STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055271	A. Building B. Wing	01/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LA Sierra Care Center	2424 M Street Merced, CA 95340

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 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. Based on interview and record review the facility failed to ensure a Registered Dietitian (RD) comprehensively and frequently evaluated the effectiveness of food service operations when lapses in the delivery of services associated with meal accuracy and nutritional value of menus, as well as food safety (cross reference F 803, F 806, and F 812) occurred.This failure resulted in lack of sufficient oversight from the RD, which placed 62 out of 65 residents who received food from the kitchen at risk for food borne illness (illness caused by food contaminated with bacteria, viruses, parasites, or toxins) and/or altered nutritional intake, both of which had the potential to result in death and/or nutritional related medical complications.During an interview on 1/22/26 at 5:00 p.m. with the Registered Dietician (RD), the RD stated she had been a remote full-time RD for the facility since 6/2025. The RD stated she visited the facility in 6/2025, 8/2025 and 11/2025. The RD stated she only had a documented onsite kitchen audit for 11/11/25. The RD stated the primary focus of her duties were record reviews which included, the completion of nutritional assessments, diet recommendations, and resident weight reviews. The RD stated she completed her duties through email or phone call. The RD stated, to her knowledge, she was the only RD the facility utilized. The RD stated she communicated primarily with the Certified Dietary Manager (CDM) and the Director of Nursing (DON) for nutritional assessments, diet recommendations, and resident weight reviews. The RD stated the CDM oversaw kitchen operations, such as test trays, tray line, and food safety. The RD stated she did not review the CDM's kitchen audits. The CDM stated she provided no direct physical oversight of kitchen operations. The RD stated the kitchen required direct physical oversight. The RD stated the facility agreed to allow her to work remote and therefore the facility was responsible for ensuring the RD role was fulfilled and met facility policy and procedures, standards of practice and job duty functions.During an interview on 1/23/26 at 12:57 p.m. with the Administrator (ADM), the ADM stated the RD was hired as an employee, rather than a consultant or contractor, in 6/2025. The ADM stated the RD had been remote since hired. The ADM stated the facility did not utilize another RD.During an interview on 1/23/26 at 1:40 p.m. with the DON, the DON stated direct oversight of kitchen operations could not be provided if the RD was remote. The DON stated she communicated by phone call with the RD throughout the week and discussed nutritional and weight needs of residents. The DON stated the RD was hired in 6/2025 and went remote shortly after starting, the DON could not state an exact date. The DON stated she was only aware of one onsite RD visit, 11/11/25, where the RD performed a kitchen audit and inspected kitchen operations. The DON stated the facility allowed the RD to be remote and therefore the facility was responsible for ensuring fulfillment of her required job duty functions that she could not perform remotely. The DON stated the facility RD job duty had not been fulfilled when the RD had been remote since 6/2025 and had only performed one onsite kitchen audit on 11/11/25. The DON stated the RD was returning full-time onsite at the end of 1/2026. The DON stated kitchen operations were at risk for errors with no physical oversight from a RD which could result in food distribution, storing and serving issues which could be detrimental to resident over all health.During a review of the RD's kitchen audit titled, Sanitation Review, dated 11/11/2025, the kitchen audit indicated the RD identified general sanitation and maintenance issues within the (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 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	kitchen. There was no documented RD follow up of identified issues. The RD could only provide kitchen audit documentation from 11/11/25.During a review of the facility's document titled, Employee Acknowledgment, dated 6/2/25, the document indicated the RD was hired on 6/2/25. The document did not indicate when the RD went remote or exemptions from job duty requirements.During a review of the facility's job duty document titled, Registered Dietician, undated, the job duty document indicated, .the purpose of your job position is to organize, plan, and supervise the overall operation of dietary department.supervise, monitor, [and] train staff to confirm competency adhering to all sanitation, safety and procedural guidelines within the department.performing weekly inspections of dietary measures to assure quality control is being maintained for sanitation, safety and infection control.observe and assesses residents to monitor food acceptance and nutritional status.ensuring food service equipment is clean and operable. checking food storage rooms.concentrates on foundational elements of standards of practice and professional performance, code (s) of ethics accreditation standards, state and federal regulations, national guidelines, and ongoing professional continuing education to maintain currency in practice.During the Re-certification Survey from 1/20/26-1/23/26, multiple issues were identified regarding: not following menu recipes (Cross-reference F803); not serving appealing options of similar nutritive value to residents who choose not to eat food initially served (Cross-reference 806) and food was not stored, prepared, and served in a safe and sanitary manner (Cross-reference F812).

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. Based on observation, interview and record review the facility failed to ensure five out of five residents on pureed diets (pudding-like consistency food, requiring no chewing and easy to swallow) received the correct serving scoop size for lunch on 1/21/26 when stir fried chicken was served with a #8 scoop (1/2 cup) instead of the required recipe #6 scoop (2/3 cup).This failure resulted in the wrong serving size of a menu item which could result in weight variances, inaccurate nutritional monitoring and lead to serious medical conditions.During a review of the facility's document titled, Diet Type Report, dated 1/22/26, the document indicated five residents at the facility received pureed diet textures.During a review of the facility's menu recipe document titled, Stir Fried Chicken, dated 2026, the recipe indicated, .suggested portion # 6 SCP [scoop].During a review of the facility's menu recipe document titled, Stir Fried Chicken Method, undated, the recipe indicated, .puree.serve with a # 6 scoop .During a concurrent observation and interview on 1/21/26 at 11:47 a.m. with [NAME] (CK) 1, at the start of lunch tray line, CK 1 was observed using a #8 scoop to serve pureed stir fried chicken. CK 1 stated she used a #8 scoop to serve pureed stir fried chicken. CK 1 stated cooks were responsible for ensuring the required menu scoop size was used during tray line. CK 1 stated it was important to use the correct scoop size during tray line to ensure residents received the right amount of food.During a concurrent observation and interview on 1/21/26 at 12:03 p.m. with the Certified Dietary Manager (CDM), during lunch tray line, the CDM stated CK 1 was using a #8 scoop to serve pureed stir fried chicken.During a concurrent observation and interview on 1/21/26 at 12:18 p.m. with [NAME] (CK) 1, at the end of lunch tray line, CK 1 was observed using a #8 scoop to serve pureed stir fried chicken. CK 1 stated she used a #8 scoop to serve pureed stir fried chicken.During a concurrent interview and record review on 1/21/26 at 12:26 p.m. with the CDM, the facility's menu recipe titled, Stir-Fried Chicken, dated 2026, and Stir-Fried Chicken Method, undated, was reviewed. The CDM stated lunch tray line was over and all meals had been plated. The CDM stated, per the menu recipe, CK 1 used the wrong scoop size to plate all pureed stir fried chicken. The CDM stated CK 1 should have used the required #6 scoop size to serve pureed stir fried chicken. The CDM stated pureed diet texture residents did not receive the correct portion of protein for lunch when a #8 scoop was used to serve pureed stir fried chicken. The CDM stated residents on a pureed diet texture received less protein for lunch than the menu recipe called for. The CDM stated residents were at risk of weight loss, weight gain, and inadequate nutrient monitoring when incorrect scoop size were used.During an interview on 1/22/26 at 5:00 p.m. with the Registered Dietician (RD), the RD stated menu recipes were expected to always be followed to ensure nutritional needs and standardized portion sizes were met. The RD stated residents were at risk of altered caloric, mineral, and vitamin intake when scoop sizes were not followed. The RD stated a #8 scoop size was equivalent to 1/2 cup and a #6 scoop size was equivalent to 2/3 cup. The RD stated residents on pureed diets received less of their prescribed meal when a #8 scoop size was used to serve stir fried chicken. The RD stated the facility housed fragile and vulnerable residents who could sustain weight gain, weight loss, and inadequate nutritional monitoring if menu recipes were not followed, which could lead to serious medical conditions.During an interview on 1/23/26 at 1:20 p.m. with the Director of Nursing (DON), the DON stated residents were at risk of not having their nutritional needs met when they were served the incorrect scoop size during lunch tray line. The DON stated it was important to follow menu recipes to ensure standardized portions were served and residents received nutrients and calories as per their prescribed diet orders. The DON stated facility policy and procedure, as well as nutritional standards of practice were not followed when a #8 scoop was used to serve stir fried chicken instead of the menu recipe #6 scoop.During a review of the facility's job description titled, Cook, undated, the job description indicated, .essential duties and responsibilities.reviewing menus prior to food preparation.following menus and recipes.serving food according to established portion control (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	recommended.adhering to all facility policies and procedures of the facility.During a review of the facility's policy and procedure (P&P) titled, Menus, dated 10/2017, the P&P indicated, .menus meet the nutritional needs of residents in accordance with the recommended dietary allowances of the Food and Nutrition Board (National Research Council and National Academy of Science).menus provide a variety of foods from the basic daily food groups and indicate standard portions at each meal.

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. Based on observation, interview and record review the facility failed to provide appealing and nutritional alternative menu items to 62 out of 65 residents eating at the facility when there was no posted or designated alternative meal menu and the kitchen only designated peanut butter and jelly, grilled cheese and ham and cheese sandwiches as an alternative meal option.This failure resulted in residents having no designated appealing and nutritional alternative meal options, and had the potential to result in decreased satisfaction and resident food intake.During an observation on 1/20/26 at 9:14 a.m. no alternative meal menu was posted outside the kitchen on the menu wall.During an observation on 1/20/26 at 9:16 a.m. no alternative meal menu was posted inside the kitchen.During an observation on 1/20/26 at 11:53 a.m. no alternative meal menu was posted inside the two dining rooms.During a concurrent observation and interview on 1/20/26 at 10:37 a.m. with Resident 20, in Resident 20's room, no alternative meal menu was posted or provided. Resident 20 stated he had a copy of the current weeks menu, but no copy of an alternative menu. Resident 20 stated an alternative menu was not posted anywhere in the facility. Resident 20 stated alternative meal menu items were never the same and he never knew what options he had. Resident 20 stated, if he asked kitchen staff, alternative menu items were peanut butter and jelly, grilled cheese and ham and cheese sandwiches. Resident 20 stated he had to ask or wait for kitchen staff to do rounds to inquire about alternative meal menu options. Resident 20 stated peanut butter and jelly, grilled cheese and ham and cheese sandwiches were not appealing or fulfilling as a meal substitute. Resident 20 stated sandwiches were not an actual meal. Resident 20 stated peanut butter and jelly, grilled cheese and ham and cheese sandwiches were a snack and not a meal replacement if he didn't want what was being served for a meal. Resident 20 stated he would rather skip a meal than choose a sandwich if he did not like what was being served. Resident 20 stated the facility rotated their menus and some months he did not want the same meal again and having alternative menu options would help provide variety.During an interview on 1/22/26 at 10:27 a.m., in the resident council meeting, Resident 9 stated he was not aware there was an alternative menu. Resident 9 stated he was not aware he could choose a meal substitute if he did not like what was being served, instead he would refuse meals and wait for the next meal. Resident 9 stated he knew where the current weeks menu was posted, outside of the kitchen, but there was no posted alternative meal menu. Resident 9 stated facility staff had never informed him of alternative menu options.During an interview on 1/22/26 at 11:17 a.m. with the Certified Dietary Manager (CDM), the CDM stated there was no designated alternative meal menu. The CDM stated there was no alternative meal menu posted or provided to residents. The CDM stated the kitchen typically provided peanut butter and jelly, grilled cheese and ham and cheese sandwiches as alternative meal options. The CDM stated sometimes the kitchen had extra chicken fingers and hamburgers which could be provided as an alternative menu option. The CDM stated she made frequent rounds to resident rooms and discussed daily menus and if residents were not interested in the menu options, she asked what they would like. The CDM stated residents were at risk of being unavailable during rounds to discuss alternative menu options which would result in not knowing their alternative meal menu options. The CDM stated she tried to accommodate resident alternative meal choices if the kitchen had the requested item. The CDM stated residents had a right to know what alternative menu options were offered and available. The CDM stated residents would not know their alternative menu options if it was not posted or provided.During an interview on 1/22/26 at 11:41 a.m. with the Registered Dietician (RD), the RD stated there was no alternative menu when she started in 6/2025. The RD stated she was not aware of a current alternative meal menu option for residents at the facility. The RD stated an RD needed to review and approve all menus. The RD stated kitchen staff made resident rounds to review menus and completed preference diet cards to accommodate resident preferences, when kitchen stock allowed. The RD stated snacks and sandwiches were (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	always available to residents. The RD stated residents had a right to refuse scheduled meal menu items and choose an alternative meal menu option. The RD stated all menus needed to be posted and provided to residents for review to ensure they were informed of their options. The RD stated residents were at risk of forgetting alternative meal menu options if only discussed verbally with kitchen staff. The RD stated if alternative menus were not posted or provided it could not be guaranteed residents knew about meal menu alternative options. The RD stated sandwiches were not an appealing or nutritional substitute to scheduled meal menus. The RD stated an alternative meal menu needed to be available for residents to choose from if they did not want what was being served and their preference diet card could not be accommodated. The RD stated with no alternative meal menu the facility was not providing a homelike environment that encouraged resident right and ability to choose. The RD stated the facility had a vulnerable and fragile population and ensuring nutritional food promoted well-being.During an interview on 1/22/26 at 3:25 p.m. with Certified Nursing Assistant (CNA) 7, CNA 7 stated she was not aware of an alternative meal menu residents could review or choose from. CNA 7 stated only the weekly menu was posted outside the kitchen and in resident rooms. CNA 7 stated if residents refused a meal, she notified the assigned licensed nurse and kitchen. CNA 7 stated if a resident requested a food item, she went to the kitchen to see if the request could be fulfilled. CNA 7 stated if the request could not be fulfilled kitchen staff would provide current available options and she would relay it to the resident.During a interview on 1/23/26 at 1:40 p.m. with the Director of Nursing (DON), the DON stated all menus were required to be posted and provided to residents for review. The DON stated residents had a right to know their meal and alternative options. The DON stated the CDM performed frequent rounds to discuss menus, but it could not be guaranteed residents would recall alternative options or be available to discuss alternative options if not posted or provided a copy. The DON stated sandwiches were not an appealing or nutritional substitute to scheduled meal menus. The DON stated residents had the right to refuse scheduled meal menus and choose an appealing and nutritional substitution. The DON stated facility policy was not followed when the alternative meal menu was not posted or provided to residents and did not provide appealing or nutritional substitutions.During a review of the facility's policy and procedure (P&P) titled, Menus, dated 10/2017, the P&P indicated, .menus are developed and prepared to meet residents choices including religious, cultural and ethic needs while following established national guidelines for nutritional adequacy.the dietician reviews and approves all menus.copies of the menus (as served, including substitutions) are kept on file.copies of menus are posted in at least two (2) resident areas, in positions and in print large enough for residents to ready them.During a review of the facility's P&P titled, Frequency of Meals, dated 7/2017, the P&P indicated, .each resident shall receive at least three (3) meals daily, at times comparable to typical mealtimes in the community, or in accordance with resident needs, preferences, requests and plan of care.alternative meals will be offered to residents who choose to eat at non-traditional or outside of scheduled mealtimes, consistent with the plan of care.During a review of the facility's job duty description titled, Registered Dietician undated, the job duty description indicated, .reviewing menus prior to food preparation .advise on menu changes and evaluates changes to the facility's menus for nutritional adequacy.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to ensure food and beverages were stored, distributed, and served safely in accordance with professional standards of food service safety for 62 out of 65 residents eating at the facility when: Four 48 fluid ounce (fl oz- a unit of measurement) prune juice bottles were not labeled with a received-on date label. The dry food storage room did not have a temperature record log. The food preparation sink did not have an air gap (space between the end of sink pipe and top of sink to prevent backflow). These failures had the potential to result in the serving of expired, spoiled, or contaminated food and beverage items which could result in foodborne illness (illness caused by food contaminated with bacteria, viruses, parasites, or toxins).1.During a concurrent observation and interview on 1/20/26 at 9:26 a.m., in the dry food storage room, with the Certified Dietary Manager (CDM), four 48 fl oz prune juice bottles were observed with no received-on date label. The CDM stated the four prune juice bottles did not have received-on dates. The CDM stated all food and beverage items required a received-on date, opened date, and expiration date label to ensure expired food items were not served. The CDM stated it was important to label all food and beverage items with a received-on date to ensure products were used in a timely manner before expiration. The CDM stated all products in the kitchen were expected to be used in a first in, first out (FIFO) method. The CDM stated the four prune juice bottles were at risk of not being used in a timely manner which could result in the serving of an expired beverage and result in food borne illness, decreased product taste or satisfaction. 2.During a concurrent observation and interview on 1/20/26 at 9:33 a.m., in the dry food storage room, with the CDM, a wall mounted thermometer, which read 60 degrees Fahrenheit (F- a unit of measurement to monitor temperature) was observed. The CDM stated the dry food storage room was required to maintain a temperature between 50F-70F to ensure food safety. No dry food temperature log was observed. A sign posted in the dry food storage room titled, Storeroom Basics, stated, .maintain temperature between 50F-70F.use FIFO, first in, first out.label and date food. The CDM stated the kitchen did not record temperatures in the dry food storage room. The CDM stated she checked the dry food storage room temperature twice a day, Monday through Friday, and cooks checked the temperature on Saturday and Sunday. The CDM could not state how dry food storage temperatures were reviewed or monitored to ensure food safety and compliance with required temperature range if there was no documentation of temperature checks. The CDM stated if something was not documented, it did not happen. The CDM stated the dry food storage room was at risk for temperature fluctuations outside of required temperature ranges which could result in the spoiling of food and lead to foodborne illness. 3.During a concurrent observation and interview on 1/20/26 at 9:41 a.m., in the kitchen, with the CDM, the food preparation sink was observed with no air gap. The CDM stated the food preparation sink was used to wash fruit and vegetables, thaw frozen food items, and prep ingredients residents consumed. The CDM stated without an air gap on the food preparation sink substances could backflow into the sink and contaminate food items residents consumed. The CDM stated air gaps prevented cross contamination and decreased the risk for food borne illness. The CDM stated an air gap on a food preparation sink was a food safety standard of practice. The CDM stated the food preparation sink had never had an air gap. The CDM stated she completed weekly kitchen audits and documented her findings, but no air gap had been placed. During an interview on 1/22/26 at 11:41 a.m. with the Registered Dietician (RD), the RD stated, all food items in the kitchen required a received-on date label to ensure product was used before it expired. The RD stated it was important to label all food and beverage items to ensure product was used in a timely manner before the expiration date to prevent the serving of old or expired food items. The RD stated serving old or expired food items could result in food borne illness. The RD stated the dry food storage room required temperatures to be maintained between 50-70 degrees Fahrenheit to prevent food spoilage. The RD stated if (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	something was not documented, it could not be guaranteed it happened. The RD stated recording dry food storage temperatures ensured temperatures were maintained to uphold food safety, monitor and trend temperature fluctuations. The RD stated it could not be guaranteed dry food storage temperatures were being monitored when there was no dry food storage temperature log. The RD stated all food preparation sinks required an air gap to prevent backflow and cross contamination of food items. The RD stated the food preparation sink did not have an air gap. The RD stated she and the CDM were responsible for identifying issues in the kitchen during audits and reporting findings so they could be corrected. The RD stated she did not review the CDM's kitchen audits. The RD stated she completed a kitchen audit on 11/11/25 and did not identify an air gap. The RD stated unlabeled food items, no dry food storage temperature log and no food preparation sink air gap should have been corrected when identified on kitchen audits. The RD stated the facility housed a fragile and vulnerable population of residents who could be seriously affected by foodborne illness caused by cross contamination. The RD stated she expected the kitchen to adhere to all facility policy and procedures, as well as food safety standards of practice. During an interview on 1/23/26 at 1:40 p.m. with the Director of Nursing (DON), the DON stated she expected the kitchen to adhere to all facility policies and procedures, as well as food safety standards of practice. The DON stated this had not occurred when four prune juice bottles were not labeled with received-on dates, no temperature log was kept for the dry food storage room, and there was no air gap on the food preparation sink. The DON stated she expected the CDM and RD to identify kitchen non-compliance, report their findings, and implement corrections. The DON stated she did not review the CDM or RD's kitchen audits. The DON stated facility residents were at risk for consuming contaminated or spoiled food which could result in food borne illness and lead to serious medical issues. During a review of the RD's kitchen audit, dated 11/11/2025, the document indicated food and beverage items were required to be labeled, dated and rotated on a first in first out method. The document indicated no air gap was identified. During a review of the CDM's kitchen audits, dated 10/21/25, 10/28/25, 11/3/25, 11/11/25, 11/17/25, 11/25/25, 12/3/25, 12/9/25, 12/23/25, 12/29/25, 1/7/26, 1/15/26, and 1/20/26, the documents indicated food and beverage items were required to be labeled, dated and rotated on a first in first out method. The document indicated no air gap was identified.During a review of the facility's policy and procedure (P&P) titled, Food Receiving and Storage, dated 11/2022, the P&P indicated, .food shall be received and stored in a manner that complies with safe food handling practices.food services, or other designated staff, maintain clean and temperature/humidity-appropriate food storage areas at all time.dry foods and goods are handles and stored in a manner that maintains the integrity of the packaging until they are ready to use.During a review of the facility's P&P titled, Food Preparation and Service, dated 11/2022, the P&P indicated, .Food and nutrition service employees prepare, distribute and serve food in a manner that complies with safe food handling practices.identification of potential hazards in the food preparation process and adhering to critical control points can reduce the risk of food contamination and thereby minimize the risk of foodborne illness.cross-contamination can occur when harmful substances, i.e.disease-causing microorganisms transferred to food by hands.food contact surfaces.equipment is arranged to facilitate food preparation, based on input from appropriate individuals including food and nutrition service staff.During a review of the facility's document posted in the dry food storage room titled, Storeroom Basics, undated, the document indicated, .maintain temperature between 50-70F.use FIFO, first in, first out.label and date food. During a review of the professional reference titled, FDA Food Code 2022, section 5-402.11 Backflow Prevention, .(A) A direct connection may not exist between the sewage system and a drain originating from equipment in which food, portable equipment, or utensils are placed. (B) Equipment and fixtures used for food preparation or utensil washing must be installed with an air gap or air brake as required to prevent backflow of sewage into the equipment.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to ensure medical records were complete and accurately documented in accordance with accepted professional standards of practice for three of eight sampled residents (Resident 4, Resident 9, and Resident 31) when Resident 4, Resident 9 and Resident 31's copy of Physician Orders for Life-Sustaining Treatment (POLST - a medical order signed by both the patient and medical provider that specifies the types of medical treatment a patient wishes to receive toward the end of life) were incomplete.This failure had the potential for Resident 4, Resident 9, and Resident 31's decisions regarding treatment options and end of life wishes to not be honored.Findings:During a concurrent observation and interview on [DATE] at 10:20 a.m. in Resident 31's room, Resident 31 was observed dressed, lying in bed. Resident stated he did not remember how long he had been at the facility or why he was at the facility.During a review of Resident 31's admission Record (AR - a summary of information regarding a patient which includes patient identification, past medical history, insurance status, care providers, family contact information and other pertinent information), dated [DATE], the AR indicated Resident 31 was admitted to the facility from an acute care hospital on [DATE] with diagnoses of dementia (loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life), hydronephrosis (swelling of one or both kidneys when the urine does not drain), chronic kidney disease (a gradual loss of kidney function where the kidneys cannot filter the blood as they should), depression (persistent feelings of sadness, despair, loss of energy, and difficulty dealing with normal daily life), dysphagia (difficulty swallowing), and displacement of nephrostomy catheter (a thin tube that drains urine from the kidney into a bag).During a review of Resident 31's Minimum Data Set (MDS - a resident assessment tool used to identify cognitive [mental processes] and physical functional level assessment), dated [DATE], the MDS section C indicated Resident 31 had a Brief Interview for Mental Status (BIMS - a test given by medical professionals to determine cognitive (involving the process of thinking, learning and understanding) understanding on a scale of 1-15) score of three (a score of 0-7 suggests severe cognitive impairment, 8-12 suggests moderately impaired, 13-15 suggests cognitively intact), which indicated Resident 31 was moderately impaired.During a concurrent interview and record review on [DATE] at 3:08 p.m. with Registered Nurse (RN) 1, Resident 31's POLST, dated [DATE] was reviewed. Resident 31's POLST indicated Section D titled, Information and Signatures was not complete. RN 1 stated all sections of Resident 31's POLST should have been completed. RN 1 stated the POLST indicated what the Resident 31's wishes were for end-of-life care.During a concurrent interview and record review on [DATE] at 2:45 p.m. with the Medical Records Coordinator (MR), Resident 31's POLST, dated [DATE], was reviewed. Resident 31's POLST indicated section D titled Information and Signatures was not complete. The MR stated Section D should have been completed as it indicated who the POLST form was discussed with, the resident or the resident's Responsible Party (RP) and if the resident had an advance directive (a legal document indicating resident preference on end-of-life treatment decisions). The MR stated the POLST form was important because it indicated what the resident or the resident's RP wishes were for end-of-life treatment, to be DNR (do not resuscitate- a medical order written by a doctor to instruct health care providers NOT to do cardiopulmonary resuscitation (CPR) if breathing stops or the heart stops beating) or not. During a concurrent observation and interview on [DATE] at 10:16 a.m. in Resident 4's room, Resident 4 was observed dressed, lying in bed. Resident 4 stated he had been at the facility since [DATE] for rehabilitation after surgery. Resident 4 stated he goes to dialysis (a treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidney(s) have failed) and the nurses at the dialysis facility changed his catheter dressing.During a review of Resident 4's AR, dated [DATE], the AR indicated Resident 4 was (continued on next page)

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	055271	A. Building B. Wing	01/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LA Sierra Care Center	2424 M Street Merced, CA 95340

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	admitted to the facility from an acute care hospital on [DATE] with diagnoses of chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing), pleural effusion (a buildup of fluid between the tissues that line the lungs and the chest), respiratory failure (a serious condition that occurs when the lungs cannot get enough oxygen into the blood or remove enough carbon dioxide [a waste gas] from the blood), congestive heart failure (CHF-a heart disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling), end stage renal disease (a condition where the kidneys can no longer function on their own and dialysis [a process of removing excess water, and waste products from the blood] or kidney transplant is required to survive), dysphagia (difficulty swallowing), and depression (persistent feelings of sadness, despair, loss of energy, and difficulty dealing with normal daily life).During a review of Resident 4's MDS, dated [DATE], the MDS section C indicated Resident 4 had a BIMS score of 13, which indicated Resident 4 was cognitively intact.During a concurrent interview and record review on [DATE] at 3:08 p.m. with RN 1, Resident 4's POLST, dated [DATE], was reviewed. Resident 4's POLST indicated section D titled, Information and Signatures was not complete. RN 1 stated Resident 4's POLST should have had section D completed. RN 1 stated the POLST indicated what the Resident 4's wishes were for end-of-life care. During a concurrent interview and record review on [DATE] at 2:45 p.m. with the Medical Records Coordinator (MR), Resident 4's POLST, dated [DATE], was reviewed. Resident 4's POLST indicated section D titled, Information and Signatures was not complete. The MR stated Section D should have been completed as it indicated who the POLST form was discussed with, the resident or the resident's Responsible Party (RP) and if the resident had an advance directive (a legal document indicating resident preference on end-of-life treatment decisions). The MR stated the POLST form was important because it indicated what the resident or the resident's RP wishes were for end-of-life treatment, to be DNR (do not resuscitate- a medical order written by a doctor to instruct health care providers NOT to do cardiopulmonary resuscitation (CPR) if breathing stops or the heart stops beating) or not.During a concurrent observation and interview on [DATE] at 11:59 a.m. in Resident 9's room, Resident 9 was observed dressed, lying in bed with a feeding pump (a machine that delivers specific amounts of fluids and nutrition) on pause next to his bed. Resident 9 stated he had been at the facility for two years due to a stroke.During a review of Resident 9's AR, dated [DATE], the AR indicated Resident 9 was admitted to the facility from an acute care hospital on [DATE] with diagnoses of acquired absence of left great toe (surgical removal of toe), type 2 Diabetes Mellitus (when the blood sugar levels in the body are too high), gastrostomy (the surgical formation of an opening through the abdominal wall into the stomach for nutritional support), gastrointestinal hemorrhage (bleeding in the gastrointestinal tract, from the mouth to the rectum), ulcer of the esophagus (open sores or breaks between the throat and the stomach), dysphagia (difficulty swallowing), and acute kidney failure (a condition when the kidneys suddenly are unable to filter waste products from the blood).During a review of Resident 9's MDS, dated [DATE], the MDS section C indicated Resident 9 had a BIMS score of 15, which indicated Resident 9 was cognitively intact.During a concurrent interview and record review on [DATE] at 3:09 p.m. with RN 1, Resident 9's POLST dated [DATE] was reviewed. Resident 9's POLST indicated Section D titled, Information and Signature was not complete. RN 1 stated all sections of Resident 9's POLST should have been completed. RN 1 stated the POLST indicated what Resident 9's wishes were for end-of-life care.During a concurrent interview and record review on [DATE] at 2:45 p.m. with the Medical Records Coordinator (MR), Resident 9's POLST, dated [DATE], was reviewed. Resident 9's POLST indicated section D titled, Information and Signatures was not complete. The MR stated Section D should have been completed as it indicated who the POLST form was discussed with, the resident or the resident's Responsible Party (RP) and if the resident had an advance directive (a legal document indicating resident preference on end-of-life treatment decisions). The MR stated the POLST form was important because it indicated what the resident or the resident's RP wishes were for end-of-life treatment, to be DNR (do not resuscitate- a medical order written by a doctor to (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	instruct health care providers NOT to do cardiopulmonary resuscitation (CPR) if breathing stops or the heart stops beating) or not.During an interview on [DATE] at 2:30 p.m. with the Director of Nursing (DON), the DON stated section D of each resident's POLSTs should have been completed. The DON stated section D of the POLST indicated who the doctor spoke with regarding end-of-life care, and who signed the POLST, the resident or the resident's RP. The DON stated the resident's POLSTs should have had all sections completed. The DON stated the signature section was important to see who the decision maker was for end-of-life care and to see what their wishes were.During a review of the facility's job description document titled, Director of Medical Records, undated, the document indicated, .to maintain resident medical records and health information in accordance with current federal, state and local standards and regulations that govern the facility and as directed by the Administrator.assembling and reviewing resident's medical records as needed.During a review of the facility's job description document titled, Charge Nurse, undated, the document indicated, .perform administrative duties such as completing medical forms, reports, evaluations, studies, charting, etc., as necessary.complete and file required recordkeeping forms/charts upon the resident's admission, transfer, and/or discharge.consult with the resident's physician in providing the resident's care, treatment, rehabilitation, etc., as necessary.ensure that personnel providing direct care to residents are providing such care in accordance with the resident's care plan and wishes.

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F 0912 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms. Based on observation, interview, and record review during the survey period of 1/20/26 through 1/23/26, the facility failed to provide the minimum of at least 80 square feet per resident in 19 of 23 multiple resident rooms (rooms 1, 2, 3, 4, 5, 6, 7, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, and 23).This failure had the potential for residents to not have reasonable accommodations for privacy or adequate space for care to be rendered.Findings:Resident rooms 1, 2, 3, 4, 5, 6, 7, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, and 23 did not meet the required square footage requirements. However, variations were in accordance with the particular needs of the residents. The residents had privacy, there was sufficient room for nursing care and resident ambulation. Wheelchairs and toilet facilities were accessible. The closets and storage space were adequate. Bedside stands were available. The waiver will not adversely affect the health and safety of residents. Room Beds Square Feet1 3 220 2 3 2203 3 2204 3 220 5 3 2106 3 2207 3 22010 3 232 11 3 21612 3 22013 3 22014 3 22815 3 22516 3 23417 3 21718 3 22419 3 22020 3 22523 3 215 Recommend waiver continue in effect. _____HFES Signature Date Request waiver continue in effect._____ Facility Administrator Signature Date

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide reasonable accommodation to meet the needs of one of eight sampled residents (Resident 28) when Resident 28, whose vision was severely impaired (no vision or sees only light, colors or shapes column eyes do not appear to follow objects) and dependent on staff for activities of daily living (ADL- a basic skill needed to carry out tasks of everyday life), call light was not within reach.This failure resulted in Resident 28 to be unable to communicate with facility staff for help when needed and be at risk for falls and injury.Findings:During a review of Resident 28's admission Record (AR - a summary of information regarding a patient which includes patient identification, past medical history, insurance status, care providers, family contact information and other pertinent information), dated 1/22/26, the AR indicated, Resident 28, was admitted to the facility on [DATE], acute care hospital and had diagnoses that included . Legal blindness, muscle weakness, cerebral infarction (death of brain tissue due to a lack of blood supply), other seizures (a sudden, temporary disruption in the brain's electrical activity), difficulty in walking, anxiety disorder, unspecified asthma, insomnia (trouble falling asleep or staying asleep), unspecified convulsions (a sudden, uncontrollable, violent shaking or jerking of the body or limbs, caused by abnormal electrical activity in the brain).During a review of Resident 28's Minimum Data Set (MDS- a resident assessment tool used to identify resident cognitive (mental) and physical functional level) assessment, dated 12/4/25, the MDS section C indicated, Resident 28's Brief Interview for Mental Status (BIMS) assessment score was 7 out of 15 (0-6 severe cognitive (pertaining to reasoning memory and judgement) deficit, 7-12 moderate cognitive deficit, 13-15 cognitively intact). The BIMS scores indicated Resident 28 had moderate cognitive deficit.During a review of Resident 28's MDS assessment section Hearing, Speech and Vision, dated 12/4/25, indicated Resident 28's vision score was 4. Resident 28's vision score of 4 is defined as . Severely impaired- no vision or sees only light, colors or shapes column eyes do not appear to follow objects.During a review of Resident 28's MDS assessment section GG Functional Abilities, dated 12/4/25, indicated Resident 28 uses wheelchair, and Resident 28's functional abilities was coded between 01 and 03. Resident 28 was code 01 (dependent: helper does all the effort, resident does none of the effort to complete self-care) for toileting hygiene, putting on/taking off footwear, personal hygiene, sitting to lying, and sit to stand. Resident 28 was code 02 (substantial/ maximal assistance: helper does more than half the effort,) for oral hygiene, shower/bath self, lower body dressing, lying-to-sitting on side of bed, chair/bed to chair transfer, toilet transfer, and tub/shower transfer. Resident 28 was code 03 (partial/moderate assistance: helper does less than half the effort in care) for eating, upper body dressing, and roll left and right. The functional abilities code indicated Resident 28 needed partial/moderate assistance in 3 abilities, needed substantial/ maximal assistance in 7 abilities and was dependent on facility staff in 5 abilities.During a review of Resident 28's MDS assessment dated [DATE], the MDS section H indicated, Resident 28's Bladder and Bowel function included Resident 28 is always incontinent (meaning the inability to control when you urinate or have a bowel movement) (no episodes of continent voiding) for urinary continence. Resident 28 is frequently incontinent (2 or more episodes of continence bowel movement) for bowel continence.During a review of Resident 28's MDS assessment dated [DATE], the MDS section N indicated, Resident 28's Medications included antianxiety (medications used to reduce, prevent, or relieve symptoms of extreme panic, and tension), antidepressants (medications used to treat depression and other conditions like anxiety). Antiplatelets (medications that work by preventing platelets from sticking together and forming clots), hypoglycemics (including Insulin- drugs used to lower high blood sugar levels), anticonvulsant (medications used to prevent, treat, or stop convulsions by calming abnormal electrical activity in the brain).During a concurrent observation and interview on 1/20/26 at 11:28 a.m. with Resident 28 during the initial tour in Resident 28's Room, (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident 28 was lying in bed facing the wall. Resident 28's call light was behind her on the bed. Resident 28 stated I am blind, they don't check on me, I do not have the call light. Resident 28 stated It should not be behind me; it should be in my hand. I do not know where they put the call light. It makes me mad because I cannot see. It can cause safety issues for me.During a record review of Resident 28's Care Plan (CP) on 1/20/26 at 3:36 p.m., the CP interventions on 9/11/25 indicated Be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed.During a concurrent observation and interview on 1/20/26 at 1:15 p.m. with Certified Nursing Assistant (CNA) 4, CNA 4 stated she brought Resident 28 into the room from the large dining room. CNA 4 stated Resident 28 could not see and needed to be directed, transferred to bed, and assisted with meals. CNA 4 stated Resident 28 could express her needs, and the call light was clipped to the side of Resident 28's bed. CNA 4 stated the call light should have been placed in Resident 28's hand based on her inability to see. CNA 4 stated it was important that the call light be handed to Resident 28 to enable Resident 28 to call for help when needed.During an interview on 1/21/26 at 2:49 p.m. with CNA 5, CNA 5 stated facility staff should have ensured the call light was within reach and informed Resident 28 of the location and what the call light was for. CNA 5 stated she was aware Resident 28 could not see and needed assistance. CNA 5 stated Resident 28 was incontinent and a feed assist (needed help with feeding). CNA 5 stated the call light should have been in Resident 28's hands because she could not see. CNA 5 stated Resident 28 did not know where the call light was at. CNA 5 stated if the call light is in her hand she will know where it is at all times CNA 5 stated there could be an outcome of injury from Resident 28 trying to get out of bed.During an interview and record review on 1/21/26 at 3:45 p.m. with Registered Nurse/Charge Nurse (RN) 2, RN 2 stated blind residents should be given a bell to call for assistance. RN 2 stated the facility had a bell. RN 2 stated blind residents could also be given the call light, Resident 28 should have been educated to where exactly the call light was. RN 2 stated this could help prevent injury for Resident 28 and ensure Resident 28's needs were met.During an interview and record review on 1/21/26 at 4:36 p.m. with Director of Staff Development (DSD), the DSD started Resident 28's sight was diminished and Resident 28 needed assistance with her meals. The DSD stated the facility staff should be doing rounds often to check on Resident 28. The DSD stated it was important so that Resident 28 can get help and not feel helpless in the room. The DSD stated Resident 28 had the potential to fall because she might attempt to get out of bed without calling for help when she needed assistance.During an interview on 1/22/26 at 4:15 p.m. with Resident 28 in Resident 28's Room, Resident 28 stated I cannot eat by myself. They do not help me with the food, they help only if they have to, if they are not busy, then they help. Resident 28 stated the facility staff do not cue or prompt (an act of assisting) her during meals. Resident 28 stated I have to wait till they are not busy and sometimes the food gets cold. Resident 28 stated I was never given a bell; I don't have a bell. Resident 28 stated they did not discuss my plan of care with me. Resident 28 stated I wear a brief, they change the brief only when I say something, they hardly ever help me. Resident 28 stated sometimes I am sitting in my soiled brief. Resident 28 stated she needed help to be transferred to the wheelchair. Resident 28 stated the only time I get to drink anything is when I am in the dining room.During an interview on 1/23/26 at 1:43 p.m. with RN 1, RN 1 stated facility staff needed to give Resident 28 the call light in her hand so that she could push the button. RN 1 stated it was important to prevent falls and to accommodate Resident 28's needs. RN 1 stated there was a risk of Resident 28 falling and injuring herself because she could not call for assistance when she needed it.During an interview on 1/23/26 at 2:23 p.m. with CNA 6, CNA 6 stated Resident 28 needed more help because it was difficult for Resident 28 to see. CNA 6 stated the call light should have been in Resident 28's hand. CNA 6 stated it was important because Resident 28 would not be able to see the call light if it was by her side. CNA 6 stated that visually impaired residents needed frequent checks. CNA 6 stated if not checked on, there was a potential for fallsDuring a concurrent interview and record review on 1/23/26 at 2:28 p.m. with the MDSC, Resident 28's Care Plan (CP) was reviewed. The CP indicated nonresident-specific interventions for Resident (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	28. The MDSC stated the admission nurse initiates a baseline CP and Interdisciplinary team (IDT) meets and completes if uncompleted by the admission nurse. The MDSC stated that MDSC develops the comprehensive CP and it is developed based on the resident's diagnosis, medications and needs. The MDSC stated the CP should be resident specific. The MDSC stated a legally blind resident, like Resident 28, is unable to see and unable to physically identify somebody. The MDSC stated a call light should be placed in Resident 28's hand or her chest so that Resident 28 could feel for it, and the facility staff should educate Resident 28 to where the call light each time they left the room. The MDSC stated that when Resident 28 is eating, the facility staff should tell her where certain things are placed on her plate. The MDSC stated Resident 28 should be introduced to her surroundings when in the dining room. The CP indicated .resident to use bell to call for assistance. The MDSC stated Resident 28 did not have a bell. The MDSC stated the facility was not implementing the CP. The MDSC stated Resident 28's care plan could be more detailed for a resident that was legally blind. The MDSC stated the CP was not resident specific to Resident 28's needs. The MDSC stated the facility did not follow the standard of practice for CPs, CPs should be specific to Resident 28's needs. The MDSC stated this was important to ensure the facility was meeting Resident 28's needs adequately. The MDSC stated not having a resident specific CP had the potential for Resident 28 to fall and not have her ADLs met.During a concurrent interview and record review on 1/23/26 at 3:08 p.m. with the Director of Nursing (DON), the DON stated the Resident 28 could not see. The DON stated she once observed that the resident was served without communication of where or what the food was, and she educated staff. The DON stated the call light should be given to the resident because she could not see. The DON stated it was important to enable Resident 28 to call for help anytime she needed help. The DON stated there was the potential outcome of Resident 28's needs not being met.During a review of the facilities policy and procedure (P&P) titled, Accommodation of Needs, dated 3/2021, the P&P indicated, Policy Statement-Our facility's environment and staff behaviors are directed toward assisting the residents maintaining and/or achieving safe independent functioning, dignity and well-being. Policy Interpretation and Implementation 1. The residents' individual needs and preferences are accommodated to the extent possible, except when the health and safety of the individual or other residents would be endangered. 2. The resident's individual needs and preferences, including the need for adaptive devices and modifications to the physical environment, are evaluated upon admission and reviewed on an ongoing basis.4. In order to accommodate individual needs and preferences. staff attitudes and behaviors are directed towards assisting the residents in maintaining ., dignity and well-being to the extent possible and in accordance with the residents' wishes. For example: a. interacting with the residents in ways that accommodate the physical or sensory limitations of the residents, promote communication and maintain dignity.During a review of the facilities policy and procedure (P&P) titled, Care Plans, Comprehensive Person centered, dated 3/2022, the P&P indicated Policy Statement: A comprehensive, 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.1. The interdisciplinary team (IDT), In conjunction with the resident and his four slash her family or legal representative, develops and implements A comprehensive, person-centered care plan for each resident.3. The care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment. 4. Each resident's comprehensive person centered care plan is consistent with the residents rights to participate in the development and implementation of his or her plan of care, including the right to: a participate in the planning process . d. request revisions to the plan of care: e. participate in establishing the expected goals and outcome of care.g receive the services and/ or items included in the plan of care. 9. Care plan interventions are chosen only after data gathering, proper sequencing of events, careful consideration of the relationship between the resident's problem areas and their causes, and relevant clinical decision making. 10. interventions address the underlying sources of the problem areas.11. Assessments of residents are ongoing, and (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	care plans are revised as information about the residents and the residents' conditions change.During a review of the facility's document titled, Job Description, Certified Nurse Assistant, no date, the document indicated . Position Summary-The purpose . is to provide each resident with routine daily nursing care in accordance with the residents assessment plan along with current federal, state, and local standards that govern the facility and as directed by supervisors. Essential duties and responsibilities- .Answering the call lights.making residents comfortable (putting them in bed, bringing them water.), assisting in feeding residents (by cutting their food and spoon feeding if needed) .abiding with all facility policies and procedures.During a review of the facility's document titled, Job Description, Registered Nurse Supervisor, no date, the document indicated . Position Summary- The purpose.is to provide each resident with routine daily nursing care in accordance with current federal, state, and local standards that govern the facility and as directed by your management. Essential duties and responsibilities- . Assessment and development of resident care plans. monitoring nursing staff to ensure they are complying with the resident's care plan.abiding with all facility policies and procedures .During a review of the facility's document titled, Job Description, Charge Nurse, no date, the document indicated . Position Summary- The purpose.is to provide direct nursing care provide direct nursing care to the residents, and to supervise the day-to-day nursing activities . Essential duties and responsibilities- . Ensure that personnel providing direct care to residents are providing such care in accordance with the resident's care plan and wishes. Ensure that residents who are unable to call for help are checked frequently. Participate in developing, planning, conducting, and scheduling in-service training classes that provide instructions on how to do the job, and ensure a well-educated nursing service department. Monitor nursing care to ensure that all residents are treated fairly, and with kindness, dignity and respect.During a review of the facility's document titled, Job Description, MDS Coordinator, no date, the document indicated . Position Summary- The purpose.is to provide direct care to residents. will conduct and coordinate the development and completion of the Resident Assessment in accordance with current federal, state, and local standards that govern the facility, and as directed by management. Essential duties and responsibilities- .13. Train and educate nursing staff on topics pertinent to provision of direct care including MDS systems and regulatory compliance.During a review of the facility's document titled, Job Description, Director of Staff Development, no date, the document indicated . Position Summary- The purpose. is to manage, develop, and direct the overall operation of the nursing department in accordance with current federal, state, and local standards that govern the facility, and as directed by the administrator and medical director. Essential duties and responsibilities- . Planning, developing, and coordinating orientation programs as well as in service educational and on the job training, . abiding with all facility policies and procedures. Attending meetings and serving on committee's.During a review of the facility's document titled, Job Description, Director of Nursing, no date, the document indicated . Position Summary- Position Summary- The purpose.is to manage, develop, and direct the overall operation of the nursing department in accordance with current federal, state, and local standards that govern the facility and as directed by the Administrator and Medical Director. Essential duties and responsibilities-. Working with DSD in monitoring the in-service trainings, . Making written and verbal recommendations to the Administrator as needed concerning the operations of the nursing department, .Maintaining and updating the policies and procedures that govern the daily functions of the nursing department. Abiding with all facility policies and procedures. Attending meetings and serving on committee's.During a review of Professional Reference titled Fundamentals of Nursing - 9th Edition ([NAME] et al; Elsevier: 2017, p. 391), the reference indicated, .call lights are additional safety features found in health care settings. During a review of National Library of Medicine.org, Professional Reference titled, Use of Notification and Communication Technology (Call Light Systems) in Nursing Homes: Observational Study, dated 3/27/20, (found at https://pmc.ncbi.nlm.nih.gov/articles/PMC7148550/) the reference indicated, .Among the technologies used in nursing homes is the call light system, which plays a key role in communication. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The call light system is critical for interactions between the nursing home staff and their residents. Research conducted in other health care settings has reported that nurse call systems significantly influence overall resident satisfaction in the delivery of their health care by creating a communication link between residents and nursing home staff. Nurse call light systems also help to ensure the safety of patients. a lifeline for patients because it is linked with patients' needs and alerts the staff to the situations in which patients may ask for help. Malfunctions of the nurse call light system can cause negative medical outcomes.During a review of National Library of Medicine.org, Professional Reference titled, Best Practices for Treating Blind and Visually Impaired Patients ., dated 5/3/2024, (found at https://doi.org/10.5811/westjem.61686) the reference indicated, .Visually impaired patients are more likely to experience multiple morbidities, . Falls and their sequelae, such as hip fractures, are among the most common reasons for blind patients to be seen in the ED. Ensure the patient knows where the call light is and how to use it. Accommodate the needs of the patient,. Tell the patient what you're going to do before doing it, including before leaving the room, .ensuring that patients are aware of the location and operation of the call light can further empower them and facilitate immediate communication,.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to develop and implement a comprehensive care plan for one of eight sampled residents (Resident 28) when Resident 28's whose vision was severely impaired (no vision or sees only light, colors or shapes column eyes do not appear to follow objects) and did not have care plan interventions that were specific to her vision needs.This failure resulted in staff not assisting with meal set up, cue (a gentle hint or signal) and prompting (an act of assisting) of meals, and assistance with activities of daily living (ADLs) care and had the potential for Resident 28 specific needs to be unmet.During a review of Resident 28's admission Record (AR - a summary of information regarding a patient which includes patient identification, past medical history, insurance status, care providers, family contact information and other pertinent information), dated 1/22/26, the AR indicated, Resident 28, was admitted to the facility on [DATE], acute care hospital and had diagnoses that included . Legal blindness, muscle weakness, cerebral infarction (death of brain tissue due to a lack of blood supply), other seizures (a sudden, temporary disruption in the brain's electrical activity), difficulty in walking, anxiety disorder, unspecified asthma, insomnia (trouble falling asleep or staying asleep), unspecified convulsions (a sudden, uncontrollable, violent shaking or jerking of the body or limbs, caused by abnormal electrical activity in the brain).During a review of Resident 28's Minimum Data Set (MDS- a resident assessment tool used to identify resident cognitive (mental) and physical functional level) assessment, dated 12/4/25, the MDS section C indicated, Resident 28's Brief Interview for Mental Status (BIMS) assessment score was 7 out of 15 (0-6 severe cognitive (pertaining to reasoning memory and judgement) deficit, 7-12 moderate cognitive deficit, 13-15 cognitively intact). The BIMS scores indicated Resident 28 had moderate cognitive deficit.During a review of Resident 28's MDS assessment Section B Hearing, Speech and Vision, dated 12/4/25, indicated Resident 28's vision score was 4 .4 Severely impaired- no vision or sees only light, colors or shapes column eyes do not appear to follow objects.During a concurrent observation and interview on 1/20/26 at 11:28 a.m. with Resident 28 during the initial tour in Resident 28's Room, Resident 28 was lying in bed facing the wall. Resident 28's call light was behind her on the bed. Resident 28 stated I am blind, they don't check on me, I do not have the call light. Resident 28 stated It should not be behind me; it should be in my hand. I do not know where they put the call light. It makes me mad because I cannot see. It can cause safety issues for me.During a record review of Resident 28's Care Plan (CP) on 1/20/26 at 3:36 p.m., the CP interventions on 9/11/25 indicated Be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed.During an interview and record review on 1/21/26 at 3:45 p.m. with Registered Nurse/Charge Nurse (RN) 2, RN 2 stated blind residents should be given a bell to call for assistance. RN 2 stated the facility had a bell. RN 2 stated blind residents could also be given the call light, the residents should be educated to where exactly the call light is. RN 2 stated this could help prevent injury for Resident 28 and ensure Resident 28's needs are met.During a concurrent observation and interview on 1/22/26 at 4:15 p.m. with Resident 28 in Resident 28's Room, Resident 28 stated I cannot eat by myself. They do not help me with the food, they help only if they have to, if they are not busy, then they help. Resident 28 stated the facility staff do not cue or prompt her during meals. Resident 28 stated I have to wait till they are not busy and sometimes the food gets cold. Resident 28 stated I was never given a bell; I don't have a bell. Resident 28 stated they did not discuss my plan of care with me.During a concurrent interview and record review on 1/23/26 at 1:43 p.m. with RN 1, Resident 28's CP was reviewed. RN 1 stated CPs should be patient-specific to meet their needs. RN 1 was unable to locate specific CPs and interventions related to Resident 28's impaired vision and the need for the call light. RN 1 stated the Minimum Data Set Coordinator (MDSC) creates the care plan.During a concurrent interview and record (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	review on 1/23/26 at 2:28 p.m. with the MDSC, Resident 28's Care Plan (CP) was reviewed. The CP indicated nonresident-specific interventions for Resident 28. The MDSC stated the admission nurse initiates the baseline CPs and Interdisciplinary team (IDT) meets and completes the baseline if uncompleted by the admission nurse. The MDSC stated that the MDSC develops the comprehensive CP and it is developed based on the resident's diagnosis, medications and needs. The MDSC stated the care plan should be resident specific. The MDSC stated a legally blind resident like Resident 28, is unable to see and unable to physically identify somebody. The MDSC stated a call light should be placed in Resident 28's hand or her chest so that Resident 28 could feel for it, and the facility staff should educate Resident 28 to where the call light each time they left the room. The MDSC stated that when Resident 28 is eating, the facility staff should tell her where certain things are placed on her plate. The MDSC stated Resident 28 should be introduced to her surroundings when in the dining room. The CP indicated .resident to use bell to call for assistance. The MDSC stated Resident 28 did not have a bell. The MDSC stated the facility was not implementing the CP. The MDSC stated Resident 28's care plan could be more detailed for a resident that was legally blind. The MDSC stated the CP was not resident specific to Resident 28's needs. The MDSC stated the facility did not follow the standard of practice for CPs, CPs should be specific to Resident 28's needs. The MDSC stated this was important to ensure the facility was meeting Resident 28's needs adequately. The MDSC stated not having a resident specific CP had the potential for Resident 28 to fall and not have her ADLs met.During a concurrent interview and record review on 1/23/26 at 3:08 p.m. with the Director of Nursing (DON), Resident 28's CPs was reviewed. The DON stated the MDSC develops the comprehensive CP and as intervention and needs changes any licensed nurse (LN) can add and update the CP. The DON stated the CP should be collaborative. The CP indicated .resident to use bell to call for assistance. The DON stated Resident 28 did not have a bell. The DON stated the individualized CP is developed based on the residents' specific needs, Resident 28 should have specific care for her impaired vision. The DON stated the facility was not following Resident 28's specific interventions and CP. The DON stated the importance of implementing the interventions was for the facility to meet Resident 28's specific needs. The DON stated failure to develop and implement Resident 28's specific CP had the potential for Resident 28's vision impaired to not be met.During a review of the facilities policy and procedure (P&P) titled, Care Plans, Comprehensive Person centered, dated 3/2022, the P&P indicated, Policy Statement: A comprehensive, 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.1. The interdisciplinary team (IDT), In conjunction with the resident and his four slash her family or legal representative, develops and implements A comprehensive, person centered care plan for each resident.3. The care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment. 4. Each resident's comprehensive person centered care plan is consistent with the residents rights to participate in the development and implementation of his or her plan of care, including the right to: a participate in the planning process . d. request revisions to the plan of care: e. participate in establishing the expected goals and outcome of care.g receive the services and/ or items included in the plan of care. 9. Care plan interventions are chosen only after data gathering, proper sequencing of events, careful consideration of the relationship between the resident's problem areas and their causes, and relevant clinical decision making. 10. interventions address the underlying sources of the problem areas.11. Assessments of residents are ongoing, and care plans are revised as information about the residents and the residents' conditions change.During a review of the facility's document titled, Job Description, Registered Nurse Supervisor, no date, the document indicated . Position Summary- The purpose.is to provide each resident with routine daily nursing care in accordance with current federal, state, and local standards that govern the facility and as directed by your management. Essential duties and responsibilities- . Assessment and development of resident care plans. monitoring nursing staff to ensure they are complying with the (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident's care plan.abiding with all facility policies and procedures .During a review of the facility's document titled, Job Description, Charge Nurse, no date, the document indicated . Position Summary- The purpose.is to provide direct nursing care provide direct nursing care to the residents, and to supervise the day-to-day nursing activities . Essential duties and responsibilities- . Review care plans daily to ensure that appropriate care is being rendered. Inform the nurse supervisor of any changes that need to be made on the care plan. Ensure that your nurses' notes reflect that the care plan is being followed when administering nursing care or treatment. Review resident care plans for appropriate resident goals, problems, approaches, and revisions based on nursing needs. Ensure that your assigned certified nursing assistants (CNAs) are aware of the resident care plans. Ensure that the CNAs refer to the resident's care plan prior to administering daily care to the resident. Assist the Resident Assessment/Care Plan Coordinator in planning, scheduling, and revising the MDS, including the implementation of RAPs and Triggers.During a review of the facility's document titled, Job Description, MDS Coordinator, no date, the document indicated . Position Summary-. is to provide direct care to residents. work to restore or maintain the resident's health and well-being by conducting a thorough evaluation of the resident's health status, which includes gathering medical history, conducting physical assessments, and collaborating with the facility IDT members. the formulation of all patient care plans that guide the direct care that patients receive. These plans are meticulously designed to address the resident's physical, psychological, and social needs providing a holistic approach to their care. will conduct and coordinate the development and completion of the Resident Assessment in accordance with current federal, state, and local standards that govern the facility, and as directed by management. Essential duties and responsibilities- . 2. Conduct comprehensive Resident Assessments upon admission of resident and develop patient care plan.3. Perform healthcare assessments and reassessments and formulate individualized nursing plans of care through documentation review, visual observations, discussions with direct care staff, and interviews with residents and family members.5. Visit residents and evaluate care plans for comprehensiveness and individuality and assess the achievement or lack of achievement of desired outcome. Ensure that the resident's care plan is reassessed and revised according to the evaluation of achievement or lack of achievement of desired outcomes. From evaluation, reassesses resident problems and goals and interventions for appropriateness, realistic value, priority and reassesses overall plan of care. From reassessment, identify new problem or potential problems, establish updated and appropriate goals, revise interventions, and continually evaluate nursing care plan and makes revisions according to change in resident's health status.12. Assess the content of each resident's MDS and medical record to ensure completeness and thoroughness of documentation. 13. Train and educate nursing staff on topics pertinent to provision of direct care including MDS systems and regulatory compliance.During a review of the facility's document titled, Job Description, Director of Nursing, no date, the document indicated . Position Summary- Position Summary- The purpose.is to manage, develop, and direct the overall operation of the nursing department in accordance with current federal, state, and local standards that govern the facility and as directed by the Administrator and Medical Director. Essential duties and responsibilities-.Maintaining and updating the policies and procedures that govern the daily functions of the nursing department. Abiding with all facility policies and procedures. Attending meetings and serving on committee's.During a review of National Library of Medicine.org Professional Reference titled, Nursing Process, dated 4/10/23, (found at https://www.ncbi.nlm.nih.gov/books/NBK499937/) the reference indicated, . Planning: The planning stage is where goals and outcomes are formulated that directly impact patient care based on guidelines. These patient-specific goals and the attainment [the level of knowledge, skills, or qualifications a learner has acquired at a specific point in time] of such assist in ensuring a positive outcome. Nursing care plans are essential in this phase of goal setting. Care plans provide a course of direction for personalized care tailored to an individual's unique needs. Overall condition and comorbid conditions play a role in the construction of a care plan. Care plans enhance communication, (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	documentation, reimbursement, and continuity of care across the healthcare continuum. vital to positive patient outcomes. the nursing process to guide care is clinically significant going forward in this dynamic, complex world of patient care. Aging populations carry with them a multitude of health problems and inherent risks of missed opportunities to spot a life-altering condition.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to meet professional standards of practice for three of seventeen sampled residents (Resident 13, Resident 19 and Resident 35) when:Resident 13 was administered hydrocodone-acetaminophen (opioid pain medication used to treat moderate to severe pain) 12 times outside of ordered administration parameters from 1/15/26-1/22/26.Resident 19 was administered tramadol HCL (opioid pain medication used to treat moderate to severe pain) 48 times outside of ordered administration parameters from 11/1/25-1/22/26.These failures had the potential to result in inadequate pain management practices of Resident 13 and Resident 19 which had the potential to lead to adverse consequences such as complications, overdose, misuse or death. 3. Resident 35 did not receive oxygen (O2- a colorless, odorless and tasteless gas essential for life) therapy as ordered by the physician on 1/8/26.This failure placed Resident 35 at risk of excessive oxygenation and respiratory complications.1.During a review of Resident 13's admission Record (AR - a summary of information regarding a patient which includes patient identification, past medical history, insurance status, care providers, family contact information and other pertinent information), dated 1/22/26, the AR indicated Resident 13 was admitted to the facility on [DATE] with diagnoses of gout (inflammation of joints), Peripheral Artery Disease (PAD-reduced blood flow to limbs), and left leg amputation below the knee (Left BKA-removal of leg below knee). During a review of Resident 13's Minimum Data Set (MDS - a resident assessment tool used to identify cognitive [mental processes] and physical functional level assessment), dated 12/30/25, the MDS indicated Resident 13 had a Brief Interview for Mental Status (BIMS - a test given by medical professionals to determine cognitive [involving the process of thinking, learning and understanding] understanding on a scale of 1-15) score of 14 (a score of 0-7 suggests severe cognitive impairment, 8-12 suggests moderately impaired, 13-15 suggests cognitively intact), which suggested Resident 13 was cognitively intact. During a review of Resident 13's Order Summary Report (OSR), dated 1/22/26, the OSR indicated, Resident 13 had an active order for hydrocodone-acetaminophen oral tablet 5-325 MG (milligrams- a unit of measurement for medications) to be given every 6 hours for severe pain of 6-10. The OSR indicated, hydrocodone-acetaminophen was ordered on 1/15/26. The OSR indicated Resident 13 had an active order for acetaminophen 325 MG as needed every 6 hours for mild pain of 1-5. During a review of Resident 13's Medication Administration Record (MAR), dated 1/22/26, the MAR indicated, .hydrocodone-acetaminophen 5-325 MG.give 1 tablet by mouth every 6 hours for severe pain 6-10.order date 1/15/2026. was administered 12 times outside of administered order parameters between 1/15/26-1/22/26, for reported pain scores of 0-5. There were 27 opportunities for administration. The order indicated hydrocodone-acetaminophen was to be administered for resident reports of severe pain of 6-10 and the facility administered the medication for resident reported pain levels of 0-5, outside of order parameters. During a concurrent observation and interview on 1/20/26 at 10:37 a.m. with Resident 13, in Resident 13's room, Resident 13 was observed lying in bed. Resident 13 stated he was recently admitted to the facility and was working on regaining strength following his left BKA. Resident 13 stated he was able to make his needs known and did not have frequent pain. Resident 13 stated he knew he could request medication if he had pain. 2. During a review of Resident 19's AR, dated 1/22/26, the AR indicated Resident 19 was admitted to (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the facility on [DATE] with diagnoses of parkinsonism (movement problems), osteoarthritis (joint disease), chronic pain syndrome, mononeuropathy (damage to peripheral nerve causing loss of function), right knee effusion (fluid in knee), hemiplegia (paralysis) and hemiparesis (weakness) following cerebrovascular disease (decreased blood flow to brain). During a review of Resident 19's MDS, dated 12/4/25, the MDS indicated, Resident 19 had a BIMS score of 13, which suggested Resident 19 was cognitively intact. During a review of Resident 19's OSR, dated 1/22/26, the OSR indicated, Resident 19 had an order for tramadol HCL oral tablet 50 MG to be given two times a day. The tramadol HCL order indicated it was to be given, .for pain 4-10 hold for [signs and symptoms] of sedation/overdose, if [respirations less than] 12, notify MD if [signs and symptoms] are present. The OSR indicated, tramadol was ordered on 7/4/25. The OSR indicated, Resident 19 had an active order for acetaminophen 325 MG as needed every 6 hours for mild pain, no pain scale was included in the order. During a review of Resident 19's MAR, dated 1/22/26, the MAR indicated, .tramadol HCL oral tablet 50 MG.give 1 tablet by mouth two times a day for pain 4-10 hold for [signs and symptoms] of sedation/overdose, if [respirations less than]12, notify MD if [signs and symptoms] are present.order date 7/4/25. The MAR indicated tramadol HCL was administered 10 times outside of administration order parameters, between 11/1/25-11/30/25, for reported pain scores of 0-3. There were 60 opportunities for administration. The MAR indicated between 12/1/25-12/31/25 tramadol was administered 16 times outside of administration order parameters, for reported pain scores of 0-3. There were 62 opportunities for administration. The MAR indicated between 1/1/26-1/22/26 tramadol was administered 22 times outside of administration order parameters, for reported pain scores of 0-3. There were 43 opportunities for administration. The order indicated tramadol HCL was to be administered for resident pain reports of 4-10 and the facility administered the medication for resident reported pain levels of 0-3, outside of order parameters. During a concurrent observation and interview on 1/20/26 at 10:31 a.m. with Resident 19, in Resident 19's room, Resident 19 was observed lying in bed. Resident 19 stated he frequently received pain medication. During a concurrent interview and record review on 1/22/26 at 9:26 a.m. with Registered Nurse (RN) 3, Resident 13 and Resident 19's Medical Records, dated 1/22/26 were reviewed. RN 3 stated routine pain medication required administration instructions. RN 3 stated routine pain medication administration instructions were expected to be followed as they were written. RN 3 stated Resident 13 had an opioid pain medication order for, .hydrocodone-acetaminophen 5-325 MG.give 1 tablet by mouth every 6 hours for severe pain 6-10. RN 3 stated Resident 13's opioid pain medication order indicated the pain medication was to be administered for a pain score rating of 6-10. RN 3 stated Resident 19 had an opioid pain medication order for, .tramadol HCL oral tablet 50 MG.give 1 tablet by mouth two times a day for pain 4-10 hold for [signs and symptoms] of sedation/overdose, if [respirations less than]12, notify MD if [sign and symptoms] are present. RN 3 stated Resident 19's opioid pain medication order indicated the pain medication was to be administered for a pain score rating of 4-10. RN 3 stated if Resident 13 and Resident 19 reported a pain score outside of their ordered administration instruction range the provider should have been contacted for administration clarification. RN 3 stated Resident 13 and Resident 19's pain medication orders had not been followed as they were written when medication was administered outside of administration instruction guidelines. RN 3 stated Resident 13 and Resident 19 were at risk for adverse effects such as opioid overdose or misuse when their opioid pain medications were administered outside of administration (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	instruction guidelines. RN 3 stated it was important to do complete and accurate pain assessments prior to the administration of pain medication to ensure medication was administered as prescribed. During an interview on 1/22/26 at 12:10 p.m. with the Pharmacy Consultant (PC), the PC stated opioid pain medications required administration instruction guidelines to protect residents from adverse effects and inappropriate pain management. The PC stated licensed nursing staff were expected to administer pain medications as prescribed. The PC stated licensed nursing staff were expected to notify the provider if residents reported pain scores outside of the scheduled pain medication administration instruction guidelines for administration clarification. The PC stated Resident 13 and Resident 19's opioid pain medications were not administered appropriately when given outside of administration instruction guidelines. The PC stated opioid pain medications needed to be managed and monitored to ensure resident pain was effectively being treated and the most appropriate medication was being administered to treat resident reported pain. The PC stated facility policy and procedure needed to be followed when assessing, treating and administering pain medications to residents. During an interview on 1/23/26 at 1:40 p.m. with the Director of Nursing (DON), the DON stated licensed nursing staff were expected, per facility policy and standards of practice, to administer medications as per provider orders. The DON stated order administration instructions were placed within provider orders as guidelines and parameters. The DON stated all guidelines and parameters needed to be followed when administering medications to ensure resident safety and appropriate treatment management. The DON stated Resident 13 and Resident 19's opioid pain medications were not administered as per provider orders when they were given outside of ordered administration instruction. The DON stated residents were at risk of opioid overdose, misuse, and adverse effects if opioids were administered outside of provider orders. During a review of Resident 13's Care Plan Report (CP), dated 1/22/26, the CP indicated, .amputation of (Left BKA).administer medications as ordered. The CP indicated, .has gout.administer analgesics as ordered by the physician . The CP indicated, .has chronic pain [related to] diabetic neuropathy, gout, PAD, Left BKA.administer analgesics as per orders.administer medications as ordered. black box warning [prescription drug warning label designated to highlight safety information]: hydrocodone-acetaminophen addiction, abuse, and misuse.use of hydrocodone/acetaminophen exposes patients and other users to the risk of opioid addiction, abuse, and misuse, which can lead to overdose and death, assess each patient's risk prior to prescribing and reassess all patients regularly for the development of these behaviors and conditions. For additional information see physician order.assess intensity of pain based on a 0-10 scale.evaluate the effectiveness of pain interventions.review for compliance , alleviating of symptoms, dosing schedules. During a review of Resident 19's CP, dated 1/22/26, the CP indicated, .has a history of other substance abuse. The CP indicated, .has Parkinson's disease.give analgesics as ordered by the physician. The CP indicated, .has chronic pain [related to] right knee effusion, osteoarthritis, chronic pain syndrome, neuropathy. administer analgesia as per MD orders.black box warning: Tramadol HCL.assess intensity of pain based on 0-10 scale. During a review of the facility's policy and procedure (P&P) titled, Pain-Clinical Protocol, dated 10/2022, the P&P indicated, .if the physician determines that opioid medication is an appropriate option for managing acute (or in some cases chronic) pain in the resident, the lowest possible effective dose is prescribed for the shortest time possible with ongoing staff monitoring for effectiveness and adverse effects.if pain is stable and the underlying cause is resolved or it is (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	unclear whether a source of pain remains, the physician will consider a trial reduction or elimination of analgesic medication; for example, reduce the standing dose of an analgesic and see if there is any changes in pain -related symptoms or use of PRN analgesics.reductions in opioid analgesics are especially important in light of their limited efficacy in the treatment of chronic non-cancer pain and their many significant side effects. During a review of the facility's P&P titled, Administering Pain Medications, dated 10/2022, the P&P indicated, .the pain management program is based on facility-wide commitment to appropriate assessment and treatment of pain, based on professional standards of practice, the comprehensive care plan, and the resident's choices related to pain management.conduct a pain assessment as indicated.administer pain medications as ordered. During a review of the facility's P&P titled, Pain Assessment and Management, dated 10/2022, the P&P indicated, .the pain management interventions are consistent with the resident's goals for treatment which are defined and documented in the care plan. Pain management interventions reflect the sources, type and severity of pain.the medication regimen is implemented as ordered.ongoing communication between the prescriber and the staff is necessary for the optimal and judicious use of pain medications.if pain symptoms have resolved or there is no longer an indication for pain medication, the multidisciplinary team and physician shall try to discontinue or taper analgesic mediations to the extent possible. During a professional reference review retrieved from https://www.nccmerp.org/recommendations-enhance-accuracy-administration-medications titled, Recommendations to Enhance Accuracy of Administration of Medications, dated 3/30/23, the professional reference review from the National Coordinating Council for Medication Error Reporting and Prevention indicated, . any order that in incomplete, illegible, or poses any concern should be clarified before preparation and administration.the right medication, in the right dose, to the right person, by the right route, using the right dosage form, at the right time, for the right reason. 3. During a concurrent observation and interview on 1/20/2026 at 10:07 a.m. with Resident 35 during the initial tour in Resident 35's Room, Resident 35 was lying in bed with eyes opened, unable to communicate and a nasal cannula (NC- thin plastic tube that delivers oxygen directly into the nose through two small prongs) in her nose, connected to a working oxygen concentrator (device that produces oxygen for breathing) was set to 2.5 LPM (liter per minute- a unit of measurement for the flow rate of oxygen). During a review of Resident 35's admission Record (AR - a summary of information regarding a patient which includes patient identification, past medical history, insurance status, care providers, family contact information and other pertinent information), dated 1/22/26, the AR indicated, Resident 35, was admitted to the facility on [DATE] from acute care hospital and had diagnoses that included . chronic obstructive pulmonary disease (COPD- a progressive lung disease that causes persistent airflow obstruction, making it hard to breathe) , encounter for palliative care (medical support for people with serious illnesses, focusing on relieving symptoms, pain, and stress to improve the patient's and family's quality of life), unspecified dementia (a progressive state of decline in mental abilities), anxiety disorder. During a review of Resident 35's Minimum Data Set (MDS- a resident assessment tool used to identify resident cognitive (mental) and physical functional level) assessment, dated 10/16/25, the MDS section C500 indicated, Resident 35's Brief Interview for Mental Status (BIMS) assessment score was (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	99 (0-6 severe cognitive (pertaining to reasoning memory and judgement) deficit, 7-12 moderate cognitive deficit, 13-15 cognitively intact, 99 indicates unable to complete the interview). The MDS section C1000 indicated, Resident 35's Staff Assessment for Mental Status- Cognitive skills for daily decision-making score was 3 (0. Independent- decision consistent/ reasonable, 1. modified independence- some difficulty in new situations only, 2. moderately impaired- decisions poor; cues/ supervision required, 3. severely impaired- never/ rarely made decisions). The score indicated Resident 35 was severely impaired. During a review of Resident 35's MDS assessment, dated 10/16/25, the MDS section O indicated, Resident 35's Special Treatment, Procedures, and Programs indicated Resident 35 was on hospice care while as a resident. During a concurrent interview and record review on 01/21/2026 at 3:45 p.m. with Registered Nurse/Charge Nurse (RN) 2, Resident 35's Order Summary Report (OSR), and a picture of Resident 35's O2 concentrator were reviewed. The OSR indicated .Oxygen at 2 L/Min (LPM-liters per minute-unit of measurement) via nasal cannula continuously for shortness of breath every shift with order start date 1/8/26. The picture indicated the flow indicator ball (FIB- ball inside the flow meter tube on an O2 concentrator that measures the flow rate of O2) was at 2.5L. RN 2 stated O2 was to be started based on the physician's order. RN 2 stated the physician's order was for O2 at 2 liters nasal cannula continuous for shortness of breath. RN 2 validated that the concentrator was for Resident 35 and the FIB was on 2.5 liters. RN 2 stated the physician's order was not followed. RN 2 stated it was important to follow the physician's orders for patient safety and patient health. RN 2 stated Resident 35 was at risk for over oxygenation and it could affect her lungs. During a concurrent interview and record review on 01/23/2026 at 1:43 p.m. with RN 1, Resident 35's Order Summary Report (OSR) for O2 with order start date 1/8/26, Resident 35's Care Plan (CP) and a picture of Resident 35's O2 concentrator with the FIB at 2.5L were reviewed. The CP with date initiated 1/8/26 indicated Resident has shortness of breath related to COPD. Started on oxygen 2 L/min via NC continuously . administer oxygen as ordered by MD. 2 L/min via NC continuously and monitor for effectiveness. RN 1 validated the O2 order and picture showing 2.5 liters. RN 1 stated licensed nurse (LN)s needed to follow the policy but did not follow the policy. RN 1stated if O2 is titrated (continuously measure and adjust the balance of medication), the physician should be notified, and it should be documented in Resident 35's progress note. RN 1 stated; when LNs do not follow the physicians orders it is not beneficial for Resident 35. RN 1 stated the potential outcome could be hyperoxia (an excess supply of oxygen to the body's tissues and organs, occurring when oxygen levels exceed the normal range) and Resident 35 could die. During a concurrent interview and record review on 01/23/2026 at 3:08 p.m. with the Director of Nursing (DON), a picture of Resident 35's O2 concentrator with the FIB at 2.5L was reviewed. The DON stated O2 should be administered according to the physician's order. The DON stated LNs had not followed the physician's O2 orders for Resident 35 and were not following the policy for administering medications. The DON stated the importance of following the physician's orders was to meet Resident 35's needs. The DON stated if there were additional needs, LNs needed to communicate with the physician. The DON stated there was the potential outcome of Resident 35 getting too much oxygen in her lungs. During a review of the facility's policy and procedure (P&P) titled, Administering Medications, dated 4/2019, the P&P indicated, Policy Statement: Medications are administered in a safe and timely manner, and as prescribed. 2. The Director of nursing services supervises and directs all personnel (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	who administer medications and /or have related functions.4.medications are administered in accordance with prescriber orders. During a review of the facility's policy and procedure (P&P) titled, Oxygen Administration, dated 10/2010, the P&P indicated, .Purpose.is to provide guidelines for safe oxygen administration.1. Verify that there is a physician's order for this procedure. Review the physician's orders or facility protocol for oxygen administration, 2. Review the resident's care plan to assess for ay special needs of the resident. During a review of the facility's document titled, Job Description, Registered Nurse Supervisor, no date, the document indicated . Position Summary- The purpose.is to provide each resident with routine daily nursing care in accordance with current federal, state, and local standards that govern the facility and as directed by your management. Essential duties and responsibilities- . Assessment and development of resident care plans, monitoring nursing staff to ensure they are complying with resident care plan, abiding with all facility policies and procedures. During a review of the facility's document titled, Job Description, Charge Nurse, no date, the document indicated . Position Summary- The purpose.is to provide direct nursing care provide direct nursing care to the residents, and to supervise the day-to-day nursing activities . Essential duties and responsibilities- . Prepare and administer medications as ordered by the physician, .review the resident's chart for specific treatment, medication orders . as necessary, .make periodic checks to ensure that prescribed treatments are being properly administered . ensure that personnel providing direct care to residents are providing such care in accordance with the resident's care plan . Must possess the ability to plan, organize, develop, implement, and interpret the programs, goals, objectives, policies and procedures, etc., that are necessary for providing quality care. During a review of the facility's document titled, Job Description, Director of Nursing, no date, the document indicated . Position Summary- The purpose.is to manage, develop, and direct the overall operation of the nursing department in accordance with current federal, state, and local standards that govern the facility and as directed by the Administrator and Medical Director. Essential duties and responsibilities- . providing assistance to nursing staff when needed., making rounds, abiding with all facility policies and procedures. During a professional reference review retrieved from https://pubmed.ncbi.nlm.nih.gov/19377391/ titled, The use of medical orders in acute care oxygen therapy, dated 2009, the professional reference review indicated, . Oxygen is considered to be a drug requiring a medical prescription and is subject to any law that covers its use and prescription . authorized by a physician following legal written instruction to a qualified nurse . This standard procedure helps prevent incidence of misuse or oxygen deprivation which could worsen the patients hypoxia and ultimate outcome .

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. Based on observation, interview, and record review, the facility failed to ensure drugs and biologicals (a substance such as vaccines or drugs derived from a living organism used for treatment) were stored and labeled in accordance with currently accepted professional standards and practice when one of eight bottles of prescription eye drops (physician prescribed medication used in the eyes) were not labeled with the resident's name, directions for use, or expiration date.This failure placed residents at risk of receiving the wrong medication which could lead to medication adverse (resulting in negative or harmful effect) reactions.Findings:During a concurrent observation and interview on 1/23/2026 at 11:03 a.m. with Registered Nurse (RN) 2 at Station 2, the medication cart was examined. One of eight prescription eye drop bottles was observed without a label of the resident's name or ordered administration instructions for use. RN 2 stated the bottle should have been labeled in case it came out of its container box so staff would know which resident it was for and so it was not given to the wrong resident.During an interview on 1/23/26 at 2:26 p.m. with the Director of Nursing (DON), the DON stated the eye drop bottle should have been labeled with the resident's name and the administration instructions, and the nurses should be checking for a label before the medication is administered to the resident. The DON stated it was important for the bottle to be labeled in case it came out of the package, so staff would know which patient it belonged to and what the administration directions were. The DON stated there was a risk of giving the medication to the wrong resident which could have caused a negative reaction to the resident.During a review of the facility's job description document titled, Charge Nurse, (undated), the document indicated, . ensure that prescribed medication for one resident is not administered to another .During a review of the facility's policy and procedure (P&P) titled, Medication Labeling and Storage, dated 2/2023, indicated, . Labeling of medications and biologicals dispensed by the pharmacy is consistent with applicable federal and state requirements and currently accepted pharmaceutical practices . the medication label includes, at a minimum . medication name . prescribed dose . strength . expiration date . resident's name . route of administration . appropriate instructions .During a review of the facility's P&P titled, Administering Medications, dated 4/2019, 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 .

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to establish and maintain an effective infection prevention and control program during medication administration for three of 15 sampled residents (Resident 9, Resident 5, and Resident 35) when:1. During a blood glucose check (a process for measuring the concentration of glucose in the blood) and medication administration to a resident on Enhanced Barrier Precautions (EBP - an infection control intervention designed to reduce transmission of resistant organisms [bacteria that have become resistant to certain antibiotics] that requires gown and glove use during high contact resident care activities), Registered Nurse (RN) 2 placed a tray containing supplies for patient care on Resident 9's bedside table who was on EBP, then placed the tray in the medication cart without sanitizing it after providing care and medication administration to Resident 9.2. Personal Protective Equipment (PPE) was not worn during care for Resident 35 and Resident 5. These failures placed residents at risk for cross-contamination (the process when germs are unintentionally transferred from one substance or object to another, which causes a harmful effect) and infection (an invasion of the body by germs that cause disease).Findings: 1. During a concurrent observation and interview on 1/22/26 at 11:55 a.m. with Licensed Vocational Nurse (LVN) 1, in the hallway outside Resident 9's room and in Resident 9's room, LVN 1 was observed preparing a tray with paper towels, a cup of water, a glucometer (an instrument for measuring the concentration of glucose in the blood), alcohol wipes, lancets (a device with a needle used to poke the skin for blood sample), glucose test strips (a strip that collects blood for the glucometer to measure blood glucose) and tissue prior to entering Resident 9's room. LVN 1 donned a gown and gloves prior to entering Resident 9's room and placed the tray on Resident 9's bedside table and proceeded to start Resident 9's artificial feeding through his g-tube (a surgical opening made through the abdominal wall into the stomach to insert a feeding tube for long-term nutritional support) and checked Resident 9's blood glucose. After administering Resident 9's medication, LVN 1 placed the tray back into the medication cart without sanitizing it. LVN 1 stated the tray should have been cleaned prior to placing back in the medication cart for infection control. LVN 1 stated since the tray was placed on Resident 9's bedside table and would be used for another resident's medication, it needed to be cleaned to prevent cross-contamination and possible infection of another resident. During an interview on 1/22/26 at 5:22 p.m. with the Infection Preventionist (IP), the IP stated EBP were initiated for wounds, urinary catheters, dialysis ports (a treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidney(s) have failed), g-tubes, any multi-drug resistant organisms (MDRO - bacteria that have become resistant to multiple types of antibiotics making them more difficult to treat, can spread rapidly, and threaten patient safety) with a sign posted outside the resident's room and a blue dot next to the resident's name to indicate which resident was on EBP. The IP stated the tray used for patient care and administration of medication should have been cleaned and sanitized prior to putting it back in the medication cart to prevent the spread of infections. During an interview on 1/23/26 at 2:33 p.m. with the Director of Nursing (DON), the DON stated trays should have been cleaned and disinfected prior to placing them back in the medication cart, after using the tray in a resident's room and placing the tray on a resident's table who was under EBP precautions. The DON stated the tray should have been disinfected prior to putting it back into the medication cart since it came from an infected room. The DON stated the nurse should have used a barrier on any resident's table prior to placing the tray down and should have disinfected the tray (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	after using it. The DON stated there was a risk of contaminating other items in the cart and other residents. During a review of the facility's policy and procedures (P&P) titled, Policies and Practices – Infection Control, dated 10/2018, indicated, . this facility's infection control policies and practices are intended to facilitate maintaining a safe, sanitary and comfortable environment and to help prevent and manage transmission of diseases and infections.the objectives of our infection control policies and practices are to .prevent, detect, investigate, and control infections in the facility.maintain a safe, sanitary, and comfortable environment.provide guidelines for the safe cleaning and reprocessing of reusable resident-care equipment. During a review of the facility's P&P titled, Standard Precautions, dated 9/2022, indicated, .Standard precautions are used in the care of all residents regardless of their diagnoses, or suspected or confirmed infection status .reusable equipment is not used for the care of more than one resident until it has been appropriately cleaned and reprocessed. During a review of the facility's P&P, titled, Cleaning and Disinfection of Resident-Care Items and Equipment, dated 9/2022, indicated, .resident-care equipment, including reusable items and durable medical equipment will be cleaned and disinfected according to current CDC recommendation for disinfection.non-critical items are those that come in contact with intact skin but not mucous membranes.non-critical environmental surfaces include bed rails, bedside tables, etc.reusable resident care equipment is decontaminated and/or sterilized between residents. 2. During a concurrent observation and interview on 1/20/2026 at 10:07 a.m. with Resident 35 during the initial tour in Resident 35's room, there was enhanced barrier precaution (EBP) signage outside the room door and a blue dot on Resident 35's name. Resident 35 was lying in bed with eyes opened, unable to communicate. Resident 35 had a gastrostomy tube (G-tube or PEG tube- a surgical opening made through the abdominal wall into the stomach to insert a feeding tube for long-term nutritional support) with no feeding pump. During an interview on 1/20/2026 at 10:32 a.m. with Certified Nursing Assistant (CNA) 3, CNA 3 stated the blue dot is for the residents on EBP. During an observation on 1/20/2026 at 11:11 a.m. the call light was observed to be unattended to outside Resident 35's room. Upon entry into Resident 35's room, CNA 3 was observed in Resident 35's room with gloves on and no gown worn, performing resident care on Resident 35; soiled brief was observed on Resident 35's bed. During a review of Resident 35's admission Record (AR - a summary of information regarding a patient which includes patient identification, past medical history, insurance status, care providers, family contact information and other pertinent information), dated 1/22/26, the AR indicated, Resident 35, was admitted to the facility on [DATE] from acute care hospital and had diagnoses that included . encounter for surgical aftercare following surgery on the digestive system, gastrostomy status, unspecified dementia (a progressive state of decline in mental abilities). During a review of Resident 35's Minimum Data Set (MDS- a resident assessment tool used to identify resident cognitive (mental) and physical functional level) assessment, dated 10/16/25, the MDS section C500 indicated, Resident 35's Brief Interview for Mental Status (BIMS) assessment score was 99 (0-6 severe cognitive (pertaining to reasoning memory and judgement) deficit, 7-12 moderate (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	cognitive deficit, 13-15 cognitively intact, 99 indicates unable to complete the interview). The MDS section C1000 indicated, Resident 35's Staff Assessment for Mental Status- Cognitive skills for daily decision-making score was 3 (0. Independent- decision consistent/ reasonable, 1. modified independence- some difficulty in new situations only, 2. moderately impaired- decisions poor; cues/ supervision required, 3. severely impaired- never/ rarely made decisions). The score indicated Resident 35 was severely impaired. During a review of Resident 35's Order Summary Report (OSR), the OSR indicated .NPO diet (nothing by mouth) NPO texture, NPO consistency- order start date 10/11/25, enteral feed order every night shift - order start date 10/10/25, . enhanced barrier precaution due to peg-tube every shift-order start date 10/10/25. During a concurrent observation and interview on 1/20/2026 at 10:47 a.m. with Resident 5 during the initial tour in Resident 5's room, there was EBP signage outside the room door and a blue dot on Resident 5's name. Resident 5 was observed to be sitting in her wheelchair. Resident 5 stated she had a pressure ulcer and the pressure ulcer was healing well. Resident 5 stated the facility staff do not put on PPE when performing wound care. Resident 5 stated they are changing the bandage everyday like they are supposed to. they have gloves on; nobody puts on the gown. During a review of Resident 5's AR dated 1/22/26, the AR indicated, Resident 5, was admitted to the facility on [DATE] from acute care hospital and had diagnoses that included . Severe sepsis without septic shock, pressure ulcer of sacral region unspecified stage, cellulitis (serious bacterial skin infection affecting the deep dermis and subcutaneous tissues) of unspecified parts of limb. During a review of Resident 5's MDS assessment, dated 10/128/25, the MDS section C indicated, Resident 5's BIMS assessment score was 15 out of 15. The score indicated Resident 5 was cognitively intact. During a review of Resident 5's MDS assessment, dated 10/28/25, the MDS section M indicated, Resident 5's Skin Conditions included Resident 5 had Stage 3 pressure ulcer. During a review of Resident 5's Order Summary Report (OSR), the OSR indicated . Cleanse pressure ulcer stage 3 to the sacral area with NS .- order date 12/30/25, . enhanced barrier precautions every shift for unhealed wounds-order date 8/4/25. During an interview on 01/20/2026 at 12:59 p.m. with CNA 3, CNA 3 stated EBP meant facility staff needed to put on PPE which included a gown and glove when a resident had a feeding tube or wound. CNA 3 validated performing resident care on Resident 35. CNA 3 stated her actions were a quick reaction without donning PPE. CNA 3 stated it was important to put on the gown to protect both Resident 35 and staff. CNA 3 stated there was a possibility of transmitting infection without proper precautions. CNA 3 stated the expectation was to follow the Infection Control policy. CNA 3 stated the policy was not followed during resident care with Resident 35. CNA 3 stated it was important that appropriate PPE was used for Resident 35's protection and facility staff's protection. CNA 3 stated there was the possibility of passing on infection. During an interview on 01/21/2026 at 2:49 p.m. with CNA 5, CNA 5 Stated EBP was required when residents had a G-tube, any type of wound, or any contagious bacteria. CNA 5 stated staff were required to put on gowns and gloves and depending on the specific precaution level some situations required masks or full PPE. CNA 5 stated this was important because it prevented liquid from (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	splattering onto staff and protected them from contact with open wounds. CNA 5 stated; when a resident had a pressure ulcer, staff were required to wear gowns, gloves and masks. CNA 5 stated this protected against any type of spread including gushing or pus that leaked from the wound. CNA 5 stated failure to use proper PPE could be life threatening if staff contracted an infection through bodily exposure or bloodstream contact. CNA 5 stated this could also result in transmission of the infection from resident to resident. During an interview on 01/21/2026 at 3:45 p.m. with Registered Nurse/Charge Nurse (RN) 2, RN 2 stated staff were required to use enhanced precautions for residents who had wounds, G-tubes, intravenous lines (IVs- a thin, flexible tube inserted into a vein to deliver fluids, medications, blood, or nutrients directly into the bloodstream), or wound vacs (treatment that uses a suction pump to create a negative pressure (vacuum) over a wound). RN 2 stated for residents with pressure ulcers, staff were required to put on gowns and gloves, and for residents with G-tubes staff were required to put on gowns, gloves and mask. RN 2 stated this prevented infection transmission to the residents, ensured patient safety, and prevented the spread of infection outside the room to other residents. RN 2 stated residents were at increased risk for infection and if infected, they could develop symptoms such as fever and the wound or G-tube site would deteriorate. During an interview on 01/23/2026 at 1:43 p.m. with RN 1, RN 1 stated when a patient had a wound, foley catheter (a flexible, thin tube inserted into the bladder to drain urine into a collection bag), ostomy (an artificial opening in an organ of the body, created during an operation), or G-tube; staff were required to put on full PPE including gown, mask and gloves. RN 1 stated the importance was to prevent infection transmission from residents to residents and protect staff members. RN 1 stated if staff did not use proper PPE they could transmit infection to other residents. During an interview on 01/23/2026 at 2:15 p.m. with the Infection Preventionist (IP), the IP stated residents with foley catheter, surgical wounds, pressure ulcers, IVs, Peripherally Inserted Central Catheter (PICC lines- a long, thin, flexible tube inserted into a peripheral vein in the arm and threaded up to a large central vein near the heart, providing long-term IV access for medications, nutrition, fluids, or blood draws, avoiding repeated needle sticks for treatments), G- tubes, dialysis ports (surgically created entry points that allow blood to be removed) or any device inserted through the skin were placed on EBP. The IP stated the facility implemented EBP to prevent multi-drug-resistant Organism (MDRO- germs, mostly bacteria, that have evolved to resist multiple antibiotics, making common treatments ineffective and infections harder to cure) infections and to protect both residents and staff. The IP stated gowns and gloves were required and staff were required to put on PPE before entering the residents on EBP's room. The IP stated the policy was not being followed. The IP stated this was necessary to prevent infection and the spread of MDRO infections. The IP stated potential outcome could be residents would contract infection and the facility would experience an outbreak. During an interview on 01/23/2026 at 2:54 p.m. with the Director of Staff Development (DSD), the DSD stated regarding EBP, CNAs were required to put on gowns before providing care to residents in designated rooms. The DSD stated this protected both the residents and the staff members from infection. The DSD stated failure to follow protocol could result in someone becoming ill. During an interview on 01/23/2026 at 3:08 p.m. with the Director of Nursing (DON), the DON stated staff were expected to know the protocol, identify which residents were on the EBP program, and they were required to put on gowns and gloves especially when providing direct resident care including tube feeding. The DON stated this was necessary for Resident 35's safety and the safety of others. The DON stated staff could spread infection and jeopardize the health of the residents. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055271	A. Building B. Wing	01/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LA Sierra Care Center	2424 M Street Merced, CA 95340

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's document titled, Job Description, Certified Nurse Assistant, no date, the document indicated . Position Summary-The purpose . is to provide each resident with routine daily nursing care in accordance with the residents assessment plan along with current federal, state, and local standards that govern the facility and as directed by supervisors. Essential duties and responsibilities- .abiding with all facility policies and procedures. follow infection and control policies. During a review of the facility's document titled, Job Description, Registered Nurse Supervisor, no date, the document indicated . Position Summary- The purpose.is to provide each resident with routine daily nursing care in accordance with current federal, state, and local standards that govern the facility and as directed by your management. Essential duties and responsibilities- . Checking that staff wear and/ or use safety equipment and supplies when providing resident care .abiding with all facility policies and procedures. follow infection and control policies. During a review of the facility's document titled, Job Description, Charge Nurse, no date, the document indicated . Position Summary- The purpose.is to provide direct nursing care provide direct nursing care to the residents, and to supervise the day-to-day nursing activities . Essential duties and responsibilities- . Assist the Director and/or Infection Control Coordinator in identifying, evaluating, and classifying routine and job-related functions to ensure that tasks in which there is potential exposure to blood/body fluids are properly identified and recorded, ensure that all personnel performing tasks that involve potential exposure to blood/body fluids participate in appropriate in-service training programs prior to performing such tasks.ensure that personnel providing direct care to residents are providing such care in accordance with the resident's care plan . Must possess the ability to plan, organize, develop, implement, and interpret the programs, goals, objectives, policies and procedures, etc., that are necessary for providing quality care. During a review of the facility's document titled, Job Description, Director of Staff Development, no date, the document indicated . Position Summary- The purpose. is to manage, develop, and direct the overall operation of the nursing department in accordance with current federal, state, and local standards that govern the facility, and as directed by the administrator and medical director. Essential duties and responsibilities- . Planning, developing, and coordinating orientation programs as well as in service educational and on the job training, . following infection and control policies, DSD will assist and may be required to fill in for infection preventionist absence on temporary basis of facility infection prevention program ., abiding with all facility policies and procedures. During a review of the facility's document titled, Job Description, Infection Preventionist, no date, the document indicated . Position Summary-. is accountable for decreasing the incidence and transmission of infectious diseases between patients, staff, visitors and the community. Essential duties and responsibilities- . Oversees the operation of the infection prevention, epidemiology and relevant safety programs, . Authority and responsibility for ensuring appropriate intervention and education occurs with staff, volunteers and medical staff when health care infection trends, outbreaks or noncompliance to infection control/ OSHA are identified, Ensures that education and counseling on infection prevention is available for staff, volunteers, medical staff, patients . During a review of the facility's document titled, Job Description, Director of Nursing, no date, the document indicated . Position Summary- The purpose.is to manage, develop, and direct the overall operation of the nursing department in accordance with current federal, state, and local standards that govern the facility and as directed by the Administrator and Medical Director. Essential duties and responsibilities- . working with the DSD in monitoring the in-service trainings, ., making rounds, . abiding with all facility policies and procedures. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055271	A. Building B. Wing	01/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LA Sierra Care Center	2424 M Street Merced, CA 95340

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's policy and procedure (P&P) titled, Infection Control dated 10/2018, the P&P indicated, Policy Statement: This facility's infection control policies and practices are intended to facilitate maintaining a safe, sanitary and comfortable environment and to help prevent and manage transmission of diseases and infections. Policy Interpretation and Implementation 1. This facility's infection control policies and practices apply equally to all personnel, consultants, contractors, residents, visitors, volunteer workers, and the general public.2. The objectives of our infection control policies and practices are to: a. prevent, detect, investigate, and control infections in the facility; b. maintain a safe, sanitary, and comfortable environment for personnel, residents, visitors, and the general public; c. establish guidelines for implementing isolation precautions, including standard and transmission-based precautions; .4. All personnel will be trained on our infection control policies and practices upon hire and periodically thereafter, including where and how to find and use pertinent procedures and equipment related to infection control. The depth of employee training shall be appropriate to the degree of direct resident contact and job responsibilities. During a review of the facility's policy and procedure (P&P) titled, Enhanced Barrier Precaution dated 04/2024, the P&P indicated, Purpose: Enhanced barrier precautions (EBP) are utilized to prevent the spread of multidrug resistant organisms (MDROs) to residents. Policy interpretation and implementation 1. Enhanced barrier precautions (EBPs) are used as an infection prevention and control intervention to reduce the spread of multidrug resistant organisms (MDROs) to residents. 2. EBPs employ targeted gowns and gloves used during high contact resident care activities when contact precautions do not otherwise apply. A gloves and gowns are applied prior to performing the high contact resident care activity. 3. Examples of high contact resident care activities requiring the use of gown and gloves. c. transferring d. providing hygiene . f. changing briefs or assisting with toileting. h. wound care (any skin opening requiring a dressing) .5. EBPs are indicated for residents with wounds and/ or indwelling medical devices regardless of MDRO colonization. 9. Staff are trained to care for residents on EBPs. During a review of Centers for Disease Control and Prevention (CDC)'s website, Professional Reference titled, Implementation of Personal Protective Equipment (PPE) Use in Nursing Homes to Prevent Spread of Multidrug-resistant Organisms (MDROs), dated 7/12/22, (found at https://www.cdc.gov/long-term-care-facilities/hcp/prevent-mdro/PPE.html) the reference indicated, .Multidrug-resistant organism (MDRO) transmission is common in skilled nursing facilities, contributing to substantial resident morbidity and mortality and increased healthcare costs. Enhanced Barrier Precautions (EBP) are an infection control intervention designed to reduce transmission of resistant organisms that employ targeted gown and glove use during high contact resident care activities. EBP may be indicated (when Contact Precautions do not otherwise apply) for residents with any of the following: Wounds or indwelling medical devices, regardless of MDRO colonization status, Infection or colonization with an MDRO. Effective implementation of EBP requires staff training on the proper use of personal protective equipment (PPE) and the availability of PPE and hand hygiene supplies at the point of care.