

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

Printed: 08/27/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055276	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/21/2026
NAME OF PROVIDER OR SUPPLIER Mission Valley Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 2400 Parkside Drive Fremont, CA 94536	
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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to provide safe, clean, and homelike environment for five of six sampled residents (Residents 21, 23, 54, 73, and 75) when: 1. Resident 21 and 75's shared room had wet floor surfaces without a caution signage.2. Resident 54 and 73's shared room had wet floor surfaces without a caution signage and multiple items on the floor, including spilled white liquid, a yogurt cup, plastic spoon, toothbrush and plastic cup.3. Resident 23's oxygen concentrator (a medical device used to provide supplemental oxygen) had scattered white powder-like speckles on the top surface. These failures had the potential to result in slips, trips, falls, injury, exposure to unsanitary conditions and decreased resident comfort and well-being due to unsafe environmental hazards.1. During a record review of Resident 75's admission record (AR) printed on [DATE], the AR indicated Resident 75 as was admitted to the facility in [DATE] with diagnoses including lack of coordination and muscle weakness.During a record review of Resident 21's AR printed on [DATE], the AR indicated Resident 21 was admitted to the facility in [DATE] with diagnosis including type II diabetes mellitus (when the body cannot use insulin correctly and sugar builds up in the blood).During an observation on [DATE] at 10:02 a.m. in Resident 21 and Resident 75's shared room, the floor area between the left side of Resident 75's bed and the edge of resident 21's bed had a wet floor surface area. Resident 21's responsible party was present at the time of observation and was advised to proceed with caution due to the wet floor surface; however, no caution or wet-floor signage had been placed to alert Resident 21 and Resident 75, staff, or visitors of the wet floor condition.2. During a record review of Resident 73's AR printed on [DATE], the AR indicated Resident 73 was admitted to the facility in [DATE] with diagnoses including cerebral infarction (death of brain tissue caused by a prolonged lack of blood flow and oxygen) and Alzheimer's disease (an irreversible, progressive brain disorder that slowly destroys memory, thinking skills, and the ability to carry out simple daily tasks).During a record review of Resident 54's AR printed on [DATE], the AR indicated Resident 54 was admitted in [DATE] with diagnoses including muscle weakness, visual hallucinations (perceptual experiences of seeing things that do not actually exist in the physical environment), and delirium (a sudden, severe change in mental function that causes extreme confusion, disorientation, and fluctuating alertness) due to known physiological (physical body and its internal biological function) condition.During an observation and interview on [DATE] at 10:26 a.m. with Resident 73, Resident 73 was unattended while seated in a wheelchair and attempting to rise up from the wheelchair. Under Resident 73's bed, a plastic spoon, spilled white liquid, and a cup of yogurt were on the floor. Between Resident 73 and Resident 54's bed, a clear plastic cup was on the floor mat, adjacent to a wet floor surface area located under Resident 54's bed. No caution or wet-floor signage had been placed. Additionally, a white toothbrush and visible white particles were on the floor near the edge of Resident 54's bed. Resident 73 stated the room's condition was not good and stated they did not like the items on the floor.During an interview on [DATE] at 10:38 a.m. with Registered Nurse (RN) 1, RN 1 stated the staff should have been checking on Resident 73 and addressing their needs, including maintaining cleanliness of the room. RN 1 stated Resident 73 and (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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident 54's floor should not have had a wet floor because it had the potential to cause injury including falls. RN 1 further stated, she would not have liked to have trash underneath her bed.3. During a record review of Resident 23's AR printed on [DATE], the AR indicated Resident 23 was admitted to the facility in [DATE] with diagnoses including Alzheimer's disease and asthma (a chronic lung disease that causes your airways to swell, narrow, and produce extra mucus).During an observation on [DATE] at 10:46 a.m. in Resident 23's room, Resident 23's nasal cannula (flexible plastic device used to deliver supplemental oxygen) was connected to an oxygen concentrator. The oxygen concentrator had white powder-like particles on the top surface area. During an observation and interview on [DATE] at 10:41 a.m. with CNA 3, the oxygen concentrator still had the white powder-like particles scattered on the top surface. CNA 3 was observed wiping the white particles with her pointer finger and stated the white powder-like particles were dust. CNA 1 stated the Central Supply (CS) staff were responsible for maintaining the oxygen concentrators.During an observation and interview on [DATE] at 10:54 a.m. with CS, CS also wiped the visible white particles from the oxygen concentrator with her finger and confirmed the particles were dust. CS stated she was responsible in maintaining the cleanliness of the oxygen at least weekly; however, she had not yet cleaned it. CS further stated the oxygen concentrator should have been kept clean so Resident 23 could breathe clean air. During an interview on [DATE] at 3:53 p.m. with the Director of Nursing (DON), DON stated the rooms should be kept tidied and cleaned every day. DON stated the facility should have provided home-like environment to Residents 21, 23, 54, 73, and 75 because the facility was their home. DON stated, if it was her room, she would have complained about the room condition. DON further stated the floors should not have been wet because the residents could have experienced falls or slips, particularly residents who were at high risk for falls. During a record review of the facility's policy and procedure (P&P), titled, Homelike Environment revised in February 2021, the P&P indicated, Residents are provided with a safe, clean, comfortable, and homelike environment.2. The facility staff and management maximizes, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting. These characteristics include.a. clean, sanitary and orderly environment.During a record review of the facility's P&P, titled, Floors revised in [DATE], the P&P indicated, Floors shall be maintained in clean, safe, and sanitary manner.1. All floors shall be mopped/cleaned/vacuumed daily in accordance with our established procedures.		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to provide ongoing assessment, monitoring, and implementation of physician orders for three of five sampled residents (Residents 1, 10, and 95) when: 1. Resident 1, who experienced a change in condition, did not receive timely nursing assessment and evaluation after Resident 1 was observed very sleepy and unresponsive despite multiple attempts by the licensed nurse to awaken Resident 1. 2. Resident 10, who had physician orders for daily weights, did not receive weight monitoring as ordered, and the physician was not notified of the refusals. 3. Resident 95, who had physician orders for daily weights due to a diagnosis of congestive cardiac failure, had incorrect weights recorded (congested heart failure or CHF means the heart is too weak to pump blood efficiently and daily weights is taken because sudden weight gain is often the very first sign that the heart is struggling). These failures had the potential to result in delayed identification of changes in condition, delayed nursing interventions and treatment, worsening conditions, hospitalization and decline in Residents 1, 10, and 95's health status. 1. During a review of Resident 1's admission Record (AR) dated on 5/20/26, the AR indicated Resident 1 was originally admitted to the facility in April 2020 and was readmitted in April 2026 with diagnoses including pneumonia due to methicillin resistant Staphylococcus aureus (an aggressive, potentially life-threatening lung infection caused by Staphylococcus aureus bacteria that resist many common antibiotics) and acute respiratory failure with hypoxia (a life-threatening medical emergency where the lungs cannot adequately oxygenate the blood). During a review of Resident 1's Progress Notes (PN) dated on 4/5/26 at 10:17 p.m., the PN indicated Resident came back from out on pass with sister at 4:15 p.m. Resident noticed to be very sleepy. Resident did not respond to LN until multiple attempts. During a review of Resident 1's record, titled, SBAR (Situation, Background, Assessment, and Recommendation) Communication Form dated on 4/5/26 at 11:00 p.m., the SBAR indicated Resident 1 had high levels of white blood cell count (indicating infection). However, the SBAR did not show Resident 1's change in mental status described in the PN dated 4/5/26. During a review of Resident 1's record, titled, Weights and Vitals Summary (WVS) dated from 4/1/26 to 4/30/26, the WVS did not show documentation of Resident 1's vital signs assessment including blood pressure, oxygen saturation levels, respirations, pulse rates, and temperature, on 4/5/26. During a review of Resident 1's record, titled, SBAR dated on 4/6/26 at 8:30 a.m., the SBAR indicated approximately at 7:50 a.m., a CNA attempted to awaken Resident 1; however, Resident 1 was unresponsive and was noted to have a large amount of mucus. SBAR further indicated Resident 1 had an elevated blood pressure of 189/110 mmHg (milli mercury), an elevated pulse rate of 125 beats per minute (bpm) and oxygen saturation level of 82% and, an altered level of consciousness. SBAR indicated Resident 1 was transferred to acute care hospital via 911. During a review of Resident 1's record, titled, After Visit Summary (AVS) printed on 4/12/26, the AVS indicated Resident 1 was admitted to acute care hospital from [DATE] to 4/12/26 with hospital problem list including acute respiratory failure, polysubstance abuse (consumption of two or more drugs or substances simultaneously or within a short period), seizure (a sudden, uncontrolled burst of abnormal electrical activity in the brain), pneumonia due to MRSA, and urinary tract infection (UTI, bacterial infection that affects any part of your urinary system) due to extended-spectrum beta (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	lactamase (ESBL) producing Escherichia coli (antibiotic-resistant bacteria that create enzymes, destroying common antibiotics like penicillins and cephalosporins). During an interview on 5/18/26 at 11:10 a.m. with Resident 1, Resident 1 stated there was a recent incident in which the facility did not provide timely nursing interventions when she became ill. Resident 1 stated after returning from an out on pass to visit her sister, Resident 1 became very sleepy, and nursing staff were unable to wake her. Resident 1 stated she stopped breathing the following day and was transferred to the acute care hospital. Resident 1 further stated the facility should have acted sooner because she was not normally sleepy. Resident 1 stated she felt the delay in care contributed to her hospitalization for approximately one week due to her condition. During an interview on 5/20/26 at 9:46 a.m. with Licensed Vocational Nurse (LVN) 5, Resident 1's electronic health record (EHR) was reviewed. LVN 5 stated Resident 1's baseline status was alert and oriented to person, place, time, and situation, was usually out of bed, and was not normally sleepy. LVN 5 stated Resident 1 developed a cough on 4/3/26 and was placed on monitoring for three days. LVN 5 stated Resident 1 returned from an out on pass on 4/5/26 and was observed to be very sleepy. LVN 5 stated the licensed nurse who documented a progress note on 4/5/26 attempted to wake Resident 1 multiple times. LVN 5 confirmed no vital signs were recorded on 4/5/26 after Resident 1 had been placed on monitoring starting 4/3/26 for three consecutive days due to coughing and after Resident 1 was observed with a change in condition. LVN 5 stated an SBAR was created on 4/5/26 for Resident 1 regarding elevated WBC; however, the SBAR did not address Resident 1's sleepiness or decreased responsiveness. LVN 5 further stated the SBAR did not contain an accurate assessment because the documented vital signs were copied from 4/4/26 rather than obtained on 4/5/26. LVN 5 stated she was assigned to Resident 1 on 4/6/26 and, after completing her rounds, a certified nurse assistant (CNA) notified her that Resident 1 was unresponsive when staff attempted to wake the resident for breakfast. LVN 5 stated upon assessment, Resident 1 had a large amount of mucus coming from the mouth and Resident 1's oxygen saturation level was 82% (normal levels ranges between 95% and 100%). LVN 5 stated Resident 1's presentation of increased sleepiness and decreased responsiveness on 4/5/26 indicated a change in condition that warranted prompt nursing assessment, monitoring, and interventions to determine whether emergency medical services and transfer to an acute care hospital were indicated. LVN 5 further stated Resident 1 had the risk of deterioration and could have had a cardiac arrest (a life-threatening medical emergency where the heart suddenly stops beating). During a concurrent interview and record review on 5/20/26 at 12:50 p.m. with the Director of Nursing (DON), Resident 1's EHR including PN dated 4/5/26, SBAR dated 4/5/26, and WVS dated from 4/1/26 to 4/30/26 were reviewed. DON confirmed no assessment, including vital signs, was performed when Resident 1 exhibited a change in condition on 4/5/26 when Resident 1 was found very sleepy with decreased responsiveness. DON stated Resident 1 should have been assessed to identify the cause of change in condition. DON further stated licensed nursing staff should have completed and documented an assessment, including vital signs accurately, to evaluate Resident 1's condition and compare findings with Resident 1's baseline. During a record review of the facility's policy and procedures (P&P), titled, Change in a Resident's Condition or Status revised in February 2021, the P&P indicated, 2. A significant change of condition is a major decline or improvement in the resident's status that a. will not normally resolve itself without intervention by staff or implementing standard disease-related clinical interventions. 3. Prior to notifying the physician or healthcare provider, the nurse will make detailed observations and gather relevant and pertinent information for the provider, including information prompted by the Interact (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	SBAR Communication Form.8. The nurse will record in the resident's medical record information relative to changes in the resident's medical/mental condition or status.9. If a significant change in the resident's physical or mental condition occurs, a comprehensive assessment of resident's condition will be conducted. 2. During a review of Resident 10's AR dated on 5/20/26, the AR indicated Resident 10 was originally admitted to the facility in September 2024 and was readmitted in May 2026 with diagnoses including acute kidney failure (rapid decline of kidney function) with tubular necrosis (a serious kidney disorder where the tiny, tube-like structures in your kidneys are damaged) and heart failure (progressive condition where the heart muscle is too weak or too stiff to pump enough oxygen-rich blood to meet the body's needs). During a review of Resident 10's Minimum Data Set (MDS, an assessment tool used to direct resident care) dated 5/14/26, the MDS indicated a Brief Interview for Mental Status (BIMS, a scoring system used to determine the resident's cognitive status in regard to attention, orientation, and ability to register and recall information) score of 3. A BIMS score of zero to seven is an indication of severe cognitive status. During a review of Resident 10's Order Summary (OS) dated 5/20/26, the OS indicated the resident had a physician's order with start date on 5/9/26 scheduled at 9:00 a.m. to Monitor weight daily in the morning at the same time, in the same clothing, and on the same scale. If weight variance is greater than or equal to 2 lbs. (pounds) in one day or greater than or equal to 5 lbs. in five days. During a review of Resident 10's Care Plan for Congestive (the buildup or congestion of fluid in the body's tissues and organs) Heart Failure initiated on 1/11/26, the care plan indicated weights as ordered. During a review of Resident 10's PN, the following Progress Notes indicated Resident 10 refused weight measurements on 5/9/26, 5/10/26, 5/13/26, 5/14/26, 5/17/26 and 5/19/26. The PN did not show documentation regarding the reason for refusals, physician and family notification of the repeated refusals. During an observation and interview on 5/20/26 at 10:41 a.m. with Resident 10 and CNA 3, Resident 10 was sleeping in bed. CNA 3 stated Resident 10 did not exhibit behaviors of refusing weight measurements. CNA 3 stated she had not yet obtained Resident 10's weight was and she was unsure if Resident 10's weight measurements were performed daily. During an interview on 5/20/26 at 10:45 a.m. with Restorative Nursing Assistant (RNA) 1, RNA 1 stated Resident 10 did not refuse weight when she performed weekly weight measurement on 5/15/26. RNA 1 further stated the CNAs were responsible for residents who were ordered on daily weight monitoring. During an interview on 5/26/26 at 10:47 a.m. with LVN 6, LVN 6 stated Resident 10 had a physician order for daily weights monitoring due to a diagnosis of CHF. LVN 6 stated she reminded CNA 3 at the beginning of the shift to get Resident 10's daily weight; however, CNA 3 did not provide her with the weight measurement. LVN 6 stated Resident 10's daily weight should have been obtained consistently to morning for fluid retention and identify changes that could have placed Resident 10 at risk of worsening of CHF symptoms such as shortness of breath and increased swelling of the body. (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a follow-up observation and interview on 5/20/26 at 11:53 a.m. with Resident 10 and CNA 3, Hoyer-lift scale (specialized weighing accessory on a person lift that allows staff to accurately measure an individual's weight while they are suspended in a sling) was present in the room. CNA 3 stated she was done measuring Resident 10's weight without difficulty and Resident 10 did not refuse the weight measurement. Resident 10 stated she was okay doing weight monitoring. Resident 10 stated she was agreeable to daily weight monitoring and had no preference regarding when nursing staff obtained weight measurements. During a concurrent interview and record review on 5/20/26 at 12:33 p.m. with the DON, Resident 10's EHR was reviewed. DON stated the CNAs were responsible for obtaining daily weights and notifying the nurse once completed. DON stated licensed nurses were responsible for following up when residents refused ordered weight measurements. DON stated two or more refusals of daily weight measurements should have required physician notification, especially for residents with CHF or on fluid restrictions. DON stated weight changes could have indicated the need for medication or treatment adjustments. DON stated daily weight monitoring should have been followed as ordered by the physician. DON confirmed Resident 10's EHR did not contain physician notification regarding Resident 10's refusals of daily weight measurements. DON further stated failure to obtain and document daily weight measurements could have a delayed identification of fluid retention and placed Resident 10 at risk for cardiac overload, breathing difficulties, and swelling. DON further stated Resident 10's refusals should have been addressed through care planning and interventions to address barriers to daily weight monitoring. During a review of the facility's P&P, titled, Change in a Resident's Condition or Status revised in February 2021, the P&P indicated, 1. The nurse will notify the resident's attending physician or physician on call when there has been a (an).f. refusal of treatment or medications two or more consecutive times. During a review of the facility's P&P, titled, Heart Failure & Clinical Protocol revised in February 2026, the P&P indicated, Treatment/Management. The physician will review and make recommendations for relevant aspects of nursing care plan; for example, what symptoms to expect, how often, and what (weights, renal function .) to monitor, when to report findings to the physician, etc. 3. During a review of Resident 95's admission Record (AR), the AR indicated Resident 95 was admitted to the facility on [DATE] with diagnoses that included dementia (a decline in mental ability severe enough to interfere with daily life) and CHF. A review of the Minimum Data Set (MDS - standardized assessment and care screening tool), dated 4/22/26, indicated Resident 95's cognition was severely impaired. During a record review of Resident 95's Physician's Order (PO) dated 5/19/26 indicated an order with a start date of 4/17/26 to monitor the resident's weight daily in the morning at the same time, with the same clothing and same scale. The PO also indicated an order that if the weight variance was greater than or equal to two lbs. in one day or greater than or equal to five lbs. in five days, to immediately notify the physician (lbs., lb. or pounds is a form of measurement also used to measure body weight). Resident 95's daily weight disclosed the following weight trend: (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5/11/26 93 lbs. 5/12/26: 92 lbs. 5/13/26: 93.6 lbs. 5/14/26: 93.5 lbs. 5/15/26: 93.4 lbs. 5/16/26: 93.3 lbs. 5/17/26: 93 lbs. 5/18/26: 88.8 lbs. (weight loss of 4.2 lbs.) 5/19/26: 79.8 lbs. (weight loss of 9 lbs.) During a record review of Resident 95's CHF care plan dated 6/10/25, the care plan indicated a goal that Resident 95, will not have signs and symptoms of respiratory distress, weight gain identified and managed daily. During a concurrent interview and record review on 5/21/26, at 10:04 a.m., with the Director of Nursing (DON), Resident 95's Medication Administration Record (MAR) was reviewed. The daily weights recorded in the MAR show a sudden weight drop for Resident 95. The resident's weight decreased from 93 lbs. on 5/17/26 to 88.8 lbs. on 5/18/26 (a 4.2 lb. loss) and fell further to 79.8 lbs. on 5/19/26 (a 9 lb. loss). The DON stated that the resident should have been reweighed on 5/18/26 and 5/19/26 to verify if the weight was accurate. Additionally, the DON stated, the physician should have been notified if a weight gain of more than 2 pounds or a rapid weight loss was confirmed and interventions could have been started. During a review of the facility's policy and procedure (P&P) titled, Heart Failure- Clinical Protocol dated 2001, the P&P indicated, . Treatment/Management: 1. The physician will review and make recommendations for relevant aspects of the nursing care plan; for example what symptoms to expect ,how often and what (weights.) to monitor, when to report findings to the physician . During a review of the facility's P&P titled, Weight Assessment and Intervention dated 2001, the P&P indicated, . 3. Any weight change of 5% or more since the last weight assessment is retaken the next day for confirmation. a. If the weight is verified, nursing will immediately notify the dietician in writing .		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on observation, interview, and record review, the facility failed to ensure the provision of pharmaceutical services when: 1. A routine medication was not available for administration for 3 days for 1 out of 4 residents (Resident 67) observed during the medication pass. 2. Controlled substance (medications that can be easily abused and are under strict government control) medications were signed out of the Controlled Drug Record (CDR, an inventory document) but not documented on the Medication Administration Record (MAR) for 2 out of 6 sampled residents (Residents 49 and 95) 3. An as-needed pain medication was not administered as ordered by the physician for 1 out of 6 sampled residents (Resident 39) 4. A controlled medication was not accurately documented as given on two occasions for 1 out of 6 sampled residents (Resident 36). The failures had the potential for complications to the resident's medical conditions; and inaccurate accountability and potential for abuse and diversion (unlawful distribution or use) of controlled medications. 1 During a medication administration observation on 5/18/26 at 9:56 AM, Registered Nurse (RN) 3 was observed preparing and administering 9 medications to Resident 67. RN 3 looked in the medication cart and stated she did not have the resident's dapagliflozin (brand name: Farxiga, medication for diabetes or congestive heart failure, a long-term condition that happens when your heart cannot pump blood well enough to give your body a normal supply) to give at this time. On 5/18/26 at 10:09 AM, RN 3 placed a call to the physician informing him she did not have Resident 67's dapagliflozin to administer. A review of Resident 67's physician's orders indicated an order for dapagliflozin 5 milligrams (mg, unit of measurement), 1 tablet daily for OBESITY, dated 4/29/26. A review of the nursing progress notes indicated the following: - 5/15/2026 at 11:47 AM, dapagliflozin . not available. f/u [follow up] with pharmacy. - 5/16/2026 at 9:42 AM, dapagliflozin .Awaiting for delivery. - 5/17/2026 at 8:12 AM, dapagliflozin .Awaiting for delivery. During a follow-up interview and record review with RN 3 on 5/18/26 at 2:20 PM, she stated she just received the Dapagliflozin for Resident 67. She reviewed Resident 67's MAR and confirmed it was not administered for 3 days, from 5/15 - 5/17/26, and stated the resident was receiving it for congestive heart failure. During a concurrent interview and record review with the Director of Nursing (DON) and Assistant DON (ADON) on 5/19/26 at 10:08 AM, the DON verified the facility did not administer Resident 67's Dapagliflozin for 3 days, from 5/15 to 5/17/26. Both the DON and ADON could not find documented evidence the nursing staff called the pharmacy when they ran out of the Dapagliflozin on those days. 2. During a concurrent interview and record review the DON and ADON on 5/19/26 at 10:20 AM, the DON stated any time an as-needed controlled medication is requested from a resident, the nursing staff would assess the resident's pain, review the medication order, retrieve the medication from the medication cart, sign the medication out from the CDR, give the medication, and document the administration on the MAR. a. A review of Resident 49's physician's orders indicated an order for Norco (hydrocodone-acetaminophen, a potent narcotic for pain) 5-325 mg, 1 tablet every 4 hours as needed for moderate pain, dated 12/23/25. On 5/19/2026 at 10:22 AM, a review of Resident 49's CDR for Norco 5/325 mg and the March 2026 MAR with the DON and ADON indicated the nursing staff signed 1 tablet out of the CDR but did not document the administration on the MAR on 2 occasions: on 5/23/25 at 9:35 AM and 3/29/26 at 9:54 AM. After reviewing the resident's clinical record including the MAR and the nursing progress notes, the ADON stated, I don't see it. She stated it should have been documented on the MAR to show it was administered to the resident. b. A review of Resident 95's physician's orders included the following orders:Roxicodone (a potent narcotic for pain) 5 mg, give 1 tablet one time daily, dated 4/24/26. Roxicodone 5 mg, give 1 tablet every 4 hours as needed for severe pain, dated 4/24/26.On 5/21/26 at 11:39 AM, a review of Resident 95's CDR for Roxicodone 5 mg and the May 2026 MAR with the ADON indicated the nursing staff signed 1 tablet out of the CDR but did not document the administration on the MAR on 2 occasions: on 5/8/26 at 6:36 PM and 5/13/26 at 8:04 PM. The ADON (continued on next page)		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	reviewed the MAR and the corresponding nursing progress notes and confirmed there was no documentation to show they were administered to the resident. 3. A review of Resident 39's physician's orders indicated an order, dated 5/2/26, for hydrocodone-acetaminophen (Norco) 5-325 mg, 1 tablet every 12 hours as needed for moderate pain (score 4-5) (numeric rating scale, scoring range, 0-10; 0 = no pain, 10 = worst pain possible). A review of Resident 39's May 2026 MAR indicated the nursing staff administered 1 tablet on 5/14/26 at 11:13 AM and another on 5/17/26 at 12:53 PM while the resident's pain score was zero (no pain). During a concurrent interview and record review with the DON and ADON on 5/19/26 at 10:28 AM, they both reviewed Resident 39's MAR and confirmed the finding. The ADON stated she could not find any reason why the Norco was administered while the pain score was zero. 4. A review of Resident 36's physician's orders indicated an order, dated 5/2/26, for Roxicodone 5 mg, give 1 tablet every 6 hours as needed for moderate pain. On 5/19/26 at 10:40 AM, a review of Resident 36's CDR for Roxicodone and May 2026 MAR indicated the nursing staff documented they administered 1 tablet on 5/8/26 at 6:36 PM and another on 5/13/26 at 8:04 p.m. but there was no removal of medications from the CDR. In other words, it was unknown where the Roxicodone came from. The DON stated she will get back to the surveyor. During a follow-up interview on 5/20/26 at 9:40 AM, the DON stated she spoke with the nurse who said she did not remember. The DON acknowledged documentation without giving the medication has the potential for medication not able to be given should the resident require a dose during this time because it would be too soon in the computer system. A review of the facility's policy and procedures (P&P) titled Administering Medications, dated 4/2019, indicated, Medications are administered in accordance with prescriber orders ., The individual administering the medication initials the resident's MAR on the appropriate line after giving each medication . and As required or indicated for a medication, the individual administering the medication records in the resident's medical record: a. the date and time the medication was administered. A review of the facility's undated P&P titled Controlled Substance indicated, The facility complies with all laws, regulations, and other requirements related to . documentation of controlled medications, and the system for reconciling controlled substances includes the medication administration records.		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, staff interview, and record review, the facility failed to store and prepare food in accordance with professional standards for safety when: Three boxes of 4-fluid-ounce milkshakes (74 pieces per box) were stored in Freezer chest 4, which was not kept at the required temperature (fluid-ounce is a form of measurement).A box of blueberry muffins and two unopened bags of frozen potato wedges were stored in the emergency storage room.Clean water pitchers were kept next to the dirty coffee drainpipes. These failures had the potential for contamination of food resulting in food borne illness for 84 residents who received food from the kitchen. An observation and interview with the Dietary Manager (DM) during the kitchen's initial tour, on 5/18/26, at 9:44 a.m., showed three boxes of 4-fluid-ounce milkshakes (74 pieces per box). The boxes indicated to keep frozen at 0 degrees Fahrenheit or below (Fahrenheit or F is a form of temperature measurement). Although freezer chest 4's temperature registered at negative 4 degrees F, the freezer felt warm. At 2:45 p.m., the freezer's temperature was rechecked, and the temperature was 20 degrees F. DM stated the freezer's temperature should be at 0 degrees F or below. DM acknowledged that freezer 4 was broken. DM stated storing milkshakes in Freezer Chest 4 at an improper temperature placed residents at risk of stomach distress.During interview on 5/20/26 at 8:29 a.m., with the Maintenance Director (MD), MD stated that he only did visual checks on freezer chest 4 and stated he had no documentation of freezer chest 4 maintenance. Review of the facility's policy and procedure (P&P) titled, Refrigerators and Freezers, revised November 2022, the P&P indicated, . 1. Refrigerators and/or freezers are maintained in good working condition.5. The supervisor takes immediate action if temperatures are out of range . 2. An observation and interview in the emergency storage room on 5/18/26, at 2:06 p.m., showed an unopened box of blueberry muffins and two unopened bags of frozen potato wedges placed on top of freezer chest 5. On observation, the emergency storage room felt warm. When DM was asked if the temperature of the room was being monitored, DM stated it was not. DM took the temperature of the blueberry muffins and was noted to be 48.9 degrees F. DM stated the temperature of the muffins should be at 41 degrees F. DM further stated that storing the blueberry muffins and potato wedges at room temperature created a risk of food spoilage. Stated if residents consumed spoiled food, they could experience stomach distress. Review of the facility's policy and procedure (P&P) titled, Food receiving and storage, revised November 2022, indicated, . Foods shall be received and stored in a manner that complies with safe food handling practices.2. Danger zone means temperatures above 41 F and below 135 F that allow the rapid growth of pathogenic microorganisms that can cause foodborne illness. Foods held in danger zone for more than four hours. may cause foodborne illness outbreak if consumed. 3. An observation and interview in the kitchen on 5/18/26, at 2:37 p.m., showed water pitchers stored next to the dirty coffee drainpipe.There were brown and black residue imbedded in different areas of the outer part of the coffee drainpipe. When DM wiped the drainpipe with a clean moist paper towel, it picked up brown residue. The DM acknowledged that the brown residue in the paper towel was dirt. The DM stated that the water pitchers were used to store clean drinking water for residents. Furthermore, the DM acknowledged that these pitchers should not have been stored next to the dirty drainpipe due to the risk of cross contamination (unintentional transfer of germs from one surface, object, or food to another). Review of the facility's policy and procedure (P&P) titled, Sanitation, revised November 2022, indicated, . The food service area is maintained in a clean and sanitary manner.1. All kitchens, kitchen areas and dining areas are kept clean, free from garbage and debris .		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observations, interviews, and record reviews, the facility failed to implement their infection prevention and control policies and procedures for five out of ten residents (Resident 9, 13, 16, 86, and 70) and a facility census of 84 when: For one of three sampled residents (Resident 9), Resident 9's clothing was on the floor and was returned to the closet without being laundered or cleaned prior to storage. For one of two sampled residents (Resident 86), Resident 86's urinal was stored directly on top of the trash receptacle without a lid and not placed in a protective bag. Laundry Personnel (LP) transported soiled linens in an uncovered laundry barrel through the hallway while wearing contaminated personal protective equipment (PPE, is equipment worn to minimize exposure to hazards) and entered the clean area of the laundry room without removing the contaminated PPE, exposing clean linens to contamination. Overflow (a secondary, dedicated storage unit in nursing facilities or hospitals used to store backup or overflow prescription medications) medication cart #1's sharps container was filled beyond capacity, with sharps extending above the manufacturer's designated fill line. For one sampled resident (Resident 13), Licensed Vocational Nurse (LVN) 3 did not perform proper hand hygiene during a wound care treatment. For one of two sampled residents (Resident 70), Resident 70's feeding bag tubing (a medical device used to deliver liquid nutrition, hydration, and medications directly into a patient's stomach or small intestine) was left uncapped and exposed. For one of three sampled residents (Resident 16), Resident 16's nebulizer (used to deliver medication in a fine mist over the nose and mouth) mask was left without a protective bag and exposed to air. One of three licensed nurses observed during the medication pass did not use the appropriate disinfectant to disinfect shared glucometers (medical device used to measure the approximate concentration of sugar in the blood) following a blood sugar monitoring procedure. These failures had the potential to increase the risk of transmission of infectious organisms, exposure to blood-borne pathogens (infectious microorganisms present in human blood), contamination of resident care items and development of healthcare-associated infections. 1. During a record review of Resident 9's admission Record (AR) printed on 5/20/26, the AR indicated Resident 9 was admitted to the facility in March 2023 with diagnoses of unstable angina (a type of chest pain that happens when your heart muscle isn't receiving enough oxygen) and personal history of Covid-19 (highly contagious infectious disease that primarily attacks the respiratory system). During an observation on 5/18/26 at 9:51 a.m. in Resident 9's room, a light gray pair of pants was on the floor directly in front of Resident 9's closet. During a subsequent observation on 5/18/26 at 10:00 a.m. in Resident 9's room, the same light gray pair of pants previously observed on the floor was returned to Resident 9's closet and stored together with Resident 9's clean clothing. During an interview and observation on 5/18/26 at 10:07 a.m. with Certified Nurse Assistant (CNA) 1, CNA 1 removed the light gray pair of pants from Resident 9's closet. CNA 1 stated the clothing should not have been returned to the closet after being on the floor because they it was considered dirty and could have contaminated Resident 9's clean clothing. CNA 1 further stated she would not want to wear clothing that had been on the floor. During an interview on 5/20/26 at 2:02 p.m. with the Infection Preventionist/Director of Staff Development (IP/DSD), the IP/DSD stated that clothing found on the floor should have been removed, placed in a plastic bag for laundering, and replaced with clean clothing. The IP/DSD further stated the clothing that had fallen onto the floor should not have been returned to Resident 9's closet because (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	germs on the floor could have transferred to Resident 9's clean clothing, creating a risk for transfer of infection. During a review of the facility's policy and procedures (P&P) titled, Departmental (Environment Services) & Laundry and Linen, revised in January 2014, the P&P indicated, The purpose of this procedure is to provide a process for the safe and aseptic handling, washing and storage of linen. Standard Precautions.1. Separate soiled and clean linen at all times.3. Considered all soiled linen to be potentially infectious and handle with standard precautions. Bagging and Handling Soiled Linen.1. All soiled linen must be placed directly into a covered laundry hamper. 2. During a record review of Resident 86's AR printed on 5/20/26, the AR indicated Resident 86 was admitted in the facility October 2024 with diagnosis of dysphagia (difficulty swallowing food, liquids, or saliva) following nontraumatic intracerebral hemorrhage (bleeding directly into the brain tissue without a history of head injury). During an observation and interview on 5/18/26 at 11:25 a.m. with Resident 86, Resident 86 was sleeping in bed. Resident 86's urinal, without a lid and not stored in a protective bag, was observed hanging on the side of the trash receptacle containing used purple gloves was located adjacent to the bathroom entrance. During an observation and interview on 5/18/26 at 11:34 a.m. with CNA 4, CNA 4 was observed removing Resident 86's urinal from the trash receptacle. CNA 4 stated the urinal should have been stored in a plastic bag and kept near Resident 86's bedside to prevent contamination and infection. During an interview on 5/20/26 at 2:02 p.m. with IP/DSD, IP/DSD stated urinals not in use should have been stored in a plastic bag with a lid and kept near the bedside drawer. The IP/DSD stated placing or hanging the urinal on the trash receptacle may contaminate the urinal from the waste or contaminated items inside the trash receptacle. The IP/DSD stated the contaminated urinal placed Resident 9's at risk for infection, including urinary tract infection (UTI, an infection in any part of your urinary system including kidneys, ureters, bladder, and urethra). During a review of the facility's P&P titled, Standard Precautions revised in September 2022, the P&P indicated, Standard precautions are used in care of all residents. Standard precautions presumed that all blood, body fluids, secretions, and excretions (except sweat). may contain transmissible infectious agents. Standard precautions include the following practices.5. Resident-Care Equipment.a. Resident-care equipment soiled with blood, body fluids, secretions, and excretions are handled in a manner that prevents skin and mucous membrane exposure. and transfer of microorganism. 3. During an observation on 5/19/26 at 11:04 a.m. outside the laundry room, in the hallway, Housekeeping/Laundry Personnel (HK/LP), HK/LP was in the hallway transporting an uncovered gray laundry barrel containing soiled linens while wearing personal protective equipment (PPE, equipment worn to minimize exposure to hazards) including mask gloves, and gown. HK/LP entered the laundry room and placed the soiled laundry barrel in front of the washer and transferred the soiled linens into Washer #2. After transferring the soiled linens, HK/LP moved the laundry barrel across the demarcation line separating the dirty area from the clean area in order to close Washer #2's door. While still wearing the same PPE used to transport and handle the soiled linens, HK/LP entered the clean area and disposed of the gloves. Resident clothing was observed on top of the table in the clean area. HK/LP then returned to the dirty area, removed and hung the same gown on the wall. HK/LP stated she forgot to remove the soiled PPE prior to entering the clean area and stated she should (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	have removed the PPE and performed hand hygiene before entering the clean area to prevent transmission of infection. During an interview on 5/19/26 at 11:20 a.m. with Housekeeping Manager (HKM), HKM stated laundry barrels containing soiled linens should have remained closed when handling and transporting to prevent contamination exposure in the hallway. HKM stated soiled linen barrel should not have crossed the demarcation line into the clean area. HKM further stated HK/LP should have removed the contaminated PPE and performed hand hygiene prior to entering the clean area to prevent contamination of clean linens and residents' clothing. HKM stated not following infection prevention practices had the risk for cross contamination and transmission of infectious organisms. During an interview on 5/20/26 at 3:35 p.m. with Director of Nursing (DON), DON stated HK/LP should not have worn contaminated PPE while transporting the soiled linens and should have removed the contaminated PPE used to transfer soiled laundry items from the hampers to the gray laundry barrel prior to entering the clean areas of the building. DON further stated contaminated PPE worn in the hallway could have come into contact with surrounding surfaces or individuals, creating a risk for cross-contamination. DON further stated HK/LP should have avoided crossing into the clean areas of laundry room without removing the contaminated PPE and should have not moved the soiled laundry barrel into the clean area of the laundry room due to the risk of contaminating clean laundry items. During a review of the facility's P&P titled, Laundry and Bedding, Soiled revised in January 2026, the P&P indicated, Soiled laundry/bedding shall be handled, transported and processed according to best practices for infection prevention and control. Handling.1. All used laundry is handled as potentially contaminated using standard precautions. d. Staff handle soiled textiles/linens with minimum agitation to avoid contamination of air, surfaces, and persons. Storage.3. Clean linen is stored separately from contaminated linen. The use of separate rooms, closet or other designated spaces with a closing door are used to reduce the risk of accidental contamination. During a review of the facility's P&P titled, Standard Precautions revised in September 2022, the P&P indicated, 4. Gowns. Soiled gowns are removed as promptly as possible and hands washed to avoid transfer of microorganisms to other residents or environments. 4. During an observation in the hallway on 5/19/2026 at 2:59 p.m., a medication cart with a sharps container mounted on the side was observed to be filled beyond the manufacturer's indicated fill line and contained sharps and other metal objects not intended for sharps disposal. During an interview with Licensed Vocational Nurse (LVN) 4 on 05/19/2026 at 3:05 p.m., LVN 4 stated the cart was used as an overflow cart for storing residents' extra medications and confirmed the sharps container should have been replaced when full to prevent items from sticking out and reduce the risk of contamination and infections, including sepsis. During an interview with IP/DSD on 5/20/2026 at 2:02 p.m., the IP/DSD stated sharps containers must never exceed the fill line due to the risk of needle stick injury and that only needles, lancets, and test strips should be placed inside During an interview with DON on 5/20/2026 at 3:35 p.m., DON stated sharps containers must be replaced once they reach the fill line and that overfilled containers are dangerous because patients or staff could be poked by contaminated sharps. During a review of facility's P&P titled, Sharps Disposal, dated January 2012, the P&P indicated, (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	designated individuals will be responsible for sealing and replacing containers when they are 75% to 80% full to protect employees from puncture and/or needlesticks when attempting to push sharps into the container. 5. During an observation on 5/19/2026 at 10:39 a.m., Licensed Vocational Nurse (LVN) 3, accompanied by the Director of Rehabilitation (DOR) who served as translator, entered the room to perform wound care for Resident 13. LVN 3 verified Resident 13's identity, disinfected the tray table, allowed the surface to dry for four minutes, donned personal protective equipment (PPE, mask, gowns, gloves, face shields, etc.), and prepared multiple wound care supplies, and performed hand hygiene between preparation steps. Certified Nursing Assistant (CNA) 2 was present in full PPE. During an observation on 5/19/26 at 10:51 a.m., LVN 3 removed a soiled dressing from Resident 13's coccyx (commonly known as the tailbone); however, she did not perform hand hygiene after removing the soiled dressing. LVN 3 put on new gloves without washing or sanitizing her hands. LVN 3 then cleansed the coccyx wound with saline moistened gauze, performed two wipes, and patted the area dry; all without changing gloves during wound cleansing. LVN 3 removed her gloves, did not perform hand hygiene again, and applied the ordered treatment for Resident 13. During an interview with LVN 3 on 5/19/2026 at 10:56 a.m., LVN 3 stated she was supposed to wash or sanitize her hands between glove changes and after removing a soiled dressing, acknowledging that failure to do so placed Resident 13 at risk for infection. During an interview with IP/DSD, on 5/20/2026 at 2:02 p.m., the IP/DSD stated that staff must wash hands with soap and water after removing a soiled dressing, before applying a new one, explaining that not washing hands can contaminate the wound and cause infections, including UTIs or wound infections. During an interview with Director of Nursing (DON) on 5/20/2026 at 3:35 p.m., DON stated staff were expected to perform hand hygiene every time they touched something dirty and specifically after removing a soiled dressing to prevent contaminating the wound. During a review of the facility's P&P titled Wound Care, dated October 2010, the P&P indicated steps in the procedure, .remove dressing. 5. Pull glove over dressing and discard into appropriate receptacle. Wash and dry your hands thoroughly. During a review of the facility's P&P titled Handwashing/Hand Hygiene, dated October 2024, the P&P indicated for Hand Hygiene, f. before moving from work on a soiled body site to a clean body site on the same resident, and g. immediately after glove removal. 6. During an observation on 5/18/26 at 10:41 a.m., Resident 70's feeding formula was running 55 ml/hour. The tube feeding tip was uncapped and exposed, with dried formula on the machine. During an interview on 5/19/26 at 2:30 p.m. with DON, DON stated, after formula is completed, the tubing should be disconnected and capped to prevent contamination. 7. During an observation on 5/18/26 at 10:45 a.m., Resident 16's nebulizer mask was uncovered and not bagged, resting on the nightstand. A review of the National Institute of Health publication titled, How to Use a Nebulizer dated October (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2021, indicated, after each treatment, wash the mask and other parts except the tubing with mild soap and warm water, rinse well and air dry on a paper towel, and store in a dry clean plastic storage. [Reference: https://www.nhlbi.nih.gov/sites/default/files/publications/How-to-Use-a-Nebulizer-21-HL-8163.pdf]. 8. During an observation on 5/18/26 at 11:59 AM, Registered Nurse (RN) 2 was observed at her medication cart with two Assure Platinum glucometers in hand. RN 2 was observed wiping each glucometer with an alcohol swab. She stated she had just finished testing the blood sugar (BS) for 5 residents using these two glucometers. She explained that she alternated them between residents by using one glucometer to measure the BS for a resident, wiping it and letting it dry after use while using the other glucometer to take the BS for another resident. RN 2 stated she used the alcohol swabs to wipe down the glucometer after each resident use. During an interview on 5/18/26 at 12:26 p.m., with the IP/DSD and DON, the IP/DSD stated glucometers are shared among residents, and nurses are to alternate them with wiping and drying them between resident uses. Both the IP/DSD and the DON stated they are to use the SaniCloth Bleach (a disinfectant wipe that contains bleach, to kill many organisms such as bacteria and viruses) wipe to disinfect the glucometers after each use. Both also stated it is not okay to use alcohol wipe to disinfect the glucometers as alcohol does not kill many organisms. During a follow-up interview with RN 2, on 5/18/26 at 2:16 p.m., she stated she was to use a bleach wipe, not the alcohol wipe, to disinfect the glucometer after each use. During an interview on 5/19/26 at 12:58 p.m. the DON stated the facility did not have a policy and procedure addressing glucometer disinfection but we follow the manufacturer's guidelines. The DON provided the undated guidelines from the manufacturer for Assure Platinum, which indicated the following under Cleaning and Disinfecting Guidelines, page 47: Cleaning and disinfecting can be completed by using a commercially available EPA-registered disinfectant [chemical product vetted and approved by the Environmental Protection Agency to kill specific pathogens like bacteria, viruses, and fungi on surfaces] detergent or germicide [germ-killing] wipe. A review of the Center for Disease Control and Prevention's (CDC's) online publication titled Considerations for Blood Glucose Monitoring and Insulin Administration, dated 8/7/24, indicated: If blood glucose meters must be shared, the device should be cleaned and disinfected after every use, per the manufacturer's instructions, to prevent the spread of blood and infectious agents.		

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

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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055276	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/21/2026
NAME OF PROVIDER OR SUPPLIER Mission Valley Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 2400 Parkside Drive Fremont, CA 94536	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep all essential equipment working safely. Based on observation, staff interview, and review of facility documents, the facility failed to ensure Freezer 3 was maintained in proper working condition, as evidenced by:1. The freezer's louvered panel was missing (a louvered panel is a cover located at the bottom of a freezer. It allows air to circulate freely for cooling, while keeping out direct light, dust, and debris).2. The freezer's right handle was missing. 1. During a concurrent observation and interview on 5/20/26 at 8:23 a.m., with Dietary Manager (DM), DM showed freezer 3's louvered panel was missing. As a result, the wiring, coils, and mechanical parts underneath were exposed. In addition, the mechanical components and wiring were coated in scattered black sticky dust and the DM described the area as dirty. DM stated the louvered panel had been missing for one year.During an interview on 5/20/26 at 8:29 a.m., with the Maintenance Director (MD), MD stated that freezer 3's louvered panel was missing and was unsure when it was damaged. MD stated the risk was food contamination if the freezer stopped working due to the missing part that protected the freezer's mechanical parts.2. During a concurrent observation and interview on 5/20/26 at 8:30 a.m., with the DM, the DM showed freezer 3's right side handle was missing. DM stated it had been broken for a long time, and it was not reported to the MD.During an interview on 5/20/26 at 8:35 a.m., with the MD, MD stated that he was unsure when the freezer's handle was damaged and it should have been fixed.A review of the facility's P&P titled, Refrigerators and Freezers, revised November 2022, the P&P indicated, . 1. Refrigerators and/or freezers are maintained in good working condition.10. Supervisors inspect refrigerators and freezers monthly for gasket condition, fan condition, presence of rust, excess condensation, and any other damage or maintenance needs. Necessary repairs are initiated immediately .		

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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, for one of one sampled resident (Resident 70) reviewed for positioning and mobility, the facility failed to ensure Resident 70's reasonable accommodation of needs and preferences when the call light was left out of reach. This failure had the potential to impair the resident's ability to request help, placing the resident at risk for unmet care needs. During a review of Resident 70's admission Record (AR) dated 5/19/26, the AR indicated Resident 70 was admitted to the facility on [DATE] with diagnoses that included hemiplegia (the severe or complete loss of motor function (paralysis) on one side of the body) and hemiparesis (weakness or partial paralysis affecting only one side of the body) affecting left non-dominant side, difficulty in walking, weakness and aphasia (disorder that affects how you communicate, impacts speech and ability to understand written or spoken language). During a review of Resident 70's Minimum Data Set (MDS, an assessment tool used to direct resident care) dated 4/13/26, the MDS indicated Resident 70 had impairment on one side of the body, both upper and lower extremities. The MDS also indicated Resident 70 was usually understood, had difficulty communicating some words or finishing thoughts but is able if prompted or given time, and usually understands and comprehends most conversation. During a review of Resident 70's fall care plan dated 4/9/26, the care plan indicated to keep call light and personal items within reach. During an observation on 5/18/26 at 12 p.m., inside Resident 70's room, Resident 70 was in a wheelchair positioned on the far-left side of the bed. Resident 70 had left side weakness, left side from shoulder down to hand slumped in wheelchair without support. Resident 70 was unable to lift left hand. Call light was placed on the right side of the bed, near Resident 70's left side. Resident 70 reported left side pain and requested repositioning. During an interview on 5/19/26 at 2:10 p.m. with Director of Nursing (DON), DON stated call light should be on the right within Resident 70's reach due to left side paralysis/weakness, as resident cannot access it if placed on the left (weak) side.		

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. Based on interview and record review, the facility failed to ensure 1 out of 5 sampled residents (Resident 8) was free from unnecessary psychotropic medications (drugs that affects brain activities associated with mental processes and behavior). Resident 8 has been receiving Olanzapine (an antipsychotic medication) without staff monitoring target behaviors quantitatively. Quantitative measure of target behaviors would be helpful in monitoring the patient's progress, assessing effects of treatment, and a factor in considering whether to conduct gradual dose reduction (GDR, a tapering of a dose to determine if symptoms, conditions, or risks can be managed by a lower dose or if the dose or medication can be discontinued). A review of Resident 8's clinical record indicated she was admitted to the facility with diagnoses including unspecified dementia (impaired ability to remember, think, or make decisions that interferes with doing everyday activities) and depression. A review of Resident 8's physician's orders indicated the resident has been receiving Olanzapine 10 milligrams (unit of measurement), 1 tablet by mouth at bedtime for unspecified dementia manifested by angry outbursts since 4/3/25 (more than a year ago). There was also a physician's order to monitor specific behavior Anti-Psychotic m/b [manifested by]: Angry outburst every shift chart # [number] of episodes, dated 4/4/25. A review of Resident 8's medication administration records (where the nursing staff also documented behavior monitoring) for February, March, April, and May 2026 indicated the nursing staff has been placing a check mark in the entry for Monitor specific behavior Anti-Psychotic m/b: Angry outburst every shift chart # of episodes every shift. In other words, there was no quantitative measure or number of episodes (such as 0, 1, 2, 3, etc. episodes) entered into the MAR during the shift in these months. During a concurrent interview and record review with the Director of Nursing (DON) and the Assistant DON (ADON) on 5/20/26 at 3:05 PM, the ADON reviewed the MARs and stated, The order was put in that way without quantity since 4/4/25 (more than a year ago). Both staff confirmed the facility has not been monitoring the number of episodes of angry outbursts as response (or effectiveness) to Olanzapine treatment. They also confirmed that the number of target symptoms and behaviors would be used by the interdisciplinary team (team composed of members from different departments involved in a resident's care) to assess whether or not to recommend a GDR during the quarterly psychotropic medication review. The American Psychiatric Association (APA) published the Guidelines Statements in an online publication, dated 5/1/16, titled The American Psychiatric Association Practice Guideline on the Use of Antipsychotics to Treat Agitation or Psychosis in Patients With Dementia. A review of Statement 3 of the Guidelines indicated, APA recommends that in patients with dementia with agitation or psychosis, response to treatment be assessed with a quantitative measure. The publication further indicated Use of a quantitative measure to document information on symptoms in a systematic fashion can be helpful in monitoring the patient's progress and assessing effects of treatment. (https://doi.org/10.1176/appi.books.9780890426807.ap02, accessed 5/26/26) A review of the facility's policy and procedures titled Antipsychotic Medication Use, dated 8/2022, indicated, The staff will observe, document, and report to the attending physician information regarding the effectiveness of any interventions, including antipsychotic medications.		

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that continued nutritional care and services were provided to one of 20 sampled residents (Resident 68) when Resident 68, who had a weight loss of 11.2 pounds which yielded 11.8% weight loss from 4/6/26 to 5/1/26, was not reweighed after 5/1/26 for a total of 20 days (pounds or lbs. is a form of measurement which is also used to measure body weight). This deficient practice had the potential to result in Resident 68's further unplanned weight loss. During a review of Resident 68's admission Record (AR) dated 5/21/26, the AR indicated Resident 68 was admitted to the facility on [DATE] with diagnoses that included depression (a serious mood disorder that causes persistent feelings of sadness, emptiness, and a loss of interest in daily activities) and malignant neoplasm of stomach (cancer of the stomach). A review of the Minimum Data Set (MDS - standardized assessment and care screening tool), dated 3/27/26, indicated Resident 68's brief interview of mental status (BIMS, an assessment for mental status) score was 12 (a score of 12 represents moderate cognitive impairment). During an observation on 5/18/26 at 1:00 p.m., Resident 68 was lying in bed asleep, and her meal tray was at the bedside untouched. During an interview on 5/21/26 at 8:45 a.m., Certified Nursing Assistant (CNA) 5, CNA 5 stated she had been taking care of Resident 68 in the past two months for dayshift (work hours from 7:00 am to 3:30 p.m.). CNA 5 stated that Resident 68 only ate around 25% most of the time and not more than 50% of her breakfast and lunch in the past two months. Resident 68's weight disclosed the following weight trend: 5/1/26 83.4 lbs. (weight loss of 10.8 lbs. or 11.46 percent from 4/17/26) 4/27/26 83.8 lbs. (weight loss of 10.4 lbs. or 11.04 percent from 4/17/26) 4/17/26 94.2 lbs. 4/10/26 94 lbs. 4/6/26 94.6 lbs. 3/28/26 94.8 lbs. 3/27/26 94.2 lbs. There was no record found that Resident 68 was reweighed from 5/1/26 until 5/21/26. During a concurrent interview and record review on 5/21/26, at 10:16 a.m., with the Director of nursing (DON), Resident 68's weight record was reviewed. The recorded weight on 5/1/26 was 83.4 lbs. which was 10.8 lbs. less than 4/17/26's weight of 94.2 lbs. DON acknowledged that the resident should have been weighed weekly to monitor if there was further weight loss. During a concurrent interview and record review on 5/21/26, at 10:33 a.m., with the Registered Dietitian (RD.), Resident 68's weight record was reviewed. RD stated that Resident 68 had 11.46 % weight loss from 3/27/26 to 5/1/26. RD could not find a record of Resident 68's weight after 5/1/26. RD acknowledged that the resident should have been reweighed after 5/1/26 at least biweekly to closely monitor for further weight loss. During a review of the facility's P&P titled, Weight Assessment and Intervention dated 2001, the P&P indicated, . 3. Any weight change of 5% or more since the last weight assessment is retaken the next day for confirmation. a. If the weight is verified, nursing will immediately notify the dietician in writing .		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, for two of three sampled residents reviewed for respiratory care (Resident 16 and 23), the facility failed to ensure residents received respiratory care in accordance with professional standards of practice when:1. Resident 16's BiPAP (machine is a non-invasive that helps people breathe easier, it delivers pressurized air through a mask, providing a higher pressure when you inhale and a lower pressure when you exhale) equipment was not applied and not maintained as ordered nor did the staff follow required procedures for equipment monitoring and troubleshooting.2. Resident 23's oxygen via nasal cannula was not positioned correctly. These failures had the potential to result in inadequate ventilation support and increased respiratory distress. 1. During a review of Resident 16's admission Record dated 5/19/26, the AR indicated Resident 16 on 5/3/26 with diagnoses that included chronic obstructive pulmonary disease (COPD, refers to a group of diseases that cause airflow blockage and breathing-related problems), bronchiectasis (a chronic lung disease where the airways (bronchi) become permanently damaged, widened, and scarred), and dependence on supplemental oxygen. During a review of Resident 16's Minimum Data Set (MDS, an assessment tool used to direct resident care) dated 5/10/26, the MDS indicated a Brief Interview for Mental Status (BIMS, a scoring system used to determine the resident's cognitive status in regard to attention, orientation, and ability to register and recall information) score of 14. A BIMS score of 13-15 is an indication of intact cognitive status. During a concurrent observation and interview on 5/18/26 at 10:45 a.m., at Resident 16's bedside, Resident 16 stated the BiPAP machine did not function properly the previous night. Resident 16 stated that he needed more oxygen and was unable to breathe, which prevented him from sleeping. Resident 16 stated he notified the nurse and requested that the doctor be called to increase his oxygen, but his concern was not addressed. Resident 16 further stated, forty minutes after starting the BiPAP, Resident 16's oxygen saturation (the amount of oxygen you have circulating in your blood) had dropped to 85 % (normal 95-100%). During a review of the Order Summary Report (OSR) dated 5/19/26, the OSR indicated an order BiPAP at bedtime. During a concurrent observation and interview on 5/18/26 at 3:10 p.m. with Registered Nurse (RN) 4 at Resident 16's bedside, RN 4 stated the BiPAP was turned on typically at 10 p.m. before leaving for the day. RN 4 stated the physician's order did not specify the BiPAP settings but believed the device was already set up and did not require staff to adjust the settings. However, RN 4 was unable to identify the required settings or locate them on the machine. RN 4 explained that her responsibilities included filling the water reservoir and was unsure how to determine if the BiPAP was malfunctioning. During a concurrent interview and record review on 5/19/26 at 2:10 p.m. with Director of Nursing (DON), DON stated the physician's order lacked information about the BiPAP settings and that a review of the hospital discharge records also did not indicate the ordered settings. DON stated the process for obtaining BiPAP equipment that included the facility's marketer coordinating with the vendor following the hospital's prescription. The vendor would set up the machine; the charge would then review the settings to confirm consistency with the physician's order. DON emphasized the (continued on next page)		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	importance of having information about the BiPAP settings, as excessive airflow would not address the residents' needs. DON said if the BiPAP machine fails, the charge nurse should inform the physician and vendor. During an interview on 5/20/26 at 9:45 a.m. with Director of Staff Development (DSD). DSD described the training procedures for BiPAP use. DSD stated, if a machine is available, staff are shown how to operate it and adjust settings. Otherwise, they are instructed to check the mask fit, read the instruction manual, and follow its guidance. Expectations include ensuring that the machine settings and mask size match the prescription. Staff are advised to ask the physician if they are unsure, as improper fit or settings could lead to breathing difficulties or insufficient oxygen delivery. During a review of Resident 16's eInteract Change in Condition Evaluation (CIC) dated 5/19/26, the CIC indicated, on 5/19/26 at 10 p.m. Resident 16's BiPAP was turned on, after 30 minutes, Resident 16 complained of shortness of breath, oxygen saturation dropped to 65 % with four liters of oxygen via nasal cannula. Resident 16 was transferred to the hospital. During a review of the facility's policy and procedure (P&P) titled, CPAP/BiPAP Support, undated, the P&P indicated, before initiating therapy, staff should review the resident's medical record to determine baseline respiratory and circulatory status, as well as physician's orders for oxygen concentration, flow, and pressure settings. 2. During a review of Resident 23's AR printed on 5/21/26, the AR indicated Resident 23 was admitted to the facility in January 2021 with diagnoses including Alzheimer's disease (a progressive, irreversible neurological disorder that destroys brain cells, leading to severe memory loss, cognitive decline, and the loss of basic daily functioning) and asthma (a chronic lung disease that causes your airways to swell, narrow, and produce extra mucus). During a review of Resident 23's MDS dated [DATE], the MDS indicated a BIMS score of three. A BIMS score of zero-seven indicates a severe cognitive status. During a review of Resident 23's Order Summary dated 2/29/24, the Order Summary indicated Resident 23 had a physician's order for oxygen (O2) therapy at 3 liters per minute via nasal cannula for asthma. During a review of Resident 23's Care Plan Report initiated on 2/26/24 with revision date on 3/20/24, the care plan for oxygen therapy related to ineffective gas exchange indicated Oxygen Settings: The resident has O2 via nasal prongs at 3(L/liters) continuously. During an observation on 5/18/26 at 10:40 a.m. with Licensed Vocational Nurse (LVN) 4, LVN 4 was inside Resident 23's room, assisting Resident 23's roommate. LVN 4 then exited the room and proceeded to the medication cart. During an observation on 5/18/26 at 10:46 a.m. with Resident 23, Resident 23 was asleep in bed while the oxygen concentrator remained powered on; however, the nasal cannula was not positioned correctly and was instead observed under Resident 23's chin. During an observation and interview on 5/18/26 at 10:49 a.m. with LVN 4, LVN 4 reapplied the nasal cannula to Resident 23's nostrils. LVN 4 stated they last observed Resident 23 approximately 30 (continued on next page)		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	minutes earlier and was unsure how long Resident 23 had been without oxygen delivery. LVN 4 stated Resident 23 frequently removed the nasal cannula and nursing staff should have performed frequent monitoring and observation to ensure the nasal cannula was properly in place. LVN 4 further stated Resident 23 could have experienced hypoxia (deprived of adequate oxygen supply) with symptoms including shortness of breath and may have required breathing treatment intervention. During an interview on 5/19/26 at 2:37 p.m. with the DON, DON stated the oxygen therapy should have been provided continuously as ordered by the physician. DON stated the nursing staff should have monitored the placement of the nasal cannula at least every two hours, or more frequently as needed for residents with confusion, to ensure oxygen therapy was being administered to maintain acceptable oxygen saturation levels (a measurement of the percentage of hemoglobin in your red blood cells that is carrying oxygen). During a review of the facility's P&P, titled, Oxygen Administration revised in October 2010, the P&P indicated, 1. Review the physician's orders or facility protocol for oxygen administration.2. Review the resident's care plan to assess for any special needs of the resident.Steps in the Procedure.11. Securely anchor the tubing so it does not rub or irritate resident's nose. Behind the resident's ears, etc.12. Check the mask, tank, humidifying jar, etc.to be sure they are in good working order and securely fastened.13. Observe resident upon set up and periodically thereafter to be sure oxygen is being tolerated.		

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. Based on interview and record review, the facility failed to ensure 2 out of 5 sampled residents (Residents 5 and 95) were free from unnecessary medications. Residents 5 had no hold parameters for an antihypertensive medication (medication to lower blood pressure); and Resident 95 had no monitoring for thyroid stimulating hormone (TSH) while receiving levothyroxine (medication to treat hypothyroidism, a condition where the thyroid gland does not produce enough thyroid hormone). The failure resulted in inadequate monitoring and had the potential for complications related to these medications such as severely low blood pressure or too low/too high TSH without dose adjustment, for the respective residents. 1. A review of Resident 5's clinical record indicated she was admitted to the facility with diagnoses including atrial fibrillation (is an irregular and often very rapid heart rhythm) and hypertension (high blood pressure [BP]). A review of Resident 5's physician's orders indicated an order for metoprolol (an antihypertensive medication) 25 milligrams (unit of measurement), give 1 tablet by mouth in the morning for Hypertension, dated 2/24/26. The order did not include hold parameters, such as when to hold or not give the medication. A review of the Prescribing Information (PI; detailed description of a drug's uses, dosage range, side effects, drug-drug interactions, and contraindications that is available to clinicians) from the manufacturer for metoprolol, revised 7/2023, indicated metoprolol's effects include lowering the blood pressure and reducing the heart rate (HR). During a concurrent interview and record review with the Assistant Director of Nursing (ADON) on 5/20/26 at 10:58 AM, she reviewed Resident 5's May 2026 medication administration record (MAR) and confirmed there should have been instructions for when to hold the medication such as when the BP or HR was below certain readings to avoid them being too low. 2. A review of Resident 95's clinical record indicated she was admitted to the facility with diagnoses including hypothyroidism. A review of physician's orders indicated Resident 95 has been receiving levothyroxine 150 micrograms (unit of measurement), 1 tablet every morning since a re-admission to the facility on 6/10/25 (almost a year ago). A review of Resident 95's laboratory results indicated no laboratory monitoring for TSH related to levothyroxine use. During a concurrent interview and record review with the ADON on 5/21/26 at 11:20 AM, she reviewed Resident 95's clinical record and stated she could not find any TSH laboratory values. During a concurrent interview and record review with the Director of Nursing (DON) and ADON on 5/21/26 at 12:52 PM, the ADON stated she identified a TSH level that was conducted on 9/8/25 by the hospital during the resident's hospital stay from 9/8/25 to 9/16/25. It was 0.03 (very low; normal value: 0.35 - 4.94 mIU/L [milli-international units per liter]). Both the DON and ADON confirmed Resident 95 has been receiving levothyroxine 150 mcg daily without TSH monitoring since 6/10/25, and the facility was not aware of the hospital's low TSH level while she was in the hospital; as a result, there has been no TSH monitoring since she returned on 9/16/25 to see if dose adjustment was needed. A review of the PI from the manufacturer for levothyroxine, revised 4/2019, indicated the following: In adult patients with primary hypothyroidism, monitor serum TSH levels after an interval of 6 to 8 weeks after any change in dose. In patients on a stable and appropriate replacement dose, evaluate clinical and biochemical response every 6 to 12 months and whenever there is a change in the patient's clinical status. A review of the facility's Medication Utilization and Prescribing- Clinical Protocol, revised 7/2016, indicated the following under Monitoring: The staff and physician will periodically re-evaluate the conditions and symptoms for which each resident is receiving medications to ensure that the medication and dosage are still relevant and are not causing undesired complications.		