concerns monthly) when Resident Council concerns of call lights not being answered timely, call lights being wrapped around the bed frame, staff speaking another language, and staff not fully completing Activities of Daily Living (ADL- these are the fundamental, routine self-care tasks individuals perform daily such as eating, bathing, dressing, toileting, and moving around) care before leaving the room were not addressed by the facility in a timely manner. This failure resulted in residents declining to attend the Resident Council meeting scheduled on 3/24/26 and feeling that issues brought forth in Resident Council meetings were not being addressed. Findings: During a review of Resident 23's clinical record titled, Face Sheet, dated 5/7/26, the record indicated that Resident 23 was admitted to the facility in 2025 with diagnoses which included muscle weakness, type 2 diabetes mellitus (a chronic metabolic disorder, affecting over 90% of diabetics, where the body resists insulin or fails to produce enough, leading to high blood sugar), and essential hypertension (high blood pressure - a chronic condition where the force of blood against artery walls is consistently too high, generally defined as 130/80 mm Hg or higher). During a review of Resident 53's clinical record titled, Face Sheet, dated 5/7/26, the record indicted that Resident 53 was admitted to the facility in 2025 with diagnoses which included major depressive disorder (persistent, severe sadness, low mood, and loss of interest in activities), cardiogenic shock (a life-threatening medical emergency where the heart suddenly cannot pump enough blood to meet the body's oxygen needs, often resulting from a severe heart attack), and hypovolemic shock (a life-threatening medical emergency caused by the loss of more than 20% [one-fifth] of the body's blood or fluid supply, preventing the heart from pumping sufficient blood to the body). During a review of Resident 56's clinical record titled, Face Sheet, dated 5/7/26, the record indicted that Resident 56 was admitted to the facility in 2024 with diagnoses which included hemiplegia and hemiparesis (neurological conditions causing one-sided body impairment due to brain injury, often from stroke, tumor, or trauma), functional quadriplegia (the complete inability to move all four limbs, generally due to extreme physical frailty or severe disability rather than structural damage to the spinal cord or brain), major depressive disorder, and dysphagia (difficulty swallowing, often caused by nerve damage, muscular issues, or blockages). During an interview on 5/5/26 at 1:45 PM with the Activities Assistant (AA), the AA stated that a lot of residents had refused to attend the Resident Council meeting on 5/5/26. The AA confirmed that only 4 residents out of all the residents that she had asked attended the Resident Council meeting on 5/5/26. During a concurrent interview and record review on 5/7/26 at 10:37 AM with the Activities Director (AD), the AD stated the facility had Resident Council meetings once a month where residents were able to discuss their concerns. The AD also stated that she documented and notified the Director of Staff Development (DSD) about issues that were brought forth by the residents during Resident Council meetings. The AD further stated that at the Resident Council meeting held on 1/27/26, residents were concerned that new staff members were not introducing themselves to the residents, call lights were being wrapped around the residents' bed rails, and residents' likes and dislikes were not being honored in the kitchen. The AD expressed that the staff were asked not to wrap the call light around the residents' bed rails. The AD stated that at the 2/24/26 Resident Council meeting, (continued on next page)		

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	residents had brought issues about long wait time for staff members to answer residents call light during the morning and noc shift (overnight shift), some staff members were not communicating with residents when staff members were going on a break, staff members were not introducing themselves to residents when entering residents room, staff members were not asking residents if residents needed anything else before leaving residents room, staff members only checked bed A and not bed B while in residents room, staff spoke another language other then English and residents likes and dislikes were not honored by kitchen staff. The AD also stated that previous residents who had attended the Resident Council meetings in the past refused to attend the Resident Council meeting on 3/24/26. The AD further stated that the residents said they did not feel there had been any changes made to the concerns that were brought up in the previous Resident Council meetings. During an interview and record review on 5/7/26 at 11:03 AM with the DSD, the DSD stated she was not aware that residents had declined to attend the Resident Council meeting on 3/24/26. The DSD also stated that she would have addressed residents' concerns if the residents' concerns were communicated better with her. The DSD further stated that the facility needed better internal communication between staff members and the DSD to address resident council issues faster. During an interview on 5/7/26 at 11:09 AM with the AA, the AA stated she went around and invited all the residents to attend Resident Council meeting on 3/24/26. The AA also stated that the residents said nothing had changed since the last Resident Council meeting and that they declined to attend the Resident Council meeting on 3/24/26. The AA further stated that it was important for residents' concerns to be addressed in a timely manner, so residents did not feel sad thinking that nothing had been done about their concerns. During an interview on 5/7/26 at 11:57 AM with Resident 56, Resident 56 stated she was invited to attend the Resident Council meeting on 3/24/26. Resident 56 also stated some of the concerns brought during the 1/27/26 and 2/24/26 Resident Council meetings were still not being addressed by the facility. Resident 56 further stated when she asked staff to help with ADL care, the staff members left her room and staff members did not come back to finish what she asked staff members to do. Resident 56 expressed staff members still leave her room without asking if she needed anything else. During an interview on 5/7/26 at 12:15 PM with Resident 53, Resident 53 stated a few staff members still wrapped her call light around the bed rail which made it hard for her to reach the call light. Resident 53 stated some staff members spoke another language other than English and she could not understand what staff members were talking about. Resident 53 further stated sometimes she had to wait for more than twenty minutes before a staff member answered her call light. During an interview on 5/7/26 at 12:20 PM with Resident 23, Resident 23 stated some staff members still did not knock on her room door before entering the room. Resident 23 also stated some staff members helped her with ADL care and then left Resident her room without asking if she needed any more help. During a review of a facility document titled Resident Council Meeting/Minutes, dated 1/27/26, the document indicated .Residents are expressing a long wait time for call lights for all shifts. Residents would like better communication with the staff to staff and staff to resident. When they are going to do a shower or going on break. Resident expressing that when assisted back to bed the staff/therapy are not giving them the call light so its within reach when resident needs it. Informed resident that the call light code should not be wrapped around the bed or other equipment. Staff are not communicating (continued on next page)		

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	with the resident when they are done, staff just leave and resident is asking for another task. Some residents are expressing that when staff answer the call lights they are only checking on A bed not both beds in the room. Staff still speaking another language on the floor and in (resident) rooms . During a review of a facility document titled Resident Council Meeting/Minutes, dated 2/24/26, the document indicated .Residents are expressing a long wait time for call lights for AM and NOC shifts. Residents expressing that there is still no communication with the staff to staff and staff to resident, only with certain staff .Resident expressing that when assisted back to bed the staff are not giving them the call light so its in within reach when resident needs it. Staff are not communicating with the resident when they are done, staff just leave and resident is asking for another task. Some residents are expressing that when staff answer the call lights they are only checking on A bed not both beds in the room .Staff still speaking another language on the floor and in pt rooms . During a review of facility document titled Resident Council Meeting/Minutes, dated 3/24/26, the document indicated .When (AA) was inviting residents to join resident council, (AA) said they all declined. (AD) went around with (ombudsman - an independent, neutral official appointed to investigate and resolve complaints, usually against government agencies, employers, or corporations) room to room to talk to the residents. Residents that talked to us expressed that they chose not to attend due to feeling that nothing is being done or changed. (AD) apologized and explained that it does take some time to get policies in place and/or train staff. Some residents talked about call light wait times and (AD) explained that staff do the best they can and that [AD] will ask all staff to be on the floor more to help, during meals and shift change when the wait times are longer . During a review of an undated facility policy and procedure (P&P) titled RESIDENT COUNCIL, the P&P indicated, .It is the policy of this facility to assist residents in establishing and maintaining a Resident Council and to provide an opportunity for residents to express their concerns, contribute ideas, and make recommendations regarding the operation of the facility.The AD or [social services director] assures that all Resident Council meeting concerns are addressed and resolved, when possible . During a review of an undated facility policy titled Resident Rights, the P&P indicated, . Employees shall treat all residents with kindness, respect, and dignity .Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the residents right to .voice grievances to the facility .have the facility respond to his or her grievances .		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observation, interview, and record review, the facility failed to implement a fall intervention for 1 of 18 sampled residents (Resident 8), when fall mat was not placed at Resident 8's bedside. This failure had the potential for Resident 8 to sustain further falls with injury. Findings: A review of Resident 8's admission Record indicated Resident 8 was admitted to the facility in 2025 with diagnoses which included chronic obstructive pulmonary disease (a progressive, treatable, but generally irreversible lung condition that restricts airflow, making it hard to breathe), schizophrenia (a chronic and severe brain disorder that affects how a person thinks, feels, and acts, often causing them to struggle with distinguishing reality from fantasy), and anxiety disorder (serious, treatable mental health conditions characterized by excessive, persistent fear or worry that interferes with daily life). A review of Resident 8's Minimum Data Set (MDS - an assessment tool), dated 1/12/26, Resident 8 scored 0 out of 15 in a Brief Interview for Mental Status (BIMS) which indicated she had severe cognitive impairment (the individual gives no correct answers, is entirely unable to recall the prompted information, or provides incoherent/nonsensical responses to questions). A review of Resident 8's progress note dated 2/21/26 indicated, Writer and CNA [Certified Nursing Assistant] both heard yelling for help. Upon entering room, [Resident 8] was found on the left side of the bed, both hands clinging onto the bed rail, both knees on the ground in sitting position. [Resident 8] unable to give description to what she was wanting to do nor where she was trying to go. Writer and CNA helped resident back to bed. Upon assessment, no visible injuries at this time. Able to perform [range of motion]; no facial pain expressions observed. Review of Resident 8's Interdisciplinary Notes, dated 2/24/26, indicated, . Staff heard a call for help coming from [Resident 8's] room. Upon entering the room, [Resident 8] was found on the left side of the bed on the floor in a sitting position while holding on to her handrail. [Resident 8] is currently on hospice care. Interventions: -Therapy to perform post fall assessment and continue with current care plan. Fall mats at bedside. Review of Resident 1's Care Plan, initiated on 7/11/25, indicated, Focus. At risk for falls .Goal .Will not sustain serious injury., Interventions initiated on 2/24/26, indicated, .Fall mats at bedside. During a concurrent observation, interview, and record review with Licensed Nurse (LN) 6 in Resident 8 's room on 5/6/26, at 11:25 a.m., LN 6 confirmed there was no fall mat found found at Resident 8 ' s bedside. LN 6 stated Resident 8 had a fall on 2/21/26 and a post fall intervention was initiated on 2/24/26 which indicated Resident 8 should have a fall mat at bedside. LN 6 stated Resident 8 was a fall risk and a fall mat at Resident 8's bedside should have been in place to prevent Resident 8 from injuries. During a concurrent observation and interview with the Director of Staff Development (DSD) in Resident 8's room on 5/6/26, at 11:30 a.m., the DSD confirmed Resident 8 did not have a fall mat at her bedside. The DSD stated the intervention of fall mat should have been followed for safety for Resident 8. During a concurrent interview and record review with the Director of Nursing (DON) on 5/6/26, at 3:09 p.m., Resident 8's fall risk care plan, initiated on 7/11/25, was reviewed. the DON stated the intervention for Resident 8 to have fall mat at Resident 8's bedside was initiated on 2/24/26 and the fall mat intervention was active as of 5/6/26. The DON stated Resident 8 should have had a fall mat at her bedside. Review of an undated facility policy titled, Falls and Fall Risk, Managing, indicated, .Based on previous evaluations and current data, the staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling. The staff, with the input of the attending physician, will implement a resident-centered fall prevention plan to reduce the specific risk factor(s) of falls for each resident at risk or with a history of falls. the staff may choose to prioritize interventions. Review of an undated facility policy titled, Care Plans, Comprehensive Person-Centered, indicated, A comprehensive, a person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. The care (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment.		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to maintain accurate and complete records for one of eighteen sampled residents (Resident 5) when, Resident 5's allergy to Levaquin (an antibiotic medication used to kill bacteria causing illness) was not updated in Resident 5's allergy profile, Resident 5 was ordered and administered Levaquin, and there was no documentation regarding communication with the ordering provider regarding the allergy, no documentation of an IDT (interdisciplinary team; a group of healthcare professionals) meeting discussing the medication allergy, or monitoring of any adverse reactions to the medication. This deficient practice had the potential to place Resident 5 at risk for adverse reactions and the care and services provided would not be known across all disciplines to assist in making medical decisions for Resident 5. Findings: During a review of Resident 5's clinical record titled, Face Sheet, dated 5/7/26, the record indicated the resident was admitted to the facility in 2026, with diagnosis of, but not limited to, urinary tract infection (UTI, a common bacterial infection in the bladder or urethra, causing pain, burning, and frequent, urgent urination). During a review of Resident 5's Progress notes dated 4/27/26, the progress notes indicated that Resident 5's allergy list included an allergy to Levaquin (a powerful antibiotic used to treat serious bacterial infections), however, there was no documented physician clarification addressing the listed allergy prior to administration of the medication to Resident 5. During a review of Resident 5's Discharge summary, dated [DATE], the summary indicated that Resident 5's documented Levaquin allergy was on Resident 5's allergy profile, but it did not appear she had one. However, the allergy continued to remain active in Resident 5's facility medical record and was not updated in the allergy profile. During a review of Resident 5's Medication Administration Record (MAR, the official, legal document used in healthcare settings to track all medications given to a patient), dated 04/2026 and 05/2026, the MAR indicated that Resident 5 was administered Levaquin, however there was no documented evidence that Resident 5 was monitored for adverse reactions or side effects following administration of Levaquin despite the listed allergy. During a concurrent interview and record review on 5/6/26 at 4:02 PM with Licensed Nurse (LN) 3, LN 3 confirmed Resident 5's allergy list included an allergy to Levaquin. LN 3 also confirmed that Resident 5 received Levaquin 500 mg (a unit of measurement) on 4/27/26, 4/28/26, 4/29/26, 4/30/26, 5/1/26, 5/2/26 and 5/3/26. LN 3 was unable to provide documentation confirming clarification of the allergy status, and monitoring for adverse effects after administration of Levaquin. During a concurrent interview and record review on 5/7/26 at 9:46 AM, with the Infection Preventionist (IP), Resident 5's progress notes were reviewed. The IP confirmed Resident 5's allergies included an allergy to Levaquin. The IP also confirmed that Resident 5 received Levaquin after her admission on [DATE]. The IP stated that the physician was notified of Resident 5' allergy to Levaquin, however it was not documented. The IP stated that they had an Interdisciplinary Team meeting (a coordinated group of healthcare professionals from different disciplines who work collaboratively to plan, deliver, and evaluate patient care) to discuss Resident 5's Levaquin allergy, but it was not documented either. The IP also stated that it should have been documented to avoid potential harm to Resident 5. During a concurrent interview and record review on 5/07/26 at 12:29 PM, with the Director of Nursing (DON), Resident 5's MAR, dated April 2026, was reviewed. The DON confirmed that there was no documented evidence that Resident 5 was monitored for adverse reactions or side effects following administration of Levaquin. The DON stated that a nurse had contacted the physician prior to the administration of Levaquin, however she could not find documentation that the physician was contacted to clarify the order. The DON verified that monitoring of adverse effects was not documented on the MAR. The DON confirmed that there should be specific instructions for monitoring adverse effects. The DON further stated that if missed, it could have led to (continued on next page)		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	possible adverse reactions.During an interview on 5/7/26 at 11:47 AM with the Pharmacist, the Pharmacist confirmed that Resident 5's allergy profile listed Levaquin as an allergy and confirmed Resident 5 had received the medication. The Pharmacist further confirmed staff should document physician clarifications, monitor, and document for side effects or adverse effects following the administration of medications. The Pharmacist stated failure to do so had the potential to harm the residents.Review of an undated facility policy titled, Charting and Documentation, indicated, .All services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional or psychosocial condition, shall be documented in the resident's medical record.The following information is to be documented in the resident medical record.Medications administered.Treatments or services performed.Documentation in the medical record will be objective .complete, and accurate.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview, and record review, the facility failed to practice appropriate infection prevention and control measures for a census of 53 residents when Resident 67's urinal (portable, handheld containers designed for men with limited mobility to urinate while in bed or seated) was not labeled with identifying information. This failure had the potential to spread infection and cause health problems to the residents in the facility. Findings: During a review of Resident 67's clinical record titled, Face Sheet, dated 5/6/26, the record indicated that Resident 67 had diagnoses that included, but were not limited to, need for assistance with personal care, hemiplegia (paralysis) and hemiparesis (weakness) following cerebral infarction (stroke) affecting right dominant side (a type of ischemic stroke, accounting for about 80% of all strokes, caused by blocked blood flow to the brain, leading to tissue death [necrosis]). During a concurrent observation and interview on 5/4/26 at 10:33 AM with Certified Nurse Assistant (CNA) 3, Resident 67's urinal was observed. CNA 3 confirmed that Resident 67's urinal was not labeled with identifying information and should have been labeled. CNA 3 stated that it was an infection control issue by not labeling Resident 67's urinal and possibly another resident could have accidentally used it. During an interview on 5/4/26 at 2:20 PM with the IP, the IP stated that her expectation was for the staff members to label the urinals for each individual resident by either placing a room number or resident initials on them. The IP also stated that if urinals were not labeled, the staff would not know who it belongs to. The IP further stated that the spread of infections such as Multidrug-resistant organisms (MDROs- Bacteria and other germs resistant to three or more classes of antimicrobial agents, making infections difficult to treat) could occur if urinals were not properly labeled. During an interview on 5/5/26 at 3:03 PM with the Director of Staff Development (DSD), the DSD stated that her expectation was for each resident that used a urinal to have labels and individual identifiers on them. The DSD also stated that by labeling the urinal, the staff would know who it belonged to and it would prevent cross-contamination and infection control issues from arising. During an interview on 5/6/26 at 10:55 AM with the DON, the DON stated that her expectation was for the staff to label urinals before giving them to the residents. The DON also stated that she did not want the residents to mix urinals, especially when they were sharing the same restroom. The DON further stated that it was a cross-contamination risk by not labeling urinals accordingly. During a review of the facility's undated Policy and Procedure (P&P) titled, Infection Prevention and Control Program, the P&P indicated, .Decrease the risk of infection to residents and personnel .During a review of the facility's undated P&P titled, Equipment Labeling Policy, the P&P indicated, . To ensure all equipment is properly labeled for identification, safety, maintenance tracking, and regulatory compliance within the long-term care environment .All equipment must be clearly labeled with durable, legible identifiers. Equipment without proper labeling must not be used until corrected .Staff must check equipment labeling before use .		

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F 0641 Level of Harm - Potential for minimal harm Residents Affected - Some	Ensure each resident receives an accurate assessment. Based on observation, interview, and record review, the facility failed to ensure an accurate assessment of the Minimum Data Set (MDS- a comprehensive assessment and screening tool) for 1 of 18 sampled residents (Resident 6), when Resident 6's oxygen therapy section was documented inaccurately. This failure had the potential to result in an inaccurate reflection of Resident 6's health status and the risk for confusion in Resident 6's plan of care. Findings: A review of Resident 6's admission RECORD, indicated Resident 6 was admitted to the facility in 2025 with diagnoses which included pleural effusion (a collection of fluid around the lungs). A review of Resident 6's MDS Section O (Special Treatments, Procedures, and Programs- a specific category to document high-intensity care, therapies, and services a resident receives), dated 1/23/26, indicated that Resident 6 was not on oxygen therapy. A review of Resident 6's MDS Section O, dated 4/29/26, indicated that Resident 6 was not on oxygen therapy. Review of Resident 6's Care Plan, initiated on 11/13/25, indicated, Focus. [Resident 6] had acute respiratory distress .Goal .Respiratory symptoms will show signs of improvement., Interventions Initiated on 2/24/26, indicated, .Administer medications as ordered. Elevate [head of bed] due to shortness of breath when lying flat. Monitor for shortness of breath. Oxygen as ordered. During an observation on 5/4/26, at 12:17 p.m., in Resident 6's room, Resident 6 was on supplemental oxygen via nasal cannula at 2.5 LPM. During a concurrent observation, interview and record review on 5/6/26, at 3:52 p.m., with Licensed Nurse (LN) 3, Resident 6's electronic medical record (EMR) was reviewed. LN 3 confirmed Resident 6 was receiving 2.5 LPM oxygen via nasal canula. LN 3 stated Resident 6's supplemental oxygen order indicated to administer between 2 to 3 LPM of oxygen to keep Resident 6's oxygen saturation above 90% (percentage of oxygen-carrying hemoglobin in your red blood cells compared to the amount that is unbound. It indicates how effectively your blood is delivering oxygen to your body's cells, with a normal, healthy range usually between 95% and 100%). LN 3 stated Resident 6 had received supplemental oxygen via nasal cannula since November of 2025. During a concurrent interview, and record review on 5/7/26, at 7:53 a.m., with LN 7, Resident 6's EMR was reviewed. LN 7 stated the MDS section for oxygen therapy for 1/23/26, and 4/29/26 was documented incorrectly for Resident 6. LN 7 further stated a resident's MDS assessment was done upon admission to the facility, and every ninety days. LN 7 stated during the MDS assessment she would look at a resident's doctors' orders to check if a resident had an order for supplemental oxygen, and how much oxygen was being administered to that specific resident. LN 7 further stated Resident 6 had a doctor's order to administer supplemental oxygen between 2L/min to 3L/min to maintain oxygen saturation above 90%. LN 7 stated Resident 6's MDS assessment should have been correctly documented indicating Resident 6 received oxygen therapy. During an interview on 5/6/26, at 4:14 p.m., with the Director of Nursing (DON), the DON stated the MDS staff could have looked at Resident 6's doctor's order, documentation of oxygen use, and asked the LN if Resident 6 was receiving supplemental oxygen. The DON further stated checking the vital signs documentation could have indicated if a resident received oxygen therapy. The DON stated there was a risk to the accuracy of the document when Resident 6's oxygen therapy assessment was not documented accurately. Review of an undated facility policy titled, Charting and Documentation, indicated, .All services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional or psychosocial condition, shall be documented in the resident's medical record. The following information is to be documented in the resident medical record. Medications administered. Treatments or services performed. Documentation in the medical record will be objective. complete, and accurate.		