STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055308	A. Building B. Wing	02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Windsor Elk Grove Care and Rehabilitation Center	9461 Batey Avenue Elk Grove, CA 95624

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 47197 Based on observation, interview, and record review, the facility failed to protect two out of 32 sampled residents' (Resident 8 and Resident 20) right to be treated with respect and dignity when facility staff were standing over Resident 8 and Resident 20 while feeding them during the 2/24/25 lunch meal. This failure resulted in Resident 8 to experience emotional distress and felt disrespected and potential for Resident 20 to feel that he was not being treated with respect and dignity. Findings: 1a. A review of Resident 8's clinical record indicated Resident 8 was admitted April of 2021 and had diagnoses that included chronic pain syndrome (condition that involves persistent pain that lasts for weeks to years), weakness, contracture (permanent shortening of muscles, skin, and nearby soft tissue that results in limited range of motion and stiffness), and major depressive disorder (persistently depressed mood or loss of interest in activities, causing significant impairment in daily life). A review of Resident 8's Minimum Data Set (MDS- a federally mandated resident assessment tool) Cognitive Patterns, dated 1/29/25, indicated Resident 8 had a Brief Interview for Mental Status (BIMS- a tool to assess cognition) score of 12 out of 15 which indicated Resident 8 had a moderately impaired cognition. A review of Resident 8's MDS Mood status, dated 1/29/25, indicated Resident 8 experienced feeling down, depressed or hopeless for several days. A review of Resident 8's care plan intervention, revised 12/7/23, indicated, Assist with meals as needed. During a concurrent observation and interview on 2/24/25 at 1:15 p.m. in Resident 8's room, Certified Nurse Assistant 7 (CNA) 7 was observe standing over Resident 8 while feeding her. CNA 7 confirmed the observation. CNA 7 stated Resident 8 required full assistance with her meals. During an interview on 2/24/25 at 1:20 p.m. with resident 8, Resident 8 stated she did not like it when staff just stands over her while feeding her. Resident 8 further stated she felt disrespected. (continued on next page)

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

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1b. A review of Resident 20's clinical record indicated Resident 20 was admitted January of 2025 and had diagnoses that included hemiplegia (complete loss of the ability to move one side of the body) and hemiparesis (partial weakness of one side of the body) affecting left non-dominant side, dementia (a progressive state of decline in mental abilities), contracture, muscle weakness, and need for assistance with personal care. A review of Resident 20's MDS Cognitive Patterns, dated 1/8/25, indicated Resident 20 had BIMS score of 2 out of 15 which indicated Resident 20 had a severely impaired cognition. A review of Resident 20's MDS Functional Abilities, dated 1/28/25, indicated Resident 20 is dependent with eating, oral hygiene, and personal hygiene. During a concurrent observation and interview on 2/24/25 at 1:26 p.m. in Resident 20's room, CNA 8 was observe standing over Resident 20 while feeding him. CNA 8 confirmed the observation and stated Resident 20 required full assistance with his meals. CNA 8 further stated she thought it was okay for them to stand over the resident while feeding them. During an interview on 2/26/25 at 4:06 p.m. with the Director of Nursing (DON), the DON stated sitting and facing the patient while feeding them is a more person-centered approach for the patient. The DON further stated that staff should always treat residents with respect and dignity. A review of the facility's policies and procedures (P&P) titled, Resident Rights, revised 12/2021, indicated, Employees shall treat all resident with kindness, respect, and dignity. A review of the facility's P&P titled, Assistance with Meals, revised 3/2022, indicated, 2. Residents who cannot feed themselves will be fed with attention to safety, comfort and dignity, for example: a. not standing over residents while assisting them with meals .

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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. 47197 Based on observation, interview, and record review, the facility failed to provide reasonable accommodation of resident needs for one of 32 sampled residents (Resident 20) when Resident 20's call light system was not appropriate and was not within reach. This failure placed Resident 20's safety at risk and had the potential for Resident 20's needs to be not met. Findings: A review of Resident 20's clinical record indicated Resident 20 was admitted January of 2025 and had diagnoses that included hemiplegia (complete loss of the ability to move one side of the body) and hemiparesis (partial weakness of one side of the body) affecting left non-dominant side, dementia (a progressive state of decline in mental abilities), contracture (a stiffening/shortening at any joint, that reduces the joint's range of motion), muscle weakness, and need for assistance with personal care. A review of Resident 20's MDS Cognitive Patterns, dated 1/8/25, indicated Resident 20 had BIMS score of 2 out of 15 which indicated Resident 20 had a severely impaired cognition. A review of Resident 20's MDS Functional Abilities, dated 1/28/25, indicated Resident 20 is dependent with eating, oral hygiene, toileting, shower/bathing self, lower body dressing, and personal hygiene. Resident 20's MDS Functional Abilities further indicated Resident 20 was dependent with rolling left and right, sit to lying, lying to sitting on the side of bed, and chair/bed-to-chair transfer. A review of Resident 20's care plan intervention, dated 1/8/25, indicated, Ensure/provide a safe environment: Call light in reach . During an observation on 2/24/25 at 10:06 a.m. in Resident 20's room, Resident 20 was observed lying on bed, awake, and his call light button was hung on the wall next to the door. Resident 20 was observed to have contractures on both hands. During a concurrent observation and interview on 2/25/25 at 9:51 a.m. with Certified Nurse Assistant (CNA) 8, in Resident 20's room, CNA 8 confirmed Resident 20 was given a call light button to use whenever he needs help. CNA 8 stated Resident 20 was not able to push the call light button because of his hand contractures. During an interview on 2/25/25 at 10:04 a.m. with Licensed Nurse (LN) 4, in Resident 20's room, LN 4 stated Resident 20 was able to move his right hand but was not able to push the call light button. LN 4 also stated Resident 20 needed the soft touch pad (call system which is activated with a very light touch) instead of the call light button. LN 4 further stated she thought Resident 20 was already provided with soft touch pad. During an observation on 2/25/25 at 12:20 p.m. in Resident 20's room, Resident 20 was observed lying on bed, awake, and his call light button was on the floor, below his bed. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview on 2/25/25 at 12:40 p.m. with CNA 9, in Resident 20's room, CNA 9 confirmed that Resident 20's call light button was on the floor, below his bed. CNA 9 stated the call light button should be within the reach of the resident. During an interview on 2/26/25 at 4:06 p.m. with the Director of Nursing (DON), the DON stated if a resident was not able to press the call light button, an alternative call system, like soft touch pad, will be provided. The DON further stated call light button should be within reach of the resident. A review of Resident 20's progress note, dated 2/26/25 at 5:52 p.m., indicated, .Reassessed resident with the use of different types of call lights, unable to use regular call light .res [resident] still unable to follow instructions to push/squeeze to activate. Resident unable to follow verbal commands. At this time resident is unable to mentally or physically use the call light to call for assistance. Resident just mumbles unable to move hands due to contracture and weakness .Resident is dependent with care . A review of the facility's policies and procedures (P&P) titled, Call System, Resident, revised 9/2022, indicated, 1. Each resident is provided with a means to call staff directly for assistance from his/her bed .4. If the resident has a disability that prevents him/her from making use of the call system, an alternative means of communication that is usable for the resident is provided and documented in the care plan.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34980 Based on observation, interview, and record review, the facility failed to meet professional standards of care for four of 32 sampled residents (Residents 21, 27, 92 and 82), when: 1. Resident 21 had no physician's order and no plan of care for self-catheterization (a procedure that involves inserting a hollow tube into one's own bladder). 2. Resident 27 did not receive an antibiotic (a drug used to treat infections caused by bacteria) order as prescribed. 3. Resident 92 had no plan of care for the use of a mouth guard. 4. Resident 82 did not have consistent and accurate documentation for urine output monitoring. These failures had the potential to compromise the residents' care and could have resulted in serious health complications. Findings: 1. A review of the Admission Record indicated the facility admitted Resident 21 in 2018 with multiple diagnoses which included paraplegia (the inability to voluntarily move the lower parts of the body), a history of urinary tract infections and neuromuscular dysfunction of the bladder (a condition that occurs when the nerves controlling the bladder are damaged resulting in the loss of bladder control). A review of Resident 21's Minimum Data Set (MDS - an assessment tool used to guide care) Cognitive (having full understanding) Patterns, dated 12/5/24, indicated Resident 21 had a Brief Interview for Mental Status (BIMS-a tool to assess a person's full understanding) score of 15 out of 15 which indicated Resident 21 was able to understand. During a concurrent observation and interview with Resident 21 on 2/24/25 at 1:49 p.m., Resident 21 was observed sitting in a wheelchair with a urinary catheter bag. The urine in the catheter bag contained dark urine with sediment. Resident 21 said his urine looks like that most of the time and was normal for him. Resident 21 further stated he had a recent urine test, and it showed no infection. Lastly, Resident 21 stated, I replace the catheter whenever it leaks or if it needs it. During an interview with Licensed Nurse 6 (LN 6) on 2/24/25 at 2:21 p.m., LN 6 stated (Resident 21), Replaces his urinary catheter himself as needed. LN 6 further stated Resident 21, Has been doing self-catheterization for several years. During a concurrent interview and record review with the Director of Nursing (DON) on 2/25/24 at 1:52 p.m., the DON verified Resident 21 had no current physician's order to do self-catheterization as needed for the most recent readmitted . The DON further verified Resident 21 had no plan of care for self-catheterization. The DON stated, It is my expectation for residents' to have a current physician's order to preform self-catheterization and to have an updated care plan addressing it. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the facility policy (P&P) titled, Physician Orders dated 3/22/22 indicated, Treatment orders will include the following: A description of the treatment, including the site, if applicable. The frequency of treatment and duration of order (when appropriate). The condition/diagnosis for which the treatment is ordered . A review of the facility policy titled, Care Plan - Baseline dated 8/25/21 indicated, A baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality of care shall be developed and implemented for each resident by the Interdisciplinary Team (IDT). The baseline care plan is developed within 48 hours of a residents' admission . 51078 2. Resident 27 was originally admitted to the facility December 2021 with diagnosis that included ulcer of the right lower extremity. During a concurrent observation and interview on 2/24/25 at 2:12 p.m. with LN 1 in the North station medication storage room., LN 1 verified six bags of IV antibiotic labeled with Resident 27's name were found on the counter. LN 1 stated the medication had been discontinued by the prescribing physician and the resident was no longer receiving it. LN 1 further stated the expectation was for night shift staff to go through all medications in the storage room and remove all discontinued/expired medications by taking them to the DON's office for proper disposal. During a concurrent interview and record review on 2/25/25 at 12:13 p.m. with the DON, Resident 27's Medication Administration Record (MAR - a daily documentation record used by a licensed nurse to document medications given to a resident) dated February 2025, was reviewed. The DON confirmed there was a Physician Order dated 2/11/25 that indicated an antibiotic was to be given IV every eight hours for seven days to treat cellulitis of the right foot. The DON acknowledged that the MAR reflected six of 21 doses of the antibiotic were not given. The DON stated the expectation was for staff to follow and complete all medication orders as prescribed. The DON further stated that Resident 27 was at risk to experience further complications of infection. During a review of the facility's P&P titled, Medication Administration General Guidelines, dated October 2017, the P&P indicated, Medications are administered and prescribed in accordance with good nursing principles and practices .Medications are administered in accordance with written orders of the attending physician. During a review of the facility's P&P titled, Physician Orders, dated March of 2022, the policy indicated, the Licensed Nurse receiving the order will be responsible for documenting and implementing the order. Medication orders will be transcribed onto the appropriate resident administration record. 39489 3. In a review of Resident 92's Admission Record, indicated, Resident 92 was admitted to the facility on [DATE] with diagnoses that included Dementia, Dysphagia (difficulty swallowing) and weakness. MDS indicated Resident 92 was cognitively impaired. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview in Resident 92's room on 2/24/25 at 1 p.m., CNA 10 assisted Resident 92 with his meal as he was unable to feed himself and needed help with his meals. CNA 10 confirmed she did not remove Resident 92's mouth guard, and he was wearing it while was she feeding him. CNA 10 asked Resident 92 to open his mouth and showed his mouth guard. CNA 10 further stated, she should have removed Resident 92's mouth guard to prevent possible aspiration or avoid food getting stuck on the side of his mouth. During an interview with family member (FM) of Resident 92 on 2/24/25 at 1:40 p.m., the FM stated Resident 92 was non-verbal, needs to be fed by the staff, and Resident 92's mouth guard needed to be removed before meals. FM further stated, she spoke with the Speech Therapist (ST) and agreed Resident 92's mouth guard must be-remove before meals as he can aspirate if not removed. During an interview with the ST on 2/26/25 at 9:10 a.m., the ST stated, she evaluated Resident 92 and said that the staff must remove his mouth guard before meals to prevent food particles from getting stuck on his mouth guard and create a breeding ground for bacteria. The ST further stated, Resident 92 might aspirate if he eats his meals with his mouth guard on. During an interview with the DON on 2/26/25 at 9:30 a.m., the DON stated the staff should follow the recommendation of the ST to remove Resident 92's mouth guard before meals to avoid possible aspiration. The DON further stated, the staff should have created a care plan for Resident 92's mouth guard to guide them about care and safety measures. In a review of Resident 92's Speech Therapy, Evaluation and Plan of Treatment, start of care 2/7/25, indicated . use of mouth of guard due to grinding teeth .Patient presents with mild to mod [moderate] risk of aspiration/dysphagia characterized by observed pocketing of food, need for cues to chew and swallow, and decreased ability to advocate for self, due to baseline being nonverbal . In a review of Resident 92's Meal Assistance Steps:, 1. Remove patient's mouth guard . 4. Check patient's mouth for pocketing before next bite of food . In a review of the facility's P&P titled Assistance with Meals, revised March 2022, indicated, Residents shall receive assistance with meals in a manner that meets the individual needs of each resident . 3. Residents who cannot feed themselves will be fed with attention to safety, comfort and dignity . 46872 4. A review of the Admission Record indicated the facility admitted Resident 82 in June 2024 with multiple diagnoses which included an overactive bladder. A review of Resident 82's MDS, dated [DATE], indicated, Resident 82 had intact cognition. A review of Resident 82's care plans initiated on 2/7/25, indicated, The resident has an indwelling catheter (thin, flexible tube inserted into the body to drain urine or other fluids). A review of Resident 82's Intake and Output Record, indicated, date 2/2 with output x2, x3, x4, date 2/3 with output x3, x2, x3, and date 2/10 with output x2, x3. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 2/27/25, at 10:54 p.m., with the DON, the DON confirmed Resident 82 had a foley catheter inserted on 2/3/25. The DON stated the expectations were for staff to write the amount of daily input and urine output for a minimum of 30 days for residents with a foley catheter. The DON reviewed Resident 82's Intake and Output Record and confirmed writing x2, x3 or x4 was not okay to document as it doesn't tell the reader the amount of the urine output. The DON stated accurate documentation of urine output was needed to assess if the foley catheter was working and to accurately report how the patient was doing to the physician. The DON confirmed she was aware monitoring intake and urine output for the first 30 days was required per State regulations. During a review of the facility's P&P titled, Nursing Documentation, dated 6/27/22, the P&P indicated, To communicate patient's status and provide complete, comprehensive, and accessible accounting of care and monitoring provided. During a review of the facility's P&P titled, Conformity with Laws and Professional Standards, undated, the P&P indicated, .facility operates and provides services in compliance with current federal, state, and local laws, regulations, codes and professional standards of practice that apply to our facility and types of services provided.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46872 Based on observation, interview, and record review, the facility failed to ensure two out of 32 sampled residents (Resident 24 and Resident 47) were assisted with nail care as part of their Activities of Daily Living (ADLs-routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves) when both residents were found with long untrimmed nails. This failure had the potential for Resident 24 and Resident 47 to sustain injury and to acquire an infection. Findings: Resident 24 was admitted to the facility October 2022 with multiple diagnoses which included multiple sclerosis (disease where nerve damage disrupts communication between the brain and the body which can result in muscle weakness, numbness and impaired coordination) and quadriplegia (partial or total loss of function in all four limbs and the torso). A review of Resident 24's Minimum Data Set (MDS, an assessment tool) dated 1/15/25, indicated, Resident 24 had moderate cognitive impairment (a stage of cognitive decline that affects a person's ability to think, learn, and remember). Resident 47 was admitted to the facility April 2020 with multiple diagnoses which included hemiplegia (loss of ability to move one side of the body) and hemiparesis (weakness or paralysis on one side of the body). A review of Resident 47's MDS, dated [DATE], indicated Resident 47 was cognitively intact. During a concurrent observation and interview on 2/24/25, at 9:35 a.m., with Resident 47, Resident 47's nails on both hands were observed long. Resident 47 confirmed her nails were long, sharp, and hurt because they cut into her hand. Resident 47 stated, Left hand needs to be trimmed really bad .cuts into my hand. During an interview on 2/24/25, at 9:50 a.m., with Licensed Nurse (LN) 1, LN 1 confirmed Resident 47's nails were long and needed trimming. LN 1 stated [nails] could potentially poke into skin and hurt. During a concurrent observation and interview on 2/24/25, at 10:14 a.m., with Resident 24, Resident 24's nails on left hand were observed long and jagged. Resident 24 confirmed her nails needed to be trimmed. Resident 24 stated, Nails are bothering me .need to be trimmed .scratch myself with them. During an interview on 2/24/25, at 10:20 a.m., with LN 8, LN 8 confirmed Resident 24's nails were long and could potentially dig into the skin and cause wounds. LN 8 stated [nails] should have been trimmed. During an interview on 2/25/25, at 2:32 p.m., with the Director of Nursing (DON), the DON stated the expectations were for staff to provide nail care as needed and to check nails on the resident's shower days. The DON further stated that if nails were not trimmed or becomes too long, residents could potentially scratch themselves and were at risk for skin breakdown. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 24's care plans initiated on 9/3/20, indicated, Check nail length and trim and clean on bath day and as necessary . During a review of Resident 47's care plans initiated on 4/21/20, indicated, Requires assistance with aspects of following ADLS .bathing/shower, dressing/clothing, personal hygiene . During a review of the facility's policy and procedure (P&P) titled, Fingernails/Toenails, Care of, revised 2/2018, the P&P indicated, The purposes of this procedure are to clean the nail bed, to keep nails trimmed, and to prevent infections .Nail care includes daily cleaning and regular trimming .Trimmed and smooth nails prevent the resident from accidentally scratching and injuring his or her skin. During a review of the facility's P&P titled, Activities of Daily Living (ADLs), Supporting, revised 3/2018, the P&P indicated, Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. 51483 Based on observation, interview, and record review, the facility failed to ensure one of 32 sampled residents (Resident 13) were offered resident centered activities. This failure decreased social interactions and increased the potential for negative impact on the physical, mental and psychosocial well-being of Resident 13. Findings: Resident 13 was admitted to the facility in Winter 2023 with diagnoses that included senile degeneration of brain (a progressive state of decline in mental abilities). During a concurrent observation and interview on 02/24/25 at 10:57 a.m., with Resident 13, Resident 13 was observed sitting on their bed. Resident 13 expressed a desire to communicate with others and reported loneliness and difficulty due to her hearing impairment. Resident 13 stated that a request for hearing assistance was made to the facility. There were no magazines, music players, game boards, amplifiers or any other activity tools observed in Resident 13's room. During an observation, on 02/24/25 at 2:15 p.m., Resident 13 was observed lying in bed, eyes opened. She was not participating in any activities at this time. During a concurrent observation and interview 02/25/25 at 9:40 a.m., Resident 13 was seen sitting in their room on their bed not doing anything. Resident 13 stated, I cannot hear well even when speaking loudly in ear my ear. During an interview on 02/25/25 at 10:58 a.m., with Resident 13 ' s Representative (RP), RP stated, they had not seen any other ways to communicate with [resident] besides talking very loud in her ear and sometimes doesn't ' t work, I write in her book . I feel like her basic needs are not being met. A review of Resident 13 ' s Care Plan Report, dated 1/18/25, indicated it was Very important for Resident 65 to Have Books, newspapers, and magazines to read. During an interview on 02/25/25 at 1:30 p.m., Certified Nurse Assistant 4 (CNA 4) stated, residents with hearing loss activities and activities of daily living (ADL) needs were communicated through hearing loss binders, language binders, and pictures were used. During an interview on 2/25/25 at 1:40 p.m., LN 4 stated If they cannot hear there are communication books and points. Books usually in room. During an observation on 2/25/25 at 1:51 p.m., Resident 13 remained in her room without activities and absence of communication forms, books, or notes in room. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 02/25/25 at 02:07 p.m., with the SSD, the SSD stated if they have an immediate need we have a super ear [picked up and showed device to help people hear. Acts as a hearing aid], and headphones if they are having a hard time hearing. The SSD was unable to locate the care plan for activities communication strategies in Resident 13 ' s record. The SSD stated, We rely on [RP Name] about asking for services and needs during the meetings. The SSD also stated they have a communication binder that is usually kept in the resident's room. She stated if resident activities and social plans were not followed, it could result in loneliness and isolation. During an interview dated 2/26/25 at 1 p.m., Activities Assistant 1 (AA 1) stated, Resident 13 had not attended any group activities. AA 1 stated resident 13, does not speak English and looks like she is happy where she is at and has not attended any activities. AA 1 further stated they had not used any translation devices and Resident 13 was always busy writing in her book in her room. During a review of Resident 13's CARE PLAN, dated 2/23/25 Recreation Quarterly PN & CP [care plan] Eval [evaluation] indicates No activity accommodation indicated for hearing loss. During a review of Resident 13 ' s CARE PLAN, dated 12/6/24, Recreation Quarterly PN & CP [care plan] Eval [evaluation] indicates No activity accommodation indicated for hearing loss. During a review of Resident 13 ' s Physician Progress Note dated 11/13/24 and 1/9/25, the physician (MD) identified Resident 13 was very hard of hearing. During a review of Resident 13 ' s Recreation Quarterly progress note, and Care Plan, dated 2/23/25, the records indicated it was important for Resident 13 to engage in activities, go outside, and would benefit from accommodation for hearing loss by use of amplifiers/headphones or hearing aids. During a concurrent interview and record review, on 2/26/24 at 2:50 pm., with Restorative Nursing Assistant (RNA) the RNA stated, there is no order for Resident 13 for RNA care for a while, since last year. RNA was unable to locate RNA notes in Resident 13 ' s medical record for past 30 days. A review of Resident 13 ' s Physicians Orders, dated 11/13/24, indicated, Have RNA program get patient to participate in activities outside her room. During an interview on 2/26/25 at 3:15 p.m., with the Director of Nursing (DON), the DON stated she expected the residents needs and preferences to be supported. The DON stated, If they do not want to participate, we should provide something in replacement. The DON stated she expected the RNA and Activities staff to update charting with any activity performed. During a review of the facility's Policy and Procedure (P&P) titled, Activity Programs Policy, undated, indicated, The activity program is provided to support the well-being of residents and to encourage both independence and community interaction .are geared to the individual resident ' s needs.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 47197 Based on observation, interview and record review, the facility failed to ensure two out of seven sampled residents (Resident 44 and Resident 59) received treatment and care in accordance with professional standards of practice, and facility's policy and procedure (P&P) when Resident 44 and Resident 59 physician's order for low-air loss mattress (LALM- a medical-grade mattress designed to prevent and treat pressure injuries by reducing moisture and heat buildup) monitoring of settings and functioning was not consistently done. This failure had the potential for Resident 44 and Resident 59's wounds to get worse, and for the residents to not achieve their highest practicable well-being. Findings: 1a. A review of Resident 44's clinical record indicated Resident 44 was admitted April of 2020 and had diagnoses that included dementia (a progressive state of decline in mental abilities), major depressive disorder (persistently depressed mood or loss of interest in activities, causing significant impairment in daily life), weakness, and malnutrition (state of poor nutrition that occurs when the body does not receive enough or the right nutrients to function properly). A review of Resident 44's Minimum Data Set (MDS- a federally mandated resident assessment tool) Cognitive Patterns, dated 12/3/24, indicated Resident 44 had a Brief Interview for Mental Status (BIMS- a tool to assess cognition) score of 6 out of 15 which indicated Resident 44 had a severely impaired cognition. A review of Resident 44's MDS Mood status, dated 12/3/24, indicated Resident 44 experienced feeling down, depressed or hopeless for several days. A review of Resident 44's MDS Skin Conditions, dated 12/3/24, indicated Resident 44 was at risk of developing pressure ulcers/injuries (localized, pressure-related damage to the skin and/or underlying tissue usually over a bony prominence) and was using pressure reducing device for bed. A review of Resident 44's active physician's order, dated 1/10/25, indicated, LALM for wound healing. Check settings and functioning q [every] shift . During an interview on 2/24/25 at 9:07 a.m. with Licensed Nurse (LN) 5, LN 5 stated Resident 44 has a wound on her back. During an observation on 2/24/25 at 9:10 a.m. in Resident 44's room, Resident 44 was observed lying on bed, awake, and was using a LALM. A review of Resident 44's treatment administration records (TAR - a daily documentation record used by a licensed nurse to document treatments given to a resident) for January and February 2025 indicated the monitoring of Resident 44's LALM were not done on the following shifts: 1/14/25- Night shift, 1/22/25- Day shift, (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1/24/25- Evening shift, 1/31/25- Day shift, 2/4/25- Night shift, 2/7/25- Evening shift, 2/11/25- Night shift, 2/13/25- Night shift, 2/15/25- Night shift, 2/18/25- Day shift, 2/19/25- Night shift, and 2/21/25- Evening shift. During a concurrent interview and record review on 2/26/25 at 3:06 p.m. with the Assistant Director of Nursing (ADON), Resident 44's clinical records was reviewed. The ADON confirmed that Resident 44's LALM monitoring of settings and functioning was not consistently done. The ADON stated Resident 44's LALM monitoring should be done consistently every shift because it could negatively affect Resident 44's wounds if the LALM was not set and/or functioning properly. 1b. A review of Resident 59's clinical record indicated Resident 59 was admitted July of 2022 and had diagnoses that included rheumatoid arthritis (a chronic progressive disease causing inflammation in the joints and resulting in painful deformity and immobility), failure to thrive (a decline caused by chronic diseases and functional impairments which can cause weight loss, decreased appetite, poor nutrition, and inactivity), major depressive disorder, and contracture (a stiffening/shortening at any joint, that reduces the joint's range of motion). A review of Resident 59's MDS Cognitive Patterns, dated 12/11/24, indicated Resident 59 had a BIMS score of 15 out of 15 which indicated Resident 59 had an intact cognition. A review of Resident 59's MDS Mood status, dated 12/11/24, indicated Resident 59 experienced feeling down, depressed or hopeless for half or more of the days in two weeks. A review of Resident 59's MDS Skin Conditions, dated 12/11/24, indicated Resident 44 was at risk of developing pressure ulcers/injuries (PU/PI- localized, pressure-related damage to the skin and/or underlying tissue usually over a bony prominence), has Stage 4 PU (Full-thickness skin and tissue loss with exposed muscle, tendon, ligament, cartilage, or bone) and was using pressure reducing device for bed. A review of Resident 59's active physician's order, dated 12/29/23, indicated, LALM for wound healing. Check settings and functioning q shift . During a concurrent observation and interview on 2/24/25 at 9:45 a.m. in Resident 59's room, Resident 59 was observed lying on bed, awake, and was using a LALM. Resident 59 stated he has an open wound on his back. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 59's TAR for February 2025 indicated the monitoring of Resident 59's LALM were not done on the following shifts: 2/4/25- Night shift, 2/7/25- Evening shift, 2/11/25- Night shift, 2/13/25- Night shift, 2/15/25- Night shift, 2/18/25- Day shift, 2/19/25- Night shift, and 2/21/25- Evening shift. During a concurrent interview and record review on 2/26/25 at 3:06 p.m. with the ADON, Resident 59's clinical records was reviewed. The ADON confirmed that Resident 59's LALM monitoring of settings and functioning was not consistently done. The ADON stated Resident 59's LALM monitoring should be done every shift per the physician's order. During an interview on 2/26/25 at 4:06 p.m. with the Director of Nursing (DON), the DON stated LALM monitoring of settings and functioning should be done consistently to make sure the LALM is on the right set-up. The DON further stated staff should always follow the physician's order. A review of the facility's P&P titled, Skin Integrity Management, dated 5/26/21, indicated, To provide safe and effective care to prevent the occurrence of pressure ulcers, manage treatment, and Promote healing of all wounds .Staff continually observes and monitors patients for changes and implements revisions to the plan of care as needed .4. Develop comprehensive, interdisciplinary plan of care including prevention and wound treatments, as indicated. 4.1 Implement pressure ulcer prevention for identified risk factors .4.6 Implement Special Wound Care Treatments/techniques, as indicated and ordered. A review of the facility's P&P titled, Resident Rights, revised 12/2021, indicated, 1. Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident ' s right to: .aj. equal access to quality care .

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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. 47197 Based on observation, interview, and record review, the facility failed to ensure proper delivery of respiratory care consistent with the facility's policy and procedures (P&P) for one out of 32 sampled residents (Resident 8) when Resident 8's physician's order for oxygen therapy was not followed. This failure had the potential to result in unsafe delivery of oxygen to Resident 8 and for Resident 8 to not achieve her highest practicable well-being. Findings: A review of Resident 8's clinical record indicated Resident 8 was admitted April of 2021 and had diagnoses that included respiratory failure (is a serious condition that develops when the lungs can't get enough oxygen into the blood and makes it difficult for a person to breathe on his own), chronic obstructive pulmonary disease (a chronic lung disease causing difficulty in breathing), weakness and major depressive disorder (persistently depressed mood or loss of interest in activities, causing significant impairment in daily life). A review of Resident 8's Minimum Data Set (MDS- a federally mandated resident assessment tool) Cognitive Patterns, dated 1/29/25, indicated Resident 8 had a Brief Interview for Mental Status (BIMS- a tool to assess cognition) score of 12 out of 15 which indicated Resident 8 had a moderately impaired cognition. A review of Resident 8's MDS Mood status, dated 1/29/25, indicated Resident 8 experienced feeling down, depressed or hopeless for several days. A review of Resident 8's MDS Health Conditions, dated 1/29/25, indicated Resident 8 experienced shortness of breath or trouble breathing when lying flat. A review of Resident 8's care plan intervention, revised 4/7/20, indicated, Give oxygen therapy as ordered by the physician. A review of Resident 8's active physician's order, dated 5/17/24, indicated, CONTINOUS OXYGEN AT 3L/MIN (liters per minute or LPM- unit of measurement for oxygen administration flow rate) VIA NC (nasal cannula- a medical device with two prongs that is connected to an oxygen source used to deliver supplemental oxygen directly into the nostrils) every shift related to CHRONIC RESPIRATORY FAILURE . CHRONIC OBSTRUCTIVE PULMUNARY DISEASE . During an observation on 2/24/25 at 9:36 a.m. in Resident 8's room, Resident 8 was seen lying on bed, awake, and was on oxygen delivered via nasal cannula with the oxygen concentrator (machine) set at 1.5 LPM. During a concurrent observation and interview on 2/24/25 at 1:19 p.m. in Resident 8's room with Certified Nurse Assistant (CNA) 7, CNA 7 confirmed that Resident 8's oxygen was set at 1.5 LPM. During an observation on 2/25/25 at 9:35 a.m. in Resident 8's room, Resident 8 was still on oxygen delivered via nasal cannula with the oxygen concentrator set at 1.5 LPM. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/26/25 at 4:06 p.m. with the Director of Nursing (DON), the DON stated there would be a risk for shortness of breath of the resident if oxygen is delivered lower than the ordered setting. The DON further stated that the physician's order for oxygen delivery should always be followed. A review of the facility's policies and procedures (P&P) titled, Oxygen Administration, dated 1/31/23, indicated, 1 .Review the physician's orders or facility protocol for oxygen administration. 2. Review the resident's care plan to assess for any special needs of the resident.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. 47197 Based on interview and record review, the facility failed to ensure one out of 32 sampled residents (Resident 17) received appropriate pain management services consistent with professional standards of practice, facility's policy and procedure (P&P), and physician's order when Resident 17's pain medication order was not followed. This failure had the potential for Resident 17 to develop medication dependence (the inability of the individual to function normally in the absence of the drug), overdose, and not attain his highest practicable well-being. Findings: A review of Resident 17's clinical record indicated Resident 17 was admitted May of 2023 and had diagnoses that included diabetes mellitus (a disorder characterized by difficulty in blood sugar control and poor wound healing), neuropathy (disease or dysfunction of one or more nerves, typically causing numbness or weakness in the hands and feet), osteoarthritis (a progressive disorder of the joints, caused by a gradual loss of cartilage), and low back pain. A review of Resident 17's Minimum Data Set (MDS- a federally mandated resident assessment tool) Cognitive Patterns, dated 1/16/25, indicated Resident 17 had a Brief Interview for Mental Status (BIMS- a tool to assess cognition) score of 15 out of 15 which indicated Resident 17 had an intact cognition. A review of Resident 17's physician's order, dated 8/22/23, indicated, Percocet [a medication for pain which contains a combination of oxycodone; a controlled pain medication, and Acetaminophen; a potent pain reliever] Oral Tablet 5-325 MG [milligrams- unit of measurement] .Give 1 tablet by mouth every 6 hours as needed for for [sic] severe pain 7-10 [numeric pain scale from 1 to 10] . A review of Resident 17's care plan intervention, dated 2/6/24, indicated, Administer pain medication as ordered and document effectiveness/side effects. During an interview on 2/24/25 at 1:46 p.m. with Resident 17, Resident 17 stated he often experienced pain and was receiving a lot of pain medication. A review of Resident 17's medication administration records (MAR- a daily documentation record used by a licensed nurse to document medications and treatments given to a resident) for the month of February 2025 indicated Resident 17 received Percocet on the following occasions: 2/1/25 at 6:32 p.m.- pain level was 6 (moderate pain) 2/9/25 at 9:20 p.m.- pain level was 4 (moderate pain) 2/12/25 at 3:04 a.m.- pain level was 0 (no pain) 2/15/25 at 3:01 p.m.- pain level was 4 (moderate pain) (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2/15/25 at 9:50 p.m.- pain level was 2 (mild pain) 2/16/25 at 4:12 a.m.- pain level was 4 (moderate pain) 2/16/25 at 8:52 p.m.- pain level was 5 (moderate pain) 2/20/25 at 1:18 a.m.- pain level was 6 (moderate pain) During a concurrent interview and record review on 2/26/25 at 3:06 p.m. with the Assistant Director of Nursing (ADON), Resident 17's clinical records were reviewed. The ADON confirmed that Resident 17's physician's order for Percocet was not followed. The ADON stated Percocet should had only be given to Resident 17 when he had severe pain. During an interview on 2/26/25 at 4:06 p.m. with the Director of Nursing (DON), the DON stated there would be a risk of medication overdose if the Percocet order was not followed. The DON further stated staff should always follow the physician's order. A review of the facility's P&P titled, Pain Management, dated 8/25/21, indicated, Pain management that is consistent with professional standards of practice, the comprehensive person-centered care plan, and the Resident's goals and preferences is provided to Residents who require such services.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 51078 Based on observation, interview, and record review, the facility failed to ensure pharmacy services were maintained for two of 129 residents when: 1. An expired resident's controlled medications (prescription medications with more risk of addiction and harm) were not removed from the medication cart for seven days, which had the potential to result in drug diversion. 2. Resident 27's Physician Order was not followed, and six omitted doses were still in the medication room without notifying the physician or pharmacy which had the potential to negatively affect Resident 27's treatment of infection. Findings: 1. During a concurrent interview and record review on 2/25/25 at 11:52 a.m. with the Director of Nursing (DON), the facility's Patient Narcotics Log was reviewed. The DON acknowledged 20 controlled medications for a resident that had expired on 2/17/25 were not brought to her office for destruction until 2/24/25. The DON stated, we created an opportunity for diversion by delaying removal of medications from the medication cart. The DON further stated the expectation was for all medications that are discontinued to be brought to the DON's office as soon as possible and secured for future destruction. During a review of the facility's policy and procedures (P&P) titled, Controlled Medication Disposal, dated January 2013, the P&P indicated, Medications included in the Drug Enforcement Administration (DEA) classification as controlled substances are subject to special handling, storage, disposal, and recordkeeping in the facility in accordance with federal and state laws and regulations .Schedule II-V controlled substances in the facility after .the order has been discontinued, are disposed of in the facility by the director of nursing . in conjunction with the pharmacist. During a review of the facility's P&P titled, Discontinued Medications, dated December 2018, the P&P indicated, When medications are discontinued by the prescriber .in the event of a resident's death, the medications are marked as discontinued or stored in a separate location and later destroyed. 2. During a concurrent observation and interview on 2/24/25 at 2:12 p.m. with Licensed Nurse (LN) 1 in the North station medication storage room., LN 1 verified six bags of IV (intravenous-through the vein) antibiotic labeled with Resident 27's name, dated 2/11/25, were found on the counter. LN 1 stated the medication had been discontinued by the prescribing physician and the resident was no longer receiving it. LN 1 further stated the expectation was for night shift staff to go through all medications in the storage room and remove all discontinued/expired medications by taking them to the DON's office for proper disposal. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 2 /25/25 at 12:13 p.m. with the DON, Resident 27's Medication Administration Record (MAR - a daily documentation record used by a licensed nurse to document medications given to a resident) dated February 2025 was reviewed. The DON confirmed a Physician Order dated 2/11/25 indicated an antibiotic was to be given IV every eight hours for seven days to treat cellulitis (infection of skin) of the right foot. The DON acknowledged the MAR reflected six of 21 doses of the antibiotic were not given; the last dose recorded was on 2/18/25. The DON stated the expectation was for staff to follow and complete all medication orders as prescribed; to follow all P&P's when medications are discontinued. The DON acknowledged that Resident 27 was at risk to experience further complications of infection. During a review of the facility's P&P titled, Discontinued Medications, dated December 2018, the P&P indicated, When medications are discontinued by the prescriber .the medications are marked as discontinued or stored in a separate location and later destroyed. During a review of the facility's P&P titled, Physician Orders, dated March of 2022, the policy indicated, the Licensed Nurse receiving the order will be responsible for documenting and implementing the order. Medication orders will be transcribed onto the appropriate resident administration record. During a review of the facility's P&P titled, Medication Administration General Guidelines, dated October 2017, the P&P indicated, Medications are administered in accordance with written orders of the attending physician .the person administering the medications reviews the MAR to ensure all necessary doses were administered and documented .If a dose of regularly scheduled medication is withheld .the space provided on the front of the MAR for that dosage administration is initialed and circled. An explanatory note is entered .

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 51078 Based on observation, interview, and record review, the facility failed to ensure medications were stored correctly when: 1. An opened multi-dose bottle of oseltamivir oral suspension (an antiviral medication used to treat or prevent influenza) was found in the refrigerator without an expiration date. 2. Staff personal belongings were kept in the medication storage room. These failures had the potential for unsafe or ineffective medication use, spread of infectious pathogens, and drug diversion. Findings: 1. During a concurrent observation and interview on 2/24/25 at 2:12 p.m. with Licensed Nurse (LN) 1 in the North station medication storage room., an opened 60 ml (milliliter, unit of measure) bottle of medication was found. LN 1 acknowledged there was a bottle of oseltamivir being stored in the refrigerator with no opened or expiration date. LN 1 stated, the expectation is for staff to label all medications with appropriate open/expired dates because it can affect the potency and effectiveness of the medication. During an interview on 2/25/25 at 12:09 p.m. with the Director of Nursing (DON), the DON stated the expectation is to label medications when opened because it affects the potency of the medication; licensed nurses need to know when to discard the expired medications to avoid them being given to residents past the expiration date. During a review of the facility's policy and procedure (P&P) titled, Accessing A Multi-Dose Vial, dated June 2018, the P&P indicated, Once accessed, multi-dose vials will be stored according to manufacturer's guidelines .will be labeled after opening with date and time, and nurses' initials. During a review of the Oseltamivir Oral Suspension: Package Insert/Prescribing Info (PI), dated January 2025, the PI indicated, Use the constituted oral suspension within 17 days of preparation when stored under refrigeration .Write the expiration date of the constituted oral suspension on the bottle label. 2. During a concurrent observation and interview on 2/24/25 at 2:12 p.m. with LN 1 in the North station medication storage room., several personal items belonging to the staff were found. LN 1 stated, I see personal bags and items in the lower cabinet and hanging on the wall. LN 1 also stated, staff are provided lockers to store personal items, and they should not be kept in the medication storage room. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 2/26/25 at 10:25 a.m. with the DON., the DON acknowledged only medications and supplies related to medication administration should be stored in the medication storage room. There is increased risk of infection transmission and drug diversion when staff use the medication room to store their personal items. The DON further stated the expectation is for staff to use their lockers or the employee lounge to store personal belongings. During a review of the facility's policy and procedure (P&P) titled, Medication Storage in The Facility, dated April 2008, the P&P indicated, Medication storage areas are kept clean, well lit, and free of clutter.

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. 50312 Based on observation, interview, and record review, the facility failed to ensure the kitchen staff had appropriate competencies and skill sets to safely carry out certain functions of the food and nutrition service when: 1. Staff were not sure of the appropriate dish machine temperature needed to appropriately clean, 2. Staff were not sure how to appropriately test the red buckets (often called sanitizer buckets, used to hold sanitizer solutions, ensuring proper sanitization of surfaces and equipment, and are easily identifiable to prevent cross-contamination) to see if the sanitizer was at the correct concentration, 3. Hand hygiene not done according to policy, 4. A cook was observed using a yellow cutting board (used for raw poultry) to cut cooked roast beef, instead of the brown board. These failures had the potential to leading to food borne illness for the 125 Residents eating facility prepared meals. Findings: 1. During an observation and interview in the kitchen on 2/25/25 at 12:50 p.m. with Dietary Aide (DA 1). DA 1 described the steps needed to effectively run the dish machine. One of the steps was to ensure the water temperature increased to the minimum needed. When asked what temperature was needed, DA 1 stated the temperature needed to be between 140 to 150 degrees Fahrenheit (F, a unit of measurement) for both the wash and rinse cycles. As DA 1 ran a few cycles, the temperature gauge did not vary from 130 F. DA 1 then changed his response, to align with the gauge being 130 F. DA 1 next showed the dish machine logbook where the temperatures were entered. The majority of the logbook entries were 120 F. During an interview with the Dietary Manager (DM) on 2/26/25 at 3 p.m., DM stated that dietary staff should know the proper temperature for the dish machine. During a review of the facility provided Sanitation Policy and Procedure, (Med Pass Inc. revised November 2022), indicated that Dishwashing machines are operated according to manufacturer's instructions. General recommendations for heat and chemical sanitation are: . b. Low-Temperature Dishwasher (Chemical Sanitation): 1. Wash temperature (120 degrees F) . (continued on next page)

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Food and Drug Administration (FDA) Food Code 2022, section 4-204.113 on Warewashing (method of cleaning and sanitizing kitchenware) Machine, Data Plate Operating Specifications indicated that A warewashing machine shall be provided with an easily accessible and readable data plate affixed to the machine by the manufacturer that indicates the machine's design and operation specifications including the: (A) Temperatures required for washing, rinsing, and sanitizing; . 2.During and observation and interview on 2/25/25 at 3 p.m., Prep cook 1 (PRP) was asked to demonstrate how to test the sanitizer concentration. PRP put the test strip in the red bucket for one second and compared the color to the test strip container bottle and stated it was at the proper range. It was at 200 PPM (parts per million, a unit of measurement). PRP was shown the instructions on the bottle that instruct the user to leave the test strip in the solution for ten seconds. PRP was requested to put another test strip in for ten seconds, and PRP counted from one to ten quickly. The instructions on the test strip bottle state that the strip is placed in the solution for ten seconds. PRP was requested to retest while surveyor counted out ten seconds. The test strip measured 750 PPM (parts per million, a unit of measurement) which was above the desired range. During a meeting with the Registered Dietician (RD) on 2/26/25 at 11 a.m., the RD stated that the 750 PPM concentration is unsafe and could harm Residents. Review of the facility provided Sanitation Policy and Procedure, (Med Pass Inc. dated November 2022), in bullet 9 indicated Service area wiping cloths are . placed in a chemical sanitizing solution of appropriate concentration. 3.During a kitchen tour on 2/25/25 at 9:34 a.m., Prep Cook, Diet Aide (PCDA) was washing dishes. PCDA was observed moving the rubber floor mat on the ground with her gloved hands and went back to washing dishes without changing gloves and performing hand hygiene. During a return to the kitchen on 2/25/25 at 11:24 a.m., PRP was preparing food. PRP wiped their nose with a paper towel. PRP went back to food prep without washing their hands and replacing their gloves. During an interview with the DM on 2/26/25 at 3 p.m., the DM acknowledged that the staff members should have removed their gloves and performed hand hygiene before going back to their duties. Review of the facility provided Infection Control for Dietary Employees Policy and Procedure (Med Pass, Inc., dated 12/6/2024), indicated in bullet 2. Proper Handwashing by any/all personnel will be done as follows: (f) After handling soiled equipment or utensils .(k) After engaging in any other activities that contaminate the hands. Review of the Food and Drug Administration (FDA) Food Code 2022, section 2-301.14 on When to Wash indicated Food employees shall clean their hands .E After handling soiled equipment . (I) After engaging in other activities that contaminate the hands. 4.During the initial kitchen tour on 2/24/25 at 10:45 a.m. [NAME] 1 was observed preparing the lunch meal which included roast beef. The cooked roast beef was placed on a yellow cutting board as she sliced the meat portions. When questioned if the color of the cutting board was important, cook 1 stated the color represents the food group they are working with. (continued on next page)

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 2/26/25 at 3:00 p.m. with the DM, the DM stated that the yellow cutting board was used for raw poultry and that the cook should have chosen the brown board as the colors are used to minimize the potential of cross contamination of foods. According to FoodDocs.com website on US Cutting Board Color Chart | Free Printable Download it indicated the following colors were used for food safety: Red -raw beef, pork, lamb, and other types of raw meats Yellow -raw poultry, such as chicken, turkey, and duck Blue -Raw fish, shellfish, and other seafood products White -Dairy and baked goods Green -Fruits, vegetables, and salads Brown -Cooked meat, such as roast beef or ham

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure therapeutic diets are prescribed by the attending physician and may be delegated to a registered or licensed dietitian, to the extent allowed by State law. 47197 Based on observation, interview, and record review, the facility failed to provide food in accordance with the physician's prescribed diet for one out of 32 sampled residents (Resident 16) when Resident 16 whom was on No Added Salt diet (NAS- a dietary restriction that limits the intake of salt) received two salt packets during the 2/25/25 lunch meal. This failure had the potential to negatively affect Resident 16's medical condition and for Resident 16 to not achieve his highest practicable well-being. Findings: A review of Resident 16's clinical record indicated Resident 16 was admitted July of 2024 and had diagnoses that included dementia (a progressive state of decline in mental abilities), malnutrition (state of poor nutrition that occurs when the body does not receive enough or the right nutrients to function properly), hypokalemia is a condition where the potassium levels in the blood are abnormally low), and hypertension (high blood pressure) A review of Resident 16's Minimum Data Set (MDS- a federally mandated resident assessment tool) Cognitive Patterns, dated 12/24/24, indicated Resident 16 had a Brief Interview for Mental Status (BIMS- a tool to assess cognition) score of 8 out of 15 which indicated Resident 16 had a moderately impaired cognition. A review of Resident 16's MDS Functional Abilities, dated 12/24/24, indicated Resident 16 needed supervision or touching assistance with eating. A review of Resident 16's care plan intervention, revised 12/7/23, indicated, Diet as ordered. A review of Resident 16's physician's order, dated 1/20/25, indicated, Fortified [a diet that includes foods that have been enriched with additional nutrients, such as vitamins and minerals], NAS diet, Soft and Bite Sized texture, Regular/Thin Liquids consistency, Ground meats, extra sauces, PRUNE JUICE WITH BREAKFAST AND LUNCH. Large portion at all meals. During a concurrent observation and interview on 2/25/25 at 1:39 p.m. with Resident 16, in Resident 16's room, Resident 16 was observed eating his lunch meal and there were two packets of iodized salt observed in Resident 16's meal tray. Resident 16's meal ticket was checked and indicated NAS diet. Resident 16 stated he did not request the salt packets. During a concurrent observation and interview on 2/25/25 at 1:41 p.m. with Certified Nurse Assistant (CNA) 7, in Resident 16's room, CNA 7 confirmed that Resident 16 was served with two salt packets even though his diet in the meal ticket indicated NAS diet. CNA 7 stated Resident 16 should not be given additional salt. During an interview on 2/26/25 at 3:51 p.m. with the Dietary Manager (DM), the DM stated a resident who was on NAS diet should not be given salt packets. (continued on next page)

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 2/26/25 at 4:06 p.m. with the Director of Nursing (DON), the DON stated residents with NAS diet should not be given salt packet on the meal tray. The DON further stated she would expect staff to follow the diet orders of the residents because it would affect the resident' s health condition. A review of the facility's policies and procedures titled, Tray Identification, revised 4/2007, indicated, 2. The Food Services Manager or supervisor will check trays for correct diets before food carts are transported to their designated areas. 3. Nursing staff shall check each food tray for the correct diet before serving the residents. 4. if there is an error, the Nurse supervisor will notify the Dietary Department immediately by phone so that the appropriate food tray can be served.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39489 50312 Based on observation, interview, and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety when: 1) Food labels were lacking or mislabeled, 2) Kitchen areas found dirty and/or rusty, 3) Smallware not discarded when no longer able to be sanitized, 4) Bin of clean plates found with food residue and a sugar packet on a plate, 5) Three steam table pans were stored wet, and one had food residue in the pan, 6) Hairnets not used consistently used in the kitchen, 7) Resident tray containing chocolate pudding was brought down the hall without a cover on top, and 8) Sprinkler cleaning occurred over food production and clean dishes that were drying. These failures had the potential to lead to food borne illness for the 125 Residents eating facility prepared meals. Findings: 1) During the initial kitchen tour on 2/24/25 beginning at 9:24 a.m., two ice cream cups were found with no label in the reach-in freezer. The refrigerator contained a box of supplemental shakes without a use-by date. The dry storage contained ten cartons of thickened apple juice dated 1/30. The cook's reach-in refrigerator had a container of cottage cheese dated 2/10. Subsequent interview, on 2/24/25 at 9:38 a.m., with the Dietary Manager (DM), DM confirmed that there was no label on the two ice cream cups. DM confirmed the supplemental shakes did not have a use-by date and stated that the shakes were good for one week. The DM also stated that the ten cartons of thickened apple juice and the cottage cheese did not have a complete date. The DM stated that labels were used to determine if food was still safe. He also stated that labels should contain a month, day and year. Review of the Food and Drug Administration (FDA) Food Code 2022, section 3-501.17 (A) (B) (C) (D) on Required Food Labeling and Dating indicated the day the original container is opened in the food establishment shall be counted as Day 1 .The date marked shall not exceed a manufacturer's use-by date . mark the date or day of preparation, with a procedure to discard the food on or before the last date or day by which the food must be consumed on the premises. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2) During the initial kitchen tour on 2/24/25 at 9:36 a.m., pipes in the ice machine area were discolored with rust markings as well as blackened areas. Cobwebs were observed by the vents on the side of the ice machine. A can of soda was found underneath the ice machine unit. During this same observation and interview on 2/24/25 at 9:33 a.m., with the DM water like fluid was noted around the ice machine. The DM stated that the ice machine had leaked earlier, and maintenance had placed a bucket underneath the ice machine. While observing the bucket underneath the ice machine, a white plastic pipe underneath the ice machine was noted above the bucket. This pipe had a black colored substance covering the top portion of the pipe closest to the ice machine for over one foot. The connector from the horizontal pipe to the machine was covered in the same black substance for over 50% of this connector closest to the horizontal pipe. The substance had a mold like appearance and seemed to follow the path of fluid. At 9:39 a.m., the dry storage racks were observed with rust spots on the bottom of two shelves. The corner shelf was observed with dirt, torn packets, and a white paper underneath. The overhead vent was covered in black/grey particles. At 10:01 a.m., in the walk-in freezer, rust was found on freezer racks. At 10:48 a.m., in the cook station, the stove and oven were discolored. The stovetop had grayish/white areas. The oven door protective coating appeared worn with black, gray and white scratches. The shelves underneath the food serving area appeared dirty. A wood support was attached underneath the food serving area, knobs were covered in a dark film. A peeling white, material supporting the sides of the tray line also appeared dirty. During a subsequent interview with the DM on 2/24/25 at 9:45 a.m., DM confirmed the areas of rust and dirt. Review of the facility provided policy titled Sanitation (MED-PASS, Inc., Revised November 2022) included the statement that the Food service area shall be maintained in a clean and sanitary manner. The following procedures were included: a. All Kitchen areas and dining areas shall be kept clean, free from litter and rubbish and protected from rodents, roaches, flies and other insects. b. All utensils, counters, shelves, and equipment shall be kept clean, maintained in good repair and shall be free from . corrosions, . and chipped areas that may affect their use or proper cleaning. c. All equipment . 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 solutions. Review of the Food and Drug Administration (FDA) Food Code 2022, Section 4-602 on Frequency, Equipment Food-Contact Surfaces and Utensils indicated. E) . shall be cleaned . (4) In equipment such as ice bins . and water vending equipment: (a) At a frequency specified by the manufacturer, or (b) Absent manufacturer specifications, at a frequency necessary to preclude accumulation of soil or mold. 3) During the initial kitchen tour on 2/24/25 at 10:18 a.m., the can opener tip was observed with dark spots on it. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a return visit to the kitchen on 2/25/25 at 10:39 a.m., plastic bowls were observed with the glaze worn and surfaces scratched. During an interview on 2/24/25 at 10:25 a.m. with the DM, he stated that he was surprised the can opener tip was showing dark spots on it. On 2/25/25 at 3:10 p.m., the DM acknowledged the worn bowls. Review of the facility provided policy titled Sanitation (MED-PASS, Inc., Revised November 2022) included the statement that the Food service area shall be maintained in a clean and sanitary manner. The following procedures were included: 12. Plastic ware . that cannot be sanitized or are hazardous because of chips, cracks, or loss of glaze are discarded. Damaged or broken equipment that cannot be repaired is discarded. According to the 2022 Federal Food and Drug Administration Food Code, Section 4-501.11 on Good Repair and Proper Adjustment indicated (C) Cutting or piercing parts of openers shall be kept sharp to minimize the creation of metal fragments that can contaminate food when the container is opened. 4) During the initial kitchen tour on 2/24/25 at 10:18 a.m., a bin containing clean plates was noted to have food residues at the bottom of the bin, as well as a sugar packet on a plate. During a concurrent interview with the Registered Dietitian (RD) she stated she expected the plates to be in a clean bin and then took the bin to be washed. During the same interview, the DM stated that the sugar packet and food residue should not have been in the bin with the clean dishes. Review of the 2022 Federal Food and Drug Administration Food Code, section 4-601.11, titled, Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces, and Utensils, 1/18/23 version, indicated, .(C) Surfaces . shall be kept free of an accumulation of dust, dirt, food residue, and other debris. 5) During the initial kitchen tour on 2/24/25 at 10:20 a.m., three steam table pans were found stored wet (wet nesting) in the ready to use area and one pan had food residue inside the pan. During an interview with the DM on 2/26/25 at 3:00 p.m., the DM stated that the pans were not supposed to be put away wet as that could lead to bacteria growth, and all pans should be completely cleaned before storing. During a review of the Food and Drug Administration (FDA) Food Code 2022, section 4-901.11 indicated items must be allowed to drain and to air-dry before being stacked or stored. Stacking wet items such as pans prevents them from drying and may allow an environment where microorganisms can begin to grow. 6) During the initial kitchen tour on 2/24/25 beginning at 9:24 a.m., Prep cook (PRP) was observed wearing a hairnet but had left a 2 inch by 2 inch area over the front part of hair uncovered. At 9:39 a.m., a pest control contractor entered the kitchen and proceeded to check traps, and did not wear a hairnet. During a return visit in the kitchen on 2/25/25 at 12:53 p.m., during the lunch meal service, Diet Aide 2 (DA 2) entered the kitchen without a hairnet and proceeded to have a conversation with the DM. DA 2 was later seen on 2/25/25 at 1:46 p.m. washing dishes, again without a hairnet. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with the DM on 2/26/25 at 3 p.m., the DM acknowledged that hairnets were supposed to be worn and should include all of the hair as no one wants to find hair in their food. Review of facility provided policy titled Infection Control for Dietary Employees, (MED-PASS, 12/6/24) indicated that the purpose of the policy was To ensure that the dietary department is maintained in a sanitary condition in order to prevent food contamination and the growth of disease producing organisms and toxins. Under procedure 1, bullet b, indicated that Clean hair-covered with an effective hair restraint while in all kitchen and food storage areas. was the expectation for everyone in the kitchen. Review of the 2022 Federal Food and Drug Administration (FDA) Food Code, section 2-402.11, 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; and unwrapped single-service and single-use articles. 7) During a concurrent observation and interview, in the Southside hallway on 2/24/25 at 12:40 p.m., coming from the kitchen, the staff pushed out a tray/coffee cart that contained uncovered food items for Resident 92 and Resident 224. The staff parked the cart outside of room [ROOM NUMBER], and then, Certified Nursing Assistant 10 (CNA 10) took the cart and brought it to Resident 92 and Resident 224's room. The Infection Preventionist (IP) nurse confirmed the food items were uncovered and should be covered for sanitary reasons. During an interview with the Dietary Manager (DM) on 2/24/25 at 2:50 p.m., the DM stated, food should be covered all the time when they leave the kitchen to prevent cross contamination. During an interview with the Director of Nursing (DON) on 2/26/25 at 9:30 a.m., the DON stated, all food items from the kitchen must be covered all the time to prevent cross contamination. In a review of the facility's policy and procedure, titled Food Preparation and Service, indicated, .When meals are assembled in the kitchen and then delivered to resident's rooms or dining areas to be distributed, covering foods is appropriate, either individually or in a mobile food cart . 8) During a return visit to the kitchen on 2/25/25 at 9:34 a.m., a maintenance worker was observed cleaning the ceiling sprinkler heads over food production of sandwiches and desserts, as well as over drying clean dishes. During an interview with the DM on 2/26/25 at 3 p.m., he acknowledged that the sprinkler head cleaning was not supposed to be completed during food production. Review of the 2022 Federal Food and Drug Administration (FDA) Food Code, section 6-501.12, titled, Cleaning, Frequency and Restrictions indicated A) Physical Facilities shall be cleaned as often as necessary to keep them clean. (B) Except for cleaning that is necessary due to a spill or other accident, cleaning shall be done during periods when the least amount of food is exposed such as after closing.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47197 Based on observation, interview, and record review, the facility failed to follow and maintain an effective infection prevention and control program for a census of 129 when: 1. Three facility staff did not wear required personal protective equipment (PPE) when assisting Resident 44 and Resident 22 whom were both on enhanced barrier precautions (EBP- also known as enhanced standard precaution/ESP, infection control intervention designed to reduce transmission of multidrug-resistant organisms [MDROs- bacteria that resist treatment with more than one antibiotic] that employs targeted gown and glove use); 2. Resident 22's nasal cannula (a medical device with two prongs that is connected to an oxygen source used to deliver supplemental oxygen directly into the nostrils) was not labelled and properly stored when not in use; 3. Resident 17's nebulizer (machine that turns liquid medicine into a mist that can be easily inhaled) face mask was not labelled and properly stored when not in use; 4. A facility staff did not wear required PPE when entering a droplet isolation precaution room (an isolation precaution implemented when a patient infected with a pathogen which is transmittable through air droplets by coughing, sneezing, talking, and close contact with an infected patient's breathing); 5. Hand hygiene was not performed by a facility staff in between administering medications; 6. Resident 85's nasal cannula was found on the floor and was placed back on the resident; and, 7. A facility staff did not wear a face mask while walking in the southeast hallway. These failures resulted in an increased risk for cross-contamination (movement or transfer of harmful bacteria from one person, object, or place to another), potential exposure of Resident 44, 22, 17, and 85 to germs, and may cause infection among residents, staff, and visitors. Findings: 1a. A review of Resident 44's clinical record indicated Resident 44 was admitted April of 2020 and had diagnoses that included dementia (a progressive state of decline in mental abilities), major depressive disorder (persistently depressed mood or loss of interest in activities, causing significant impairment in daily life), weakness, and malnutrition (state of poor nutrition that occurs when the body does not receive enough or the right nutrients to function properly). (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 44's Minimum Data Set (MDS- a federally mandated resident assessment tool) Cognitive Patterns, dated 12/3/24, indicated Resident 44 had a Brief Interview for Mental Status (BIMS- a tool to assess cognition) score of 6 out of 15 which indicated Resident 44 had a severely impaired cognition. A review of Resident 44's MDS Skin Conditions, dated 12/3/24, indicated Resident 44 was at risk of developing pressure ulcers/injuries (localized, pressure-related damage to the skin and/or underlying tissue usually over a bony prominence). A review of Resident 44's active physician' order, dated 1/13/25, indicated, Enhanced barrier precautions will remain in place every shift for wound. During a concurrent observation and interview on 2/24/25 at 9:07 a.m. with Licensed Nurse (LN) 5, in front of Resident 44's room, LN 5 confirmed that Resident 44's room door has a signage which indicated, STOP . Enhanced Barrier Precautions .Everyone must: Clean their hands, including before entering and when leaving the room .PROVIDERS AND STAFF MUST ALSO: .Wear gloves and a gown for the High-Contact Resident Care Activities .Changing briefs or assisting with toileting . LN 5 stated Resident 44 was on EBP because of her wound on the back. During an observation on 2/24/25 at 9:08 a.m., in Resident 44's room, Certified Nurse Assistant (CNA) 6 was observed changing Resident 44's briefs while wearing gloves and not wearing a gown. During an interview on 2/24/25 at 9:10 a.m. with CNA 6, in Resident 44's room, CNA 6 confirmed that she only wore gloves when she changed Resident 44's briefs. CNA 6 stated she was not sure if Resident 44 has a wound on her back. CNA 6 stated, I don't think so, when asked if she was supposed to wear a gown when changing Resident 44's briefs. 1b. A review of Resident 22's clinical record indicated Resident 22 was admitted January of 2025 and had diagnoses that included dementia, osteomyelitis (inflammation of bone or bone marrow, usually due to infection), Parkinson ' s disease (a progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movements), chronic obstructive pulmonary disease (COPD- a chronic lung disease causing difficulty in breathing), and diabetes mellitus (a disorder characterized by difficulty in blood sugar control and poor wound healing) A review of Resident 22's MDS Cognitive Patterns, dated 1/27/25, indicated Resident 22 had a BIMS score of 11 out of 15 which indicated Resident 22 had a moderately impaired cognition. A review of Resident 22's active physician' order, dated 1/31/25, indicated, Enhanced barrier precautions remains in place every shift for wound. During a concurrent observation and interview on 2/24/25 at 10:17 a.m. with LN 5, in front of Resident 22's room, LN 5 confirmed that Resident 22's room door has a signage which indicated, STOP .Enhanced Barrier Precautions .Everyone must: Clean their hands, including before entering and when leaving the room . PROVIDERS AND STAFF MUST ALSO: .Wear gloves and a gown for the High-Contact Resident Care Activities .Transferring .Changing briefs or assisting with toileting . LN 5 stated Resident 22 was on EBP because of his wound. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 2/24/25 at 10:22 a.m., in Resident 22's room, CNA 7 was observed changing Resident 22's briefs while wearing gloves and not wearing a gown. After which, CNA 7, with another CNA, were observed transferring Resident 22 to his wheelchair while wearing gloves and not wearing a gown. During an interview on 2/24/25 at 10:34 a.m. with CNA 7, in Resident 22's room, CNA 7 confirmed that he only wore gloves when he changed Resident 22's briefs. CNA 7 further confirmed that they only wore gloves when they transferred Resident 22 to his wheelchair. CNA 7 stated there was no need for them to wear a gown when changing briefs or transferring Resident 22. During an interview on 2/26/25 at 3:39 p.m. with the Director of Staff Development (DSD), the DSD stated staff should wear gloves and gown when changing briefs or transferring a resident on EBP so that staff would not transfer germs to the resident. During an interview on 2/26/25 at 4:06 p.m. with the Director of Nursing (DON), the DON stated when staff performs a high-contact activity with a resident on EBP, the staff should follow the PPE precaution to prevent transmission of infection. A review of the facility's policies and procedures (P&P) titled, Enhanced Standard/Barrier Precautions, revised 2/21/25, indicated, 3. Implementation of Enhanced Barrier Precautions: .b. PPE for enhanced barrier precautions is only necessary when performing high-contact care activities .4. High-contact resident care activities include: .c. Transferring .f. Changing briefs or assisting with toileting. 2. A review of Resident 22's active physician' order, dated 1/24/25, indicated, START OXYGEN AT 2L/MIN [liters per minute- unit of measurement for oxygen administration flow rate) FOR SHORTNESS OF BREATH, CHEST PAIN, OXYGEN SATURATION [percentage of oxygen carried in the blood] LESS THAN 90% [percent- measurement of one part in every hundred] AND NOTIFY PHYSICIAN as needed. During an observation on 2/24/25 at 10:22 a.m., in Resident 22's room, Resident 22's oxygen nasal cannula was observed placed on top of Resident 22's bedside drawer, uncovered, and next to other personal items. The Nasal cannula was not labelled with the date it was first used. During an interview on 2/24/25 at 10:49 a.m. with CNA 7, in Resident 22's room, CNA 7 confirmed that Resident 22's nasal cannula was placed on top of Resident 22's bedside drawer, uncovered, next to other personal items, and was not labelled with the date it was first used. 3. A review of Resident 17's clinical record indicated Resident 17 was admitted May of 2023 and had diagnoses that included COPD, diabetes mellitus, atherosclerosis of native arteries (hardening of arteries from plaque building up gradually causing slowed or blocked blood flow), and need for assistance with personal care. A review of Resident 17's MDS Cognitive Patterns, dated 1/16/25, indicated Resident 17 had a BIMS score of 15 out of 15 which indicated Resident 17 had an intact cognition. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 17's physician's order, dated 1/11/24, indicated, Sodium Chloride Inhalation [treats conditions that cause thick mucus in your lungs] Nebulization Solution 7 % (Sodium Chloride (Inhalant)) 4 ml [milliliters- unit of measurement] inhale orally via nebulizer every 6 hours as needed for wheezing [a high-pitched, whistling sound that occurs when air passes through narrowed airways in the lungs]. During an observation on 2/24/25 at 11:08 a.m., in Resident 17's room, Resident 17's nebulizer face mask was observed placed inside of Resident 17's bedside drawer, uncovered, and next to other personal items. The nebulizer face mask was not labelled with when it was first used. During an interview on 2/24/25 at 11:10 a.m. with CNA 7, in Resident 17's room, CNA 7 confirmed that Resident 17's nebulizer face mask was placed inside of Resident 17's bedside drawer, uncovered, next to other personal items, and was not labelled with when it was first used. During an interview on 2/26/25 at 3:39 p.m. with the DSD, the DSD stated respiratory equipment such as nasal cannula and nebulizer face mask should be placed inside an infection control pouch when not in use so the equipment would not be exposed to germ and to prevent infection. The DSD further stated that nasal cannulas and nebulizer face masks should be changed weekly, that's why the respiratory equipment should be labelled of the date it was first used so staff would know when to change it. During an interview on 2/26/25 at 4:06 p.m. with the DON, the DON stated nasal cannula and nebulizer face mask should be placed in a bag when not in used. The DON further stated that nasal cannulas and nebulizer face masks should be dated and changed weekly. The facility's P&P for storage and labelling of respiratory equipment was requested. The DON stated the facility does not have specific written P&P for storage and labelling of nasal cannula and nebulizer face mask. 4. During a concurrent interview and record review on 2/25/25 at 8:35 a.m. with the DON, the DON stated they had readmitted a resident who tested positive for Influenza A (a type of respiratory virus that can cause the flu) at room [ROOM NUMBER] bed A. The DON further stated they had placed room [ROOM NUMBER] on droplet isolation precaution. During an observation on 2/25/25 at 9:16 a.m., in room [ROOM NUMBER], there was no posted signage that the room was on droplet isolation precaution. CNA 8 was then observed entering room [ROOM NUMBER] while only wearing face mask. During an interview on 2/25/25 at 9:24 a.m. with CNA 8, in front of room [ROOM NUMBER], CNA 8 confirmed that she went inside room [ROOM NUMBER] while only wearing face mask. CNA 8 stated she went inside room [ROOM NUMBER] to assist resident in bed A with his personal belongings. CNA 8 further stated she was aware that the resident in room [ROOM NUMBER] bed A tested positive for Influenza A and that staff should wear N95 mask, gloves, gown, and face shield before entering the room. CNA 8 also confirmed that there was no posted signage that room [ROOM NUMBER] was on droplet isolation precaution and stated that the droplet isolation precaution signage was important so that residents, staff, and visitors would be aware and get reminded before they enter the room. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 2/26/25 at 3:39 p.m. with the DSD, the DSD stated residents with Influenza A were placed on droplet isolation precaution room. The DSD further stated that staff should wear all the required PPE such mask, gown, gloves, and eye protection outside the room before entering. During an interview on 2/26/25 at 4:06 p.m. with the DON, the DON stated she would expect staff to wear all the required PPE before entering a droplet isolation room in order not to transfer infection to other residents or staff. A review of the facility's P&P titled, Influenza, Prevention and Control of Seasonal, undated, indicated, Infection Precautions 1 .droplet precautions are implemented for residents with suspected and confirmed influenza . A review of the facility's P&P titled, Isolation- Categories of Transmission-Based Precautions, revised 9/2022, indicated, Droplet Precautions .3. Mask are worn when entering the room. 4. Gloves, gown and goggles are worn if there is a risk of spraying respiratory secretions. 51078 5. During a medication pass observation on 02/24/25 at 9:41 a.m. on the Northeast wing, LN 5 was observed retrieving a blood pressure machine from the end of the hallway, entering a resident's room and taking the resident's blood pressure without sanitizing the machine beforehand. LN 5 then prepared, administered, and exited the resident's room without washing her hands with soap and water or using alcohol-based hand rub. During an interview on 02/25/25 at 12:30 p.m. with the DON, the DON stated the expectation for medication administration included sanitizing any equipment if needed before and after use; perform hand hygiene prior to preparing medications, and before and after medication administration. The DON further stated that by not disinfecting equipment before each use and not performing hand hygiene it puts the residents and staff at risk for the spread of germs. During a review of the facility's policy and procedures (P&P) titled, Procedures For All Medications, dated April 2008, the P&P indicated, To administer medications in safe and effective manner .Cleanse hands according to facility policy. During a review of the facility's P&P titled, Handwashing/Hand Hygiene, dated September 2023, the P&P indicated, This facility considers hand hygiene the primary means to prevent the spread of infections .all personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitor .use an alcohol-based hand rub containing at least 62% alcohol before and after contact with the resident. 51483 6. During an observation on 02/24/25 at 09:03 a.m., Resident 85 was observed asleep in their bed. Oxygen compressor (a device to provide continuous oxygen) was at bedside, turned off and the nasal cannula was on the floor. During an observation and interview on 02/24/25 at 11:32 a.m., the oxygen compressor was at bedside, turned off and the nasal cannula was on the floor. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation and interview on 02/24/25 at 11:58 a.m., Resident 85 was observed with oxygen compressor on and nasal cannula placed into nose. Resident 85 indicated she did not place the nasal cannula on themselves. During an observation and interview on 02/24/25 at 11:59 a.m., CNA 2 assisted Resident 85 at bedside. CNA 2 stated The nurses will usually turn on their (residents) oxygen. I found hers here (on the ground and put it on her. During a concurrent interview and record review 02/25/25 09:12 p.m., with LN 1, LN 1 confirmed Resident 85 had an order for continuous oxygen. LN 1 stated, the chart has information, the tubing is changed every week, and the concentrator as needed. She is on continuous oxygen. Every shift documents in the chart on the medication administration record (MAR). The expectation if tubing was found on the floor would be to throw it away and get a new one and date it. During an interview on 02/25/25 at 12:56 p.m., CNA 3 stated they would expect to notify the nurse if a nasal cannula was found on the floor, and it should be replaced. Stated it CNA 3 stated it would put the patient at risk for infection or to get sick. During a review of Resident 85 ' s Order Summary Report, the Order Summary Report indicated Resident 85 had MD orders for Continuous oxygen orders for SOB [shortness of breath]. During an interview on 2/26/2025 at 3 p.m., with the DON, the DON stated she would expect that if tubing was on the floor a staff member would pick it up and dispose of it due to possible germ transmission. During a review of the facility's P&P titled Infection Prevention and Control Program, dated 9/18/2023, indicated the facility has established precautions to prevent individuals from contracting infections. 39489

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep all essential equipment working safely. 50312 Based on observation, interview, and record review, the facility failed to maintain equipment in safe operating condition when: 1. Walk-in freezer found with ice build-up on the floor, 2. The ice machine leaked, and a bucket was placed underneath the unit to catch the water, 3. The dish machine temperature gauge was not moving and did not indicate the temperature of the water, and 4. Food service (tray line) rack did not hold position and was held in position with plastic wrap. These failures had the potential of leading to food borne illness for the 125 Residents eating facility prepared meals. Findings: 1.During a concurrent observation and interview on 2/24/25 at 10:01 a.m., with the Dietary Manager (DM) in the walk-in freezer, ice build-up was on the floor. DM stated that the ice machine had leaked earlier in the day and some water had gone into the freezer and had frozen on the floor. During an observation on 2/25/25 at 2:50 p.m., the walk-in freezer still had ice build-up on the floor. During an interview on 2/26/25 at 3:00 p.m., with the DM, DM stated that he thought the ice on the floor had been taken care of. Review of the Food and Drug Administration (FDA) Food Code 2022, Section 6-101.11 Surface Characteristics. (A) Except as specified in . (B) of this section, materials for indoor floor, wall, and ceiling surfaces under conditions of normal use shall be: (1) Smooth, durable, and easily cleanable for area where food establishment operations are conducted; . (3) Nonabsorbent for areas subject to moisture such as food preparation areas, walk-in refrigerators, . 2.During a concurrent observation and interview on 2/24/25 at 9:33 a.m., with the DM water like fluid was noted around the ice machine. The DM stated that the ice machine had leaked earlier, and maintenance had placed a bucket underneath the ice machine. During this same observation on 2/24/25 at 9:33 a.m. a white plastic pipe underneath the ice machine was noted above the bucket. This pipe had a black colored substance covering the top portion of the pipe closest to the ice machine for over one foot. The connector from the horizontal pipe to the machine was covered in the same black substance for over 50% of this connector closest to the horizontal pipe. The substance had a mold like appearance and seemed to follow the path of fluid. (continued on next page)

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Food and Drug Administration (FDA) Food Code 2022, Section 4-501 on Equipment, Good Repair and Proper Adjustment indicated (A) Equipment shall be maintained in a state of repair and condition that meets the requirements specified under Parts 4-1 and 4-2 . The FDA Food Code 2022 further indicated that Proper maintenance of equipment to manufacturer specifications helps ensure that it will continue to operate as designed. Failure to properly maintain equipment could lead to violations of the associated requirements of the Code that place the health of the consumer at risk . Review of the Food and Drug Administration (FDA) Food Code 2022, Section 4-602 on Frequency, Equipment Food-Contact Surfaces and Utensils indicated. E) . shall be cleaned . (4) In equipment such as ice bins . and water vending equipment: (a) At a frequency specified by the manufacturer, or (b) Absent manufacturer specifications, at a frequency necessary to preclude accumulation of soil or mold. 3.During an observation on 2/25/25 at 2:45 p.m., with the DM, it was observed that the dish machine temperature gauge was not moving at all. The DM and [NAME] President of Food and Nutrition (VPFN) confirmed this and the VPFN called the dish machine repair company to come out and check the temperature gauge. A decision was made to use paper plates to serve the evening dinner. During a review of the facility provided Sanitation Policy and Procedure, (Med Pass Inc. revised November 2022), indicated that Dishwashing machines are operated according to manufacturer's instructions. General recommendations for heat and chemical sanitation are: . b. Low-Temperature Dishwasher (Chemical Sanitation): 1. Wash temperature (120 degrees F) . Review of the Food and Drug Administration (FDA) Food Code 2022, section 4-204.113 on Warewashing (method of cleaning and sanitizing kitchenware) Machine, Data Plate Operating Specifications indicated that A warewashing machine shall be provided with an easily accessible and readable data plate affixed to the machine by the manufacturer that indicates the machine's design and operation specifications including the: (A) Temperatures required for washing, rinsing, and sanitizing; . 4.During an observation and interview on 2/24/25 at 10:48 a.m. with the DM, the adjustable tray line rack was being held in place with plastic wrap. DM acknowledged that the rack needed to be repaired. During an observation of the meal service on 2/25/25 at 12:42 p.m., the DM was assisting with the tray line. As he moved trays down the rack a tray was noted to fall due to the slanted position. During a review of the facility's policy titled, Sanitization (MED-PASS, Inc., Revised November 2022) indicated, in bullet 2. All utensils, counters, shelves and equipment are kept clean, maintained in good repair .

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that a working call system is available in each resident's bathroom and bathing area. 46872 Based on observation, interview, and record review, the facility failed to ensure call light system was accessible for four out of 32 sampled residents (Resident 41, Resident 11, Resident 52, and Resident 20), when call light buttons were observed not within reach. This failure had the potential to result in residents' needs not being met and prevent communication for assistance when needed. Findings: A review of Resident 41's clinical record indicated Resident 41 was admitted to the facility June 2024 with multiple diagnoses which included hemiplegia (loss of ability to move one side of the body) and hemiparesis (weakness or paralysis on one side of the body). A review of Resident 11's clinical record indicated Resident 11 was originally admitted to the facility March 2008 with multiple diagnoses which included muscle weakness and other reduced mobility. A review of Resident 52's clinical record indicated Resident 52 was originally admitted to the facility January 2025 with multiple diagnoses which included muscle weakness and need for assistance with personal care. During a concurrent observation and interview on 2/24/25, at 9:52 a.m., with Certified Nursing Assistant (CNA) 3, Resident 41 was observed in bed with her call light button pinned to the top of the bed and not within her reach. CNA 3 confirmed the call light button was not within Resident 41's reach and stated, [call light button] should be closer to her. CNA 3 acknowledged Resident 41 would not have been able to ask for help if needed. During a concurrent observation and interview on 2/24/25, at 10:33 a.m., with CNA 12, Resident 11 was observed in bed with her call light button pinned behind the bed and not within her reach. CNA 12 confirmed the call light button was not in Resident 11's reach and stated, She couldn't reach it .She wouldn't have been able to call for help if she needed to. During a concurrent observation and interview on 2/24/25, at 10:43 a.m., with CNA 13, Resident 52 was observed in bed with her call light button on the floor. CNA 13 confirmed the call light button should be within reach of the resident at all times so they can call for help when they need it. CNA 13 stated, All residents supposed to have access to call light. A review of Resident 41's care plans initiated on 2/16/2025, indicated, Ensure/provide a safe environment: Call light in reach .Avoid isolation. A review of Resident 11's care plans initiated on 9/28/2020, indicated, Ensure/provide a safe environment: Call light in reach .Avoid isolation. A review of Resident 52's care plans initiated on 1/19/2025, indicated, Place call light within reach while in bed .When resident is in bed, place all necessary personal items within reach. (continued on next page)

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For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 2/25/25, at 2:39 p.m., with the Director of Nursing (DON), the DON confirmed the expectations were for call lights to always be within reach. The DON stated if call lights were not within reach of residents, potentially the resident would not be able to call for assistance and have their needs attended to timely. 47197 A review of Resident 20's clinical record indicated Resident 20 was admitted January of 2025 and had diagnoses that included hemiplegia (complete loss of the ability to move one side of the body) and hemiparesis (partial weakness of one side of the body) affecting left non-dominant side, dementia (a progressive state of decline in mental abilities), contracture (a stiffening/shortening at any joint, that reduces the joint's range of motion), muscle weakness, and need for assistance with personal care. A review of Resident 20's MDS Cognitive Patterns, dated 1/8/25, indicated Resident 20 had BIMS score of 2 out of 15 which indicated Resident 20 had a severely impaired cognition. A review of Resident 20's MDS Functional Abilities, dated 1/28/25, indicated Resident 20 is dependent with eating, oral hygiene, toileting, shower/bathing self, lower body dressing, and personal hygiene. Resident 20's MDS Functional Abilities further indicated Resident 20 was dependent with rolling left and right, sit to lying, lying to sitting on the side of bed, and chair/bed-to-chair transfer. A review of Resident 20's care plan intervention, dated 1/8/25, indicated, Ensure/provide a safe environment: Call light in reach . During an observation on 2/24/25 at 10:06 a.m. in Resident 20's room, Resident 20 was observed lying on bed, awake, and his call light button was hung on the wall next to the door. Resident 20 was observed to have contractures on both hands. During an observation on 2/25/25 at 12:20 p.m. in Resident 20's room, Resident 20 was observed lying on bed, awake, and his call light button was on the floor, below his bed. During a concurrent observation and interview on 2/25/25 at 12:40 p.m. with CNA 9, in Resident 20's room, CNA 9 confirmed that Resident 20's call light button was on the floor, below his bed. CNA 9 stated the call light button should be within the reach of the resident. During an interview on 2/26/25 at 4:06 p.m. with the DON, the DON stated call light button should be within reach of the resident. A review of the facility's policies and procedures (P&P) titled, Call System, Resident, revised 9/2022, indicated, 1. Each resident is provided with a means to call staff directly for assistance from his/her bed . During a review of the facility's P&P titled, Answering the Call Light, revised 10/2024, the P&P indicated, Ensure that the call light is accessible to the resident when in bed .