STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055304	A. Building B. Wing	05/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Brookside Care Center	1221 Rosemarie Lane Stockton, CA 95207

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to organize and participate in resident/family groups in the facility. Based on interview, and record review, the facility failed to hold a residents' monthly resident council meeting for a census of 88 residentswhen, the resident council meeting was not held for the months of February 2026 and March 2026. This failure resulted in not honoring the residents' rights to meet for the resident council meeting and had the potential for residents' not to have their grievances or other concerns being heard and resolved. Findings: During the facility's resident council meeting on 5/11/26, at 10:37 AM, Residents 29, Resident 32, Resident 44, Resident 52, Resident 61, and Resident 66 voiced their concerns about not having a resident council meeting for the months of February 2026 and March 2026 despite their request to have a meeting. During a concurrent interview and record review on 5/11/26, at 8:46 AM, with the Activity Director (AD), resident council meeting minutes and monthly activities calendar were reviewed. The AD confirmed there was no evidence of a resident council meeting during both February of 2026 and March of 2026. The AD further confirmed the resident council meetings were scheduled for February 19th 2026 and March 19th 2026 as per monthly activities calendar but were not held. The AD stated the resident council meeting should be held monthly because it was the residents' right. During an interview on 5/13/26, at 10:07 AM, with the Administrator (ADM), the ADM confirmed the facility did not provide the residents' a resident council meeting for the months of February of 2026 and March of 2026. A review of the facility's policy and procedure titled, Resident Council Meetings, dated 2025, indicated, .This facility supports the rights of residents to organize and participate in resident groups, including a Resident Council. This policy provides guidance to promoting structure, order, and productivity in these group meetings. [Resident or family group] is defined as a group of residents.or family members that meet regularly to discuss and offer suggestions about facility policies and procedures affecting residents' care, treatment, and quality of life; support each other; plan resident and family activities; participate in educational activities; or for any other purpose.The residents meets.no less than determined by the group. The date, time, and location of the meetings are noted on the Activities Calendar.

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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(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. Based on observation, interview, and record review, the facility failed to provide a safe environment for 5 of 26 sampled residents (Resident 17, Resident 44, Resident 54, Resident 63, and Resident 90) when:1.Resident 54's cabinet and closet were not in good repair and the sliding door was not functional as a door; and2.Resident 17, Resident 44, Resident 63, and Resident 90's sliding door was not functional as a door.These cumulative failures resulted in Resident 17, Resident 44, Resident 54, Resident 63, and Resident 90 a lack of a homelike environment and had the potential to negatively impact Resident 17, Resident 44, Resident 54, Resident 63, and Resident 90's psychosocial well-being.1. A review of Resident 54's admission RECORD indicated Resident 54 was admitted to the facility with diagnosis that included anxiety disorder (persistent, excessive fear or worry that is out of proportion to the actual situation). During a concurrent observation and interview on 5/10/26, at 12:54 p.m., with Resident 54 in Resident 54's room, the closet was observed with the bottom hinge not screwed into the closed leaving the door unable to close exposing Resident 54's belongings, a cabinet without a handle and not flush to the cabinet, and the sliding door to the courtyard was only able to open a few inches. Resident 54 stated the closet bothers her because she did not want her personal belongings exposed and the cabinet without the handle and not flushed worried because her belongings would be exposed if the cabinet fell off. Resident 54 further stated that the sliding door did not open all the way, and it made her feel trapped. During an interview on 5/11/26, at 4:15 p.m., with the Maintenance Director (MS), the MS verified Resident 54's closet and cabinet were not in good repair and that the sliding door did not open all the way. The MS stated residents room cabinetry should be in good repair and the sliding door working properly because that was part of the homelike environment Resident 54 had a right to have. Review of the facility's policy and procedure (P&P) titled, Safe and Homelike Environment the undated P&P indicated, .In accordance with residents' rights, the facility will provide a safe, clean, comfortable and homelike environment.an uncluttered physical environment that is neat and well-kept. 2a. A review of Resident 90's admission RECORD indicated Resident 90 was admitted to the facility with diagnosis that included quadriplegia (the partial or total paralysis of all four limbs, both arms and legs and the torso [trunk]). During a concurrent observation and interview on 5/10/26, at 3:43 p.m., with Resident 90 in Resident 90's room, the sliding door to the courtyard was observed to open only a few inches. Resident 90 stated that she had been living in the facility for seven years and recently the sliding door to the courtyard was not fully functioning and was only able to open a few inches. Resident 90 further stated that the condition of the sliding door made her feel trapped and did not provide a home-like environment. 2b. A review of Resident 44's admission RECORD indicated Resident 44 was admitted to the facility with diagnosis that included generalized anxiety disorder (a mental health condition characterized by excessive, uncontrollable, and persistent worry about everyday events and activities, making it difficult to relax), and depression. During an interview on 5/11/26, at 7:43 a.m., Resident 44 stated that she had concerns regarding the (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	condition of the sliding door to the courtyard in her room and that she was unable to open it fully when needed, which made her feel anxious. Resident 44 further stated that the facility had provided a fan; however, the fan was not adequately circulating the air and was not comparable to having the sliding door fully open. Resident 44 further added that she had been living in the facility and did not feel it was a home-like environment when she was only able to open the sliding door a few inches. 2c. A review of Resident 63's admission RECORD indicated Resident 63 was admitted to the facility with diagnosis that included depression, and shortness of breath. During a concurrent observation and interview on 5/11/26, at 8:32 a.m., with Resident 63 in Resident 63's room, the sliding door to the courtyard was observed to open only a few inches. Resident 63 stated that he had been living in the facility for a few months and wished that he could fully open the sliding door to the courtyard to get more fresh air. Resident 63 further stated that he felt trapped in the room when he was unable to fully open the sliding door to the courtyard. 2d. A review of Resident 17's admission RECORD indicated Resident 17 was admitted to the facility with diagnosis that included depression, and hemiplegia and hemiparesis following cerebral infarction (conditions that affect movement on one side of the body, caused by strokes). During a concurrent observation and interview on 5/11/26, at 8:42 a.m., with Resident 17 in Resident 17's room, the sliding door to the courtyard was observed to open only a few inches. Resident 17 stated that the facility placed a lock on the screen and that sliding door to the courtyard could be opened only a few inches. Resident 17 further stated the sliding door was not functioning properly, and that he felt trapped and annoyed because he was unable to fully open the sliding door. During an interview on 5/11/26, at 10:22 a.m., Licensed Nurse (LN) 1 stated residents were unable to fully open their room sliding doors. LN 1 stated that the facility was the residents' home environment, and residents could feel that they were not living in their own homes when the sliding doors to the courtyard were not fully functioning and could only be opened a few inches. During an interview on 5/12/26, at 7:22 a.m., LN 5 stated that the sliding doors to the courtyard were not functioning properly and residents were unable to fully open those doors. LN 5 stated residents could feel trapped in their rooms when the sliding doors were only able to open a few inches. LN 5 further stated that the facility was the residents' home for the duration of their stay. LN 5 further added that the sliding doors were like windows, and people living in their own homes were normally able to fully open their windows; however, residents who had sliding doors as a window in their rooms were unable to do so. During an interview on 5/12/26, at 7:45 a.m., Certified Nursing Assistant (CNA) 1 stated that the facility was residents' home, and the sliding doors functioned like windows that opened to the courtyard. CNA 1 further stated that when residents were unable to fully open the sliding doors, they could feel frustrated and upset with the situation, which might lead to agitation when attempting to open them. During an interview on 5/12/26, at 10:43 a.m., the MS stated that approximately two months ago, the facility decided to place locks on the courtyard screens to prevent insects from entering the building and installed locks on the sliding doors to prevent them from opening fully for the safety of residents who wandered around the courtyard and due to the presence of a wild cat that residents were feeding, which could potentially scratch them. The MS further stated that the sliding doors to the (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	courtyard functioned as windows, and residents might feel trapped when they were unable to open them all the way. During a review of the facility's undated policy and procedure (P&P) titled, Safe and Homelike Environment, the P&P indicated, .In accordance with residents' right, the facility will provide a safe, clean, comfortable and homelike environment.the resident can receive care and services safely and that the physical layout of the facility, both inside and outside, maximizes resident independence and does not pose a safety risk.Definitions.A homelike environment.should include the resident's opinion the living environment. During a review of the facility's undated P&P titled, Preventative Maintenance Program, the P&P indicated, .A Preventative Maintenance Program shall be developed and implemented to ensure the provision of a.functional.and comfortable environment for residents.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on observation, interview, and record review, the facility failed to develop, implement, and update comprehensive care plans (a dynamic, individualized, and multidisciplinary document outlining a resident's medical, functional, and psychosocial needs) for 5 of 26 sampled residents when:1. Resident 95's Enhanced Barrier Precautions (EBP, an infection control strategy used primarily to prevent the spread of multidrug-resistant organisms [MDROs, superbugs/bacteria that have developed resistance to multiple classes of antibiotics, making the infections harder to treat]) care plan intervention was not implemented;2. The care plan was not initiated for resident 62's oxygen therapy;3. Resident 111's low air loss mattress (LAL mattress, a specialized medical mattress designed to prevent and heal bedsores) intervention was not initiated; and4. Resident 105's care plan for LAL was not implemented.These failures had the potential to place Resident 85, Resident 95, Resident 62, Resident 111, and Resident 105, at risk for not receiving effective, individualized care. As a result, these failed practices could negatively impact the health, safety, and well-being of residents. Findings: 1. A review of Resident 95's admission RECORD, indicated Resident 95 admitted to the facility with diagnoses including urinary tract infection (UTI, bacterial infections that invade the tissues in urinary system that could result in kidney complications), extended spectrum beta lactamase (ESBL, an infection that caused by bacteria that they have developed special chemical shields that destroy many common antibiotics, and harder to treat) resistance, and repeated falls. During a concurrent observation and interview on 5/10/26, at 2:43 PM, Resident 95 stated he had been transferred to the hospital a few weeks earlier for an infection in the pelvic area (the lower part of the human torso located between the abdomen and the thighs). Resident 95 further stated he had been receiving IV antibiotics (intravenous antibiotics, used for severe, fast-moving, or resistant infections because they deliver medication directly into the blood) for the infection and that the course of treatment had been completed a few days earlier. Resident 95 further stated there were no precautions in place, and the facility staff had not been wearing Personal Protective Equipment (PPE, is special gear worn by healthcare workers to create a physical barrier against infections). During a concurrent interview and record review on 5/10/26, at 3:26 PM with the Infection Preventionist (IP), Resident 95's clinical record titled, Care Plan Report, dated 3/13/26, was reviewed. The review of the care plan indicated, .Focus: Enhanced Barrier Precautions per MD [Medical Director] order. R/T [related to] .ESBL.Interventions.Communicate with family members and visitors about ESBL and their importance. Staff will follow EBP during care include Dressing, bathing/showering. changing linens. The IP stated Resident 95 was supposed to be on EBP related to a history of ESBL in the urine. The IP confirmed that the care plan interventions were not followed, as there was no evidence of PPE supplies or signage with instructions for use. The IP stated that the purpose of the care plan was to direct facility staff and visitors to wear appropriate PPE and follow infection control guidelines to ensure the safety of everyone entering Resident 95's room. The IP further stated that the expectation for nursing staff was to implement and follow the care plan interventions during direct contact with Resident 95 including cleaning, changing linens, and bathing/showering the resident. The IP further added that the expectations were not met. During an interview on 5/11/26, at 10:22 AM, Licensed Nurse (LN) 1 explained the purpose of care planning and stated that care plans should reflect residents' current health conditions and be individualized to meet each resident's specific needs. LN 1 further stated care plans served as (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	guidelines for providing proper care to residents and that staff were responsible for following the interventions to meet residents' needs. LN 1 further added care plans were an educational tool to help improve residents' health conditions. During an interview on 5/12/26, at 7:22 AM, LN 5 stated care plan interventions should be implemented and followed to ensure all staff members were providing proper care to the residents. LN 5 explained that care plans served as a guiding tool by providing directions on how to provide care for residents to meet their needs. LN 5 further stated when the care plan interventions for residents were not followed, the residents were not being helped, and their needs were not being met. During an interview on 5/13/26, at 10:25 AM, the Director of Nursing (DON) explained the purpose of care planning and that care plans were essential for a plan of care for residents. The DON stated it was important to create individualized care plans, implement interventions, and follow those interventions to provide proper care that meets residents' needs. The DON stated she expected nursing staff to follow the interventions as instructed in the care plans. The DON further stated that when Resident 95's EBP care plan interventions were not followed, there was a potential risk of negatively affecting the health and safety of other residents and staff members by increasing the possibility of spreading infection throughout the facility and to individuals outside the facility. 2. A review of Resident 64's admission RECORD, indicated Resident 62 was diagnosed with shortness of breath and asthma (a long term lung disease where airways narrow, swell, and produce extra mucus, making it difficult to breathe). During a concurrent observation and interview with Resident 62, on 5/10/26, at 10:03 AM, Resident 62's nasal cannula was wrapped around the oxygen tank without any container. Resident 62 stated she uses her oxygen tank in the evening when she was in bed. During an interview on 5/13/26, at 9:39 AM, with the Infection Preventionist (IP), the IP stated oxygen therapy should be care planned because it was part of the intervention and there was an order for the oxygen therapy. During a concurrent interview and record review with the Assistant Director of Nursing (ADON), on 5/12/26, at 10:02 AM, Resident 62's electronic health record (EHR) was reviewed. Resident 62's Order Summary, indicated .Oxygen 2 LPM [at 2 liters per minute] and may titrate oxygen up to 5 LPM via nasal cannula as needed for respiratory distress/SOB/wheezing as needed. dated 9/26/25. Resident 62's care plan was reviewed with the ADON, the ADON confirmed there was no care plan for Resident 62's oxygen therapy or respiratory treatment. 3. During a concurrent observation and interview with Resident 111, on 5/10/26, at 3:05 PM, Resident 111 was noted to have a LAL mattress. Resident 111 stated her bed was uncomfortable and a little bit flat. Resident 111 further stated that her bed needs more air. A review of Resident 111's electronic health record (EHR), Order Summary indicated that there was no order for a LAL mattress. Resident 111's care plan was reviewed, and there was no care plan initiated regarding Resident 111's LAL mattress. During a concurrent interview and record review with the ADON, on 5/12/26, at 9:37 AM, Resident 111's care plan was reviewed. The ADON confirmed that there was no care plan initiated prior to 5/10/26 for a LAL mattress for Resident 111. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with the Director of Nursing (DON), on 5/13/26, at 12:25 PM, the DON stated the importance of care plan, would help or guide them with resident care. The DON further stated that without a care plan, the facility and staff could possibly not get the right interventions for the resident. 4. A review of Resident 105's admission RECORD indicated Resident 105 was admitted to the facility with diagnosis that included nontraumatic intracranial hemorrhage (spontaneous brain bleed), dysphagia (difficulty swallowing), and encounter for attention to gastrostomy (a surgical opening directly into the stomach, usually to provide nutrition or medicine) During a concurrent observation and interview on 5/10/26, at 4:19 p.m., with licensed nurse (LN) 6, Resident 105 was observed laying on an LAL mattress, LN 6 verified that the mattress was set to 350 lb. LN stated Resident 105 did not weight 350 lb and the LAL mattress should have been set to the same weight as Resident 105 which was 175.6 lb. LN 6 further stated Resident 105 was at risk of skin breakdown due to the LAL that was not adjusted to Resident 105's weight. During an interview and record review on 5/12/26, at 11:32 a.m., with the treatment nurse (LN 10), Resident 105's care plan for the LAL mattress dated 10/21/26, was reviewed. LN 10 stated the care plan was not implemented when Resident 105's LAL mattress was set to 350 lb. LN 10 further stated Resident 105 was at risk for developing skin breakdown due to the LAL setting not set Resident 105's weight. During a review of the facility's undated policy and procedure (P&P) titled, Comprehensive Care Plans, the P&P indicated, . Policy: It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident.that includes measurable objectives and timeframes to meet a resident's medical, nursing and mental and psychosocial needs and ALL services that are identified in the resident's comprehensive assessment.Policy Explanation and Compliance Guidelines.3. The comprehensive care plan will describe, at a minimum, the following: a. The services that are to be furnished to attain or maintain the resident's highest practicable physical.well-being.f. Resident specific interventions that reflect the resident's needs.8. Qualified staff responsible for carrying out interventions, initially and when changes are made.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide activities to meet all resident's needs. Based on observation, interview, and record review, the facility failed to implement an adequate activities program for 4 of 26 sampled residents (Resident 5, Resident 49, Resident 69, and Resident 85) when:1. Resident 5's initial activity review was not completed,2. Resident 69 was not provided one-to-one activities,3. Resident 85 was not provided opportunities to attend group activities; and,4. Resident 49 did not receive his one to one activities services and there were no accessible activities offered for his visual impairment,These cumulative failures had the potential to negatively impact the psychosocial well-being for Resident 5, Resident 49, Resident 69, and Resident 85.Findings: 1. A review of Resident 5's, admission RECORD, indicated Resident 5 was admitted to the facility with diagnoses that included but not limited to paraplegia (loss of movement and sensation in the lower half of the body, usually affecting both legs), major depressive disorder (persistent feelings of deep sadness, emptiness, and a complete loss of interest in activities that bring joy), and schizoaffective disorder (mix of schizophrenia symptoms, such as hallucinations and delusions, and mood disorder symptoms, such as depression). A review of the facility's undated policy and procedure (P&P) titled, Activities, indicated, .It is the policy of this facility to provide an ongoing program to support residents in their choice of activities based on their comprehensive assessment, care plan, and preferences.Facility-sponsored group, individual, and independent activities will be designed to meet the interests of each resident, as well as support their physical, mental, and psychosocial well-being.All staff will assist residents to and from activities when necessary.The facility will consider accommodations in schedules, supplies and timing to optimize a resident's ability to participate in an activity of choice. 2. A review of Resident 69's, admission RECORD, indicated Resident 69 was admitted to the facility in March of 2026 with diagnoses that included but not limited to major depressive disorder, secondary malignant neoplasm of the brain (a type of cancer that started somewhere else in the body and spread to the brain, and cognitive communication deficit (someone struggles to talk, listen, or understand others because of problems with their thinking skills). Review of Resident 69's MDS section C (a standardized scoring system assessment used by healthcare facilities to measure a resident's mental status), dated 3/20/26, indicated Resident 69 had a brief interview for mental status (BIMS) score of 12 out of 15 (moderate cognitive impairment, moderate problems with thinking and memory abilities). During an interview on 5/10/26, at 4:30 p.m., with Resident 69, in Resident 69's room, the resident was observed on neutropenic precautions (a strict infection-control protocol used to protect immunocompromised patients—typically those undergoing chemotherapy—from common germs). Resident 69 stated she had not received any activities and that it would get quiet in the room. During a concurrent interview and record review on 5/11/26, at 3:06 p.m., with the AD, Resident 69's, Activities -Initial Review dated 4/13/26, were reviewed. The AD confirmed the initial review indicated Resident 69's wish for one-to-one activities with a list of activity preferences. The AD further confirmed Resident 69 did not have any participation notes for activities since admission. The AD stated it was important for residents who preferred one-to-one activities to have them; and without activities Resident 69 was at risk to experience loneliness and boredom. 3. Review of Resident 85's admission RECORD, indicated he was admitted to the facility with (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	diagnoses that included retention of urine, chronic obstructive pulmonary disease (lung and airway disease that restricts your breathing), and unspecified asthma (when asthma symptoms such as wheezing, coughing, and chest tightness are present but diagnostic records lack details on type or severity of asthma). Review of Resident 85's MDS section C, dated 4/7/26, indicated Resident 85 had a brief interview for mental status (BIMS) score of 13 out of 15 (Cognitively intact, meaning normal thinking and memory abilities with no significant impairment.) During a concurrent observation and interview on 5/10/26, at 3:49 p.m., with Resident 85, in Resident 85's room. There was no wheelchair observed in the room. Resident 85 stated he stopped going to group activity because he no longer had a wheelchair. Resident 85 further stated he would have liked to participate in group activities more often. During a concurrent interview and record review on 5/11/26, at 3:06 p.m., with the AD, Resident 85's activities participating progress notes were reviewed. The AD confirmed Resident 85 was last offered to participate in group activities on 11/14/25, and 1/19/26, was the last date Resident 85 was provided an activity. The AD stated it was important for Resident 85 to participate in activities for his emotional well-being and opportunity to get out of bed. During a concurrent interview and record review on 5/11/26, at 3:06 p.m., with the Activities Director (AD), Resident 5's, Activities – Initial Review dated 7/8/25, and Resident 5's, Activities – Initial Review dated 10/10/2 were reviewed. The AD confirmed both reviews were not completed. The AD stated the activities reviews for Resident 5 should have been done and the specific reviews that were not completed were used to determine resident preferences for activities. The AD stated the activity care plan may not reflect Resident 5's preferences if the initial activity reviews were not done. 4. Review of Resident 49's admission RECORD, indicated Resident 49 was admitted with macular degeneration (a disease that damages central vision), occlusion and stenosis of vertebral artery (reduced blood flow to the back of the brain), degenerative disease of nervous system (the nerves in your brain break and die), and unsteadiness on his feet. During a concurrent interview and observation on 5/11/26, at 10:39 AM, with Resident 49 in his bedroom. Resident 49 was lying flat on his back with his arms bent behind his neck looking at the ceiling. Resident 49 stated he was interested in attending activities but since he was legally blind (vision severely impaired) that when he attended activities in the past, he was unable to see the numbers on the BINGO cards. Resident 49 further stated everything he saw was a blur and all the words and numbers were meshed. Resident 49 attempted to read the monthly activities calendar posted in his room and stated the letters on the calendar were too small for him to see. Resident 49 stated he would attend activities if he was able to participate. Resident 49 further stated that he wished he had a radio or television in his room. During a concurrent interview and record review on 5/11/26, at 4:19 PM, with the AD, Resident 49's care plan and his initial activities review were reviewed. The AD confirmed that both documents indicated Resident 49 was legally blind and should have been receiving one-to-one activities that included reading to him and music in his room. The AD further confirmed Resident 49 was not receiving the services listed in his care plan or the one to one activities. The AD stated due to Resident 49's visual impairment alternative supplies and interventions should be available to (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	accommodate and support him during activities. The AD confirmed the writing on the Activities Calendar was too small for a visually impaired resident. The AD further confirmed the facility did not have any assistive devices for residents with visual impairment. The AD stated this placed Resident 49 at risk for depression and isolation. A review of the facility's policy and procedure titled, Activities, dated 2025, indicated, .It is the policy of this facility to provide an ongoing program to support residents in their choice of activities based on their.care plan, and preferences. Facility-sponsored group, individual, and independent activities will be designed to meet the interest of each resident as well as support their physical, mental, and psychosocial well-being. Activities will encourage both independence and interaction with the community .Activities may be conducted in different ways.one-to-one Programs.Person Appropriate-activities relevant to the specific needs, interests.

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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, interview, and record reviews, the facility failed to provide food storage and preparation, as well as maintain kitchen equipment and food contact surfaces in accordance with professional standards for food safety for 85 residents when:1. A dietary staff was observed not wearing her hairnet properly while walking in the kitchen;2. Food preparation areas, and equipment were not kept clean per food safety standards;3. The rack above the stove was observed to be dusty;4. Three wet containers were observed stacked on top of each other in the clean area;5. An open container of yogurt stored in the walk-in refrigerator was observed without proper labeling; 6. The inside of the Walk-in freezer was observed with heavy frost built up; 7. The cleaning log for the ice machine was not consistently signed;8. The chute/slide inside the ice machine was observed visibly discolored; 9. The temperature log was not maintained in the dry storage area to document and monitor storage temperature; and,10. The kitchen floor and dry storage area were observed to be sticky and discolored. These failures had the potential to put residents at risk for foodborne illnesses (an illness that comes from eating contaminated food. Common signs include nausea, vomiting, watery or bloody diarrhea, abdominal cramps, and fever).Findings: 1.During the initial kitchen tour on 5/10/26, at 8:40 AM, [NAME] (CK) 1 was observed walking inside the kitchen without a hairnet (a lightweight, fine-meshed net or cap worn over the hair to keep it securely in place to prevent hair from falling into food).During a concurrent observation and interview on 5/10/26, during the initial kitchen tour at 8:42 AM with CK 1 in the kitchen, CK1 stated the purpose of wearing hairnets properly was to prevent hair from falling into food. CK 1 confirmed that she had not worn the hairnet properly and stated hairnets should be worn correctly to fully cover all hair. CK 1 further stated there was a possibility that her hair could fall into food, cooking equipment, or dishes, which could result in contamination. During an interview on 5/10/26, at 11:32 AM, the Certified Dietary Manager (CDM) stated dietary staff should wear hairnets and beard nets properly to fully cover all hair and facial hair to prevent hair from falling into food, dishes, cooking equipment, or the kitchen environment, which could contaminate food. The CDM further stated that contaminated food could cause residents to become ill if consumed.During an interview on 5/12/2026, at 11:51 AM, the Registered Dietitian (RD) acknowledged that staff were expected to wear hair restraints properly to fully cover all hair in the kitchen as hair could contaminate the food served to residents.During a review of facility's undated policy and procedure (P&P) titled, Food Safety Requirements, the P&P indicated, .Policy Explanation and Compliance Guidelines.7. Staff shall adhere to safe hygienic practices to prevent contamination of foods from hands or physical objects.d. Dietary staff must wear hair restraints (e.g., hairnet.) to prevent hair from contacting food. According to the 2022 Federal Food and Drug Administration (FDA) Food Code 2-402.11, January 18, 2023 version, indicated, FOOD EMPLOYEES shall wear hair restraints such as hats, hair coverings or nets, beard restraints, and clothing that covers body hair, that are designed and worn to effectively keep their hair from contacting exposed FOOD ; clean EQUIPMENT, UTENSILS, and LINENS. 2.a. During a concurrent observation and interview on 5/10/26, during the initial kitchen tour, at 8:45 AM with CK1 in the kitchen, in a shelf, a large sheet pan was stored in ready-to-use area with food debris and food residue, oil/grease buildup that were present throughout the interior surface of the pan, with black residue along portions on the inner rims. During a subsequent interview CK 1, CK 1 confirmed the finding, and stated that the sheet pan had food debris and was not cleaned properly. CK 1 further stated prior placing pans in the ready-to-use area in the kitchen, staff should make sure the pans were properly washed to prevent contamination, and that residents could develop foodborne illnesses from consuming food served on contaminated items. During an interview on 5/10/26, at 9:30 AM, Dietary Aide (DA) 1, explained the dishwashing process and stated that cooking dishes, including pans, should be completely and thoroughly washed and allowed to air dry before placed into the ready-to-use area to prevent bacterial growth and avoid (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	attracting pests.During an interview on 5/11/26, at 11:32 AM, the CDM stated his expectation of dietary staff was to ensure all dishes, including pans, were free of food debris and food residue before being placed in the ready-to-use area. The CDM further stated that storing pans and dishes that were not properly washed could attract pests and create the possibility of bacterial growth. During an interview on 5/12/26, at 11:57 AM, the RD stated cooking utensils should not be stored in the ready-to-use area when food debris, residue, or oil and grease buildup remained on the cooking surfaces. The RD further stated there was a possibility of contaminating food items cooked in those dishes.b. During a concurrent observation and interview on 5/10/26, during the initial kitchen tour, at 8:49 AM, with CK1 in the kitchen, there were food debris and residue on the food preparation tables. CK 1 confirmed the findings and stated that cleanliness of food preparation tables and surfaces should be always maintained to prevent contamination of food items.During an interview on 5/11/26, at 11:32 AM, the CDM stated his expectation of dietary staff was to clean food preparation tables and surfaces after preparation and serving each meal to prevent contamination of food items.During an interview on 5/12/26, at 11:57 AM, the RD stated that, to remain in compliance with guidelines and adhere to sanitation standards, all food preparation areas and surfaces should be maintained clean and in good condition to prevent contamination of food.c. During a concurrent observation and interview on 5/10/26, during the initial kitchen tour, at 8:50 AM with CK 1 in the kitchen, there were dark brown stains inside the steamer and on both surfaces of the steamer doors, dark brown stains inside the oven next to the steamer. The stove and the oven beneath the stove were also observed with dark brown stains and food residue. CK 1 confirmed the findings and stated dietary cooks were responsible for cleaning the cooking equipment at the end of every shift, and that the stains and discoloration appeared old. CK 1 further stated that when cooking equipment was not cleaned properly, it could result in contamination of food items being cooked. CK1 further added there was a possibility that residue could fall into food items being cooked and cause residents consuming those foods to become sick.During an interview on 5/11/26, at 11:32 AM, the CDM stated his expectation of dietary staff was to clean the cooking equipment every AM (morning) and PM (afternoon) shift. The CDM further stated that when the cooking equipment such as the steamer, ovens, and stove were not cleaned properly and contained food residue or discoloration, those substances could fall into food items and contaminate them, placing residents at risk for foodborne illnesses from consuming the contaminated foods.During an interview on 5/12/26, at 11:57 AM, RD stated kitchen equipment such as steamers, stoves, and ovens should be cleaned daily and after each use, and the cleaning should be documented in the cleaning logs. The RD further stated there was a risk for contamination of food items and foodborne illness for anyone consuming those foods. The RD further added that improper cleaning could also affect the quality of the food items being cooked.During a review of facility's policy and procedure (P&P) titled, Sanitation, revised in October 2008, the P&P indicated, .The food service area shall be maintained in a clean and sanitary manner.Policy Interpretation and Implementation.2. All.counters, shelves and equipment shall be kept clean.3. All equipment, food contact surfaces.shall be washed to remove or completely loosen soils by using the manual or mechanical means necessary and sanitized using hot water and/or chemical sanitizing solution.17.Food service staff.to clean after each task before proceeding to the next assignment.A review of the US FDA 2022 Food Code, section 4-601.11, titled, Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces, and Utensils, January 18, 2023, version, indicated, (A) EQUIPMENT FOOD-CONTACT SURFACES and UTENSILS shall be clean to sight and touch. (B) The FOOD-CONTACT SURFACES of cooking EQUIPMENT and pans shall be kept free of encrusted grease deposits and other soil accumulations. (C) NonFOOD-CONTACT SURFACES of EQUIPMENT shall be kept free of an accumulation of dust, dirt, FOOD residue, and other debris. 3.During a concurrent observation and interview on 5/10/26, during the initial kitchen tour, at 8:50 AM with Ck 1 in the kitchen, the rack above the stove was observed to be dusty. CK 1 confirmed the finding and stated that dust could contain germs and should be cleaned immediately. During an interview on 5/11/26, at (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	11:32 AM, the CDM stated that food preparation areas expected to be free of dust and always maintained cleanliness. The CDM further stated that dust from the rack above the stove could drop into food items and contaminate them, placing residents at risk for foodborne illness from eating the contaminated foods.During an interview on 5/12/26, at 11:57, the RD stated the expectation of dietary staff was to always maintain the cleanliness of the rack above the stove, and that it should be free from dust and debris to decrease the risk of contamination of food items. The RD further stated that dust could fall into food items and cause foodborne illness.During a review of facility's policy and procedure (P&P) titled, Sanitation, revised in October 2008, the P&P indicated, .All.shelves.shall be kept clean.A review of the US FDA 2022 Food Code, section 4-601.11, titled, Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces, and Utensils, January 18, 2023, version, indicated, .(C) Non-FOOD-CONTACT SURFACES of EQUIPMENT shall be kept free of an accumulation of dust, dirt, FOOD residue, and other debris. 4.During a concurrent observation and interview on 5/10/26, during the initial kitchen tour, at 9:02 AM with CK 1, three wet containers were observed stacked on top of each other in the clean area in the kitchen. CK1 confirmed the finding and stated all all dishes should be air dried prior to being stored in clean areas. CK 1 further stated there was a possibility of bacterial growth if those items were not used frequently.During an interview on 5/11/26, at 11:32 AM, the CDM stated per guidelines, all dishes and containers should be washed thoroughly and air dried prior to being stored in clean areas in the kitchen to prevent mildew (a type of mold that grows on wet or damp surfaces) growth.During an interview on 5/12/26, at 11:57 AM, the RD stated the expectation of dietary staff was not to store wet containers in the clean areas. The RD further stated she did not want puddles of water in the clean area, and staff should ensure containers were properly dried before being stored in the clean areas of the kitchen. The RD further added there was a risk for bacterial growth and contamination when containers were stored wet in the clean area.During a review of facility's undated policy and procedure (P&P) titled, DISH WASHING, the P&P indicated, .PROCEDURE.5. Dishes are to be air dried in racks before stacking and storing.A review of the US FDA 2022 Food Code, section 4-901.11, titled, Equipment and Utensils, Air-Drying Required, January 18, 2023, version, indicated, After cleaning and SANITIZING, EQUIPMENT and UTENSILS: (A) Shall be air-dried. 5.During a concurrent observation and interview on 5/10/26, during the initial kitchen tour, at 9:15 AM with CK 1, an open container of yogurt stored in the walk-in refrigerator was observed without proper labeling. CK 1 confirmed that label on the container of yogurt was not properly completed. CK 1 explained that proper labeling should include the received date, open date, and use-by-date (UBD). CK 1 stated that if the item was consumed past the UBD, it could become unsafe for consumption and potentially make residents sick. CK 1 further stated that the purpose of proper labeling was to communicate to dietary staff that food items should be used by the designated date and not beyond that day to prevent residents from becoming ill from consuming expired food items. During an interview on 5/11/26, at 11:32 AM, the CDM stated that all food products and containers containing food items should be properly labeled. The CDM explained that a proper label should include the open date, UBD, and expiration date. The CDM further stated that all items stored in the refrigerator should be labeled, and improperly labeled items, such as the yogurt container missing a UBD, should be discarded and not kept in the refrigerator. The CDM further added that dietary staff were expected to follow the facility's labeling policy and this expectation was not met.During an interview on 5/12/26, at 11:57 AM, the RD stated that the purpose of labeling food items was to notify dietary staff when food items should be discarded because they were no longer safe to serve to residents. The RD further stated that the open date and UBD were essential information that should be included on all labeled food items.During a review of facility's undated policy and procedure (P&P) titled, LABELING AND DATING OF FOODS, the P&P indicated, All food items in the.refrigerator.need to be labeled and dated.Newly opened food items will need to be.labeled with an open date and used by date.During a review of facility's undated P&P titled, Food Safety Requirements, the P&P indicated, .3. Proper storage.c. Refrigerated storage.iv. Labeling, dating, and monitoring refrigerated food, including, (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	but not limited to.used by its use-by date. 6.During a concurrent observation and interview on 5/10/26, during the initial kitchen tour, at 9:22 AM with CK 1, there was heavy frost buildup inside the walk-in freezer near the upper left side of the left side of the freezer. CK 1 confirmed the finding and stated that the freezer should not have frost buildup. CK 1 explained that excessive frost accumulation could affect the freezer temperature and compromise the quality of food items stored in the freezer.During an interview on 5/11/26, at 11:32 AM, the CDM stated that the freezer was supposed to defrost automatically. The CDM explained there was a small air leak between the freezer door and the door frame, which caused the frost buildup. The CDM further stated that moisture and frost accumulation could increase the possibility of bacterial growth, cause freezer burns on products stored in the freezer and decrease the quality of the food items.During an interview on 5/12/26, at 11:57 AM, the RD explained that her responsibilities included conducting sanitation audits and checking the freezer and refrigerator units. The RD stated that frost buildup could result in freezer burn and negatively affect the quality of items stored in the freezer. The RD further stated that the expectation of dietary staff was to check the freezer every shift for frost buildup and notify maintenance if the freezer required defrosting.A review of the US FDA 2022 Food Code, section 4-501.11, titled, Good Repair and Proper Adjustment, January 18, 2023, version, indicated, (A) EQUIPMENT shall be maintained in a state of repair and condition that meets the requirements.(B) EQUIPMENT components such as doors, seals, hinges, fasteners, and kick plates shall be kept intact, tight. 7.During a concurrent observation and interview on 5/10/26, during the initial kitchen tour, at 9:06 AM with CK 1, the cleaning log for the exterior of the ice machine was reviewed and noted to be incomplete, with no documentation or signature for 5/4/26. CK 1 confirmed the finding and stated dietary staff were responsible for cleaning the exterior surfaces of the ice machine daily to prevent cross contamination of the ice stored inside the machine. CK 1 further stated staff had missed documenting the cleaning for that day and she could not confirm whether the exterior surfaces had been cleaned because, if it was not documented and not signed, it was considered not done. CK 1 explained that failure to clean the exterior surfaces of the ice machine could result in cross contamination, as germs from contaminated surfaces could be transferred into the ice machine when staff removed ice. She further stated contaminated ice could potentially make residents sick.During an interview on 5/10/26, at 9:30 AM, DA 1 stated dietary staff were responsible for cleaning the exterior surfaces of the ice machine daily. DA 1 explained that the purpose of the cleaning log was to ensure the ice machine remained clean and to prevent possible exposure of the ice inside the machine to germs that could be present on the exterior surfaces. DA 1 further stated the absence of a signature on the cleaning log indicated the cleaning had not been completed.During an interview on 5/11/26, at 11:32 AM, the CDM stated the expectation of dietary staff was to clean the exterior surfaces of the ice machine daily and sign the cleaning log after each cleaning. The CDM explained there could be germs present on the exterior surfaces of the machine that could potentially be transferred inside the machine when employees removed ice, resulting in contamination of the ice stored inside. The CDM further stated that cross contamination could cause residents to become sick from consuming contaminated ice and that missing the required cleaning of the exterior surfaces was not safe.During an interview on 5/12/26, at 11:57 AM, the RD stated that the purpose of the cleaning logs was to document completion of required cleaning tasks to help prevent cross contamination. The RD explained dietary staff were required to clean the exterior surfaces of the ice machine daily and document completion on the cleaning log located on the outside surface of the machine. The RD further stated failure to consistently clean and document the cleaning of the ice machine could negatively affect residents' health by consuming that ice.During a review of facility's undated P&P titled, Ice Machines and Portable Ice Carts, the P&P indicated, .It is the policy of this facility to ensure that ice machines/carts .cleaned.Policy Explanation: Ice machines/carts can be prone to microbial contamination due to.poor cleaning.Compliance Guidelines.2. The facility will determine the frequency at which the ice machine (.exterior.) will be cleaned/sanitized (.daily.) with documentation to support (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the cleaning procedures. 8.During a concurrent observation and interview on 5/10/26, during the initial kitchen tour, at 9:06 AM with CK 1, the chute/slide inside the ice machine was observed visibly discolored. CK 1 confirmed the finding and stated dietary staff were required to clean the exterior surfaces of the ice machine daily and maintenance staff were responsible for performing a deep cleaning monthly. CK 1 further stated that ice slides down the chute/slide area and the discoloration could contaminate the ice stored inside the machine, making the ice unsafe for consumption.During an interview on 5/11/26, at 11:32 AM, the CDM stated the chute/slide inside the ice machine should be maintained clean because ice drops and slides through that surface before dispensing. The CDM explained the chute/slide must be kept clean to prevent possible cross contamination of the ice stored inside the machine. The CDM further stated that an unclean chute/slide could contribute to foodborne illness for individuals consuming the ice.During a concurrent interview and record review on 5/12/26, at 10:43 AM with the Maintenance Director/Supervisor (MS), the facility provided document titled LOGBOOK DOCUMENTATION, dated 4/30/2026 was reviewed. The review indicated the document was completed via TELS [stands for Total Environmental Life Safety. It refers to comprehensive facility and asset management platform often used by maintenance and operations teams to track work orders, regulatory compliance, and life-safety equipment] The MS stated, per manufacturer recommendation, the ice machine should be cleaned and sanitized every six months, and the last cleaning was completed on 4/30/26. The MS explained that cleaning process included emptying the ice storage bin, cleaning and wiping the inside and outside of the ice machine, sanitizing the inside and outside of the machine, and discarding multiple batches of ice to ensure the ice was safe for consumption. The MS further stated that if the chute/slide was not clean, the machine would not be considered sanitary, and the ice should be discarded and not served to anyone. During an interview on 5/12/26, at 11:57 AM, the RD stated ice machine should be always maintained in a sanitary condition and that if it was observed to be unclean, all ice should be discarded, and the machine should be thoroughly cleaned. The RD further stated the discolored chute/slide could lead to cross contamination of the ice and the ice should not be served to anyone.During a review of facility's undated P&P titled, ICE MACHINE CLEANING PROCEDURES, the P&P indicated, .The ice machine needs to be cleaned and sanitized monthly. The internal components cleaned monthly or per manufacture recommendation's, and the date recorded when cleaned.PROCEDURE.3. Clean inside of the ice machine.During a review of the facility provided undated clean instruction for ice machine titled, Cleaning Instruction for [brand name] Series Ice Machines, the review indicated, .General Maintenance Procedure.1. Clean the ice-making section per the instructions below.Proper cleaning of an ice machine requires two parts: descaling and sanitizing. Descaling: should be scheduled at a minimum of twice per year but no more than once per month.dissolves the mineral deposits on the evaporator and other surfaces. It removes scale, calcium, lime scale and other mineral buildup.Sanitizing should be performed after each descaling but no more than once per month. Sanitizing disinfects the machine and removes microbial growth including mold and slim.A review of the US FDA 2022 Food Code, section 4-601.11, titled, Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces, and Utensils, January 18, 2023, version, indicated, (A) EQUIPMENT FOOD-CONTACT SURFACES.shall be clean to sight and touch. 9.During a concurrent observation and interview on 5/10/26, during the initial kitchen tour, at 10:03 AM with CK 1 in dry storage inside of the kitchen, CK 1 stated there was no temperature log available to document the dry storage temperature. CK 1 explained the purpose of documenting temperatures on the temperature log and stated it was used to monitor and track the temperature every shift to ensure the storage temperature remained within the required range of 50 to 70 degrees Fahrenheit (Fahrenheit [F], a temperature measurement unit). CK 1 further stated that when the dry storage lacked a temperature log, dietary staff were unable to determine what the temperature was on previous shifts or whether corrective actions had been taken when temperatures were outside the required range. CK 1 also stated that food items stored in the dry storage could become spoiled due to excessive heat and may no longer be safe for (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	use or consumption.During an interview on 5/11/26, at 11:32 AM, the CDM confirmed that dry storage area lacked a temperature log to document and track the temperature inside the storage area. The CDM stated the required temperature range for the dry storage was between 50 and 70 degrees F to maintain food safety. The CDM explained that the purpose of checking and documenting temperature was to monitor the storage temperature each shift and ensure consistent temperature monitoring was maintained. The CDM further stated that failure to implement temperature documentation using a log could increase the possibility of early spoilage of products stored in the dry storage are and could result in becoming unsafe for use in preparing food for residents.During an interview on 5/12/26, at 11:57 AM, the RD stated that dry storage temperature should be recorded to ensure the temperature remained appropriate for storing food and other products. The RD further stated that failure to document the temperature could negatively affect temperature control, which was essential to maintaining food quality and safety.During a review of facility's undated P&P titled, SANITATION, the P&P indicated, .The Food & Nutrition Services Department shall have equipment of the type and in the amount necessary for the proper preparation, serving, and storing of food.19. Correct temperatures for the storage.All logs will be kept on file 90 days.During a review of facility's undated P&P titled, STORAGE OF FOOD AND SUPPLIES, the P&P indicated, . Food and supplies will be stored properly and in a safe manner.1. Thermometers should be placed in all storage areas and checked frequently.If dry food storage goes over 85.F take corrective actions. 10.During a concurrent observation and interview on 5/10/26, during the initial kitchen tour, at 9:47 AM with DA 2 in dry storage, dry storage floor was observed sticky with multiple discolorations. DA 2 confirmed the findings and stated the storage area should be cleaned to prevent contamination of products stored in the storage.During a concurrent observation and interview on 5/10/26, during the initial kitchen tour, at 9:57 AM 9:57 AM, DA 2 confirmed that the kitchen floor was unclean, sticky, and had multiple dark brown discoloration and scratches throughout the floor. DA 2 stated dietary staff should clean the floor every shift and as needed to keep the floor clean and free from stains and sticky residue, as those conditions were not safe for food preparation and could potentially lead to cross contamination. DA 2 further stated the sticky floors increased the risk of falls for dietary staff working in the kitchen and retrieving products and supplies from the dry storage area, which could result in injury.During an interview on 5/11/26, at 11:32 AM, the CDM stated the kitchen floor, and all storage areas should be always kept clean. The CDM added that dietary staff were required to clean the floors every shift and as needed to prevent discoloration and sticky buildup from food residue. The CDM further stated that sticky and unclean floors could potentially attract pests, and dietary staff might stumble, fall, and injure themselves.During an interview on 5/12/26, at 11:57 AM, the RD stated the kitchen floor and food storage areas should be cleaned and mopped every shift and maintained in good condition. The RD further stated that the cleaning should be documented in cleaning logs to ensure sanitation practices were completed and to prevent possible cross contamination of food items prepared in the kitchen.During a review of the undated facility provided document titled, GENERAL APPEARANCE OF FOOD & NUTRITION DEPARTMENT, the document indicated, Floors, floor mats and walls must be scheduled for routine cleaning and maintained in good condition.12. Wipe up all spills as they occur.During a review of facility's undated P&P titled, STORAGE OF FOOD AND SUPPLIES, the P&P indicated, .1. The storeroom should be.dry, and clean at all times.During a review of facility's undated P&P titled, Sanitation, the P&P indicated, .The food service area shall be maintained in a clean and sanitary manner.1. All kitchens, kitchen areas.shall be kept clean, free from litter and rubbish.16. Kitchen.surfaces not in contact with food shall be cleaned on a regular schedule and frequently enough to prevent accumulation of grime.17.cleanliness throughout their work areas during all tasks, and to clean after each task before proceeding to the next assignment.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observation, interview, and record review the facility failed to ensure safe infection prevention and control practices with resident census of 88 when:1. Resident 62's oxygen tubing was not properly kept when not in use.2. Enhanced Barrier Precautions (or EBP, an infection control measure designed to prevent the spread of infection) were not implemented for Resident 95. 3. Shared glucometer (a device that measures blood sugar) was not cleaned and sanitized based on standards of practice and manufacturer specifications for Resident 4, Resident 39 and Resident 50.4. Nursing staff handled the pills with bare hands during medication administration for Resident 13 and Resident 93.5. An Air Vent (an opening connected to heating and cooling system and used to manage airflow in the room) in the ceiling of [NAME] medication room was loose with dust/debris and dark particles spilled/pouring on the Automated Dispensing Machine (or ADM, drug dispensing machine). These unsafe practices could result in spread of infection among vulnerable elderly residents in the facility. 1. A review of Resident 62's admission RECORD, indicated Resident 62 was diagnosed with shortness of breath and asthma (a long term lung disease where airways narrow, swell, and produce extra mucus, making it difficult to breathe). During a concurrent observation and interview with Resident 62, on 5/10/26, at 10:03 AM, Resident 62's nasal cannula was wrapped around the oxygen tank without any container. Resident 62 stated she uses her oxygen tank in the evening when she was in bed. During a concurrent observation and interview with Licensed Nurse (LN) 3, on 5/10/26, at 1:25 PM, Resident 62's oxygen tubing was wrapped around the oxygen tank. LN 3 confirmed the findings and stated that the oxygen tubing was supposed to be in a bag. LN 3 further stated that the respiratory therapist (RT) was supposed to change it every week. LN 3 stated the oxygen tubing could be contaminated and it could cause an infection to the resident using it. During an interview with Resident 62, on 5/12/26, at 8:50 AM, Resident 62 stated that the staff removed her oxygen yesterday (5/11/26) but she needs it every night. During a concurrent interview and record review with the Assistant Director of Nursing (ADON), on 5/12/26, at 10:02 AM, Resident 62's Order Summary, indicated .Oxygen 2 LPM [at 2 liters per minute] and may titrate oxygen up to 5 LPM via nasal cannula as needed for respiratory distress/SOB/wheezing as needed. dated 9/26/25. The ADON stated there should be plastic bag and the tubing should be dated when it was changed. The ADON stated oxygen tubing, and the water change should be done weekly. The ADON stated the oxygen tubing should not be wrapped around the oxygen tank and it should be in the plastic bag. The ADON stated that the nurses, the respiratory therapist (RT) and everybody working with the resident including the CNAs, was responsible with putting the oxygen tubing in the plastic bag if the resident was not using it. During an interview with the Infection Preventionist (IP), on 5/13/26, at 9:39 AM, the IP stated proper care for residents receiving oxygen therapy includes labeling and dating the oxygen tubing, and nebulizers and it should be kept in a clean bag when not in use. The IP further stated that the RT was responsible with changing the tubing and putting it in the bag. The IP stated the oxygen tubing could be contaminated if not placed in a clean bag. During an interview with the RT 1, on 5/13/26, at 9:57 AM, the RT 1 stated all RTs were responsible in changing the tubing, and the water for the oxygen concentrator. RT 1 stated per facility protocol, all oxygen equipment has to be in a bag with label if not in use for infection control. RT 1 stated that even if the order for oxygen was used as needed only, it should be stored in a bag. RT 1 further stated that contaminated oxygen tubing could lead to respiratory infection. During an interview with the Director of Nursing (DON), on 5/13/26, at 12:20 PM, the DON stated they must change the oxygen tubing every 7 days and it should be in the bag if not in use for infection (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	prevention. The DON further stated that the oxygen tubing could fell on the floor if not placed on a plastic bag. The DON stated all the facility staff was responsible in placing the oxygen tubing in a bag. A review of the facility's undated policy and procedure titled, Infection Prevention and Control Program, indicated, .Supplies Protocol.Non-sterile supplies are stored and maintained as clean prior to use. 2. A review of Resident 95's admission RECORD indicated Resident 95 was admitted to the facility with diagnosis that included urinary tract infection (UTI, bacterial infections that invade the tissues in urinary system that could result in kidney complications), extended spectrum beta lactamase (ESBL, an infection that caused by bacteria that they have developed special chemical shields that destroy many common antibiotics, and harder to treat) resistance. During a concurrent observation and interview on 5/10/26, at 2:43 PM, Resident 95 stated he had been transferred to the hospital a few weeks earlier for an infection in the pelvic area (the lower part of the human torso located between the abdomen and the thighs). Resident 95 further stated he had been receiving IV antibiotics (intravenous antibiotics, used for severe, fast-moving, or resistant infections because they deliver medication directly into the blood) for the infection and that the course of treatment had been completed a few days earlier. Resident 95 further stated there were no precautions in place, and the facility staff had not been wearing Personal Protective Equipment (PPE, is special gear worn by healthcare workers to create a physical barrier against infections). During a concurrent interview and record review on 5/10/26, at 3:26 PM with the Infection Preventionist (IP), Resident 95's clinical record titled, Order Summary Report, was reviewed. The review revealed an active order for Enhanced Barrier Precautions [EBP, an infection control protocol used to prevent the spread of multidrug-resistant organisms. Healthcare staff require to consistently wear gowns and gloves during high-contact resident care activities] per MD order. The IP confirmed the finding and stated Resident 95 was required to be on EBP due to a history of recent ESBL infection. The IP stated the purpose of EBP signage was to alert staff to wear proper PPE during direct high contact care to Resident 95 to prevent possibility of spreading infection to other residents. The IP acknowledged that no EBP signage was present, and no PPE supplies were observed next to Resident 95's doorway. The IP further stated his expectation of nursing staff was to place EBP signage and a PPE supply kit next to Resident 95's doorway and to follow the instructions on the signage to prevent possible spread of infection to other residents, staff, and visitors. The IP further added that his expectation was not met. During an interview on 5/11/26, at 10:22 AM, LN 1 stated EBP signage was a tool to alert staff that they were required to wear proper PPE as instructed on the signage to prevent possibility of spreading infection to other residents and staff, and staff could also carry the infection home. During an interview on 5/12/26, at 7:22 AM, LN 5 stated nurses were responsible to ensure EBP signage was placed at Resident 95's doorway and PPE supply available for staff entering room to provide high contact direct care including changing bed sheets, showering and cleaning room/bathroom. LN 5 further stated EBP signage was guiding tool and a communication method to alert staff that they were required to wear PPE properly to prevent spreading infection to other (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	residents throughout the facility. During an interview on 05/12/2026 7:45 AM, Certified Nursing Assistant (CNA) 1 stated all staff were required to wear proper PPE while providing direct care to residents who were on EBP. CNA 1 stated the EBP signage contained instructions regarding the types of PPE required during resident care. CNA 1 further stated that without EBP signage and PPE supplies available at the residents' doorways, she would not know whether PPE was required. CNA 1 further added that without the use of proper PPE, there was a risk of spreading infection to other residents, exposing herself to infection, or taking the infection home. During an interview on 05/13/26, at 8:14 AM, Medical Director (MD) 1 stated his expectation of nursing staff was to place EBP signage to alert staff that they were required to wear proper PPE as instructed on the EBP signage. MD 1 stated those were basic infection control and prevention requirement and that he relied on nursing staff and the IP to ensure those precautions were implemented for Resident 95. MD 1 added he did not know how the omission had been missed. MD 1 further stated that without EBP signage and PPE supplies available at Resident 95's doorway, there was a risk of spreading infection to other residents and staff, and staff could also carry the infection home. MD 1 further added there was a medical reason for implementing EBP and always following the instructions on the EBP signage without exception. During an interview and record review on 5/13/2026 at 10:25 AM, the Director of Nursing (DON) stated it was necessary to have EBP signage and PPE supplies available at Resident 95's doorway. The DON explained that Resident 95 had a history of ESBL in the urine and had completed a course of antibiotic treatment a few days prior. The DON stated the purpose of following EBP guidelines was to protect staff, other residents, and visitors from possible infection. The DON further stated the purpose of EBP signage was to alert staff about the type of infection, the interventions that should be implemented such as proper PPE that were required to prevent the spread of infection throughout the facility. The DON further added the expectation of nursing staff was to place EBP signage and PPE supplies at Resident 95's doorway to ensure proper PPE was worn during high-contact direct care. The DON added that the expectation was not met. During a review of facility's undated P&P titled, Enhanced Barrier Precautions, the P&P indicated, .Policy: It is the policy of this facility to implement enhanced barrier precautions for the prevention of transmission of multidrug-resistant organisms.Enhanced barrier precautions (EBP) refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and gloves use during high contact resident care activities.Policy Explanation and Compliance Guidelines.1 c. The facility will have the discretion on how to communicate to staff which residents require the use of EBP.prior to providing high-contact care activities.3. Implementation of Enhanced Barrier Precautions: a. Make gowns and gloves available immediately near or outside of the resident's room. 3a. During a medication administration observation, accompanied by Licensed Nurse 4 (LN 4), on 5/10/26, at 11:46 AM, at East Long hallway, LN 4 gathered blood sugar measurement supplies into Resident 4's room. LN 4 placed the glucometer on tabletop next to Resident 4 bed. LN 4 with gloved hand then used the lancet device (sterile needle used to prick the skin and draw a small drop of blood) to prick the right point finger of the resident to collect the blood sample for testing. LN 4 then soaked the test strip (disposable plastic strip coated with special chemicals to measure blood sugar) (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	attached to glucometer with blood and measured the blood sugar. LN 4 stated no insulin (injectable drug to treat high blood sugar) administration was required. When out of Resident 4's room, LN 4 removed the gloves and used two small alcohol pads to clean the outer surface of the glucometer. LN 4 then washed her hand in the sink with soap and water. In an interview with LN 4 on 5/11/26, at 12:14 PM, at East Long hallway, LN 4 stated she did not have the sanitizing wipes in her cart, and she should have used the authorized wipe approved by the facility instead of alcohol pad. 3b.During a medication administration observation, accompanied by Licensed Nurse 3 (LN 3), on 5/10/26, at 12:16 PM, in the East Short hallway, LN 3 gathered blood sugar measurement supplies into Resident 39's room. LN 3 placed the glucometer on tabletop next to Resident 39 bed. LN 3 with gloved hand then used the lancet device to prick the left middle finger of the resident to collect the blood sample for testing. LN 3 then soaked the test strip attached to glucometer with blood and measured the blood sugar. LN 3 stated blood sugar was 183 (the normal level is between 80-120) and insulin administration was required. When out of Resident 39's room, LN 3 removed the gloves and placed the uncleaned glucometer inside the cart without cleaning and sanitizing the glucometer. LN 3 then proceeded to administer insulin to Resident 39. 3c. During another medication administration observation, accompanied by Licensed Nurse 3 (LN 3), on 5/10/26, at 12:29 PM, in the East Short hallway, LN 3 gathered blood sugar measurement supplies and a glucometer from the cart drawer into Resident 50's room. LN 3 placed the glucometer on Resident 50's bed sheet. LN 3 with gloved hand then used the lancet device to prick the right point finger of the resident to collect the blood sample for testing, then had to re-do finger pricking of the right middle finger to get blood for testing. LN 3 then soaked the test strip attached to glucometer with blood and measured the blood sugar. LN 3 stated blood sugar was 284 (the normal level is between 80-120) and insulin administration was required. When out of Resident 50's room, LN 3 removed the gloves and wrapped the glucometer with two wipes without cleaning or wiping the outer surface. LN 3 then proceeded to administer insulin 10 units (units is a measure insulin dosage) to Resident 50. In an interview with LN 3, in the East short Hallway, on 5/10/26, at 12:40 PM, LN 3 stated she had two glucometers in the cart and alternated the use. LN 3 stated wrapping the glucometer helped sanitize the glucometer. In an interview with facility's Infection Prevision nurse (IP), on 5/13/26, at 10:45 AM, the IP stated he had provided education and training to staff upon hire and regularly when needed on use of glucometer. The IP nurse stated he expected nursing staff to follow the two-step process of cleaning and disinfecting share glucometer using two wipes in-between resident care. The IP stated two step process was to ensure blood borne diseases are not transmitted among residents. Review of facility's undated policy, titled Glucometer Disinfection, the policy indicated The facility will ensure blood glucometers will be cleaned and disinfected after each use and according to manufacturer instruction for multi resident use. Review of CDC (Center for Disease Control, nation's leading science-based, data-driven, service organization that protects the public's health) recommendation titled Considerations for Blood Glucose Monitoring and Insulin Administration last accessed on 5/20/26 via https://www.cdc.gov/injection-safety/hcp/infection-control/index.html the recommendation under (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	blood glucose meters in healthcare setting indicated Whenever possible, assign blood glucose meters to a person and do not share them. Dedicated meters should be cleaned and disinfected per the manufacturer's instructions and, at a minimum, anytime the device is reassigned to a different person. Dedicated meters should be stored in a manner that prevents cross-contamination and inadvertent use for the wrong patient. 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. If the manufacturer does not specify how the device should be cleaned and disinfected, it should not be shared. Review of the facility's preferred anti-microbial wipe label called Super Sani-Cloth, the label on the packet indicated Cleaning Procedure: All blood and other body fluids must be thoroughly cleaned from surfaces and objects before disinfection by the germicidal wipe. Open, unfold and use first germicidal wipe to remove visible soil . Use second germicidal wipe to thoroughly wet the surface. Allow to remain wet for two (2) minutes, let air dray. Review of Evencare G2 glucometer (brand name glucometer used in the facility) manufacturer instructions, dated 2017, last accessed on 5/20/26 via https://www.medline.com/media/catalog/Docs/MKT/LITe22140_MAN_EvenCare%20G2_19W4233811.pdf, the document indicated steps for cleaning and disinfecting the meter. The document indicated that to clean the meter, use moist (not wet) lint-free wipe. Wipe all external areas of the meter until visibly clean . To disinfect the meter, wipe with one of the validated disinfecting wipes and wipe all external areas of the meter including both front and back surfaces until visibly clean allow to remain wet for the contact time (time needed for the disinfectant stay in touch with the outer surface of the glucometer to kill all the germs) listed on the wipe's directions for use. 4. During a medication administration observation, accompanied by Licensed Nurse 6 (LN 6), at the [NAME] nursing station, on 5/10/26, at 3:07 PM, LN 6 administered three medications in pill form to Resident 13 who was sitting in his wheelchair at the nursing station. The medications were Norco (opioid pain medication), baclofen (muscle relaxant), and hyoscyamine (or Levsin, drug used to treat stomach cramps) which were packed in a bubble pack (or blister pack) from provider pharmacy. LN 6 was observed popping the pills in her bare hand before putting them in the medication cup for administration. During a subsequent medication observation with LN 6, at [NAME] nursing station, on 5/10/26, at 3:10 PM, LN 6 administered two Tylenol (or acetaminophen, pain reliver) tablets to Resident 93. LN 6 poured the Tylenol pill from the bottle into her bare hand before placing it in the cup for administration. In an interview with LN 6, at the [NAME] nursing station, on 5/10/26, at 3:20 pm, LN 6 stated she should have popped it into the medication cup and agreed that her bare hand could be a source of infection. In an interview with the facility's Infection Prevision nurse (IP), on 5/13/26, at 10:45 AM, the IP stated the facility's policy and standard of care is not to touch any medication with bare hands to both protect the nurse and resident. The IP nurse stated this could contribute to spread of infection from nurses' hand to the residents. Review of facility's undated policy, titled Medication Administration, the policy on section 14 indicated Remove medication from source, taking care not to touch medication with bare hand. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5. During a concurrent interview with Licensed Nurse 1 (LN 1), and the inspection of facility's [NAME] station medication room, on 5/10/26, at 10:49 AM, the air vent in the medication room was located above the Automated Dispensing Machine (ADM) and the air vent had dust, black and brown particles with fluff/fuzzy clumps of dust. The brown/black particles were covering the back of the ADM. LN 1 stated the dust and particle should be cleaned and she needed to notify the facility manager to fix the air vent. LN 1 was not sure why it was not reported earlier and agreed the vent may bring unhealthy air inside the medication room. In an interview with the Director of Nursing (DON), in her office, on 5/12/26, at 11:38 AM, the DON stated the nursing staff should have noticed the dust and debris and should have notified the facility manager or created an electronic work order. The DON stated the facility manager had no access to medication room to see the issue. The DON stated accumulation of dust and debris on the vent could affect the staff's health and contaminate the medications stored in the room., Review of facility's undated policy, titled Medication Storage, the policy indicated It is the policy of this facility to ensure all medications housed in our premises will be stored in the pharmacy and/or the medication rooms according to manufacturer's recommendations and sufficient to ensure proper sanitation, temperature, light, ventilation, moisture control, segregation, and security.

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. Based on interview and record review, the facility failed to inform and document an informed consent (a signed document requires healthcare providers to disclose risks, benefits, alternatives to ensure patients make educated decisions about their care or medication use) for use of trazodone (a mind altering medication used for sleep or depression) in 1 out of 5 residents (Resident 50) reviewed for unnecessary drug use.This failure could violate Resident 50's right to be aware of consequences (risks versus benefits) of using a mind-altering drug that could contribute to unwanted adverse effects.Findings:During a review of Resident 50's electronic medical record titled, Medication Administration Record, (MAR, a record nursing staff document drugs given), dated 5/26, the record indicated the following order: .trazodone HCl Oral Tablet 50 MG [or Deseryl; MG is milligram, a unit of measure];Give 0.5 tablet by mouth at bedtime for Depression Insomnia [sleepless].; Dated: 3/9/26 .The MAR record indicated Resident 50 had been refusing the trazodone regularly. Resident 50 had refused to take trazodone 5 times between May 1st and May 12th of 2026. During an interview on 5/10/26, at 12:29 PM, with Licensed Nurse 3 (LN 3), LN 3 stated Resident 50 refused her medications regularly with no explanation. LN 3 stated the facility was monitoring the number of times she refused drugs on every shift. LN 3 stated the doctor should be aware of this as it was documented in the clinical records.During an interview on 5/13/26, at 9:45 AM, with Medical Doctor (MD) 1, MD 1 stated he was aware of Resident 50's refusal of medication and was not sure if Resident 50 or her representative were involved in medication use.During a concurrent interview on 5/13/26, at 11:14 AM, with the Assistant Director of Nursing (ADON), Resident 50's medical record was reviewed. The ADON could not locate documentation for an informed consent on use of trazadone. The ADON stated all paper records, including the informed consent sheet, should have been scanned into the electronic medical record. The ADON stated an informed consent was required for use of all mind altering medications.Review of the facility's undated policy titled, Use of Psychotropic Medications, the policy's section 9 indicated, .Prior to initiating or increasing a psychotropic medication, the resident, family and/or resident representative must be informed of the benefits, risks, and alternatives for the medication, including any black box warning (BBW- highest level of warning by manufacturer of drug) for antipsychotic medications, in advance of such initiation or increase . The policy on section 10 and 11 indicated, .The residence has the right to accept or decline the initiation or increase of psychotropic medication. The facility will document that the resident or resident representative was informed in advance of the risks and benefits of proposed care, the treatment alternative or other options, and the preferred option to accept or decline in a format the facility deems to use (written consent form, narrative notes, etc) .

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. Based on observation, interview, and record review, the facility failed to provide reasonable accommodation of resident needs for 1 of 26 sampled residents (Resident 85) when, Resident 85 was not provided with a wheelchair.This failure had the potential for Resident 85 to be at risk for emotional distress, feelings of isolation, and at risk for falls. Findings:Review of Resident 85's admission RECORD, indicated Resident 85 was admitted to the facility with diagnoses that included retention of urine, chronic obstructive pulmonary disease (lung and airway disease that restricts your breathing) and unspecified asthma (when asthma symptoms such as wheezing, coughing, and chest tightness are present but diagnostic records lack details on type or severity of asthma).A review of Resident 85's Minimum Data Set (MDS, an assessment tool) section GG (assessment to measure a resident's functional abilities) dated 4/7/26, indicated that Resident 85 was able to use a manual wheelchair with supervision.A review of Resident 85's MDS section C (to measure a resident's mental status), dated 4/7/26, indicated that Resident 85 had a brief interview for mental status (BIMS) score of 13 out of 15 (cognitively intact, meaning normal thinking and memory abilities with no significant impairment).During a concurrent observation and interview on 5/10/26, at 3:49 p.m., with Resident 85, in Resident 85's room, Resident 85 confirmed that he did not have a wheel chair in his room. Resident 85 stated he used to have one and would go to group activities using his wheelchair, but because he no longer had a wheelchair he stopped attending group activities.During a concurrent observation and interview on 5/11/26, at 4:40 p.m., with the MDS Coordinator (MDSC), in Resident 85's room, the MDSC confirmed Resident 85 did not have a wheelchair available to him. The MDSC stated Resident 85 should have had a wheelchair and without one he was not able to leave his room when he liked to. The MDSC further stated the risk of a wheelchair not being provided to Resident 85 was the potential for falls.Review of an undated facility policy and procedure (P&P) titled, Accommodation of Needs, indicated, .The facility will teat each resident with respect and dignity and will evaluate and make reasonable accommodations for the individual needs and preferences of a resident, except when the health and safety of the individual or other residents would be endangered.The facility will ensure that common areas frequented by residents are accommodating of physical limitations and enhance their abilities to maintain independence.Based on individual needs and preferences, the facility will assist the resident in maintaining and/or achieving independent functioning, dignity, and well being to the extent possible.

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. Based on interview and record review, the facility failed to ensure 1 of 26 sampled residents (Resident 68), remained free from abuse (verbal, mental, sexual, or physical abuse) when, Resident 95 hit Resident 68 on his head on 5/4/26.This failure caused Resident 68 to feel sad and fearful for his safety while residing in the facility and had the potential to result in emotional distress and ongoing fear.Findings:A review of Resident 68's admission RECORD indicated Resident 68 was admitted with the diagnosis of depression (persistent feeling of sadness), paraplegia (the loss of movement and feeling in the lower half of the body).During an interview on 5/11/26 at 2:57 PM, Resident 68 stated on 5/4/26 around 10:30 AM, while smoking a cigarette in the courtyard located in the front portion of the facility, himself and another resident (Resident 95), began to disagree on the way Resident 68 spoke to another resident. Resident 68 stated, Resident 95 threatened to physically harm him while expressing his affiliation with a gang and the harm he has done to people in the past while they were arguing back and forth. Resident 68 then stated that Resident 95 began to walk towards him while yelling when the Activities Assistant (AA) heard them and quickly attempted to diffuse the situation. Resident 68 stated Resident 95 was able to reach over the AA and hit Resident 68 on the head prior to Resident 95 walking back in the facility. Resident 68 stated he was afraid because of the incident and the threats to further harm him that were made by Resident 95. Resident 68 stated he called the police for protection and made a report.During an interview on 5/11/26 at 3:19 PM, the AA stated on 5/4/26 around 11 AM she was walking outside to courtyard when she heard Resident 95 and Resident 68 arguing. The AA stated she witnessed Resident 95 walk towards Resident 68 who was in a wheelchair and hit Resident 68 on the back of the head and then walked back in the facility. The AA stated she attempted to diffuse the situation, separate both residents, and call for assistance, but was unable to prevent Resident 95 from hitting Resident 68 in the head. The AA stated after the incident occurred, she reported it to the Administrator (ADM).During an interview on 5/11/26 at 4:38 PM with Resident 95, Resident 95 stated on 5/4/26 Resident 65 was being rude to another resident who had memory issues. Resident 95 stated he defended that resident and told Resident 68 he should not talk to people like that. Resident 95 then stated that he and Resident 68 began to argue only verbally until Resident 68 called him a derogatory word that made him get up and pop Resident 68 in the back of his head one time. Resident 95 stated he felt like Resident 68 deserved it and that Resident 68 had previously been rude to other residents and staff members at the facility. Resident 95 stated that he believed if someone finally hit Resident 68, then he would be nicer to people. Resident 95 stated the evening of the incident that the police came and searched his room for weapons and took his statement. Resident 68 stated the police did not find any weapons and that he had no plans on harming Resident 68 after the incident.During an interview on 5/11/26 at 5 PM, the ADM stated the incident occurred on 5/4/26 around 10:45 AM. The ADM stated she was aware of the incident and stated the facility initiated an investigation into what occurred. The ADM stated the facility's investigation determined that the incident did occur and the conclusion on the facility's behalf considered the incident between Resident 68 and Resident 95 did occur. The ADM stated she expected the staff to protect all the residents in the facility. The ADM acknowledged the negative impact physical abuse can have on a resident's mental health and stated Resident 68 is scheduled to have a psychological evaluation.During a review of the facility's undated policy and procedure (P&P) titled, .Abuse, Neglect and Exploitation., the P&P indicated, .It is the policy of this facility to provide protection for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse.The facility will make sure efforts to ensure all residents are protected from physical and psychosocial harm, as well as additional abuse, during and after the investigation.

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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 that an as needed (PRN) psychotropic medication (any drug that affects brain activities associated with mental processes and behavior) was limited to 14 days for 1 of 26 sampled residents (Resident 12), when Resident's 12's PRN psychotropic medication did not have a stop date.This failure placed Resident 12 at risk of being chemically restrained (the use of any drug for discipline or that makes it more convenient for staff to care for a resident) due to ongoing psychotropic medication use without proper evaluation by the physician. Findings:A review of Resident 12's admission RECORD, indicated Resident 12 was admitted to the facility with diagnoses that included but not limited to depression and unspecified dementia (when a person shows clear signs of memory loss and cognitive decline that affect daily life).A review of Resident 12's Medication Administration Record, dated 4/26, indicated Resident 12 received the PRN Lorazepam (a fast acting drug to calm the brain and central nervous system) at-least daily.During a concurrent interview and record review on 5/12/26, at 11:05 a.m., with the Director of Nursing (DON), Resident 12's Order Summary, dated 5/12/26, was reviewed. The DON confirmed Resident 12 had a PRN order for Lorazepam that started on 4/7/26, without a stop date. The DON stated the order for Lorazepam should have had an end date and it was important to have an end date after 14 days for the physician to evaluate whether Resident 12 needed to stop, continue the medication as a PRN, or to continue taking the medication long term.Review of the undated facility policy and procedure (P&P) titled, Restraint Free Environment, indicated, .It is the policy of this facility that each resident shall attain and maintain his/her highest practicable well-being in an environment that prohibits the use of physical or chemical restraints.If a medication was initially administered for a medical symptom and continues to be administered in the absence of such symptom, the facility should re-evaluate the need for such medication to ensure that it does not sedate the resident or make it easier for the staff to care for the resident, causing it to be deemed a chemical restraint .

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on interview and record review the facility failed to ensure an allegation of physical abuse was reported in a timely manner, within 2 hours to the department for 2 of 26 sampled residents when Resident 95 hit Resident 68 on 5/4/26 and it was not reported to the required entities until 5/5/26.This failure led to the delayed immediate protection of Resident 68 and delayed abuse investigation process. This failure had the potential to put Resident 68's psychosocial, physical health and safety at risk.Findings:A review of Resident 68's admission RECORD indicated Resident 68 was admitted with the diagnosis of depression (persistent feeling of sadness), paraplegia (the loss of movement and feeling in the lower half of the body).During an interview on 5/11/26 at 2:57 PM, Resident 68 stated on 5/4/26 around 10:30 AM, he was assaulted by another resident while in the courtyard of the facility smoking a cigarette. Resident 68 stated after the altercation multiple staff witnessed the incident. Resident 68 stated after he was assaulted, he waited in his room for a few hours to see if the staff was going to check on him or notify the police. Resident 68 stated after waiting for a while he called the police himself to report the incident on 5/4/26 at 3:30 PM. Resident 68 stated he was afraid during this time due to the type of threats the aggressor made to him and his level of vulnerability and inability to defend himself.During an interview on 5/11/26 at 3:19 PM, the Activities Assistant (AA) stated on 5/4/26, around 11 AM, while she was walking outside to facility's courtyard, she heard Resident 68 and Resident 95 arguing. The AA stated she witnessed Resident 95 walked towards Resident 68 who was wheelchair bound. The AA stated she stood between both Resident 68 and Resident 95 while calling for assistance and trying to diffuse the situation but Resident 95 was able to hit Resident 65 in the back of his head prior to walking back in the facility. The AA stated she reported the incident to the Administrator (ADM).During an interview on 5/11/26 at 4:38 PM, with Resident 95, Resident 95 stated on 5/4/26, Resident 65 was being rude to another resident who had memory issues. Resident 95 stated he defended that resident and told Resident 68 he should not talk to people like that. Resident 95 then stated that he and Resident 68 began to argue only verbally until Resident 68 called him a derogatory word that made him get up and pop Resident 68 in the back of his head one time. Resident 95 stated he felt like Resident 68 deserved it and that Resident 68 had previously been rude to other residents and staff members at the facility. Resident 95 stated that he believed if someone finally hit Resident 68, then he would be nicer to people. During an interview on 5/11/26 at 5 PM, the ADM stated the incident occurred on 5/4/26 around 10:45 AM. The ADM stated she was aware of the incident and stated the facility initiated an investigation into what occurred. The ADM stated she reported the abuse to the required entities the following day 5/5/26 around 11 AM. The ADM stated she believed the report time was 24 hours and not 2 hours. The ADM stated the facility's investigation determined that the incident did occur and the conclusion on the facility's behalf considered the incident between Resident 68 and Resident 95 did occur. The ADM acknowledged the negative impact physical abuse can have on a resident's mental healthDuring a review of the facility's undated policy and procedure titled, .Abuse, Neglect and Exploitation., indicated, .It is the policy of this facility to provide protection for the health, welfare and rights of each resident by developing and implementing written policies and procedures that prohibit and prevent abuse.Reporting of all alleged violations to the Administrator, state agency, adult protective services and to all other required agencies.Immediately, but no later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. Based on interview and record review, the facility failed to ensure resident assessments accurately reflected a resident's status for 2 out of 26 sampled residents (Resident 49 and Resident 29) when: Resident 49's quarterly Minimum Data Set (MDS - a standardized, federally mandated clinical assessment tool used to evaluate the health, functional capabilities, and care needs of all residents in nursing homes) assessment was not accurate, and The facility did not accurately document Resident 29's diagnosis in the electronic medical record and MDS database.These failures had the potential to negatively affect the care and services provided to Resident 49 and Resident 29, due to the inaccurate assessment of their strengths, needs, diagnosis, and health status and the of risk of not treating the residents accordingly based on resident's medical needs. Findings: 1. A review of Resident 49's admission RECORD, indicated Resident 49 was admitted with the diagnosis of macular degeneration (a disease that damages central vision), occlusion and stenosis of vertebral artery (reduced blood flow to the back of the brain), degenerative disease of nervous system (the nerves in your brain break and die), and unsteadiness on his feet. During a concurrent interview and record review on 5/12/26 at 11:03 AM, with the Minimum Data Set Coordinator (MDSC), Resident 49's MDS section B (evaluates the residents hearing, speech and vision), and section GG (evaluates the resident's physical function), and Resident 49's care plans were reviewed. The MDSC confirmed that section B in Resident 49's medical record was completed on 4/22/26 and indicated that Resident 49 had no visual impairment and was able to see fine details, such as regular print in a newspaper. The MDSC stated section B was not accurate because it did not align with Resident 49's medical diagnosis of macular degeneration and Resident 49's care plan that indicated he was legally blind and needed accommodation. The MDSC stated this inaccurate documentation placed Resident 49 at risk of not meeting Resident 49's needs. The MDSC stated if this section was completed accurately, it would have triggered a further assessment into Resident 49's visual impairment and needs that would align with his vision impairment. The MDSC further confirmed section GG in Resident 49's MDS indicated he was wheelchair bound. During an observation and interview on 5/12/26 at 11:41 AM, Resident 49 stated he did not own a wheelchair and was able to walk around the facility without a wheelchair. There was no wheelchair observed in Resident 49's room. During an interview on 5/12/26 at 12:22 PM with Licensed Nurse (LN) 5, LN 5 stated she had been Resident 49's nurse since he was admitted into the facility. LN 5 stated Resident 49 walked all around the facility and that she had never seen him in a wheelchair. During a concurrent interview and record review on 5/12/26, at 12:35 AM, with the Director of Rehabilitation (DOR), Resident 49's rehabilitation plan and treatment and treatment encounters dated 11/19/25, 5/12/26, and rehabilitation progress note for certification period 1/16/26 to 2/13/26, were reviewed. The DOR stated after reviewing Resident 49's documents there was no indication that Resident 49 had been assessed for or needed a wheelchair. During a concurrent interview and record on 5/13/26 at 9:39 AM, with the Director of Nursing (DON), Resident 49's MDS section B, section GG, and medical diagnoses, dated 4/22/26, were reviewed. The DON confirmed the documentation discrepancy between the MDS assessment section B and section (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	GG and Resident 49 never being in a wheelchair and his visual impairment. The DON stated her expectations were for her staff to document and evaluate the residents accurately. The DON stated Resident 49 was at risk for his care to be negatively impacted and the staff to have a misunderstanding of his health challenges and vision capabilities. The DON stated she expected the MDS assessment to accurately reflect the resident's health status because the care Resident 49 received was based on that MDS assessment. During a review of the facility's policy and procedure (P&P) titled, Documentation in Medical Record, dated 2025, indicated, .Each resident's medical record shall contain representation of the actual experiences of the resident including enough information to provide a picture of the residents progress through complete, accurate, and timely documentation.Licensed staff and interdisciplinary team members shall document all assessments, observations, and services provided in the resident's medical record in accordance with state law and facility policy.Documentation shall be accurate, relevant, and complete. 2. During a review of Resident 29's electronic medical record, titled Order Summary Report, dated 5/2026, the record indicated 4 medications that did not have a documented diagnosis in the diagnosis section of the medical record for five main drugs as follows: Pantoprazole Oral tablet 40 MG . (Protonix, MG is milligram, a unit of strength); Give 1 tablet by mouth in the morning for GERD (Gastroesophageal Reflux Disease, a chronic digestive condition where stomach acid or bile flows back into the esophagus); Active since 4/12/26. Clonazepam Oral Tablet 1 MG (Clonazepam); Give 1 tablet by mouth two times a day for anxiety . ;Active since 4/11/206. Mirtazapine Oral Tablet 15 MG (or Remeron): Give 1 tablet by mouth at bedtime for depression . ; Active since 4/11/26. Ropinirole Oral Tablet 1 MG (or Requip); Give 1 tablet by mouth two times a day for Parkinson (a progressive nerve disease causing tremor, rigidity and balance instability); Active since 4/11/26. Levothyroxine Oral Tablet 50 MCG (or Synthroid, a hormone primarily used to treat low thyroid levels by replacing the natural hormone that body cannot produce; MCG is microgram and unit measure); Give 1 tablet by mouth in the morning for hypothyroidism (Low thyroid hormone level in body); Active since 4/12/26. The record indicated each drug order line had an indication for use in the body of the order. During a review of the Resident 29's electronic medical record under Diagnosis Information, date 1/27/26 and 2/10/26, the record did not include the five main diagnosis for Depression, Anxiety, Parkinson, GERD and Hypothyroidism. During a concurrent interview with MDS coordinator (MDSC), on 5/12/26, at 12:30 PM, and review of Resident 29's MDS dataset under section I- Active Diagnosis, dated 4/30/26, the MDSC confirmed the MDS record did not include the five missing diagnoses in the electronic medical record. During a concurrent interview with the MDSC and review of Resident 29's medical record under Diagnosis Information, on 5/12/26, at 12:37 PM, the MDSC stated when a resident admitted or (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	re-admitted to the facility, they looked at the hospital discharge summary and medical doctor's history and physical (or H&P—a summary resident history of medical issues and how to provide care) to document the diagnosis and inputted it in the computer system and the MDS database. The MDSC stated that he was not sure why the 5 main diagnoses were not added to computer record and MDS database. During a concurrent review of Resident 29's admission H&P and interview with the MDSC, on 5/12/26, at 12:45 PM, the H&P record dated 4/22/26 was reviewed. The H&P record written by Medical Doctor 1 (MD 1) indicated Resident 29's diagnosis of Depression, Anxiety, Parkinson, GERD and Hypothyroidism were recorded in both active and past medical history. The MDSC acknowledged the H&P record was not documented in the diagnosis section of the medical record. During a concurrent interview with the ADON, in her office, on 5/13/26, and review of Resident 29's diagnosis and MDS section in the electronic medical record, the ADON stated upon admission the nursing staff were supposed to enter the resident diagnosis in the diagnosis section by clicking on a box in the body of the order. The ADON stated the MDS staff additionally will include the listed diagnosis in H&P and hospital records into the MDS database. The ADON confirmed that the documentation in both computer and the MDS records was missing. The ADON stated this could risk unsafe care without an accurate record of diagnosis. Review of the facility's undated policy, titled MDS 3.0 Completion, the policy indicated, The residents are assessed using a comprehensive assessment process in order to identify care needs and to develop an interdisciplinary care plan . According to federal regulations, the facility conducts initially and periodically a comprehensive, accurate and standardized assessment of each residence's functional capacity using the RAI (Resident Assessment Instrument. A comprehensive, standardized system used by long-term care facilities to evaluate a resident's clinical status, functional abilities, and care needs) specified by the state . The policy further indicated, .admission assessment completed within 14 days of admission . Review of the facility's undated policy, titled Maintaining Minimum Data Set (MDS) Assessments, the policy indicated, .When a resident is discharged return anticipated and returns to facility within 30 days, the facility will copy the previous resident assessment instrument document and place them in the new record.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. Based on observation, interview, and record review, the facility failed to provide adequate care and services to promote healing and for the prevention of a pressure injury (a localized injury to the skin and/or underlying tissue because of prolonged pressure) for 4 of 8 sampled residents (Resident 105, 111, 64, and 4), when:Low-air loss mattress (LAL mattress, a mattress designed to prevent and treat pressure wounds that uses a continuous, gentle flow of air through a surface of tiny holes to reduce pressure helping to prevent and treat skin breakdown and pressure wounds) pump was not correctly adjusted according to the weight of Resident 105, Resident 64, and Resident 4. This deficient practice had the potential to delay wound healing and placed Resident 105, Resident 111, Resident 64, and Resident 4 at increased risk for developing pressure injury and/or skin breakdown. 1.A review of Resident 105's admission RECORD indicated Resident 105 was admitted to the facility with diagnosis that included nontraumatic intracranial hemorrhage (spontaneous brain bleed), dysphagia (difficulty swallowing), and encounter for attention to gastrostomy (a surgical opening directly into the stomach, usually to provide nutrition or medicine) A review of Resident 105's, BRADEN SCALE FOR PREDICTING PRESSURE ULCER RISK (pressure ulcer, areas of damaged skin typically caused by staying in one position for too long) dated 9/18/25, the scale indicated Resident 105 had a score of 15 (at risk, for the development of pressure ulcer). During an observation on 5/10/26, at 4:13 p.m., in Resident 105's room. Resident 105 was observed laying on an LAL mattress and the setting was 350 pounds (lb., a unit of measurement for weight) During a concurrent observation and interview on 5/10/26, at 4:19 p.m., with licensed nurse (LN) 6, Resident 105 was observed laying on an LAL mattress, LN 6 verified that the mattress was set to 350 lb. LN stated Resident 105 did not weight 350 lb and the LAL mattress should have been set to the same weight as Resident 105 which was 175.6 lb. LN 6 further stated Resident 105 was at risk of skin breakdown due to the LAL that was not adjusted to Resident 105's weight. During an interview on 5/12/26, at 11:32 a.m., with the Treatment Nurse (LN 10), LN 10 stated if an LAL setting was not adjusted to Resident 105's weight and was set to higher, Resident 105 would be at risk of developing skin breakdown, and the LAL would not be implemented as intended. 1b. A review of Resident 64's admission RECORD, indicated Resident 64 was diagnosed with morbid (severe) obesity due to excess calories, and generalized muscle weakness During a concurrent observation and interview with Resident 64, on 5/10/26, at 9:39 AM, Resident 64 was on LAL mattress with a bariatric bed and a bed extender. Resident 64 stated he did not like his bed because it was uncomfortable. During a concurrent interview and record review with LN 4, on 5/11/26, at 9:25 AM, Resident 64's Weights and Vitals Summary was reviewed. LN 4 confirmed that Resident 64's latest recorded weight was 415 pounds. In a concurrent observation and interview with LN 4, LN 4 confirmed the LAL mattress pressure scale pump Resident 64 was at the maximum 460. During a concurrent interview and record review with the ADON, on 5/12/26, at 8:57 AM, Resident 64's EHR was reviewed. Resident 64's Order Summary dated 4/21/26 indicated, .LAL Mattress. Set mode and setting based on comfort and/or weight. The ADON stated the indication for LAL mattress for Resident 64 was to prevent pressure ulcer. The ADON stated if the pressure on the LAL mattress (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was on the lower side, it would not be effective. The ADON further stated that if it was on the higher side it would be over inflated. A review of the Resident 64's Care Plan Report, indicated, .[Resident 64 has LAL mattress -makes use of bariatric bed.Interventions.Keep mattress at appropriate setting. A review of the facility provided undated document, titled, Procare Elite User's Manual [Brand Name], indicated, .This product is intended to help and reduce the incidence of pressure ulcers while optimizing patient comfort. It also provides following purposes: to help and reduce the incidence of pressure ulcers while optimizing patient comfort.General Operation.According to the weight and height of the patient, adjust the pressure setting to the most comfortable level without bottoming out. After the pressure in mattress reach the intended level, the air mattress is ready to use. 1c. A review of Resident 4's admission RECORD, indicated Resident 4 has diagnoses of paraplegia (paralysis of the lower half of the body), morbid (severe) obesity with alveolar hypoventilation (breathing disorder where insufficient air reaches the lungs), generalized muscle weakness, and right hip open wound. During a concurrent observation and interview with Resident 4 on 5/10/26, at 12:05 PM, Resident 4 has a bariatric bed with LAL mattress. Resident 4 stated his bed was uncomfortable. During a concurrent interview and record review with LN 4, on 5/11/26, at 9:22 AM, Resident 4's Weights and Vitals Summary was reviewed. LN 4 confirmed that Resident 4's latest recorded weight was 215 pounds dated 1/1/26. In a concurrent observation and interview with LN 4, LN 4 confirmed the LAL mattress pressure scale pump of Resident 4 was at 350. During a concurrent interview and record review with the ADON, on 5/12/26, at 9:11 AM, Resident 4's EHR was reviewed. Resident 4's Order Summary dated 1/23/26 indicated, .LAL Mattress. Set mode and setting based on comfort and/or weight. The ADON stated that Resident 4 started using the LAL mattress on 10/16/25 based on the order history. Resident 4's latest Braden scale dated 12/19/25 was reviewed with the ADON, indicated that Resident 4's score was at 12 which means that Resident 4 was at high risk. The ADON confirmed that Resident 4's weight was 215 pounds on 1/1/26. The ADON stated that Resident 4 was on hospice care (a special kind of care that focuses on a person's quality of life and dignity as they near the end of their life), and hospice agency usually discontinues the order for weighing the resident. The ADON stated that Resident 4 should be on the scale less than 250 pounds in the pressure scale pump of the LAL mattress. A review of the Resident 4's Care Plan Report, indicated, .[Resident 4] on LAL mattress.Interventions.Keep at appropriate setting. A review of the facility provided undated document, titled, [Brand Name] Med-Aire 14029 [model] Low Air Loss Mattress Replacement System User Manual, indicated, .This system is designed to assist in the prevention and treatment of pressure ulcers by providing alternating pressure therapy and microclimate control.Adjusting Comfort Settings Adjust the pressure range based on the patient's weight and comfort needs. During an interview with the ADON, on 5/12/26, at 9:43 AM, the ADON stated they use LAL mattress when resident has pressure ulcer and when resident was high risk in developing wound to act as prevention. The ADON stated using LAL mattress on a resident needed doctor's order. The ADON stated that the pressure setting of the LAL mattress was according to the resident's weight and they (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	also follow the manufacturer's instruction to make sure that the machine was working. The ADON further stated that sometimes the resident would request for LAL mattress even though they do not have wounds. During an interview with the Medical Director (MD) 1, on 5/13/26, at 8:19 AM, MD 1 stated that staff had to notify him when they are putting the LAL mattress to make sure it was appropriate for the resident. The MD 1 stated that LAL mattress needs a doctor's order. The MD 1 stated that he expected the staff to do a quick notification to the doctor before putting any interventions in place. The MD 1 further stated that the doctor needed to review the intervention, and clarified what other interventions has been done before. During an interview with LN 10, on 5/13/26, at 9:23 AM, LN 10 stated if the resident have wounds at their buttocks, they might need LAL mattress as a comfort measure and to prevent the wounds from getting worse. LN 10 stated that she would let the doctor know and the doctor would determine if the LAL mattress was necessary. LN 10 further stated the LAL mattress needs doctor's order before implementing. LN 10 stated that some residents would request LAL mattress and they informed the doctor about the request and do a care conference, but the doctor will have the final decision. LN 10 stated that the LAL mattress pressure would be set up according to manufacturer instructions and doctor's order. LN 10 further stated that the pressure of the LAL mattress would be based on resident's weight and comfort. LN 10 stated that the pressure could go higher than the weight based on the comfort of the resident. LN 10 stated if the pressure was below the weight of the resident, it would not be effective, but it was still based on resident's comfort and preference. LN 10 further stated that the resident would be educated about the risks and benefits of the LAL mattress. During a concurrent interview and record review with the Director of Nursing (DON), on 5/13/26, at 12:13 PM, the DON stated the order for LAL mattress usually comes from the hospital, or wound doctor. The DON stated it was indicated if resident has wounds or high risk for wound. The DON stated for every new admission, they need to do the Braden scale. The DON stated she was not sure if LAL needs doctor's order, but it needs to be part of the care plan. The DON stated that the LAL mattress should be turned on. The DON stated LAL mattress pressure should be based on manufacturer's recommendation. The DON stated Resident 111 needs bariatric bed and they put LAL mattress because she could not move. The DON stated she was not sure why there was no order for the LAL mattress of Resident 111. During an interview with the Maintenance Supervisor (MS), on 5/13/26, at 1:10 PM, MS stated when there was an MD order for LAL mattress, he usually gets a work order, or the DON would tell him, and Housekeeping supervisor would also help him put it in place to make sure they get the correct mattress and right bed. MS stated the pressure of the LAL mattress would be according to the weight of the resident and the nursing staff would be the one to adjust the pressure. A review of the facility's undated policy and procedure titled, Pressure Injury Prevention Guidelines, indicated, .To prevent the formation of avoidable pressure injuries and to promote healing of existing pressure injuries, it is the policy of this facility to implement evidence-based interventions for all residents who are assessed at risk or who have a pressure injury present.The goal and preferences of the resident and/or authorized representative will be included in the plan of care.Interventions will be implemented in accordance with physician orders, including the type of prevention devices to be used and, for tasks, the frequency for performing them.In the absence or prevention orders, the licensed nurse will utilize nursing judgment in accordance with pressure injury prevention guidelines to provide care, and will notify physician to obtain orders.Preventions devices will be utilized in accordance with manufacturer recommendations (e.g., heel flotation devices, cushions, mattresses).Interventions will be documented in the care plan and communicated to all relevant staff.Pressure Relieving Devices:.Provide alternative support surfaces as needed. Considerations for utilizing specialized support surfaces: a. Medical condition and weight.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. Based on interview and record review, the facility failed to ensure accurate intake and output was recorded in the electronic health record (EHR) for one of 26 sampled residents (Resident 2) with an indwelling urinary catheter (a hollow tube inserted into the bladder to drain or collect urine). This failure had the potential to lead to late detection of fluid status abnormalities which could adversely affect Resident 2's health status.Findings:A review of Resident 2's, admission Record indicated Patient 2 was admitted to the facility with diagnoses that included urinary tract infection (UTI), presence of urogenital implants (medical devices surgically placed in the urinary or reproductive tracts to restore function, relieve blockages, or treat incontinence), and anxiety disorder.During a concurrent interview and record review on 5/12/26, at 11:19 a.m., with the Director of Nursing (DON), Resident 2's, Order Summary dated 5/12/26, and Resident 12's, Medication Administration Record dated April 2026, was reviewed. The DON verified Resident 12 had a physician order to monitor urine output every shift and urinary output was not monitored and documented on 4/8/26 p.m., shift and on 4/30/26 night shift. The DON stated it was important to monitor urinary output for Resident because he had an indwelling urinary catheter and monitoring output was important for determining Resident 2's fluid status and if he was retaining fluid. The DON further stated if urinary output was not monitored every shift we would not know Resident 12's fluid status or a delayed response to fluid status abnormalities.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on observation, interview, and record review, the facility failed to ensure respiratory care provided was consistent with professional standards of practice for 1 of 16 sampled residents receiving respiratory treatment (Resident 29), when Resident 29's oxygen tubing was not dated and labeled to indicate when it was last changed.This failure had the potential to result in a negative impact on Resident 29's health and safety including risks for ineffective oxygen therapy, and respiratory distress.Findings:A review of Resident 29's admission RECORD, indicated Resident 29 was admitted to the facility with the diagnosis of chronic obstructive pulmonary disease (long-term lung diseases that cause breathing to become difficult), shortness of breath, and acute bronchiolitis (swelling of the tubes in the lungs).During a concurrent observation and interview on 5/10/26, at 11:09 AM, with Licensed Nurse (LN) 3, in Resident 29's room, LN 3 confirmed Resident 29's oxygen tubing that was connected to her concentrator (a machine that produces oxygen), was not dated. LN 3 stated the facility's process was to write the date on the tubing when it was changed. LN 3 further stated the oxygen tubing should be changed and dated every week. LN 3 stated the importance of the tube being dated and changed was that the tubing could get old and develop cracks and be ineffective.During an interview on 5/13/26, at 9:39 AM, with the Director of Nursing (DON), the DON stated the oxygen nasal cannula tubing needed a change date on it. The DON further stated this did not meet her expectations and presented an infection control risk to the residents' in the facility.A review of the facility's policy and procedure titled, Oxygen Administration, dated 2025, indicated, .Oxygen is administered under orders of a physician, except in the case of an emergency.Staff shall perform hand hygiene and.gloves when administering oxygen or when in contact with oxygen equipment. Other infection control measures. Change oxygen tubing and mask/cannula weekly and as needed if it becomes soiled or contaminated. A review of the facility's policy and procedure titled, Infection Prevention and Control Program, dated 2025, indicated, .This facility has established and maintains an infection prevention and control program designed to provide sanitary, and comfortable environment and to help prevent the development and transmission of communicable disease.Staff Education.All staff shall receive training, relevant to their specific roles and responsibilities, regarding the facility's infection control program, including policies and procedures related to their job function.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on observation, interview and record review the facility failed to ensure the Emergency IV Kit (or IV-Ekit, a sealed container storing emergency intravenous [into the vein, or IV] medication and supplies) in the [NAME] station medication room was replaced in timely manner and communicated to the provider pharmacy after it was opened and used with census of 88 residents.This failed practice could contribute to unsafe medical care when IV medications were not available in a timely manner.Findings: During a concurrent inspection of the [NAME] station medication room, and interview with Licensed Nurse 1 (LN 1), on 5/10/26, at 10:49 AM, the IV-Ekit was observed sitting on the floor with an opened red tag. The contents of the IV-Ekit were checked and a one liter IV bag of saline (sterile salt solution) was missing in addition to an out of wrap bag of Dextrose 10% solution (high concentration sterile sugar solution;% is percent, a fraction of 100). LN 1 stated once the Ekit was opened based on a doctor's order for medication removal, the pharmacy should have been notified for replacement. LN 1 stated the provider pharmacy had daily delivery to the facility.During a concurrent inspection of the [NAME] station medication room, and interview with LN 1, on 5/10/26, at 10:55 AM, the binder for emergency kit documentation had a multiple yellow color paper slips titled Emergency Drug Kit Usage Report on medication removal for the past 3 years, the record was not on any order and could not find any record for use of IV-Ekit recently. LN 1 stated the nursing staff should fill out the duplicate form with information, fax the white copy to provider pharmacy and keep inside the kit and the yellow slip for facility documentation. LN 1 was not sure who and when the IV-Ekit was opened and the missing IV bag used for which resident.In an interview with the Director of Nursing (DON), in her office, on 5/12/26 at 12:17 PM, the DON stated she expected the nursing staff to fax Emergency kit (Ekit) medication to use to the pharmacy for processing and timely replacement. The DON stated the nursing staff should have communicated the information to the next shift for follow up.Review of the facility's policy, Titled Emergency Pharmacy Service and Emergency Kits, dated 1/2020, indicated When an emergency or STAT (urgent) medication is needed, the nurse first verifies and reviews the prescriber order for appropriateness, . removes the required non controlled medication from the emergency kit. Emergency medications are only administered with a valid prescriber order. The policy on section 8 further indicated Upon removal of any medication or supply item from the emergency kit, the nurse documents the medication or item used on an emergency kit log. One copy of this information should be immediately faxed to the pharmacy or placed within a resealed emergency kit until it is scheduled for exchange. This process will be defined by provider pharmacy. The hard copy will be retained in the nursing care center.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Based on observation, interview, and record review the facility failed to ensure safe medication administration practices when medication error rate was more than 5% (% or percentage- number or ratio that expressed as a fraction of 100) with the census of 88 residents. Medication administration observations were conducted over multiple days, at varied times, in random locations throughout the facility. The facility had a total of six errors out of 31 opportunities which resulted in a facility wide medication error rate of 19.35 % in five out of 16 residents (Resident 69, Resident 12, Resident 7, Resident 50, Resident 13) during medication administration observation as follows:1. Resident 69 was given a medication labeled as Senna-Plus (a combination of Senna and Docusate; a stool softer plus stimulant laxative) when the doctor's order was for Senna (stimulant laxative) only.2. Resident 69 medication called potassium ER tablet (an extended-release form of supplement) was crushed when the product labeling indicated not to crush the medication.3. Resident 12 was given a medication labeled as Senna-Plus (a combination of Senna and Docusate; a stool softer plus stimulant laxative) when the doctor's order was for Senna (stimulant laxative) only.4. Resident 7's medication called potassium ER was crushed when the product labeling indicated not to crush the medication.5. Resident 50 administered an incorrect dose of insulin (drug to reduce blood sugar) when the order for noon time administration called for a scheduled insulin dose in addition to sliding scale (a method of determining insulin doses based on blood sugar level) dose based on blood sugar level as ordered by medical provider.6. Resident 13's medication called baclofen (or brand name Lioresal, a muscle relaxant) was administered outside of the scheduled time and was given 2 hours before it was due. These failures resulted in unsafe use of medications, medication error, and not following the doctor's orders and manufacturer specifications.Findings:1. During a medication administration observation with LN 2, on 5/10/26, at 9:25 a.m., in [NAME] Long hall, LN 2 administered six medications including a laxative called Senna Plus to Resident 69.Review of Resident 69's medical record, titled Medication Administration Record (MAR), dated May 2026, the MAR record indicated a laxative order as follow: Senna Oral Tablet 8.6MG (Sennosides; MG is milligram a unit of measure); Give 2 tablet by mouth one times a day for constipation; Start date:3/14/26. LN 2 administered a combination drug called Senna-Plus that had a stool softener in addition to senna as a stimulant laxative.2. During a medication administration observation with Licensed Nurse (LN) 2, on 5/10/26, at 8:50 a.m., at [NAME] Long hall, LN 2 crushed the potassium pill belonging to Resident 69 and mixed it with pudding. LN 2 then spoon-fed the pudding mixed with medication to Resident 69.Review of Resident 69's medical record, titled Medication Administration Record (MAR), for the month of May 2026, indicated the following order: Potassium Chloride ER Oral Tablet Extended Release 10 MEQ (Potassium Chloride; MEQ is milliequivalent, a unit of strength); Give 1 tablet by mouth one time a day for low potassium. Start date 5/1/26.Review of Resident 69's medical record, titled Order Summary Report, dated 5/2026, the record did not have an order to crush medications.Review of medication label from provider pharmacy, labeled as potassium Cl ER (Potassium Chloride, Extended Release), dated 4/20/26, the label for Resident 69 potassium pill indicated Do not Chew or Crush.During an interview with LN 2, at the [NAME] nursing station, on 5/10/26, at 2:50 PM, LN 2 stated she followed the doctor's order the way it was written in the MAR. LN 2 acknowledged she didn't realize potassium should not have been crushed. 3. During a medication administration observation with LN 2, on 5/10/26, at 9:53 a.m., in [NAME] Long hall, LN 2 administered seven medications including two laxatives called Senna Plus and Docusate gel cap (Laxative known as DSS) to Resident 12.Review of Resident 12's medical record titled, Medication Administration Record (MAR), for the month of May 2026, the MAR record indicated the following orders: Senna Oral Tablet 8.6MG (Sennosides; MG is milligram a unit of measure); Give 1 tablet by mouth two times a day for bowel care.Start Date: 12/13/25 in addition to Resident 12 receiving Docusate . oral capsule 100 mg; Give 1 capsule by mouth two times per day for bowl management. Start date 12/13/25. LN 2 gave Senna-Plus instead (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	of senna only and Docusate capsule. 4. During a medication administration observation with Licensed Nurse (LN) 4, on 5/11/26, at 11:46 a.m., in East Long hall, LN 4 crushed the potassium pill belonging to Resident 7 and mixed it with apple sauce. LN 4 then spoon-fed Resident 7 the apple sauce mixed with medication.Review of Resident 7's medical record titled, Medication Administration Record (MAR), for the month of May 2026, the MAR record indicated, Potassium Oral Tablet (potassium) Give 20 mEq (mEq is milliequivalent, a unit of drug strength) by mouth one time a day for low potassium. Start Date: 11/14/25. The order did not indicate crushing the pill.Review of Resident 7's medical record titled, Order Summary Report, dated 5/2026, the record indicated May Crush all crushable medications and open capsules until contraindicated; Dated:11/10/25Review of medication label from provider pharmacy, labeled as Potassium Cl ER (Potassium Chloride, Extended Release), dated 4/20/26, the label for Resident 7 potassium pill indicated Do not Chew or Crush.During an interview with LN 4 on 5/11/26 at 12:15 p.m., LN4 confirmed that she crushed the potassium pill. LN 4 further stated she understood that she should not have crushed it. 5. During a medication administration observation with LN 3, on 5/10/26, at 12:29 p.m., in the East Short hall, LN 3 measured Resident 50's blood sugar and stated that she needed to give insulin. LN 3 once out of the room, drew up 10 units of insulin from vial marked as Novolog (or Insulin Aspart; a brand name for insulin) and administered it to Resident 50's abdominal area. The label on the insulin bottle further indicated Inject 5 units subcutaneously (under the skin) before meals and per sliding scale (before meals and at bedtime). Review of Resident 50's medical record, titled Medication Administration Record (MAR), for the month of May 2026, the MAR record indicated the following orders: NovoLOG Injection Solution . (Insulin Aspart, a brand name for regular insulin) Inject as per sliding scale . 241-300 (blood sugar level; normal is 80 to 120) =10 UNITS . Start date: 11/13/25. Another order for NovoLOG Injection Solution . (Insulin Aspart) Inject 5 unit subcutaneously before meals .; Start date: 11/13/25. LN 3 did not add the second insulin dose for before meal as ordered, which was 5 units of insulin.During an interview with LN 3 after the medication administration observation on 5/10/26, at 12:35 p.m., LN 3 confirmed she administered 10 units of insulin to Resident 50 per the sliding scale as Resident 50's finger stick blood glucose (a common capillary blood test used to check current blood sugar levels) level was 284.During an interview with LN 3 on 5/13/26, at 8:44 a.m., LN 3 stated she thought she gave both doses of insulin to Resident 50 on 5/10/26 at noon time.During an interview with the Director of Nursing (DON), in her office, on 5/12/26, at 11:23 a.m., the DON confirmed that the nurse should have given 15 units and not 10 units. 6. During a medication administration observation with LN 6, on 5/10/26, at 3:07 p.m., in the [NAME] Long nursing station, LN 6 gave Resident 13 one baclofen tablet along with two other medications when resident asked for pain medication.Review of Resident 13's medical record, titled Medication Administration Record (MAR), for the month of May 2026, the MAR record indicated an order for Baclofen Oral Tablet 10MG (Baclofen); Give 1 tablet by mouth two times a day for muscle spasm. Start date: 12/02/25 which was due at 1700 (or 5 p.m.). LN 6 administered baclofen at 3:07 p.m. , about 2 hours earlier than the due time noted in the MAR.During an interview with the Director of Nursing (DON), in her office, on 5/12/26, at 11:23 a.m., the DON confirmed that the potassium tablet should not have been crushed. The DON further confirmed that Senna plus should not have been given in place of Senna. The DON stated she expected the nursing staff to administer the medication based on policy within 1 hour of due time. The DON further stated insulin administration required following both the sliding scale and pre-meal dose of insulin per doctor's order.During a review of the facility's undated policy, tilted Medication Administration, the policy indicated .Ensure that the six rights of medication administration are followed: a. Right resident b. Right drug c. Right dosage d. Right route e. Right time f. Right documentation.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. Based on interview and record review, the facility failed to ensure one of sixteen resident's (Resident 69) were free from medication errors when Resident 69's once-monthly drug called Ibandronate for osteoporosis (also called Boniva, a drug used to treat and prevent osteoporosis, a bone disease that weakens bones by decreasing bone mass and caused bone fracture) was administered more than once a month against manufacturer specification.This failed practice could compromise the safety of Resident 69 with over-exposure to a long-acting drug (drug that stays in the body for a long time) with adverse effects and outcomes. Findings:A review of Resident 69's admission RECORD, indicated Resident 69 was admitted to the facility with multiple diagnosis including breast cancer, was on active chemotherapy treatment (drug used to treat cancer), age related osteoporosis (bone disease that weakens bones by decreasing bone mass), and difficulty walking, among others.Review of Resident 69's medical record titled, Medication Administration Record [MAR], dated 5/1/26 to 5/31/26, the MAR record indicated an order for an osteoporosis drug called ibandronate as follows: .Ibandronate Sodium Oral Tablet 150 MG [MG is milligram, a unit of measure]; Give one tablet by mouth one time a day every 1 month(s) starting on the 1st for 28 day(s) for to prevent osteoporosis. Administer on empty stomach before breakfast with full glass of water separated from other meds.Start Date: 4/1/26 . Resident 69's MAR record indicated Ibandronate was administered three times during the month of MAY 2026 on 5/1/26, 5/12/26, and 5/13/26 at 9 AM when it should have been given once a month. The MAR record on a daily basis from 5/2/26 to 5/11/26 marked the drug as not given See Nurse Notes. The MAR record further indicated Ibandronate to be given on empty stomach separated from other medications when it was scheduled to be given at 9 am along with calcium supplement and other medications.During a medication administration observation on 5/10/26, at 9:25 AM, with Licensed Nurse 2 (LN 2), LN 2 administered all the medications for 9 AM except ibandronate that was marked as not given.Review of Resident 69's electronic medical record under the notes section, last accessed on 5/12/26, the record indicated the nursing staff progress note on Ibandronate from 5/2/26 to 5/12/26, marked as not given and waiting on pharmacy (means medication not available from pharmacy).During an interview on 5/10/26, at 2:50 PM, with LN 2, LN 2 stated they followed the order as it was written in the MAR which was the doctor's order.Review of facility's Consultant Pharmacist (CP) drug regimen review for Resident 69 titled, Note to Attending Physician/Prescriber, dated 4/21/26, the record indicated CP notified the doctor and facility on Possible Medication Error and indicated, Per the MAR Ibandronate once monthly was incorrectly administered 3 times in two weeks on 4/2, 4/12, and 4/13 by nurse. The note further indicated that Per manufacturer labeling .150 mg is intended for once monthly administration on the same calendar day each month, not at 28-day intervals. Administration more frequently than monthly is not recommended and may increase the risk of adverse effects .To improve clarity and prevent recurrence, it is recommended to revise the order to a fixed monthly calendar date rather than a rolling interval. The note further indicated, Given that the residents appear to have received three doses in the same month, please advise whether the next scheduled monthly dose should be held or delayed. The note under Physician/Prescriber Response, indicated Agree and a handwritten note indicated hold for 60 days then resume monthly. It was not clear when the physician reviewed the pharmacy note. The facility did not follow or document the physician response and order, as the drug continued to be given three more times during month of May 2026.During a concurrent record review and interview on 5/13/26, at 11:14 AM, with the Assistant Director of Nursing (ADON), in her office, the ADON reviewed the way ibandronate was entered in the computer and stated it was entered wrong. The ADON stated the nurse should have entered it as once monthly so the system could not allow additional administration. The ADON stated the instruction line on the order indicated to be given one time a month and the long instruction was confusing and the nurses gave it three times during the month of MAY on 5/1, 5/12 and 5/13/26. The ADON stated the front-line nurses were (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	responsible for admitting new residents in their area, entering admission drug orders, and entering new orders for existing residents on the computer. The ADON stated they needed to have a better double check system to prevent transcription errors.During an interview on 5/13/26, at 11:30 AM, with the Director of Nursing (DON), in her office, the DON stated pharmacy recommendations were emailed to her, and she printed them to share with the doctors and nursing staff. The DON stated, she along with the nursing team reviewed them and made sure the notes to physician were addressed by the medical doctor when he visited the facility 2-3 times per week. The DON stated the signed/completed pharmacy notes to the doctor were kept in her office as the facility had staffing issues with the medical record office.Review of drug information DailyMed (the official, publicly accessible database of FDA-approved medication labels (package inserts). Operated by the U.S. National Library of Medicine (NLM), it provides healthcare professionals and patients with standardized, up-to-date prescribing information and consumer safety guidelines), last accessed on 5/20/26 via https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=d6d7711f-541b-47d1-b937-2c6a021eb6c3, the package insert indicated BONIVA 150 mg tablets: supplied as a 3 blister pack of 1 tablet.or 1 blister pack of 1 tablet each. The package-insert under drug Interactions indicated products containing calcium.are likely to interfere with absorption of Boniva. Boniva should be taken at least 60 minutes before any oral medications. The package insert under overdosage indicated .based on knowledge of this class of compounds, oral overdosage may result in hypocalcemia (low calcium), Hypophosphatemia ((low phosphate level), and upper gastrointestinal adverse events, such as upset stomach, dyspepsia (indigestion), esophagitis(inflammation, irritation, or swelling of the esophagus), gastritis (inflammation of stomach's protective mucus lining) and ulcer.Review of the facility's undated policy titled, Medication Administration, indicated .Ensure that the six rights of medication administration are followed: Right resident, Right drug.Right time, right documentation. Review MAR to identify medication to be administered.Refer to drug reference material if unfamiliar with the medication. The policy further indicated, .Administer medication as ordered in accordance with manufacturer specifications.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure safe medication storage practices in the medication room and medication carts with resident census of 88 when: 1. The refrigerator in the medication room (a room that stores medications given to residents) at [NAME] Long station was heavily frosted where insulin and vaccines were stored. 2. The medication cart (a wheeled cart that stores medications given to residents on daily basis) in [NAME] Long station contained medications not dated upon opening. 3. The medication cart at East station contained medications not labeled with open date upon opening. These failures could result in unsafe medication storage and the risk of residents receiving ineffective or contaminated products. Findings: 1. During a concurrent interview and medication room inspection, accompanied by Licensed Nurse (LN) 9, at the [NAME] Long nursing station, on 5/10/26, at 10:08 a.m., the medication room' refrigerator was heavily frosted where insulin (blood sugar drug) and vaccine (used to prevent serious disease) products were stored next to it. LN 9 confirmed the findings and stated she wasn't sure when or who was responsible for upkeeping and defrosting the refrigerator. Review of the facility's undated policy, titled Storage of Medications Requiring Refrigeration, the policy indicated It is the policy of this facility to assure proper and safe storage of medications requiring refrigeration and to prevent the potential alteration of medication by exposure to improper temperature controls. The policy did not address how the freezer section of dorm style refrigerator and the frosting should be addressed. 2. During a concurrent interview and medication cart inspection, accompanied by Licensed Nurse (LN) 6, in [NAME] Long station, on 5/10/26, at 2:55 p.m., the medication cart contained the following expired medications and medications without a date marked when opened as follows: a. Novolog (a rapid-acting man-made insulin used to control high blood sugar in adults and children with diabetes mellitus) insulin pen (Insulin in a pen shaped form), with a discard after date of 4/19/26. b. Budesonide (a inhalation drug used to treat inflammation in lungs) inhalation suspension (special liquid form), out of foil wrap packaging marked on the box with 01/06. The manufacturer label on the packing box indicated, Once the foil envelope is opened, use the vials within 2 weeks. c. Ipratropium Bromide and Albuterol Sulfate (or Duoneb, a combination prescription drugs used to treat asthma or breathing issues) was found out of foil [NAME] and with an open date of 4/10/26. Manufacturer directions on the foil packaging indicated, Once the foil envelope is opened, use the vials within 2 weeks. d. Another Ipratropium Bromide and Albuterol Sulfate was found out of the foil wrap with an open date of 3/25/26. Manufacturer directions on the foil packaging indicated, Once the foil envelope is opened, use the vials within 2 weeks. LN 6 confirmed the findings and stated that they should have discarded the medications as indicated in a timely manner based on label instruction. 3. During a concurrent interview and medication cart inspection, accompanied by Licensed Nurse (LN) 8, in the East long station, on 5/10/26, at 3:40 p.m., the medication cart contained the following medications without a date marked when first opened as follows: a. An open vial of Lantus (a prescription long-acting insulin used to treat blood sugar) insulin, found without an open date marking. b. Two open and used containers of Breo Ellipta (prescription inhaler used to treat asthma) inhaler was found out of its sealed packaging with no open date markings on the container. Breo Ellipta product label on the container indicated Discard the inhaler 6 weeks after opening the moisture-protective foil tray . c. An eye drop called Vyzulta (or Latanoprost, eye drop for eye disease) not dated when first opened and taken out of refrigerator. The product label on the box indicated it was good for 8 weeks at room temperature and out of refrigerator. LN 8 confirmed the findings and stated that they should have been dated when they first opened and they needed to discard the medications per drug label instruction. LN 8 stated the insulin once opened and out of refrigerator was good for a month. In an (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	interview with the Director of Nursing (DON), in her office, on 5/12/26, at 12:17 a.m., the DON stated the nursing staff documenting the refrigerator should have notified the management and helped with defrosting the refrigerator. The DON stated the standard of nursing care was to read the label for storage and how to handle the drugs and products. Review of the facility's undated policy, titled Storage of Medications Requiring Refrigeration, the policy on section 2 indicated The facility will ensure that all drugs and biological used will be labeled in accordance with professional standards, including expiration date (when applicable) and with appropriate accessory and precautionary instructions (Such as shake well, take with meals, do not crush, special storage instruction). Review of the facility's undated policy titled, Labeling of Medications and Biologicals, the policy indicated, . All medications and biologicals will be labeled in accordance with applicable federal and state requirements and current accepted pharmaceutical principles and practices. 2. Medication labels must be legible at all times.Labels for individual drug containers must include.The expiration date when applicable.Labels for each floor/unit's stock medications must include.the expiration date when applicable.Labels for over-the-counter (OTC) medications must include.The expiration date when applicable.All opened are accessed vials should be discarded within 28 days unless the manufacturer specifies a different (shorter or longer) date for that open vial.

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or get specialized rehabilitative services as required for a resident. Based on interview and record review, the facility failed to provide adequate physical therapy services to 1 of 26 sampled residents (Resident 49) when, Resident 49 who was visually impaired, was provided therapy services with a white cane (a tool used by people who are blind or visually impaired to scan the environment in front of them) instead of being provided an appropriate mobility device of a walking stick (a mobility tool used to help with balance and walking).This failure had the potential for Resident 49 not to attain, maintain, or restore his highest practicable level of physical function and well-being. This failure also presented an increased risk for falls for Resident 49.Findings:Review of Resident 49's admission RECORD, indicated Resident 49 was admitted with the diagnosis of macular degeneration (a disease that damages central vision), occlusion and stenosis of vertebral artery (reduced blood flow to the back of the brain), degenerative disease of nervous system (the nerves in your brain break and die), and unsteadiness on his feet.During a concurrent observation and interview on 5/10/26 at 10:39 AM, with Resident 49 in his room, Resident 49 was observed lying in bed. Next to Resident 49's bed, within arm's reach, was a cane that was a white cane. Resident 49 stated he was legally blind and he used the white cane to help him see. Resident 49 stated he was given the cane from a place that supports people with blindness and visual challenges.During an interview on 5/12/26 at 12:35 PM, with the Director of Rehabilitation (DOR), the DOR stated the rehabilitation department had been working with Resident 49 since the end of last year on using a walking stick for balance and walking. The DOR stated a walking stick is usually not the typical walking aid used for physical, however, Resident 49 was evaluated and cleared by the therapy department to use the walking stick for his therapy sessions.During a concurrent observation and interview, on 5/12/26 at 3:55 PM, with the DOR and Licensed Nurse (LN) 7, the DOR stated when a resident was being evaluated by the Physical Therapist (PT), the PT gathers all the resident's historical data which included the documents from the hospital medical diagnosis and the residents themselves. The DOR stated the resident must be evaluated with an actual walking stick. The DOR stated if the stick was not a walking stick the stick could break and harm the resident and result in the resident being sent to the hospital. During an observation in Resident 49's room, the DOR confirmed the white cane therapy used as a walking stick for Resident 49 was not a stick made for walking or even a stick. The DOR verified that the white cane being used for physical therapy services for Resident 49 was not a walking stick. LN 7 stated Resident 49 had the white cane due to his blindness and used the white cane for seeing assistance to walk around the facility. The DOR stated he was unaware of Resident 49's visual impairment or any diagnosis related to his vision.During a review of the facility's policy and procedure (P&P) titled, Use of Assistive Devices, dated 2025, the P&P indicated, .The purpose of this policy is to provide reliable process for the proper and consistent use of assistive devices for the residents requiring equipment to maintain or improve function, dignity and quality of life.Assistive devices are tools, products, types of equipment, or technology that help individuals perform tasks and activities. They may help the individual move around, see.Assistive devices include.Mobility aids.cane.Facility staff will provide appropriate assistance to ensure that the resident can use the assistive devices safely. This may include assessment, education or therapy sessions for training the use of the device.A nurse with responsibility for the resident will monitor for consistent use of the device and safety in the use of the device.During a review of the facility's document titled, .PHYSICAL THERAPIST., dated 2022, indicated, Plans, develops, organizes, implements, evaluates, and directs the execution of physical therapy services in accordance with physicians orders.Provide resident information needed for the resident assessment instrument according to the facility policy such as functional abilities and goals, functional status, range of motion, balance during transitions and walking, physical therapy.Promotes safe work practices.and accident prevention procedures to prevent resident/employee injury.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. Based on interview, and record review, the facility failed to implement an effective immunization program to offer, obtain informed consent and provide education to a resident or resident representative (RP) about the influenza (or flu, is a contagious viral infection of the respiratory system that can range from mild to severe, causing symptoms like fever, cough, sore throat, muscle aches, and fatigue) vaccine and pneumococcal (a serious bacterial infection that can cause respiratory illness) vaccine for three out of five sampled residents when:1. Resident 64, Resident 46, and Resident 96 were not offered the Influenza vaccine during the 2025- 2026 flu season; and,2. Resident 64 was not offered a Pneumonia vaccine.These failures had the potential for the residents and resident's responsible parties to not be fully informed about the risks and benefits, and potential side-effects of the flu and pneumonia vaccine prior to receiving or declining the vaccination. It also increased the risk of impacting Resident 64, Resident 46, and Resident 96's health.Findings: 1a. A review of Resident 64's admission RECORD, indicated Resident 64 was admitted to the facility early 2026.A review of the Resident 64's Progress Notes dated 3/24/26, indicated, .writer [Infection Preventionist- IP] spoke to Resident [Resident 64] asked about immunization record, per Resident stated he is not sure and Resident mentioned that He was [at other facility name]. Writer called [other facility name] and left a message to IP to get information.During a concurrent interview and record review on 5/12/26, at 1:51 PM, with the Infection Preventionist (IP), Resident 64's immunization record was reviewed. The IP stated the flu season started on October 1st and that was when the facility would start offering the flu vaccine to the resident or resident representative (RP) to obtain consent and the flu season would end by March 31st. The IP further stated they would offer the flu vaccine in between those dates unless the resident or the RP requested the flu vaccine beyond March 31st. The IP stated that Resident 64 was not sure if he had been vaccinated for the flu and the resident told him that his records was at another other facility that he resided in. The IP further stated he requested Resident 64's immunization record from the previous facility where Resident 64 resided in, but he did not get a response. The IP confirmed that he had no documentation that the flu vaccine was offered to Resident 64 or that a consent form was signed.1b. A review of Resident 46's admission RECORD, indicated Resident 46 was admitted to the facility in 2023.During a concurrent interview and record review on 5/12/26, at 2:05 PM, with the IP, Resident 46's immunization record was reviewed. The IP confirmed that there was no documentation indicating that the influenza vaccine was offered to Resident 46 for the 2025- 2026 flu season.1c. A review of Resident 96's admission RECORD, indicated Resident 96 was admitted to the facility in 2025.During a concurrent interview and record review on 5/12/26, at 2:36 PM, with the IP, Resident 96's immunization record was reviewed. The IP confirmed that there was no documentation that influenza vaccine for the 2025-2026 flu season was offered to Resident 96 and a consent form was not obtained.2. During a concurrent interview and record review on 5/12/26, at 1:51 PM, with the IP, Resident 64's immunization record was reviewed. The IP stated that they offered pneumococcal vaccine upon admission. The IP further stated that they would obtain consent, provide education to the resident or RP. The IP further stated if there was a history of a pneumococcal vaccine being given, he would document that it in the electronic health record (EHR) of the resident. The IP stated that Resident 64 was not sure if he was vaccinated for pneumonia and Resident 64 told him that his records were at the other facility. The IP stated he requested Resident 64's immunization record from the previous facility where Resident 64 resided in, but he did not get a response. The IP confirmed that he did not have the immunization record of Resident 64 for the pneumonia vaccine. The IP further confirmed that he had no documentation the pneumonia vaccine was offered to Resident 64 or that a consent form was signed.During an interview on 5/12/26, at 2:57 PM, with the IP, the IP stated it was important to offer the influenza and pneumonia vaccines to the residents in order to prevent the risk of infection from the influenza virus or getting pneumonia. During an interview on 5/13/26, at 12:22 PM, with the (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Director of Nursing (DON), the DON stated the facility needed the immunization record of the residents to prevent double dosing. The DON further stated the facility had to document the residents' vaccine history including vaccines given in the past as well as vaccines given in the facility.A review of the facility's undated policy and procedure titled, Influenza Vaccination, indicated, .It is the policy of this facility to minimize the risk of acquiring, transmitting or experiencing complications from influenza by offering our residents, staff members, and volunteer workers annual immunization against influenza .Influenza vaccinations will be routinely offered annually from October 1st through March 31st unless such immunization is medically contraindicated. A review of the facility's undated policy and procedure titled, Pneumococcal Vaccine (Series), indicated, .It is our policy to offer residents and staff immunization against pneumococcal disease in accordance with current CDC guidelines and recommendations.Each resident will be assessed for pneumococcal immunization upon admission. Self-report of immunization shall be accepted. Any additional efforts to obtain information shall be documented, including efforts to determine date of immunization or type of vaccine received.Each resident will be offered a pneumococcal immunization unless it is medically contraindicated or the resident has already been immunized.A review of the facility's undated policy and procedure titled, General Immunization/Vaccination, indicated, .Residents, staff, and volunteer workers will be offered immunizations against infectious diseases as per current federal, state and local guidance.The resident's medical record or staff/volunteer's medical file will include documentation that the staff, volunteer, resident and/or the resident's representative was provided education regarding the benefits and potential side effects of immunization(s), and that the resident received or did not receive the immunization(s) due to medical contraindication or refusal.A review of the facility's undated policy and procedure titled, Infection Prevention and Control Program, indicated, .Influenza and Pneumococcal Immunization: a. Residents will be offered the influenza vaccine each year between October 1 and March 31, unless contraindicated or received the vaccine elsewhere during that time. b. Residents will be offered the pneumococcal vaccines recommended by the CDC upon admission, unless contraindicated or received the vaccines elsewhere.Documentation will reflect the education provided and details regarding whether or not the resident received the immunizations.

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. Based on interview, and record review, the facility failed to provide the COVID-19 vaccine, for one of five sampled residents (Resident 64), when there was no documentation in Resident 64's medical record that the COVID-19 vaccine was offered to the resident and the vaccine history (including previous administered COVID- 19 vaccines) was not obtained for Resident 64.This deficient practice placed Resident 64 at risk to be infected with the COVID-19 virus that could lead to severe illness, hospitalization, and/or death.Findings:A review of Resident 64's admission RECORD, indicated Resident 64 was admitted to the facility early 2026.During a concurrent interview and record review on 5/12/26, at 1:51 PM, with the Infection Preventionist (IP), Resident 64's immunization record was reviewed. The IP stated they offered the COVID-19 vaccine to residents upon admission. The IP further stated that they would offer, obtain consent, provide education to the resident or resident representative (RP) if there was a new COVID-19 vaccine. The IP stated if there was a history of the COVID-19 vaccine being given to the resident, he would document that it in the electronic health record (EHR) of the resident. The IP confirmed that he did not have the immunization record of Resident 64 for the COVID-19 vaccine. The IP stated that the resident informed him that he was not sure if he had the COVID-19 vaccine because his immunization record was at another facility where he previously stayed. The IP further stated he requested Resident 64's immunization record from the previous facility where Resident 64 was at, but he did not get a response. The IP confirmed that he did not have the immunization record for Resident 64's COVID-19 vaccine. The IP further confirmed that he had no documentation that the COVID-19 vaccine was offered to Resident 64 or that a consent form was signed. The IP stated it was important to offer the COVID-19 vaccine to the residents, to prevent the risk of a COVID-19 infection. During an interview on 5/13/26, at 12:22 PM, with the Director of Nursing (DON), the DON the facility obtained consents for immunizations from the resident or the RP stated for newly admitted residents. The DON further stated that the facility needed the immunization record of the residents to prevent double dosing of vaccines. The DON stated the facility should have documented a resident's vaccine history, if a vaccine was offered and when a new vaccine was given to the resident in the facility.A review of the Resident 64's Progress Notes dated 3/24/26, indicated, .writer [IP] spoke to Resident [Resident 64] asked about immunization record, per Resident stated he is not sure. and Resident mentioned that He was [at other facility name]. Writer called [other facility name] and left a message to IP to get information.A review of the facility's undated policy and procedure titled, COVID-19 Vaccination, indicated, .It is the policy of this facility to minimize the risk of acquiring, transmitting or experiencing complications from COVID-19 (SARS-CoV-2) by educating and offering our residents and staff the COVID-19 vaccine.COVID-19 vaccinations will be offered to residents when supplies are available, as per CDC [Centers for Disease Control and Prevention] and/or FDA [Food and Drug Administration] guidelines unless such immunization is medically contraindicated, the individual has already been immunized during this time period, or refuses to receive the vaccine.The facility will educate and offer the COVID-19 vaccine to residents, resident representatives and staff and maintain documentation of such.A review of the facility's undated policy and procedure titled, General Immunization/Vaccination, indicated, .Residents, staff, and volunteer workers will be offered immunizations against infectious diseases as per current federal, state and local guidance.The resident's medical record or staff/volunteer's medical file will include documentation that the staff, volunteer, resident and/or the resident's representative was provided education regarding the benefits and potential side effects of immunization(s), and that the resident received or did not receive the immunization(s) due to medical contraindication or refusal.A review of the facility's undated policy and procedure titled, Infection Prevention and Control Program, indicated, .COVID-19 Immunization: a. Residents and staff will be (continued on next page)

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	offered the COVID-19 vaccine when vaccine supplies are available to the facility.The resident's medical record includes documentation that indicates, at a minimum, the following.Each dose of COVID-19 vaccine administered to the resident, or.If the resident did not receive the COVID-19 vaccine due to medication contraindications or refusals.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. Based on observation, interview, and record review, the facility failed to ensure a functioning call light system (system/device used by residents to call staff for assistance) was in place for 1 of 26 sampled residents (Resident 63) when Resident 63's call light was not working.This failure had the potential to result in Resident 63 being unable to call staff for help when needed and the resident's needs not being met. Findings:A review of Resident 63's admission RECORD, indicated Resident 63 was admitted to the facility in March 2026 with diagnoses including cellulitis of right lower limb (a common, potentially serious bacterial skin infection that affects the lower legs, ankles, or feet), unsteadiness on feet (imbalance), acquired absence of right great toe (the loss of the right big toe due to a past surgical amputation, accident, or injury), and shortness of breath. A review of Resident 63's clinical record titled, Care Plan Report, dated 3/12/26, indicated, .Focus: The resident has an ADL [Activities of Daily Living] self-care performance deficit r/t [related to] Impaired balance.Interventions.Encourage the resident to use bell to call for assistance.Focus: The resident is at risk for falls r/t Gait/balance problems.Interventions.Be sure The resident's call light is within reach and encourage the resident to use it for assistance as needed. The resident needs prompt response to all requests for assistance. During a concurrent observation and interview on 5/11/26, at 8:32 AM, with Resident 63, Resident 63 pressed his call light; however, the light did not activate. Resident 63 stated the call light system had not been functioning since he had been in the room and that it was annoying having to use the call bell provided as the nursing staff could not hear it or would state they were helping someone else. Resident 63 further stated he preferred to keep his room door closed and wanted a proper call light system to use instead of the call bell.During a concurrent observation and interview on 5/11/26, at 8:39 AM, with Licensed Nurse (LN) 1, LN 1 stated the call light system for Resident 63 had not been functioning for quite a while. LN 1 stated Resident 63 preferred to keep his room door closed for privacy and that it was difficult to hear the call bell when the door was closed. LN 1 further stated there was a possibility of delayed care and longer response times when Resident 63 required assistance.During an interview on 5/13/26, at 10:25 AM, with the Director of Nursing (DON), the DON stated the call light system should be audible to raise staff awareness and ensure residents in need of assistance were attended to promptly. The DON further stated that if the call light system was not functioning, an alternative option, such as a call bell, should have been effective and audible to staff even when residents' room doors were closed. The DON stated not being able to hear the call bell when Resident 63's room door was closed could result in delayed staff response and failure to meet the resident's needs in a timely manner.During a review of the facility's undated policy and procedure (P&P) titled, Call Lights: Accessibility and Timely Response, the P&P indicated, .The purpose of this policy is to assure the facility is adequately equipped with a call light at each residents' bedside.to allow residents to call for assistance. Call lights will directly relay to a staff member or centralized location to ensure appropriate response.6. The call system will be accessible to residents while in their bed or other sleeping accommodations within the resident's room.9. Ensure the call system alerts staff members directly or goes to a centralized staff work area.