STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055318	A. Building B. Wing	06/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Skyline Healthcare Center - San Jose	2065 Forest Avenue San Jose, CA 95128

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 4. During an observation on 6/25/25, at 1:41 p.m., certified nursing assistant C (CNA C) was feeding lunch to Resident 163, who was lying in bed with the head of the bed slightly elevated. CNA C was standing over Resident 163 while feeding her. During an observation and concurrent interview with nurse supervisor D (NS D) on 6/25/25, at 1:41 p.m., NS D confirmed the above observation and stated CNA C should sit at eye level while feeding the resident. During an interview with the director of staff development (DSD) on 6/27/25, at 8:16 a.m., the DSD explained staff should sit at eye level while feeding the residents in order to maintain the residents' comfort and dignity. The facility's undated policy titled Assisting the Resident to Eat indicated, Sit at eye level in front of the resident. Based on observation, interview, and record review, the facility failed to ensure respect and dignity were maintained for 2 of 36 sampled residents (Residents 103 and 163) and two non-sampled residents (Residents 381 and 168) when: 1. For Resident 381, the meal tray was served late and not at the same time as with the other residents on the same table at the big dining room; 2. For Resident 168, his food was also served late and not at the same time as the other residents seated in th same table in the big dining room; 3. For Resident 103, his drainage bag was not covered from public view and 4. For Resident 163, certified nursing assistant (CNA) was standing over this resident while feeding her. These failures had the potential to affect the emotional and psychosocial well-being of the residents. Findings: (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 - Some	1. During the big dining room observation on 6/23/25 at 11:58 a.m., three residents (Residents 381, 168 and 200), were seated at the same table for lunch. Resident 200 was already eating his lunch while Residents 381 and 168 were still waiting for their meal trays and looking hungry. During the concurrent observation and interview with Resident 381 on 6/23/25@12:10 p.m., Resident 381 finally received his lunch meal tray. Resident 381 was alert and verbally responsive and verified that his meal tray was served late while the other resident in the same table had been eating his lunch already and almost done with it. He further stated that he was already hungry. During the interview with the activity director (AD) on 6/27/25 at 1:55 p.m., the AD acknowledged that for residents sitting in the same table, they should be served with their meal trays at the same time or one after the other, before serving the next table. During the interview with the assistant director of nursing (ADON) on 6/27/25 at 2:04 p.m., the ADON verified that for residents eating in the same table, their meals should be served at the same time or finish serving them first before serving other residents on the next or different table. 2. During the big dining observation on 6/23/25 at 11:58 a.m., Resident 168 was sitting in one of tables in the big dining room waiting for staff to serve his lunch. Another resident (Resident 200), in the same table, was already eating his lunch. Resident 381, who was also in that same table was also waiting for his meal tray to be served. During an interview with Resident 168 on 06/23/25 at 12:00 p.m., Resident 168 verified that he was waiting for his lunch tray for 5 minutes now and was already hungry while looking at the other resident in front of him, Resident 200 who was already eating lunch at 11:55 a.m. During an interview with the director of nursing (DON) on 6/26/25 at 4:12 p.m., the DON verified the above observation and stated that the food should be served in short interval not having to wait for a long time. The DON also stated, the resident might not feel good and get impatient when he would wait for a long time for his food while others had been served for their meals already. Review of the undated facility's policy and procedure (P&P) titled, Resident Dining Program, the P&P indicated, The goal is to ensure that all residents in the facility receive meals that are nutritionally appropriate and served in a respectful, safe, and timely manner, in accordance with their care plans, physician orders, and federal/state regulations Meals will be served in a manner that promotes dignity, autonomy, and social interaction among residents C. Meal service Protocol:1. Food trays are delivered by table order to ensure fairness and minimize cold meals 3. Review of Resident 103's clinical record indicated, Resident 103 was admitted on [DATE] with diagnoses that include urinary tract infection(an infection in any part of urinary system), retention of urine, obstructive and reflux uropathy (a condition in which the flow of urine is blocked), benign prostatic hyperplasia (a non-cancerous condition where the prostate gland grows larger than normal) with lower urinary tract symptoms, acute kidney failure(a sudden and rapid decrease in kidney function) . During an observation on 6/24/25 at 8:26 a.m., Resident 103 was lying in bed, with indwelling foley catheter connected to drainage bag positioned lower than the bladder. The drainage bag was not covered, and the contents were visible. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview on 6/24/25 at 8:31 a.m., with the Infection Preventionist (IP), the IP inside Resident 103 room's, confirmed Resident 103's drainage bag was not covered and visible. The IP stated the drainage bag should have privacy bag to cover. During a review of the facility's policy and procedure (P&P) titled, Quality of Life- Dignity , undated, the P&P indicated, Each resident shall be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life, and feelings of self-worth and self-esteem.11. Demeaning practices and standards of care that compromise dignity are prohibited. Staff are expected to promote dignity and assist residents, for example: e. Helping the residents to keep urinary catheter bags covered.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure the call light button (a cord with a button used by the resident to request assistance) for one of 238 residents (Resident 25) was within reach and appropriate for her condition. This failure had the potential to result in delays of care and treatment. Findings: Review of Resident 25's medical record indicated Resident 25 was initially admitted on [DATE] and had diagnoses including Epilepsy (a neurological disorder characterized by recurring seizures [sudden , uncontrolled surges of electrical activity in the brain]), unspecified, intractable, without status epilepticus, other lack of coordination, unspecified disorder of psychological development (a condition that affects a person's cognitive, emotional, and behavioral development, often originating in childhood), and delayed milestone in childhood. During an observation on 6/23/25, at 9:36 a.m., Resident 25 was asleep, and the call light button was on the floor. During a concurrent observation and interview on 6/23/25, at 11:16 a.m., with Licensed Vocational Nurse (LVN) L, LVN L confirmed Resident 25's call light button was on the floor and verified the resident should have another device appropriate for the resident. During a review of the facility's undated policy and procedure (P&P) titled, Resident Call System, the P&P indicated, Residents are equipped with communication system, allowing them to request assistance by contacting either a staff member or a centralized workstation. 4. If a resident has a disability that prevents them from using the call system, an alternative means of communication that is usable for the residents is provided and documented in the care plan.

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F 0577 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure that the residents would know and be reminded of the results of the previous state recertification surveys when 5 out of 14 residents who attended the Resident Council meeting, (Residents 5, 33, 52, 80, and 106), did not know about the results of the previous state recertification surveys or where the binder containing the survey results was located. These failures jeopardized the right of the residents to know and examine the results of the previous state recertification surveys and the plan of corrections that the facility did for those failures. Findings: During the resident council meeting (gathering where residents of a facility come together to discuss issues) on 6/24/25 at 10:00 a.m., 5 residents, (Residents 5, 33, 52, 80, and 106), were among the attendees of the meeting. During a concurrent observation and interview with Resident 5 during the resident council meeting on 6/24/25 at 10:30 a.m., Resident 5 was seated in a wheelchair, alert, oriented and verbally responsive. Resident 5 verbalized that he was not aware of the results of the previous state recertification surveys or where the survey binder was located. Review of Resident 5's admission record (document created when a resident is admitted to a healthcare facility, containing the vital information about the resident) indicated, Resident 5 was readmitted to the facility on [DATE] with diagnoses including acute respiratory disease (a condition that affects the lungs and airways making it difficult for air exchange in the lungs), chronic pulmonary edema (the buildup of fluid in the lungs), atrial fibrillation (an irregular heart rhythm which can lead to blood clots and stroke) and muscle weakness. Resident 5's BIMS (brief interview for mental status- cognition level score of 13 to 15 points suggests that cognition is intact) score was 15. During a concurrent observation and interview of Resident 33 on 6/24/25 at 10:30 a.m., Resident 33 was seated in her wheelchair, alert, oriented, verbally responsive and participating in the resident council meeting. Resident 33 stated she was not aware of the results of the previous state recertification surveys or where the binder with the survey results was located. Review of the admission record of Resident 33 indicated, Resident 33 was readmitted to the facility on [DATE] with diagnoses including chronic atrial fibrillation, diabetes mellitus (a condition which affects the way the body processes blood sugar), peripheral vascular disease (a blood vessel disorder that affects blood circulation), and cellulitis (a bacterial infection of the skin and tissues beneath the skin) of the left lower limb. Resident 33's BIMS score was 14. During a concurrent observation and interview with Resident 52 on 6/24/25 at 10:30 a.m., Resident 52 was alert, oriented, calm, comfortable, verbally responsive and actively participating in the resident council meeting. Resident 52 also stated that she was not aware of the results of the previous state recertification surveys or where the binder containing survey results was located. (continued on next page)

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F 0577 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the admission record of Resident 52 indicated, Resident 52 was readmitted to the facility on [DATE] with diagnoses including diabetes mellitus, hyperlipidemia (high levels of fat particles in the blood), osteoarthritis (a condition where there's gradual wearing down of protective tissue at the ends of bones) and generalized muscle weakness. Resident 52's BIMS score was 14. During a concurrent observation and interview with Resident 80 on 6/24/25 at 10:30 a.m., Resident 80 was alert, oriented, verbally responsive and actively participating in the resident council meeting. Resident 80 stated he was not aware of the results of the previous state recertification surveys or where the survey binder was located. Review of the admission record of Resident 80 indicated, Resident 80 was readmitted to the facility on [DATE] with diagnoses including congestive heart failure (heart works less efficiently and can lead to buildup of fluid in the lungs and shortness of breath), diabetes mellitus, hemiplegia (severe muscle weakness or partial paralysis on one side of the body) affecting the right dominant side, muscle weakness and difficulty walking. Resident 80's BIMS score was 14. During a concurrent observation and interview with Resident 106 during the resident council meeting on 6/24/25 at 10:30 a.m., Resident 106 was seated in her wheelchair, alert, oriented and verbally responsive. Resident 106 verbalized not being aware of the results of the previous state recertification surveys or where the survey binder was located. Review of Resident 106's admission record indicated Resident 106 was readmitted to the facility on [DATE] with diagnoses including acute respiratory disease, hypertension (a condition in which the force of the blood against the artery walls in the heart is too high), and seizures (uncontrolled jerking movements of the arms and legs caused by abnormal brain activity). Resident 106's BIMS score was 15. During an interview on 6/25/25 at 10:55 a.m. with the Activity Director (AD), the AD verified being employed at the facility for twenty-five years and acknowledged not knowing about the results of the previous state recertification surveys or where the survey binder for the results of the previous surveys was located. The AD then stated, It's probably in the administrator's office. During an interview with the administrator (ADM) on 6/27/25 at 11:56 p.m., the ADM verified that the AD should know where the survey binder for the results of the previous surveys was located so she could in turn inform and remind the residents about the binder location. The ADM stated that he would in-service the AD about it. During an interview on 6/27/25 at 2:04 p.m., with the Director of Nursing (DON) the DON also verified that the AD should know where the survey binder containing results of the previous surveys is located and that all staff members should know the location of the survey binder. (continued on next page)

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F 0577 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility's policy and procedure titled, Access to Survey Results, undated indicated, Survey results and approved plan of correction, if applicable, are available in a readable form . and are available to residents without having to ask a staff person. Survey results may be placed in a binder . Results of the most recent survey are placed readily accessible to residents in a place such as a lobby or other areas frequented by most residents, where individuals wishing to examine survey results do not have to ask to see them . Residents should be notified at least annually during Resident Council meetings of the survey results . Minutes of Resident Council meetings should reflect that survey results were communicated.

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. Based on interview and record review, the facility failed to provide a Skilled Nursing Facility Advance Beneficiary Notice of Non-Coverage (SNF ABN, a notice that transfers potential financial liability when a resident comes off Medicare Part A) for two of three residents (Residents 95 and 186). This failure had the potential to compromise the residents' right to appeal (apply for reversal of) the facility's decision to discontinue Medicare Part A services (skilled treatments paid for by Medicare). This failure also had the potential to result in the residents or residents' representatives not being informed of their payment responsibilities to the facility after Medicare Part A services ended. Findings: Review of Resident 95's medical record indicated she was admitted under Medicare Part A on 4/30/25. Review of the Beneficiary Notice section of the Entrance Conference Worksheet, filled out by the facility and presented to the survey team on 6/24/25, indicated Resident 95 was to be discharged from Medicare Part A services on 6/26/25 and continue living in the facility. Review of Resident 95's SNF Beneficiary Protection Notification Review, filled out by the facility and presented to the survey team on 6/25/25, indicated the facility initiated Resident 95's discharge from Medicare Part A services when benefit days were not exhausted (the resident still had Medicare Part A days remaining). The SNF Beneficiary Protection Notification Review further indicated the facility did not provide a SNF ABN to Resident 95. Review of Resident 186's medical record indicated he was admitted under Medicare Part A on 3/4/25. The medical record further indicated Resident 186 came off Medicare Part A on 5/20/25 and continued living in the facility. Review of Resident 186's SNF Beneficiary Protection Notification Review, filled out by the facility and presented to the survey team on 6/25/25, indicated the facility initiated Resident 186's discharge from Medicare Part A services when benefit days were not exhausted. The SNF Beneficiary Protection Notification Review further indicated the facility did not provide a SNF ABN to Resident 186. During an interview with the interim social services director (ISSD) on 6/25/25, at 10:41 a.m., the ISSD confirmed the facility did not provide a SNF ABN to Residents 95 and 186. The Department of Health and Human Services and Centers for Medicare & Medicaid Services Form CMS-20052, dated 2/2022, indicated the facility must provide a SNF ABN when residents are discharged from Medicare Part A services, with skilled benefit days remaining, and continue to live in the facility. According to the Centers for Medicare & Medicaid Services (CMS, https://www.cms.gov/Medicare/Medicare-General-Information/BNI/FFS-SNF-ABN-), the facility must provide a SNF ABN prior to providing custodial care.

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to complete an annual Minimum Data Set (MDS, an assessment tool) for one of three residents (Resident 89). This failure had the potential to compromise the facility's ability to develop and implement care plan interventions. Findings: Review of Resident 89's medical record indicated she was admitted to the facility on [DATE]. The medical record indicated the facility completed an annual MDS assessment on 5/12/24. Further review of the medical record indicated the facility did not complete an annual MDS assessment for Resident 89 in May of 2025. During an interview and concurrent record review with Minimum Data Set Coordinator B (MDSC B) on 6/26/25, at 1:17 p.m., MDSC B reviewed Resident 89's medical record and stated the facility should have completed an annual MDS assessment in May of 2025. MDSC B confirmed the facility did not complete this annual MDS assessment. The Centers for Medicare & Medicaid Services (CMS) Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual (RAI Manual, MDS coding instructions), dated 10/2024, indicated, The Annual assessment is a comprehensive assessment for a resident that must be complete on an annual basis (at least every 366 days). The RAI manual indicated the date of the annual MDS assessment must be set within 366 days of the previous annual assessment, and must be completed no later than 14 days after the set date.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to accurately complete the Minimum Data Set (MDS, an assessment tool) for two of 36 sampled residents (Residents 164 and 192) when: 1. For Resident 164, multiple falls were not coded on the MDS; and 2. For Resident 192, tobacco use was not coded on the MDS. Failure to accurately complete the MDS had the potential to compromise the facility's ability to develop and implement care plan interventions. Findings: 1. Review of Resident 164's medical record indicated she was admitted on [DATE] and had a history of falling. Review of Resident 164's SBAR (situation, background, assessment, recommendation - a communication tool used by healthcare workers when there is a change in a resident's condition), dated 11/16/24, indicated Resident 1 had a witnessed fall in her room. Review of Resident 164's Progress Notes, dated 11/21/24, indicated she slid down and was found on the floor in her room. During an interview and concurrent record review with Minimum Data Set Coordinator B (MDSC B) on 6/25/25, at 10:50 a.m., MDSC B reviewed Resident 164's medical record and confirmed the resident fell on [DATE] and 11/21/24. MDSC B stated these falls should have been coded on Resident 164's MDS dated [DATE]. MDSC B reviewed Resident 164's MDS, dated [DATE], and confirmed section J1800 was coded No, indicating Resident 164 did not fall during the specified time frame. MDSC B confirmed section J1800 should have been coded Yes, to indicate Resident 164 fell during the specified time frame. The Centers for Medicare & Medicaid Services (CMS) Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual (RAI Manual, MDS coding instructions), dated 10/2024, indicated for section J1800, Code 1, yes if the resident has fallen during the specified time frame. 2. Review of Resident 192's medical record indicated he was admitted on [DATE] with diagnoses including osteomyelitis (bone infection) of vertebra, sacral and sacrococcygeal region (bones in the spine), fracture (a break in a bone) of T7-T8 vertebra (the seventh and eight bones in the spine). Review of Resident 192's Safe Smoking Assessment Evaluation (an assessment tool), dated 3/28/25, indicated Resident 192 smoked cigarettes. During a concurrent interview and record review with MDSC A ,on 6/27/25 at 9:11 a.m., MDSC A reviewed Resident 192's medical record and confirmed the resident smoked cigarettes. MDSC A reviewed Resident 192's MDS, dated [DATE], and confirmed section J1300 Current Tobacco Use was coded No', indicating Resident 192 did not smoke cigarettes. MDSC A confirmed section J1300 should have been coded Yes, to indicated Resident 192 smoked cigarettes. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The RAI Manual, dated 10/2024, indicated for section J1300, Code 1, yes: if the resident or any other source indicates that the resident used tobacco in some form during the look-back period.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure resident-centered baseline care plans were developed within 48 hours of admission for two of thirty-six sampled residents, (Residents 337 and 380), when: 1. For Resident 337, there was no communication problem care plan that was initiated and 2. For Resident 380, there was no baseline activity care plan that was created, and she had no activity care plan at all. These deficient practices had the potential to cause delays in the continuity of care and communication which could negatively affect residents' health, safety and delivery of care. Findings: 1. Resident 337 was admitted to the facility on [DATE] with diagnosis of Cerebral infarction (necrotic tissue in the brain resulting from a blockage or narrowing in the arteries supplying blood and oxygen to the brain), Aphasia (a disorder that makes it difficult to speak), abnormalities of gait and mobility, Dysphagia (difficulty swallowing). During a concurrent interview and record review on 6/26/25 at 9:52 a.m., with the assistant Director of Nursing (ADON), the ADON reviewed 337's clinical records and stated that Minimum Data Set (MDS - a federally mandated resident assessment tool) dated 6/17/25 indicated Resident 337 has no speech, absence of spoken words, sometimes can make self-understood and sometimes understands others due to diagnosis of Aphasia. The ADON further stated that there was no communication problem care plan that was initiated upon admission and up to this day 6/26/25. During a concurrent interview and record review on 6/26/25 at 11:24 a.m., with Minimum Data Set Coordinator A (MDSC A), MDSC A reviewed Resident 337's MDS and Care plan confirmed the above MDS record review was accurate and there was no communication problem baseline care plan that was developed within 48 Hrs. after admission of Resident 337 on 6/10/25. Review of the undated facility's policy and procedure titled, Baseline Care Plan, indicated, A baseline plan of care to meet the resident's immediate needs shall be developed for each resident within forty-eight hours of admission To assure that the resident's immediate care needs are met and maintained, a baseline care plan will be developed within forty-eight (48) hours of the resident's admission The baseline care plan will be used until the staff can conduct the comprehensive assessment and develop an interdisciplinary person-centered care plan 2. During the observation of Resident 380 on 6/23/25 at 12:33 p.m., Resident 380 was lying in her bed and looked calm and comfortable. She was confused and could not answer questions. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 380's face sheet (document created when a resident is admitted to a healthcare facility, containing the vital information about the resident) indicated, Resident 380 was admitted to the facility on [DATE] with the primary diagnosis of malignant neoplasm (cancerous tumor characterized by uncontrolled growth and potential spread to other parts of the body) of unspecified site of unspecified female breast. Review of Resident 380's physician order report from 5/24/25 to 6/24/25 indicated, Resident 380 may participate in activity as tolerated if not in conflict with treatment/care plan and the order was started on 6/19/25. Review of Resident 380's care plans indicated that Resident 380 did not have a resident-centered baseline activity care plan that was created and she did not have an activity care plan at all. During the concurrent review of Resident 380's clinical records and interview with the activity director (AD) on 6/27/25 at 11:48 a.m., the AD verified that Resident 380 was not assessed for her activities since she was admitted on [DATE] and there was no resident-centered baseline activity care plan that was created for her. The AD further verified that resident-centered baseline activity care plans should be created within 48 hours of admission. The AD also stated that Resident 380 was admitted on [DATE] and her baseline activity care plan should have been created and implemented already, and she did not have an activity care plan at all. Review of the undated facility's policy and procedure titled, Baseline Care Plan, indicated, A baseline plan of care to meet the resident's immediate needs shall be developed for each resident within forty-eight hours of admission To assure that the resident's immediate care needs are met and maintained, a baseline care plan will be developed within forty-eight (48) hours of the resident's admission The baseline care plan will be used until the staff can conduct the comprehensive assessment and develop an interdisciplinary person-centered care plan

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, medical record review, and facility P&P review, the facility failed to revise the comprehensive care plans to address the individual care needs for two of thirty-six sampled residents, (Residents 202 and 18), when: 1.Resident 202's care plan interventions were not revised or modified related to falls and cognitive function. 2.Resident 18's care plan for antibiotic, not resolved. This failure placed the residents at risk of not being provided appropriate, consistent, individualized care. Findings: 1.Resident 202 was admitted to the facility on [DATE] with diagnosis of Schizophrenia (a chronic and severe mental disorder that affects how a person thinks, feels, and behaves), Cerebral infarction cerebral infarction (necrotic tissue in the brain resulting from a blockage or narrowing in the arteries supplying blood and oxygen to the brain), Hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) and hemiparesis (weakness on half of the body) , abnormalities of gait and mobility and weakness. Review of Minimum Data Set (MDS - a federally mandated resident assessment tool) dated 4/16/25 indicated his cognition (mental, thought processes) and brief interview for mental status (BIMS, cognition level) score of eight is moderately impaired cognition. During a concurrent interview and record review on 6/26/25 at 2:13 p.m., with the assistant Director of Nursing (ADON), the ADON reviewed Resident 202's long term care plan dated 1/2/25 and the interventions were not revised or modified related to three falls interventions on 1/2/25, 1/7/25 and 2/26/25, and the cognitive function was not indicated. The ADON further stated that it should have been revised and modified for individualized care. Review of the facility's Comprehensive Plan of Care policy and procedure, undated, indicated Re-evaluate and modify care plans: as necessary to reflect changes in care, service and treatment; .with significant change in status assessment . 3. A review of Resident 18's Resident Face Sheet, indicated Resident 18 was admitted to the facility on [DATE] with diagnoses including nontraumatic intracerebral hemorrhage (a type of stroke, caused blood to pool between the brain and skull), major contusion of left kidney (injury to the kidney), sepsis (body's extreme and potentially dangerous response to infection) . Review of Resident 18's clinical record indicated Resident 18 had a Physician order of Cefepime (antibiotic, used to treat bacterial infections) 2 grams (G, unit of measurement) every 12 hours for 7 days, dated 6/5/25. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review with the Director of Nursing (DON), on 6/26/25 at 2:04 p.m., the DON confirmed Resident 18's antibiotic was completed on 6/12/25. The DON also confirmed the care plan for antibiotic was still active and should have been resolved. Review of the facility's Comprehensive Plan of Care policy and procedure, undated, indicated Re-evaluate and modify care plans: as necessary to reflect changes in care, service and treatment; .with significant change in status assessment .

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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** 2. During the observation of Resident 7 on 6/23/25 at 12:43 p.m., Resident 7 was alert, calm, comfortable, verbally responsive and able to answer questions. Review of Resident 7's face sheet indicated, Resident 7 was readmitted to the facility on [DATE] with the primary diagnosis of unspecified paraplegia (a condition characterized by the paralysis of the lower half of the body, typically including the legs and sometimes the torso or the trunk of the human body). Review of Resident 7's physician order report from 5/24/25 to 6/24/25 indicated, Resident 7 had an order to monitor weekly weights every Saturday, at 9:00 a.m., once a day, ordered on 4/6/25. Review of Resident 7's weight records indicated that Resident 7's weights were checked on the following dates: a. 5/20/25 - 190 pounds (lbs, unit used to measure the mass); b. 5/7/25 - 195 lbs; c. 4/22/25 - 195 lbs; d. 3/19/25 - 182 lbs; e. 2/18/25 - 191 lbs and f. 1/21/25 - 200 lbs. During the concurrent review of Resident 7's clinical records and interview with nursing supervisor D (NS D) on 6/26/25 at 2:55 p.m., NS D verified that Resident 7 had an order to monitor her weight weekly every Saturday, once a day at 9:00 a.m., and they were not done. Resident 7's weight was last monitored on 5/20/25, which was 190 lbs. and there were no records that Resident 7's weights were checked weekly after that. NS D further verified that the weight monitoring order of Resident 7 was not followed. NS D then stated that she would clarify with Resident 7's physician about her weight monitoring order and would follow the order. During the interview with the director of nursing (DON) on 6/27/25 at 8:15 a.m., DON acknowledged that physician orders should be followed and Resident 7's physician order to monitor her weight weekly was not followed and would follow up on it. Review of the undated facility's policy titled, Carrying Out Physician's Orders, indicated, All physician orders must be documented, reviewed, and carried out accurately and promptly to ensure the highest standard of patient care. This policy applies to all nursing staff and healthcare providers within the facility Nursing staff: Carry out physician's orders accurately and promptly, ensuring patient safety and proper documentation (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Based on observation, interview and record review, the facility failed to ensure care and services were provided to meet the professional standard of practice for three of four residents (Residents 116, 30 and 7) when: 1. Two Licensed Vocational Nurses (LVN) did not wear proper Personal Protective Equipment (PPE, equipment worn to minimize exposure to a variety of hazards) when handling hazardous drugs; and 2. The weight monitoring order for Resident 7 was not followed. These failures had the potential to compromise the residents' health and safety. Findings: 1. During a medication administration observation at Station 4 with LVN J on 6/25/25 at 8:36 a.m., LVN J was observed removing a medication called Divalproex Sodium (Depakote, anticonvulsant used to treat seizures and bipolar disorders) from a blister pack (packaging used for medications) for Resident 116. LVN J confirmed the blister pack have the Hazardous Drug label and that she did not wear gloves when handling the medication. LVN J stated she should have worn gloves. During a medication administration observation at Station 5B with LVN M, on 6/25/25 at 10:32 a.m., LVN M was observed removing a medication called Divalproex Sodium from a blister pack for Resident 30. LVN M confirmed the blister pack have the Hazardous Drug label and that she was not wearing gloves. LVN M stated she should wear gloves when handling the medication. During an interview with the Director of Nursing (DON) on 6/26/25 at 2:01 p.m., the DON stated the Hazardous Drug label on medications was an indication of special instructions on how to administer the medication. The DON also stated the licensed nurses should wear gloves as protection when handling the medication. During an interview with the Consultant Pharmacist (CP) on 6/27/25 at 10:47 a.m., the CP stated the facility should follow the required precautions for medications with hazardous drug label. The CP stated the staff should wear gloves depending on the risk of exposure to the medication. Review of the facility's Hazardous Drug Handling policy and procedure (P&P), dated 1/23, indicated Scope: The facility must develop and maintain a health and safety management system which shall, at a minimum, include the following: .5. Proper use of appropriate Personal Protective Equipment (PPE) .D. Personal Protective Equipment .a. Appropriate PPE must be worn when handling HDs . Review of the facility's Hazardous Drug Handling P&P, dated 1/23, indicated H. Administering 1) The facility should provide all PPE needed and monitor use according to established policies and procedures that minimize employee and patient exposure.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the proper use of side or bed rails (adjustable rigid bars attached to the side of a bed) for one (Resident 380), of six residents who used side rails that were investigated, when Resident 380 did not have a physician's order for her use of side rails. This failure caused the resident, to not have the proper approval from the physician for her use of side rails which could jeopardize the resident's safety. Findings: During the observation of Resident 380 on 6/23/25 at 12:33 p.m., Resident 380 was lying in bed and looked calm and comfortable. She was confused and could not answer questions. Resident 380 had bilateral (both sides) half side rails that were up. Review of Resident 380's face sheet (document created when a resident is admitted to a healthcare facility, containing the vital information about the resident) indicated, Resident 380 was admitted to the facility on [DATE] with the primary diagnosis of malignant neoplasm (cancerous tumor characterized by uncontrolled growth and potential spread to other parts of the body) of unspecified site of unspecified female breast. Review of Resident 380's physician order report or MD (Doctor of Medicine) order report from 5/24/25 to 6/24/25 indicated, there was no physician's order for Resident 380's use of side rails. During the concurrent review of Resident 380's medical records and interview with nurse supervisor D (NS D) on 6/27/25 at 3:19 p.m., NS D verified that Resident 380 had side rails but did have a physician's order for her use of side rails. NS D further stated she would notify Resident 380's physician about side rail use and then update the orders. Review of the undated facility's policy titled, Side Rails, indicated, Requirements are the same as for other physical restraints, whether or not the side rails enable mobility: Obtain MD order, including diagnosis/medical necessity for use

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on interview and record review, the facility failed to ensure accurate accountability of controlled medication (medication with high potential for abuse and addiction) when random controlled medication use audit for seven of 12 residents (Resident 347, 28, 174, 67, 38, 65, and 226) did not reconcile when: 1. The medication was documented on the Medication Administration Record (MAR, used to document medications taken by each individual) to indicate they were administered to Residents 65, 38, and 28 but was not signed out of the Controlled Drug Record (CDR, an inventory sheet that keeps record of the usage of controlled medications.), and 2. The medication was signed out of the CDR but not documented on the MAR for Residents 347, 67, 174, 65, and 226. These failures resulted in inaccurate accountability and had the potential for misuse or diversion of controlled medications. Findings: 1. The Controlled Drug Record (CDR) for 12 randomly selected residents receiving controlled medications were requested for review during the survey. A review of Resident 65's clinical record indicated he had a Physician's order for Methadone (a narcotic, used to treat moderate to severe pain) 5 milligrams (mg, unit of measurement) two tablets once a day for chronic pain, dated 6/20/25. During a concurrent interview and record review of the CDR, with Minimum Data Set Coordinator (MDSC) A, on 6/25/25 at 1:48 p.m., MDSC A confirmed three tablets were unaccounted in the CDR. During a concurrent interview and record review with Licensed Vocational Nurse (LVN) J, on 6/25/25 at 1:50 p.m., LVN J stated she administered the medication and documented in the MAR but did not sign out in the CDR. A review of Resident 38's clinical record indicated he had a Physician order for Lorazepam (an anti-anxiety medication) 1 mg 1 tablet once a day for anxiety, dated 5/14/25. During a concurrent interview and record review of the CDR with LVN K, on 6/25/25 at 1:53 p.m., LVN K confirmed the medication was documented in the MAR but was not signed out in the CDR. A review of Resident 28's clinical record indicated he had a Physician order for Hydrocodone-Acetaminophen (Norco, used for moderate to severe pain) 5-325 mg 1 tablet three times a day. During a concurrent interview and record review of the CDR with LVN K, on 6/25/25 at 2:04 p.m., LVN K confirmed the medication was documented in the MAR but was not signed out in the CDR. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. A review of Resident 347's clinical record indicated she had a Physician order for Oxycodone (used to treat moderate to severe pain) 5 mg 1 tablet twice a day as needed for severe pain, dated 6/22/25. During a concurrent interview and record review on 6/26/25 at 2:20 p.m., with the Director of Nursing (DON), a review of Resident 347's CDR for Oxycodone and the 6/2025 MAR reflected the nursing staff removed the medication from the locked controlled medication compartment in the medication cart and signed of the CDR on 6/21/25 at 11:11 a.m., but did not document the respective administration in the MAR. The DON acknowledged that the controlled medication was not accounted for in the MAR. A review of Resident 67's clinical record indicated he had a Physician order for Tramadol (used to treat moderate to severe pain) 50 mg 1 tablet every 8 hours as needed for severe pain, dated 6/23/25. During a concurrent interview and record review on 6/26/25 at 2:24 p.m., with the DON, a review of Resident 67's CDR for Tramadol and the 4/2025 MAR reflected the nursing staff removed the medication from the locked controlled medication compartment in the medication cart and signed of the CDR on 4/22/25 at 9:54 p. m., but did not document the respective administration in the MAR. The DON acknowledged that the controlled medication was not accounted for in the MAR. A review of Resident 174's clinical record indicated he had a Physician order for 50 mg Tramadol every 4 hours as needed for pain management, dated 6/9/24. During a concurrent interview and record review on 6/26/25 at 2:32 p.m., with the DON, a review of Resident 174's CDR for Tramadol and the 2/2025 MAR reflected the nursing staff removed the medication from the locked controlled medication compartment in the medication cart and signed of the CDR on 2/25/25 at 9:54 p. m. and 2/26/25 at 6:26 a.m., but did not document the respective administrations in the MAR. The DON acknowledged that the controlled medications were not accounted for in the MAR. A review of Resident 65's clinical record indicated he had a Physician order for Oxycodone 20 mg 1 tablet every 4 hours as needed for severe pain, dated 6/20/25. During a concurrent interview and record review on 6/26/25 at 2:40 p.m., with the DON, a review of Resident 65's CDR for Oxycodone and the 6/2025 MAR reflected the nursing staff removed the medication from the locked controlled medication compartment in the medication cart and signed of the CDR on 6/21/25 at 8:27 a. m., but did not document the respective administration in the MAR. The DON acknowledged that the controlled medication was not accounted for in the MAR. A review of Resident 226's clinical record indicated he had a Physician order for Oxycodone 5 mg 1 tablet every 4 hours as needed for moderate pain, dated 5/16/25. During a concurrent interview and record review on 6/26/25 at 2:48 p.m., with the DON, a review of Resident 226's CDR for Oxycodone and the 5/2025 MAR reflected the nursing staff removed the medication from the locked controlled medication compartment in the medication cart and signed of the CDR on 5/17/25 at 11:30 a.m., but did not document the respective administration in the MAR. The DON acknowledged that the controlled medication were not accounted for in the MAR. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the facility's Medication Administration General Guidelines policy and procedure (P&P), dated 1/24, indicated Documentation: 1. The individual who administers the medication dose, records the administration on the resident's MAR immediately following the medication being given . A review of the facility's Medication Administration Controlled Substances P&P, dated 1/23, indicated 4. When a controlled medication is administered, the licensed nurse administering the medication immediately enters the following information on the accountability record when removing dose from controlled storage .5. Administer the controlled medication and document dose administration on the MAR.

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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. Based on observation, interview, and record review, the facility failed to ensure medications were stored in accordance with facility policies when: 1. In one of six medication rooms, the were medications with different routes of administration stored in the same bin. There were also active and discontinued medications stored in this bin; 2. One opened bottle of 1,000 milliliters (ml, a unit of measurement for volume) 0.9% sodium chloride solution (known as normal saline- a common medical solution containing 0.9 grams of sodium chloride per 100 milliliters of water. It is an isotonic solution, meaning it has the same concentration of solutes as the blood and body fluids (NS) and small bottle of 0.9% (NS) was stored at Resident 65's bedside table unattended. and 3. One bottle of used 100 ml NS was stored at Resident 205's bedside table unattended. These failures had the potential to compromise the health and safety of the residents. Findings: 1. During an observation and concurrent interview with nurse supervisor H (NS H) on 6/23/25, at 8:32 a.m., one medication room was inspected. Inside the room, there was a clear plastic bin that contained face shields (personal protective equipment meant to protect the face). Upon further inspection, it was observed that this bin also contained the following: 1.) One bottle of liquid Lithium (medication used to treat psychiatric conditions) 8 milliequivalents per 5 milliliters (meq/ml, unit of dose measurement) that belonged to Resident 212; 2.) One bottle of Atorvastatin tablets (medication used to treat high cholesterol) 40 milligrams (mg, unit of dose measurement) that belonged to Resident 212; 3.) One Symbicort inhaler (medication used to treat breathing problems) 80-4.5 micrograms (mcg, unit of dose measurement) that belonged to Resident 4; 4.) One house stock (not belonging to a specific resident) bottle of normal saline (a solution that can be used for several medical purposes, including, but not limited to hydration and wound treatments); and 5.) Multiple house stock wound dressings that contained alginate (a substance added to help promote wound healing). NS H confirmed this observation and confirmed these items should not have been stored together. During an interview and concurrent record review with the director of nursing (DON) on 6/26/25, at 11:47 a.m. , the DON reviewed the medical records for Resident 212 and Resident 4. The DON verified that Resident 212 had active orders for liquid Lithium 8 meq/5 ml and Atorvastatin 40 mg tablets (medications that were stored in the clear plastic bin in the medication room). She also verified that Resident 4's order for Symbicort inhaler 80-4.5 mcg had been discontinued (this medication was also stored in the clear plastic bin in the medication room). The DON confirmed active and discontinued medications should not be stored together. She also confirmed medications with different routes of administration should not be stored together. The facility's policy titled Medication Storage, dated 1/2024, indicated, Medications should be stored so that various routes of administration are separated. The policy further indicated discontinued medications are immediately removed from stock and disposed of. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. During an initial tour of the facility on 6/23/25 at 9:55 a.m., one opened bottle of 1,000 ml of 0.9 % sodium chloride (NS) and small bottle of 0.9% (NS) were stored at Resident 65's bedside table unattended. During a concurrent observation and interview on 6/23/25 at 9:58 a.m., with the minimum Data Set Coordinator B (MDSC B), she confirmed the above observation and stated that the 0.9% NS bottles found was used for wound treatment and should have been stored inside the treatment cart. 3. During an initial tour of the facility on 6/23/25 at 10:15 a.m., one bottle of used 100 ml NS was stored at Resident 205's bedside table unattended. During a concurrent observation and interview on 6/23/25 at 10:17 a.m., with the MDSC B, she acknowledged the above observation and stated that 0.9% NS was used by a treatment nurse and should have been stored inside the treatment cart and not at the bedside table of the resident. The facility's policy titled Medication Storage, dated 1/2024, indicated, Medications and biologicals are stored properly to keep their integrity and to support safe,effective drug administration. The medication supply shall be accessible only to licensed nursing personnel, pharmacy personnel, or staff memebers lawfully authorized to administer medications.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observation, interview, and document review, the facility failed to ensure two of 36 sampled residents (Residents 106 and 195) received their lunch in accordance with scheduled meal times. This failure had the potential to result in reduced food palatability (quality of taste), which could negatively affect the residents' meal intake and nutritional status. Findings: During an interview with Resident 106 on 6/23/25, at 9:20 a.m., Resident 106 stated her food always came late and was cold most of the time. During an interview with Resident 195 on 6/23/25, at 9:54 a.m., Resident 195 also stated her food always came late and was cold most of the time. The facility's untitled document titled Meal Service Times was reviewed. The document indicated lunch was to be served to the residents between 11:40 a.m. and 1:00 p.m., depending on the area of the facility. During a dining observation on 6/23/25, the cart containing the lunch trays for Residents 106 and 195 arrived in their area of the facility at 1:32 p.m. Staff delivered the lunch trays for both residents at 1:34 p.m. During another dining observation on 6/25/25, the cart containing Resident 106's lunch tray arrived in her area of the facility at 1:43 p.m. Staff delivered the lunch tray to Resident 106 at 1:50 p.m. During an interview with the dietary manager (DM) on 6/25/25, at 2:01 p.m., the DM confirmed the last resident lunch tray should be delivered by 1:00 p.m. The facility's undated policy titled Resident Dining Program indicated, Lunch shall be served between 11:30 a.m. and 1:00 p.m.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 3. During an observation and concurrent interview with nurse supervisor H (NS H) on 6/23/25, at 8:55 a.m., one of the facility's medication rooms was inspected. There was a refrigerator inside this medication room, which was designated to store the residents' food. There was one pitcher of pinkish-red fluid and one unopened container of applesauce in this refrigerator. The thermometer inside this refrigerator had a temperature reading of 60 degrees Fahrenheit (F, unit of temperature measurement). NS H confirmed this observation and confirmed the temperature of the food refrigerator should be maintained between 35 and 41 degrees F. During a follow-up observation and concurrent interview with NS H on 6/23/25, at 9:03 a.m., the thermometer inside the refrigerator was checked again. At this time, the refrigerator door had been closed for eight minutes. The thermometer inside the refrigerator still had a temperature reading of 60 degrees F. NS H confirmed this observation. During another follow-up observation and concurrent interview with NS H on 6/23/25, at 9:12 a.m., the thermometer inside the refrigerator was checked again. At this time, the refrigerator door had been closed for an additional nine minutes. The thermometer inside the refrigerator still had a temperature reading of 60 degrees F. NS H confirmed this observation. The facility's document titled REFRIGERATOR TEMPERATURE LOG (FOR FOOD), dated 6/2025, indicated, Normal Temperature: 35-41 DEGREES F. The document further indicated, NOTIFY DON [director of nursing] IF TEMPERATURE IS NOT WITHIN RANGE. Based on observation, interview, and record review, the facility failed to ensure food items were labeled and stored in accordance with professional standards for food safety when: 1. Ten cups of cottage cheese that were past their use by dates, were still stored in the kitchen refrigerator; 2. A pitcher of colored fluid with no label and an open container of thickened water were found in the refrigerator inside two medication storage rooms. 3. The temperature of one refrigerator designated to store residents' foods which was located in one of the medication rooms was above the desired temperature. These failures had the potential to cause the growth of micro-organisms which could cause foodborne illness (illness resulting from contaminated food) and cross-contaminated food for the two hundred thirty-four residents who received foods from the facility kitchen. Findings: 1. During the initial kitchen tour observation on 6/23/25 at 8:10 a.m., there were ten cups of cottage cheese that had use by dates of 6/22/25 and they were all past by the date already, that were still stored in one of the kitchen refrigerators. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During the interview with the dietary manager (DM), who was assisting me with the kitchen tour observation on 6/23/25 at 8:11 a.m., the DM verified that the ten cups of cottage cheese were past their use by dates and should not be stored anymore in the kitchen refrigerator and he removed them right away. During the interview with the registered dietitian (RD), on 6/25/25 at 1:15 p.m., the RD verified that the cups of cottage cheese that were past their use by dates should not be kept in the kitchen refrigerator and should have been discarded already. RD further verified that she would follow up on this concern. Review of the undated facility's policy titled, Food Storage Principles, indicated, Proper food storage is essential for preserving food quality Discard foods that have exceeded their expiration date 2a. During a concurrent observation and interview with Minimum Data Set Coordinator (MDSC) A, on 6/23/25 at 8:26 a.m., medication storage 5 was inspected. The refrigerator inside the room, which was designated to store food for residents, contained one pitcher with brown-colored fluid with no label and a container of Lemon Flavored Thickened Water with open date of 6/19/25. The pitcher with brown-colored liquid with a date made label on the lid, indicated June 17. MDSC A stated the pitcher should be labeled and discarded after 2 days. The MDSC A stated the thickened water should be discarded 24 hours after opening. Review of the facility's Food Storage Principles policy and procedure (P&P), undated, indicated Procedure . 2. Label each package, box, can, etc. with the expiration date, date of receipt, or when the item was stored after preparation .b. Discard leftover food that have not been used within 48 hours of preparation . Review of facility's Labeling and Dating Food/Beverages in Refrigerators P&P, undated, indicated To ensure the safe storage of food and beverages in facility refrigerators by requiring proper labeling and dating in accordance with health regulations and infection control standards. All foods and beverages stored in the facility refrigerators must be clearly labeled and dated to ensure safety, prevent spoilage, and reduce the risk of foodborne illness. Review of facility's Labeling and Dating Food/Beverages in Refrigerators P&P, undated, indicated Dating & Discard Guidelines: Thickened liquids (premixed), 24 hours max shelf life after opening, after opening discard unused portion. 2b. During an observation and concurrent interview with nurse supervisor H (NS H) on 6/23/25, at 8:55 a.m., medication storage 2 was inspected. One refrigerator inside the room, which was designated to store food for residents, contained one pitcher of pinkish-red fluid. The pitcher was not labeled. NS H confirmed the pitcher was not labeled. The facility's undated policy, titled Labeling and Dating Food/Beverages in Refrigerators, indicated all food and beverages stored in facility refrigerators must be clearly labeled.

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Dispose of garbage and refuse properly. Based on observation, interview and record review, the facility failed to ensure that garbage was stored properly when two out of four outside dumpsters were overfilled of garbage, with their lids, not fully closed and plastic bags with trash were not placed in the covered dumpsters. These failures had the potential to attract insects, rodents, and other pests to the facility that could affect the two hundred thirty-eight residents residing in the facility. Findings: During the concurrent observation of the dumpster area and interview with maintenance assistant E (MA E) on 6/25/25 at 2:30 p.m., two out four dumpsters were overfilled with garbage and their lids were not completely closed. There were also plastic bags with trash that were not put in the covered dumpsters. MA E acknowledged that these dumpsters should not be overfilled with garbage and should be properly covered. MA E further acknowledged that plastic bags with trash should be put in the covered dumpsters. He then stated that he would endorse them to have the garbage picked up. During the interview with the maintenance director (MD) on 6/25/25 at 2:40 p.m., the MD also verified that the dumpsters should not be overfilled with garbage and their lids should be properly closed. The MD further verified that the plastic bags with trash should be placed in the covered dumpsters. He then stated that he would have the garbage, be picked up right away. During the interview with the director of nursing (DON) on 6/27/25 at 8:17 a.m., the DON acknowledged the above concerns and then stated that she would check on it. Review of the undated facility's policy titled, Pest Control, indicated, Keep the dumpster area clean and the lid closed The United States Food and Drug Administration's 2022 Food Code 5-501.110 indicated, Refuse (waste), recyclable and returnable shall be stored in receptacles or waste handling units so that they are inaccessible to insects and rodents. The Food Code further indicated, Outside receptacles must be constructed with tight-fitting lids or covers to prevent the scattering of the garbage or refuse by birds, the breeding of flies, or the entry of rodents.

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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** Based on observation, interview, and record review, the facility failed to ensure infection control practices were implemented when: 1.Resident 345's used and opened urinal was next to the spirometer (an apparatus for measuring the volume of air inspired and expired by the lungs- measures ventilation, the movement of air into and out of the lungs) on top of the bedside table; 1a. Resident 46's yankauer suction tube (oral suctioning tool) that was attached to suction machine was stored inside of the open clean gloves box on top of the bedside table; 1b. Resident 9's suction machine and nebulizer machine (device used to deliver medication in the form of a mist for inhalation) were covered by a used wash basin at the bedside table; 1c. Resident 128's used urinal without covering was on top of the bedside table ; 1d. Resident 330's soiled linens were on the floor; 2. Urinal full and on the floor; 3. No EBP sign on door; 3a. Treatment nurse (TN) wearing a surgical face mask below the nose during wound care for one resident and 4. Two kitchen staff were not wearing their face masks properly while preparing foods for the tray line. These failures could result in the spread of infection and cross-contamination that could affect the 238 residents who reside in the facility, staff, and visitors. Findings: 1.During an initial tour of the facility on 6/23/25 at 9:03 a.m., Resident 345's used and opened urinal was next to the spirometer on top of the bedside table. During a concurrent observation and interview on 6/23/26 at 9:04 a.m., with the assistant director of nursing (ADON), She confirmed the above observation and stated the urinal should be stored at the bedrail with cover and should not be stored next to the spirometer to prevent contamination. 1a. During an initial tour of the facility on 6/23/25 at 9:12 a.m., Resident 46's yankauer suction tube that was attached to suction machine was stored inside of the open clean gloves box on top of the bedside table. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview on 6/23/26 at 9:14 a.m., with the ADON, she confirmed the above observation and stated that the yankauer suction tube should have been detached from the suction machine and stored in a plastic bag with label to prevent contamination. 1b. During an initial tour of the facility on 6/23/25 at 9:31 a.m., Resident 9's suction machine and nebulizer machine were covered by a used wash basin at the bedside table. During a concurrent observation and interview on 6/23/26 at 9:35 a.m., with Minimum Data Set Coordinator B (MDSC B), she confirmed the above observation and stated that the suction machine and nebulizer machine should not have been covered by the used wash basin to prevent cross contamination. 1c. During an initial tour of the facility on 6/23/25 at 9:44 a.m., Resident 128's used urinal without covering was on top of the bedside table. During a concurrent observation and interview on 6/23/26 at 9:46 a.m., with MDSC B, she confirmed the above observation and stated the urinal should be stored at the bedrail with cover to prevent contamination. During a concurrent observation and interview on 6/23/26 at 9:47 a.m., with certified nursing assistant O (CNA O), he confirmed the above observation and stated the urinal should be stored at the bedrail with cover to prevent the spread of infection contamination. 1d. During an initial tour of the facility on 6/23/25 at 10:10 a.m., Resident 330's soiled linenes was on the floor. During a concurrent observation and interview on 6/23/26 at 10:14 a.m., with the ADON, she confirmed the above observation and stated that soiled linens should not have been on the floor to prevent cross contamination. Review of the undated facility's policy titled, Linen Storage indicated prevent cross-contamination by storing soiled linen in a room or area that is separate from wash areas and clean linen storage areas Store soiled linen airtight containers Store soiled linen a manner that prevents cross- contamination. 4. During the tray line (a system of food preparation or an assembly line system where individual food trays are prepared for residents) observation and concurrent interview with cook F (COOK F) on 6/25/25 at 11:20 a.m., COOK F was not wearing his face mask properly while preparing the foods for the tray line. His face mask was not covering his nose and mouth. COOK F verified that he was not wearing his face mask properly and fixed it right away. During the interview with the dietary manager (DM) on 6/25/25 at 11:21 a.m., the DM acknowledged that COOK F should wear his face mask properly while preparing foods for the tray line and would talk to him about it. During the continued tray line observation and concurrent interview with dietary aide G (DA G) on 6/25/25 at 11:35 a.m., DA G was also not wearing her face mask properly while helping with the tray line preparation. It was only covering her mouth and her nose was still exposed. DA G verified that she was not wearing her face mask properly and fixed it right away. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During the interview with the DM on 6/25/25 at 11:36 a.m., the DM also acknowledged that DA G should wear her face mask properly while helping with the tray line preparation and would also talk to her about it. During the interview with the registered dietitian (RD) on 6/25/25 at 1:15 p.m., the RD verified that kitchen staffs should wear their face masks properly, covering their nose and mouth and would remind them about it. Review of the undated facility's policy titled, COVID-19 (coronavirus disease 2019 which is a contagious disease caused by a virus called SARS-CoV-2) Using Personal Protective Equipment (PPE, equipment used to prevent or minimize exposure to hazards), indicated, Personnel working in areas with minimal to no community transmission adhere to the following infection prevention and control strategies: Employees, contracted personnel, and volunteers adhere to standard and transmission-based precautions In addition, universal use of a well-fitting face mask for source control is recommended for personnel if not otherwise wearing a respirator All personnel receive training on and demonstrate an understanding of: how to properly don, use, and doff PPE in a manner to prevent self-contamination 2. During an observation on 6/23/25, at 8:49 a.m., inside Resident 194's room, there was one full urinal, with lid closed, inside a plastic urinal holder (a plastic strap or cage that can be fastened to the resident's bed or wheelchair). There was another half-full plastic urinal, with lid closed, on the floor of Resident 194's room. During a concurrent observation and interview with certified nursing assistant N (CNA N) on 6/23/25, at 8:57 a.m., CNA N confirmed Resident 194's two urinals were not emptied, and should have been emptied. During an interview with the infection preventionist (IP) on 6/26/25 at 2:38 p.m., the IP stated urinals should be emptied to prevent the spread of infection. During a review of the facility's undated policy and procedure (P&P) titled, Bedpan or Urinal, the P&P indicated, To provide for elimination when a resident is unable to use bathroom or bedside commode. After Use of Bedpan or Urinal: 6. Empty and rinse bedpan or urinal with disinfectant . 3. Review of Resident 480's medical record indicated Resident 480 was admitted on [DATE] with diagnoses including acute cholecystitis (redness and swelling of the gallbladder [a small pear-shaped organ located under the liver in the upper right abdomen]), and viral hepatitis (infectious disease that causes liver inflammation and damage). During an observation on 6/23/25 at 8:15 a.m. in the room of Resident 480, Resident 480 was observed awake, alert and sitting on the side of the bed with a biliary drainage bag (allows the digestive fluid from the gallbladder and liver to flow out from a blocked duct) attached to a band positioned on the right leg of Resident 480. There was no enhanced barrier precaution (EBP) signage posted on the door and no personal protective equipment (PPE) outside the entrance to Resident 480's room. Review of Resident 480's Physician Order Report dated 6/13/25 indicated biliary drain on right lower abdomen: cleanse with normal saline and pat dry with dry dressing and cover it with patch dressing. Special instructions: change the dressing daily or as needed once a day. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview on 6/23/25 at 9:36 a.m. with Licensed Vocational Nurse I (LVN I), LVN I stated there should be an EBP sign posted on the door of Resident 480's room and there should be PPE at or near the door since Resident 480 has a biliary catheter. During an interview on 6/26/25 at 2:00 p.m. with the Infection Preventionist (IP), the IP confirmed there was no EBP signage posted at the entry to Resident 480's room and no PPE. The IP stated there should be an EBP sign and PPE outside the room of Resident 480 because Resident 480 has a biliary catheter to prevent the spread of infection. Review of the facility's policy and procedure titled, Enhanced Barrier Precautions, undated indicated, EBP are indicated for residents with any of the following: .b. Wounds and/or indwelling devices even if the resident is not known to be infected . 6. For residents for whom EBP are indicated, EBP shall also be used when performing the following high-contact resident care activities: Dressing, Bathing/showering, Transferring, Providing hygiene, Changing linens, Changing briefs or assisting with toileting, Device care or use, e.g., central line, urinary catheter, feeding tube, tracheostomy/ventilator, Wound care, e.g., any skin opening requiring a dressing . 10 .EBP shall be in place for the duration of a resident's stay in the facility or until resolution of the wound or discontinuation of the indwelling medical device that placed the resident at high risk. 3a. During a concurrent observation and interview on 6/26/25 at 9:49 a.m., with the treatment nurse (TN), the TN was observed wearing a surgical face mask below the nose during wound care for Resident 35. The TN confirmed the face mask was not covering TN's nose during wound care. The TN adjusted the mask to cover the nose. The TN stated the facial surgical mask should have covered both nose and mouth for infection control. During an interview on 6/26/25 at 10:50 a.m., with the Director of Nursing (DON), the DON stated all personal protective equipment should be worn properly and the surgical face mask should be worn covering both the nose and mouth for infection prevention and control. Review of the facility's policy and procedure titled, COVID-19 Using Personal Protective Equipment (PPE), undated indicated, 1. a. Employees . adhere to standard and transmission-based precautions based on anticipated exposures and suspected or confirmed diagnoses. B. In addition, universal use of a well-fitting facemask for source control is recommended for personnel . 2. Personnel working in facilities . adhere to the following infection prevention and control strategies: c. One of the following is worn for source control while in the facility and for protection during resident care encounters: (3) A well-fitting facemask, for example: a) selection of a facemask with a nose wire to help the facemask conform to the face.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. Based on observation, interview and record review, the facility failed to ensure a safe and sanitary environment when the floors in the dishwashing area of the kitchen were very wet and there was no safety sign in the area. These failures could affect the health and safety of kitchen staffs and individuals that might go inside the kitchen. Findings: During the initial kitchen tour observation with dietary manager (DM) on 6/23/25 at 8:16 a.m., the floors in the dishwashing area were very wet with water and there was no caution sign around to warn staffs and individuals that might go inside the kitchen and into the dishwashing area. During the interview with DM on 6/23/25 at 8:17 a.m., DM acknowledged that the floors in the dishwashing area were very wet with water. DM further acknowledged that he would put a warning sign right away to keep dietary staff safe. During the interview with the registered dietitian (RD) on 6//25/25 at 1:15 p.m., RD verified that kitchen areas including dishwashing areas should be kept safe at all times. RD further verified that there should be signage for wet floors to warn staffs for safety. Review of the facility's undated policy titled, Kitchen Safety, indicated, Purpose: To establish and maintain a safe working environment in the dietary department and kitchen area by ensuring adherence to sanitation, equipment use, fire safety and injury prevention practices. This protects staff, residents, and visitors from harm and complies with state and federal regulations. All dietary and kitchen staff must follow established safety guidelines at all times while in the food service area Registered Dietitian: Ensures kitchen sanitation, food service, and compliance with safety procedures during scheduled visits. Dietary Manager: Ensures staff training, implementation, and compliance with kitchen safety procedures Keep walkways clear; promptly clean spills using Wet Floor signs

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F 0945 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Include as part of its infection prevention and control program, mandatory training that includes written standards, policies, and procedures for the program. Based on interview and record review, the facility failed to maintain an effective infection control training program for laundry staff regarding routine cleaning of dryer lint. The facility's documentation indicated laundry staff did not clean the dryer lint for several hours on multiple days. This failure had the potential to compromise the health and safety of the residents in the facility. Findings: During a record review on 6/26/25, at 1:08 p.m., the facility's laundry lint cleaning log was inspected. The laundry lint cleaning log was left blank from 2:00 p.m. to 8:00 p.m. on 4/11/25, 4/12/25, 4/21/25, 4/29/25, 4/30/25, 5/12/25, 5/14/25, 5/16/25, 5/17/25, 5/28/25, and 6/21/25. During an interview and concurrent record review with the housekeeping supervisor (HS) on 6/26/25, at 1:19 p.m., the HS reviewed the facility's laundry lint cleaning log and confirmed it was left blank on the above dates and times. The HS explained that the documentation on this log was proof that staff cleaned the laundry lint. During an interview with the infection preventionist (IP) on 6/27/25, at 10:48 a.m., the IP stated laundry staff needed to check the laundry lint and document on the cleaning log every hour. During a review of the facility's undated policy and procedure (P&P) titled, Laundry Area Practices, the P&P indicated, To conduct laundry operations in a clean, safe environment. Cleaning Schedule: Establish a schedule to keep the laundry area clean. Modify as necessary, to comply with Company and/or state specific requirements. CAUTION: Clean the dryer lint traps after each load! Place a checkmark in the appropriate column to establish a cleaning schedule.