STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055322	A. Building B. Wing	03/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Pavilion at Ocean Point	3202 Duke Street San Diego, CA 92110

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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 0692 Level of Harm - Actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to monitor intake, initiate weekly weights and implement timely interventions to address significant weight loss for 1 of 3 residents (116) reviewed for nutritional status.This failure resulted in a significant decline in Resident 116's weight from 141.8 pounds (lbs.) in December 2025 to 112.6 lbs. by February 2026.Findings:Resident 116 was admitted to the facility on [DATE] with a diagnosis of dysphagia (difficulty swallowing) and major depression per the facility admission record.Facility weight records indicated Resident 116 weighed 153.8 pounds (lbs.) on 7/27/25.The nutritional risk assessment (NRA), dated 7/31/25, indicated a goal weight range (GWR) of 145 to 165 lbs. and recommended a regular diet with mechanical soft texture and standard portions.Facility weight records indicated Resident 116 weighed 156.4 lbs. on 9/1/25 and 148.8lbs on 10/6/25.The NRA, dated 10/9/25, indicated registered dietitian (RD) 1 reviewed Resident 116's recent weight measurements and identified a 7.6 lb. weight loss over approximately one month, calculated as 4.9% of the resident's body weight. The RD noted the weight loss was just below the 5 percent threshold for significant weight loss and was potentially related to inadequate energy intake. The RD recommended increasing the meal portion size to large to prevent further fluctuation. The NRA did not recommend initiating weekly weights.Physician's orders, active as of 12/1/25, indicated Resident 116's order had been updated to minced and moist, but the portion size remained a regular standard portion.Facility weight records indicated Resident 116 weighed 141.8 lbs. on 12/1/25.The change of condition (COC) report, dated 12/5/25, indicated licensed nurse (LN) 3 documented Resident 116 experienced significant weight loss of 14.6 lbs. over the previous three months.A record review indicated the facility did not complete a NRA for Resident 116 in November 2025 or December 2025.Resident 116's Nutrition - Amount Eaten flow sheet for December 2025 indicated staff did not document intake for 16 meals and documented less than 50% intake for 38 meals.Physician's orders, active as of 1/1/26, indicated Resident 116 continued to have an active diet order of minced and moist with standard portion size.Facility weight records indicated Resident 116 weighed 127.2 lbs. on 1/6/26.The NRA, dated 1/13/26, indicated RD 1 reviewed Resident 116's weight history and documented continued weight decline as follows:1. One month weight loss: 127.2 lbs. on 1/6/26 compared to 141.8 lbs. on 12/1/25 (-10.3% weight loss).2. Three-month weight loss: 127.2 lbs. on 1/6/26 compared to 148.8 lbs. on 10/13/25 (14.5% weight loss).3. Six-month weight loss: 127.2 lbs. on 1/6/26 compared to 153.8 lbs. on 7/27/25 (17.3% weight loss).RD 1 documented the continued weight loss was likely due to inadequate intake related to decreased ability to consume sufficient energy. The RD noted Resident 116 was no longer attending meals in the dining room and there was a noticeable decrease in intake. The RD documented Resident 116 would benefit from assistance and encouragement with meals. The RD recommended one magic cup daily at lunch and a fortified diet. The NRA did not recommend starting weekly weights.Resident 116's Nutrition - Amount Eaten flow sheet for January 2026 indicated staff did not document intake for nine meals, 50 meals were documented with less than 50 percent of the meal consumed, and two meals were documented as refused.Physician's orders, active as of 2/1/26, indicated there were no orders for weekly weights.Facility weight records indicated Resident 116 weighed 119.4 lbs. on 2/2/26.The NRA, dated (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 0692 Level of Harm - Actual harm Residents Affected - Few	2/5/26, indicated the RD 1 reviewed Resident 116's last weight of 119.4 lbs. on 2/2/26 and recommended weekly weights be implemented.Facility weight records indicated the next documented weight of 112.6 lbs. was obtained on 2/19/26.Interdisciplinary team (IDT) meeting notes indicated, the first documented IDT team meeting notes addressing Resident 116's weight loss occurred on 2/6/26.The care plan addressing Resident 116's nutritional status, initiated on 8/1/25, indicated the resident had a nutritional problem or potential nutritional problem related to multiple medical conditions including dysphagia and major depressive disorder (MDD). The care plan established goals for the resident to maintain oral intake at 75% of most meals and maintain weight within the goal weight range without unintended weight change.The care plan directed staff to weigh Resident 116 at the same time of day monthly and as needed (PRN). The intervention for monthly weight monitoring was initiated on 10/20/25 and last revised on 10/23/25.The care plan directed staff to provide and serve the diet as ordered. This intervention was initiated on 10/20/25 and was not revised to reflect the fortified diet order until 2/24/26.The care plan did not include an intervention directing staff to monitor or document Resident 116's oral intake or provide staff assistance or supervision during meals.During an interview and record review on 2/24/26 at 11:17 A.M., Certified Nursing Assistant (CNA) 1 stated she was assigned to care for Resident 116. CNA 1 stated the facility did not have dedicatedfeeding assistants and that CNAs or restorative nursing assistants (RNAs) supervised and assisted residents with meals as needed. Review of the daily assignment sheet with CNA 1 indicated Resident 116 was not listed as requiring feeding assistance. CNA 1 stated Resident 116 did not eat much of her breakfast that day.Resident 116's Nutrition - Amount Eaten flow sheet entry for 8 A.M. on 2/24/26 indicated CNA 1 documented Resident 116 ate 0-25% of the breakfast meal.During an observation on 2/24/26 at 1:03 P.M., Resident 116 was lying in bed with a lunch tray placed in front of her. The meal on her plate appeared partially eaten with only a few bites consumed. No staff were observed in the room assisting Resident 116 with the meal at the time of the observation.Resident 116's Nutrition - Amount Eaten flow sheet entry for 12 PM on 2/24/26 indicated CNA 1 documented Resident 116 ate 0-25% of the lunch meal.The Nutrition - Amount Eaten flow sheet indicated staff did not document meal intake entries for 8 A.M. and 12 P.M. on 2/25/26.During an interview on 02/26/2026 at 12:05 PM Resident 116 stated she had eaten a little of her breakfast meal that morning but did not provide additional information regarding her food intake.During an interview on 2/26/26 at 12:12 PM, CNA 2 stated Resident 116 did not eat much and had just been placed on the feeding assistant list that day. CNA 2 stated staff were required to document the percentage of food consumed for every meal in the electronic health record. CNA 2 stated Resident 116 had eaten about 25% of her breakfast. During an interview on 2/26/26 at 4:30 P.M., licensed nurse (LN) 1 stated she was serving as the charge nurse and familiar with Resident 116's care. LN 1 stated Resident 116 did not have problems eating and was not on the list of residents requiring supervised or assisted eating.During an observation and interview on 2/27/26 at 9:39 A.M., CNA 3 stated CNAs are required to chart amount of each meal eaten in the EHR. CNA 3 demonstrated how to enter meal percentage eaten into the EHR. CNA 3 stated if a resident continues to have below 50% meal intake the nurse should be notified.During an interview on 2/27/26 at 9:48 A.M., LN 2 stated CNAs are required to chart the percentage of each meal eaten in nutritional task in the EHR and notify the nurse of any refused meals. LN 2 stated it is important CNA's chart every meal to make sure the facility stays on top of residents at risk for weight loss. LN 2 stated if a Resident ate less than 25% of any meal the nurse should be notified to ensure weight is monitored.During an interview and record review on 2/27/26 at 9:58 A.M., Registered Dietician (RD) 2 stated residents with weight variances should be discussed in weekly interdisciplinary team (IDT) weight meetings and that Certified Nursing Assistants (CNAs) were expected to document the percentage of food consumed for each meal in the EHR flowsheet for nutrition intake. RD 2 stated oral intake documentation and resident weights were objective measures used to evaluate nutritional status and determine the need for dietary interventions. RD 2 stated significant weight loss was defined as 5% loss in one month, 7.5% loss in three months, and 10 percent (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	loss in six months. RD 2 stated if significant weight loss was identified it should trigger weekly weight monitoring and an IDT review.During a review of Resident 116's NRAs, intake documentation, and weight records, RD 2 stated nursing documented a change of condition for significant weight loss on 12/5/25 but a nutritional assessment was not completed until a month later on 1/6/26. RD2 acknowledged meal intake documentation contained multiple entries of less than 50% intake and had multiple missing entries. RD 2 acknowledged an NRA should have been completed following the identification of a significant weight loss.RD 2 stated weekly weight monitoring should have been initiated when the significant weight loss was first identified, and acknowledged weekly weights were not recommended until the NRA on 2/5/26 and were not obtained until two weeks later on 2/19/26.RD 2 stated when staff did not document meal intake the facility could not determine whether nutritional interventions were effective. RD 2 stated weekly weight monitoring and meal intake documentation were important data to identify continued weight loss and implement timely interventions.During an interview and record review on 2/27/26 at 2:06 P.M., the Director of Nursing (DON) and the Assistant Director of Nursing (ADON) stated residents were weighed monthly and that weight variances of 5% or 5 lbs loss in one month, 7.5% loss in three months, 10% loss in six months, or a 2% loss in one week required nursing to complete a COC report and notify the RD.The DON and ADON stated CNAs were required to document the percentage of food consumed for each meal in the EHR flow sheets and report meals with intake below 50% to the nurse. The DON and ADON stated nursing should review intake documentation and follow up when intake was low or documentation was missing. The DON and ADON further stated significant weight loss should trigger weekly weight monitoring, weekly IDT weight meetings, and care plans should be updated based on interventions discussed during IDT review.During the record review of Resident 116's chart, the DON stated the significant weight loss documented in the nurses COC on 12/5/26 should have triggered weekly weight monitoring. The DON further stated the continued significant weight loss identified on 1/6/26 in the NRA should also have triggered weekly weights, an IDT review, and updated care plan interventions reflecting IDT recommendations.A review of the facility policy, titled, Evaluation of Weight and Nutritional Status, revised 1/30/25, indicated, .Policy: 1. The facility will maintain an acceptable nutritional status for residents per professional standards by:. b. Analyzing the assessment information to identify the medical conditions, causes and/or problems. c. Implementing interventions for maintaining or improving nutritional status. e. Monitoring and evaluating the resident's response, or lack of response to interventions. Clinical Evaluation:. b. Any resident weight that varies from the previous reporting period by 5% in 30 days, 7.5% in 90 days, 10% in 180 days. will be evaluated by the IDT to determine the cause of the weight loss/gain and the interventions required. Once weight gain or loss as describe above is identified, the IDT will: 1. Identify and implement appropriate interventions; 2. Update and revise the Care Plan. d. Any resident meeting the criteria for physician prescribed weight loss and any resident at risk for weight loss or gain will be weighed and documented weekly. Weekly weights will be reviewed by the IDT. Resident's at risk who should be weighed weekly include. 2. Significant weight loss or gain identified in a 30, 90, 180-day period. Monthly evaluation will continue for all residents.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. Based on interview and record review, the facility failed to ensure that sufficient staff were available to provide care and services to the residents in a timely manner. As a result, there was a delay in the staff's ability to provide care and services to the resident.Findings:Per the PBJ Staffing Data Report CASPER Report 1705D FY Quarter 4 2025 (July 1 -September 30), the report indicated the facility had a one star staffing rating and excessively low weekend staffing.During an interview on 2/25/2026 at 10:00 A.M. with Resident 13, Resident 13 stated there are times when I wait a long time for help, but I can do most things on my own. So that's good. Others can't, I feel bad for them when they have to wait. I get frustrated when I have to wait .During an interview on 2/25/2026 at 10:10 A.M. with Resident 11, Resident 11 stated that he has had to wait for help and he feels bad.I wish I didn't have to rely on the nurses, but I do. I think nights and weekends are when I wait the longest.During an interview on 2/26/2026 at 2:24 P.M. with Certified Nursing Assistant 31(CNA31), CNA31 stated we need more care staff, we are often short of CNAs and that impacts resident care, they may not get the help they need or have to wait a long time.During an interview on 2/26/2026 at 2:32 P.M. with Licensed Nurse 31 (LN31), LN31 stated We need more staff .well, nurses for all shifts and all days, not just the weekends. Resident care is definitely impacted, mainly by delays in care.During an interview on 3/2/2026 at 9:00 A.M. with Housekeeper 1 (HSK1), HSK1 stated .This weekend was bad, but the CNAs work hard. But I think they need more. Especially on the weekends .During an interview on 3/2/2026 at 9:55 A.M. with Housekeeper 2 (HSK2), HSK2 stated .I do work on Saturdays. They can definitely use more staff. On the weekends, I do not know about the night shift.During an interview on 3/2/2026 at 11:30 A.M. with the Director of Nursing (DON), the DON stated I am aware of the staffing issues. The facility had been using registry a lot. The data comes from PBJ, we are working on improving it.

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a plan that describes the process for conducting QAPI and QAA activities. Based on interview and record review the facility's Quality Assessment and Assurance Committee (QAA-facility group that monitors concerning trends in a facility) failed to identify areas of improvement and include in the facility's Quality Assurance Performance Improvement plan (QAPI-plan developed by QAA to help improve conditions in the facility), the facility's staffing needs identified during the facility's recertification survey and in the Payroll-Based Journal (PBJ- a mandatory , electronic reporting system which tracked hours worked, staff turnover, tenure and census data for long-term care facilities).Cross reference F725 This failure had the potential to affect resident care.Findings: During a review of the facility's PBJ Staffing Data Report, Quarter four 2025 (July 1- September 30), the PBJ indicated, Excessively Low Weekend Staffing. A QAPI meeting on 3/2/26 at 12:09 P.M. was conducted with the facility's Administrator, Director of Nursing (DON), Assistant Director of Nursing (ADON), and a charge nurse. The DON stated the areas of concern identified by the QAA committee included call light response, falls, skin/wounds, infection control, weight loss/nutrition, hygiene care, change in condition and care conference scheduling. The DON stated staffing has not been addressed by QAA committee. The Administrator stated it was important to address areas of concern in the QAPI meeting because those areas affect resident safety and well-being. A review of the facility's policy and procedure (P&P) titled, Quality Assurance and Performance Improvement [QAPI] Program, revised on 3/28/24 was conducted. The P&P indicated, The facility implements and maintains an ongoing, facility-wide Quality Assurance and Performance Improvement [QAPI] Program designed to monitor and evaluate the quality of resident care, pursue methods to improve quality of care, and resolve identified issues.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to use professional nursing standards using when licensed nurse (LN) 23 did not administer Resident 10's medication via gastronomy tube (G-tube - a soft, flexible tube placed directly into the stomach through a small opening in the belly) by gravity (a technique where liquid medication is allowed to flow solely by the force of gravity and not by a syringe plunger or a pump).This failure had the potential to increase the risk of tube clogging, dislodgement, and medication reflux for Resident 10. Per the admission record, Resident 10's was admitted to the facility on [DATE] with diagnoses that included gastrostomy status (means a person has a G-tube placed directly into their stomach through the skin of the belly, creating a permanent or temporary opening for feeding, fluids, and medicine). On 2/26/26 at 8:30 A.M., an observation and interview were conducted with LN 23 during a medication administration observation. LN 23 administered the following medications to Resident 10 via G-tube: -Aspirin 162mg [medication for stroke prophylaxis (steps to prevent a stroke before it happens)-Bupropion HCL 50mg (medication to treat depression)LN 23 was observed to administer the medications by flushing with a syringe plunger. On 2/27/26 at 9:00 A.M., an interview was conducted with LN 23. LN 23 stated he did use gravity when administering medications to Resident 10 because the G-tube has issues when administering via gravity. LN 23 stated there was not a doctor's order but there should have been for flushing medications with a syringe. On 3/2/26 at 9:00 A.M., an interview was conducted with the director of nursing (DON). The DON stated it was her expectation that nurses are to follow professional nursing standards and doctor's orders when administering medications. A review of the facility policy titled Feeding Tube - Administration of Medication, dated 6/12/24, indicated that nursing staff are to .administer medications by syringe via gravity into the feeding tube.A review of the facility policy titled Medication - Administration, dated 8/19/25, indicated that All medications shall be administered by licensed nursing staff according to physician orders, current best practices and federal and state regulations.

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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** Based on observation, interview and record review, the facility failed to assess, care plan, and implement interventions to address severe hair matting and hygiene refusals for 1 of 2 sampled residents (116).This failure resulted in Resident 116 having severely matted hair with scalp irritation and had the potential to result in further skin breakdown and infection. Resident 116 was admitted to the facility on [DATE] with a diagnosis of anxiety and major depression per the facility admission record.During an observation and interview on 2/24/26 at 10:12 A.M., Resident 116 was observed sitting up in bed. The resident's gray hair was tightly matted across the top and back of the scalp. Yellow crusted material and flaking were present on the right forehead at the hairline. Skin discoloration and red splotching were present on the right and left cheeks.During the interview, Resident 116 stated, What do you mean? when the condition of the resident's hair was discussed. The resident then stated, Is there something wrong with my hair? Resident 116 patted the top of her head, removed a large [NAME] pin and adjusted the matted hair before replacing the pin. After adjusting the hair, Resident 116 stated, Does it look OK? Review of the nursing clinical admission assessment, dated 7/24/25 indicated Resident 116 underwent a :comprehensive nursing assessment upon admission. The assessment did not document matted hair, scalp irritation, or other concerns related to the residents' hair or scalp condition. Review of the history and physical (H&P) examination, dated 7/25/25, indicated Resident 116 was admitted to the facility from the hospital for rehabilitation following a urinary tract infection due to suspected elder neglect. The physical examination did not document matted hair, scalp irritation, or concerns related to hair hygiene. Review of the initial psychiatric evaluation, dated 7/31/25, indicated the resident appeared well-groomed with mild distress related to anxiety and low mood. The evaluation did not document matted hair or scalp irritation.During an interview on 2/26/26 at 12:12 P.M., certified nursing assistant (CNA) 2 stated Resident 116 had matted hair. CNA 2 stated Resident 116 did not allow staff to brush her hair. CNA 2 stated staff attempted to address the resident's hair during showers. CNA 2 stated attempts to brush the resident's hair were not documented.During an interview on 2/26/26 at 12:24 P.M., certified nursing assistant (CNA) 3 stated Resident 116 frequently refused showers and did not like to get her hair wet. CNA 3 stated the resident often declined hair care. CNA 3 stated the facility did not have specific interventions in place to address the resident's hair matting. CNA 3 stated refusals of showers and hair care were documented on the shower sheets. Record review of shower sheets and electronic flow charts for bathing from December 2025 through January 2026 was conducted. Resident 116 was scheduled to receive showers twice weekly on Tuesdays and Fridays. The December 2025 shower and bathing records indicated Resident 116 was scheduled to receive nine showers during the month. Shower sheets and electronic flowsheets for bathing indicated Resident 116 refused showers six times (12/2, 12/5, 12/9, 12/12, 12/16, 12/23). Neither the shower sheets nor the electronic flowsheets indicated refusals of hair care or attempts to address the resident's matted hair. The January 2026 shower and bathing records indicated Resident 116 was available at the facility for eight scheduled showers during the month. Shower sheets and electronic flowsheets for bathing indicated Resident 116 refused showers five times (1/2, 1/9, 1/13, 1/23, 1/27). Neither the shower sheets nor the electronic flowsheets indicated refusals of hair care or attempts to address the resident's matted hair.During an interview and record review on 2/26/26 at 4:30 P.M., Licensed Nurse (LN) 1 stated Resident 116 had matted hair since she was admitted to the facility the previous year on 7/24/25. LN 1 stated the resident would not allow staff to brush her hair. Review of Resident 116's progress notes with LN 1 indicated the only documentation referencing the resident's hair or scalp condition was in a skin check note, dated 2/19/26, that indicated the resident's hair was extremely matted with dry flaked areas to top of head. LN 1 acknowledged no other documentation of matted hair was in Resident 116's health record. LN 1 stated if Resident 116 refused a shower and (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	hair care, the refusal should be documented and the clinical team should be informed.Review of Resident 116's care plans with LN 1 indicated the only care plan addressing hair care was initiated on 2/26/26. LN 1 acknowledged Resident 116 did not have a care plan in place prior to that day. LN 1 stated Resident 116's hair matting had been an ongoing issue since admission on [DATE] and a care plan should have been implemented prior to 2/26/26.Review of physician orders, active 2/1/26, did not identify orders related to hair care or treatment of the resident's scalp condition. Review of the care plan, initiated on 8/1/25, indicated Resident 116 had a problem of activities of daily living (ADL) self-care performance deficit related to multiple diagnoses including, major depressive disorder (MDD) and anxiety. The care plan did not include interventions related to hair care or management of hygiene refusals.During an interview on 2/27/26 at 2:16 P.M., with the Director of Nursing (DON) and the Assistant Director of Nursing (ADON), the DON and ADON stated Resident 116 did not want staff to touch her hair and was sensitive about how her hair was styled. The DON and ADON stated Resident 116's matted hair had been a long-standing issue known to the facility. The DON and ADON acknowledged the facility did not have a care plan in place prior to 2/26/26 to address the resident's matted hair. The DON and ADON stated when the facility identifies a problem with resident care needs the issue should be care planned and appropriate interventions implemented and monitored.The facility did not provide a policy regarding monitoring activities of daily living upon request.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide necessary care and services in accordance with professional standards of practice when: 1. Insulin injection sites were not rotated for two of six residents (Resident 7 and Resident 16), 2. The facility failed to reassess the vital signs of one of eight sampled residents (Resident 126). This deficient practice had the potential for residents to develop complications such as hardened, scarred skin and unpredictable insulin absorption. In addition, this failure had the potential for Resident 126's condition to decline without proper interventions. Findings: 1a. Resident 16 was admitted to the facility on [DATE] with diagnoses including type 2 diabetes mellitus with hyperglycemia (high blood sugar levels) according to the facility's admission Record. During an observation and interview on [DATE] at 8:05 A.M., Resident 16 was sitting up in a wheelchair in his room. Resident 16 stated the facility staff administered insulin (medication that helps regulate blood sugar levels) for him. An interview and joint record review on [DATE] at 10:26 A.M. was conducted with Licensed Nurse (LN) 11. LN 11 reviewed the February 2026 Medication Administration Record (MAR) in Resident 16's electronic health record (EHR). LN 11 stated Resident 16 had been receiving insulin glargine (a long-acting insulin). LN 11 stated the injection sites on Resident 16 were not rotated. The MAR indicated insulin gargline was administered to Resident 16 on the following sites: [DATE] at 12 P.M.- right arm [DATE] at 12 P.M.- right arm [DATE] at 11:54 A.M.- abdomen-left upper quadrant [DATE] at 12:59 P.M.- abdomen-left upper quadrant [DATE] at 12 P.M.- left arm [DATE] at 12:43 P.M.- left arm [DATE] at 12:42 P.M.- abdomen-left lower quadrant [DATE] at 2:20 P.M.- abdomen-left lower quadrant [DATE] at12:29 P.M.- left arm [DATE] at 12:14 P.M.- left arm [DATE] at 11:58 A.M.- left arm 1b. Resident 7 was admitted to the facility on [DATE] with diagnoses including type 2 diabetes mellitus (a long-term condition in which the body has trouble controlling blood sugar) and muscle (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	weakness according to the facility's admission Record. During an observation and interview on [DATE] at 10:19 A.M., Resident 7 stated she was on insulin and the nurses administered the injection for her. During a review on [DATE] at 2:52 P.M. of physician's orders (PO) in the electronic health record (EHR) for Resident 7, the PO indicated, Insulin Lispro [a fast acting insulin] Inject as per sliding scale [method of insulin administration where the dose is base on the pre-meal blood sugar result] and Insulin Glargine.inject 10 unit subcutaneously [fatty tissue, just under the skin] at bedtime for diabetes rotate sites. An interview and joint record review on [DATE] at 10:37 A.M. was conducted with Licensed Nurse (LN) 11. LN 11 reviewed the February 2026 Medication Administration Record (MAR) in Resident 7's EHR. LN 11 stated Resident 7 had been receiving insulins. The MAR indicated insulin gargline was administered to Resident 7 on the following sites: [DATE] at 9:04 P.M. - right arm [DATE] at 9:25 P.M. - right arm [DATE] at 9:50 P.M. - Abdomen-RUQ (right upper quadrant) [DATE] at 10:03 P.M. -Abdomen-RUQ [DATE] at 8:45 P.M. - left arm [DATE] at 9:25 P.M. - left arm [DATE] at 9:38 P.M. - rear upper arm [DATE] at 9:29 P.M. - rear upper arm The MAR indicated insulin lispro was administered to Resident 7 on: [DATE] at 6:35 A.M. – right arm [DATE] at 8:08 A.M. – right arm [DATE] at 12:57 P.M. – right arm [DATE] at 5:26 P.M. – right arm LN 11 stated insulin injection sites should be rotated to prevent bruising or hardening of the skin. An interview on [DATE] at 10:15 A.M. was conducted with the facility's consultant pharmacist (CP). The CP stated he reviewed residents' MARs monthly to check if medications were administered but did not check the rotation injection sites for insulin. The CP stated it was standard of practice to rotate sites because redness and skin discoloration can occur if sites were not rotated. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview on [DATE] at 2:59 P.M was conducted with the Director of Nurses (DON). The DON stated insulin injection sites should be rotated to prevent side effects, tissue damage and allow sites a chance to heal. A review of the facility's policy and procedure (P&P) titled, Medication Administration, with revision date of [DATE] was reviewed. The P&P indicated, All medications shall be administered by licensed nursing staff according to physician orders, current best practices, and federal and stated regulations. During a review of the facility's P&P titled, Diabetic Care, revised on [DATE], the P&P indicated, The Facility will provide the necessary care and services to permit each diabetic resident to attain or maintain optimal well-being while monitoring their care in accordance with their individualized Comprehensive Assessment and Care Plan. The P&P did not address guidance regarding rotation of insulin administration sites. 2.Per the facility's admission record, Resident 126 was admitted on [DATE] with a diagnosis of metabolic encephalopathy (a brain dysfunction caused by an illness, such as diabetes, liver failure, or kidney disease, rather than structural brain damage). Resident 126 died at the facility on [DATE]. During an interview on [DATE] at 2:24 P.M. with Certified Nursing Assistant 31(CNA31), CNA31 stated I take the resident vitals. There is a normal range and if something was out of that range, we would tell the med nurse and the charge nurse. CNA31 further stated .for temperature below 97 or above 101 we will tell the nurses. If we did not tell the nurses something bad could happen to the resident. During an interview on [DATE] at 2:32 P.M. with Licensed Nurse 31 (LN31), LN31 stated The CNAs take the resident vitals. There are normal ranges for each one. If they have a reading out of range, the expectation is that they would retake the vital and if still out of range they would tell me and the medication nurse. LN31 continued If an out of range vital was recorded and not addressed, the resident could be really sick and we would not know. During a concurrent interview and record review on [DATE] at 11:35 A.M. with the Director of Nursing (DON), Resident 126's recorded vital signs were reviewed. The record indicated that on [DATE] at 5:22 p.m. Resident 126's temperature was 72 degrees Fahrenheit and that this temperature was taken orally. The record further indicates that on [DATE] at 12:13 a.m. resident 126's temperature was again 72 degrees Fahrenheit and that this temperature was a tympanic (through the ear) temperature. The DON stated If a vital sign is out of normal range, the measurement should be repeated, if it remains out of range then it needs to be reported and a change of condition initiated. The DON continued .for this case, I would expect this to have been re-evaluated at the early reading. The expectations are not being met here. During a review of the facility's policy and procedure titled Obtaining Vital Signs date [DATE], the policy indicated that vital signs are .clinical measurements that indicate the state of a resident's basic body functions. and .Vital signs will be taken . F. When there is a change in the resident's condition.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to assess, document, and implement interventions to address contractures affecting the left index and left little fingers for 1 of 2 residents (17) reviewed for mobility limitations.This failure had the potential to result in worsening contractures decreased functional use of Resident 17's left hand.Resident 17 was admitted to the facility on [DATE] with a diagnosis Parkinson's disease (progressive movement disorder of nervous system that causes stiffness and tremors) per the facility admission record.During an observation and interview on 2/24/26 at 11:27 A.M., Resident 17 was observed seated in a wheelchair, propelling down the hallway with his feet. The resident's right hand appeared severely contracted at the wrist. The resident's left index finger and left little finger appeared contracted and positioned in flexion (condition of being bent). The resident was unable to provide additional information regarding the condition of his hands upon questioning. Review of history and physical (H&P) note, dated 2/5/19, indicated Resident 17 had bilateral hand contractions. Review of nurse practitioner progress note dated 11/12/20, reconfirmed Resident 17 had bilateral hand contractures. Review of physician progress note, dated 10/25/21, indicated Resident 17 had a contracture of the right hand and a small contracture of the left fingers. During an observation and interview on 2/26/26 at 10:29 A.M., certified nursing assistant (CNA) 4 stated Resident 17 was supposed to have a hand splint for his right-hand contracture but was not aware of anything for the residents left hand. CNA 4 stated restorative nursing assistants (RNA) were responsible for putting the splint on the resident's right hand.During an interview on 2/26/26 at 10:43 A.M., restorative nursing assistants (RNA) 1 and 2, stated Resident 17 wore a splint on his right arm daily and performed sit-to-stand style exercises for balance five days a week. RNA 1 and 2, stated the resident had no ordered RNA interventions for the left hand. Review of the physician orders, active 3/1/26, indicated Resident 17 had orders for passive range of motion (ROM) exercises for the RUE with splint and sit to stand exercises for balance. There were no active orders for ROM exercises to the left hand or fingers. During an interview on 2/26/26 at 10:52 A.M., Occupational Therapist (OT) 1 stated Resident 17 had functional limitations and wore a splint on the right hand while continuing active range of motion exercises. OT 1 stated she was not aware of contractures affecting the left-hand fingers.During a subsequent observation and interview on 2/26/26 at 11:02 A.M., with OT 1, Resident 17's left index finger and left little finger appeared contracted. OT 1 sated the resident's fingers had been positioned that way previously and did not consider the condition to be a contracture.An OT evaluation dated 10/20/25 indicated Resident 17 had limitations related to a RUE contracture but did not identify contractures affecting the left-hand fingers. During an observation, interview and record review on 3/2/26 at 11:46 A.M., the Director of Rehabilitation (DOR) attempted to have Resident 17 extend fingers on the left hand. Resident 17 was unable to extend his fingers upon request. The DOR attempted passive range of motion on the left-hand fingers and was unable to fully extend the resident's left index finger and left little finger. The DOR stated Resident 17's left index and little finger should be documented and assessed as contractures and the resident should receive stretching and range of motion (ROM) exercises to prevent worsening of the contractures.Review of Resident 17's care plan with the DOR indicated interventions addressing RNA sit to stand exercises and right wrist flexion contracture ROM exercises, including splinting. The care plan did not include goals or interventions addressing contractures of the left index or left little finger.During an interview on 3/2/26 at 3:55 P.M., the Director of Nursing (DON) stated if a contracture is identified it should be documented and referred to the DOR for assessment and preventative exercises. DON stated it is important to identify and treat early to make sure the contracture does not worsen. DON stated all contractures should be monitored and reassessed. A review of the facility policy titled, Rehab Rounding and Screening, revised (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	8/28/25, indicated, POLICY: To identify residents with potential functional changes and allow those residents to receive therapy services if possible functional declines or improvements are present and skilled services are required. PURPOSE: To ensure timely identification of residents experiencing possible functional changes whether decline or improvement, to facilitate appropriate assessment and provision of skilled therapy services as clinically indicated.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure one of one resident (Resident 15) reviewed for dialysis (the process of removing toxic substances from the blood via machine when a person's kidneys no long function adequately) care, received care and treatment that followed the physician's orders and/or the residents' plan of care when fluid restriction was not followed. This deficient practice placed Resident 15 at risk for fluid overload (excessive accumulation of fluid in the body's tissues) which may cause shortness of breath, swelling, rapid weight gain, high blood pressure, fatigue and heart failure.Findings: Resident 15 was re-admitted to the facility on [DATE] with diagnoses including end stage renal [kidney] disease and dependence on renal dialysis (process of removing excess water and toxins from the blood in people whose kidneys can no longer perform these functions naturally). During an observation and interview on 2/25/26 at 9:06 A.M. with Resident 15, Resident 15 was in bed with a blanket covered up to his head. Resident 15 stated he went for dialysis treatments but did not know the schedule. An interview on 2/26/26 at 8:15 A.M. was conducted with Certified Nurse Assistant (CNA) 14. CNA 14 stated Resident 15 was confused and went out for dialysis treatments. CNA 14 stated Resident 15 ate well and was not on fluid restriction. An interview on 2/26/26 a 9:13 A.M was conducted with CNA 16. CNA 16 stated she was assigned to Resident 15. CNA 16 stated Resident 15 had episodes of agitation and screaming. CNA 16 stated she provided a snack to calm Resident 15. CNA 16 stated Resident 15 went out for dialysis and was not on fluid restriction. During an observation on 2/26/26 at 9:22 A.M., Resident was wheeled out of the room by staff. Resident 15's overbed table in the room was observed with a pitcher that was 3/4 full of fluid. An interview and joint record review on 2/26/26 at 9:39 A.M. was conducted with Licensed Nurse (LN) 11. LN 11 reviewed physician's orders for Resident 15. LN 11 stated there was a physician's order for 1200 ml [milliliter] fluid restriction per day. LN 11 stated the physician's order indicated, dietary: 600 ml, night shift: 100 ml, morning shift: 300ml and afternoon shift: 200 ml. LN 11 reviewed Resident 15's fluid intake in the Medication Administration Record (MAR). LN 11 stated Resident 15 received 480 ml of fluids during morning shift on 2/1/26, 2/3/26, 2/13/26, 2/17/26, 2/22/6, 2/23/26 and on 2/24/26. LN 11 stated Resident 15 received 300 ml of fluid during afternoon shift on 2/20/26. LN 11 stated Resident 15 received 240 ml of fluid during night shift on 2/1/26, 2/2/26, 2/14/26, 2/24/26 and 2/25/26. LN 11 stated Resident 15 received more than the fluid restriction. LN 11 further stated the medication nurses and CNAs should know that Resident 15 was on fluid restriction. During an another observation on 2/27/26 at 7:55 A.M., Resident 15 was observed sitting at the edge of the bed with breakfast tray being served. A water pitcher with 3/4 full of fluid was on the overbed table. During an interview on 2/27/26 at 9:07 A.M with LN12, LN 12 stated residents on dialysis and on fluid restriction should not have a water pitcher because drinking too much fluid can cause water retention and fluid overload. An interview on 3/2/26 at 2:59 P.M. was conducted with the Director of Nursing (DON). The DON stated residents on dialysis were on fluid restriction to prevent fluid overload and staff had to monitor how much fluid was being provided to the resident. A review of the facility's policies and procedures (P&P) titled, Dialysis Management, dated 1/25/24 was conducted. The P&P indicated, A pre and post dialysis evaluation will be completed by the licensed nurse.Diet and fluid restrictions will be followed as ordered.

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews and record reviews, the facility failed to ensure two of two residents (Resident 16 and 1) reviewed for Trauma Informed Care (TIC - an intervention and organization approach that focuses on how trauma may affect an individual's life and his or her response to behavioral health), received care and services in accordance with professional standards when Resident 16 and Resident 1's diagnosis of post-traumatic stress disorder (PTSD- a disorder that may occur in people who have experienced or witnessed a traumatic event) was not identified and addressed by the healthcare providers. This failure resulted in the facility's inability to identify Resident 16's and Resident 1's possible triggers that could result in re-traumatization (the reactivation of trauma symptoms via thoughts, memories, or feelings related to the past traumatic experience).Findings: 1. Resident 16 was admitted to the facility on [DATE] with diagnoses including post-traumatic stress disorder and acute pain due to trauma according to the facility's admission Record. During an observation and interview on 2/24/26 at 8:05 A.M. Resident 16 was sitting up at the edge of his bed in his room. Resident 16 stated he had PTSD because he was raped at the age of five and was beaten until the age of 17. Resident 16 stated he saw a psychologist in the facility but hearing residents screaming made him anxious. Resident 16 stated he did not want to close his room door. During a review of the facility's Trauma Informed Care Screening, for Resident 16 dated 9/16/24, the Trauma Informed Care Screening indicated, No traumatic event. Score: 0. An interview on 2/26/26 at 8:38 A.M. was conducted with Certified Nurse Assistant (CNA)13. CNA 13 stated Resident 16 had complained about noise and other residents yelling. CNA 13 stated she offered to close the door or earplugs but Resident 16 declined. CNA 13 stated she was not sure if Resident 16 had a diagnosis of PTSD. During an interview on 2/26/26 at 10:26 A.M. with Licensed Nurse (LN) 11, LN 11 stated she was unsure if Resident 16 had PTSD. An interview and joint record review on 2/26/26 at 12:26 P.M. was conducted with the Minimum Data Set nurse (MDSN- a nurse who assessed and evaluated the quality of care being given to residents). The MDSN stated the quarterly Minimum Data Set (MDS-a clinical assessment tool) For Resident 16, dated 12/21/25 indicated PTSD. The MDSN stated all staff should know if a resident had PTSD to prevent triggering the experience. A review of a follow up psychology note (PN) dated 2/18/26, the PN indicated, Pt [patient] appears in mild distress, discussing past physical and emotional trauma.Cognition: Pt [patient] exhibits normal alertness and attention with some difficulty concentration due to PTSD symptoms, but maintains memory and knowledge appropriate for age. 2. Resident 1 was re-admitted to the facility on [DATE] with diagnoses including post traumatic disorder, major depressive disorder and anxiety according to the facility's admission Record. During an observation and interview on 2/24/26 at 12:47 P.M., Resident 1 was sitting in a wheelchair in his room. Resident 1 stated he had a diagnosis of PTSD due to work history of being a firefighter for 20 years. Resident 1 stated as a firefighter he had seen multiple traumatic events such as people burning and suicides. Resident 1 stated he had seen it all and was often feeling anxious. An interview on 2/26/26 at 9:04 A.M. was conducted with Certified Nurse Assistant (CNA) 15. CNA 15 stated Resident 1 was compliant with care but did not know that Resident 1 had a diagnosis of PTSD. CNA 15 stated it was important to know Resident 1's diagnosis because certain things can be triggered from Resident 1's past experience. An interview and joint record review on 2/26/26 at 10:44 A.M. was conducted with Licensed Nurse (LN) 11. LN 11 stated she did not know if Resident 1 had a diagnosis of PTSD. LN 11 reviewed Resident 1's care plans in Resident 1's electronic medical record and stated Resident 1 had a care plan which indicated mood problem related to PTSD. LN 11 stated staff should know if a resident had PTSD to know how to care for the resident. During an interview on 2/26/26 at 12:41 P.M. with the Social Service Director (SSD), the SSD stated staff should be aware of residents' PTSD to know the trauma experienced by the resident and to try not to recreate the experience. A review of a follow up psychology note (PN) dated (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1/21/26 for Resident 1 was conducted. The PN indicated, Cognition: Pt [patient] is alert and oriented x3 [name, time, place] .ASSESSMENT/Diagnosis.PTSD. Patient described experiencing persistent nightmares related to past military and firefighting trauma.Patient described constant anxiety from waking up until the end of the day. During an interview on 3/2/26 at 2:59 P.M. with the Director of Nursing (DON), the DON stated it was important for staff to know which residents had the diagnosis of PTSD and be aware of the triggers to prevent re-traumatization. A review of the facility's policies and procedures (P&P) titled, Trauma Informed Care-Screening, Training and Care Integration Program, revised 2/27/25 was conducted. The P&P indicated, A [traumatic event] can involve interpersonal events.Trauma may also be described as [individual trauma resulting from an event, series of events, or circumstances that an individual experiences that has a lasting adverse effects on the person's physical functioning, and mental, social, emotional and/or spiritual well-being].The IDT [Interdisciplinary Team- team members with various areas of expertise who work together toward the goals of their residents] will meet to discuss the Trauma Informed Screen and implement a plan of care to address potential Trauma Triggers and prevent re-traumatization.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to follow a physician's order when licensed nurse (LN) 22 failed to administer a medication as ordered by a physician for a resident (98). This failure had the potential for ineffective medication efficacy (the ability to produce a desired or intended result).Per the admission Record, Resident 98 was admitted to the facility on [DATE] with diagnoses that included Chronic Obstructive Pulmonary Disorder (COPD - a treatable lung disease that makes it difficult to breathe).A review of Resident 22's physician's orders indicated an order for Tiotropium Bromide inhaler (medication to treat COPD) - inhale 1 puff daily for COPD. On 2/26/26 at 11:40 A.M., a concurrent observation and interview was conducted with LN 22 during an inspection of medication storage cart (Med cart 5). During the inspection, a single and unopened package of a Tiotropium Bromide was found for Resident 98. LN 22 stated he forgot to administer the medication and that the resident should have received it between 8:00 A.M. and 10:00 A.M. as ordered by the physician. LN 22 stated it is important to administer medication as ordered by a physician to ensure the medication's effectiveness. According to LN 22, Resident 22's unopened Tiotropium Bromide inhaler was intended to be administered on 2/26/26 and there was not another opened Tiotropium Bromide inhaler for Resident 22 available in the med cart. On 3/2/26 at 9:00 A.M., an interview was conducted with the director of nursing (DON). The DON stated it was her expectation that nurses administer all medications as ordered by the physician. A review of the facility policy titled Medication - Administration, dated 8/19/25, indicated that All medications shall be administered by licensed nursing staff according to physician orders, current best practices and federal and state regulations.

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview record review, the facility failed to ensure food items were stored and labeled with contents, received dates, and use-by or expiration dates in the walk-in refrigerator, freezer, and dry storage areas for food prepared and served to residents. This failure had the potential to result in residents consuming expired or unidentified food products, increasing the risk of foodborne illness. During a kitchen observation on 2/24/26 at 8 A.M., the facility's walk in refrigerator was inspected.The following items in the refrigerator were found unlabeled with contents, a received date, or a use-by or expiration date: A. One small metal container covered in foil filled with a browned ground meat, unlabeled and undated. B. One small metal container covered in foil filled with a gelatinous tan substance, unlabeled and undated. C. Three large boxes of whole leaf lettuce with a use-by date of 2/20/26. D. One plastic container labeled lettuce with six large bags of chopped lettuce labeled with a use-by date of 2/20/26. E. One large whole ham stored in a plastic container with a use-by date of 2/22/26. F. Two extra-large casings of raw meat with no label identifying the contents and no use-by or expiration date.In addition one metal tumbler mug containing a brown liquid was stored on the food shelving next to resident food items.During an observation and interview on 2/24/26 at 8:30 A.M the facility cook (CK) observed the metal tumbler stored in the walk-in refrigerator next to resident food items and stated the tumbler was his personal mug containing coffee. The CK stated his personal beverages should not be stored with resident food because doing so creates an infection control risk and could cause cross contamination. The CK stated food items should be labeled with contents, date received, and use-by date, and that food items past expiration should be discarded. The CK stated the boxes of lettuce, unlabeled containers and meat products should be removed from use.During a kitchen observation and interview on 2/24/26 at 8:45 A.M., the facility's freezer was inspected with registered dietitian (RD) 3. Four boxes of ready to bake 10-inch apple pies were not labeled with a received on date and did not have an expiration date. RD 3 stated all food items should be labeled with the date received and use-by date. RD 3 stated items without an expiration date should not be used because they could create a foodborne illness risk.During a kitchen observation and interview on 2/24/26 at 9:00 A.M., with the registered dietician (RD) 2 and the Dietary Manger (DM) , the facility's dry storage room was inspected. The following items were unlabeled and undated: 1. Five racks, each with 10 loaves of bread each with no received on date, use-by date or expiration date. 2. One box of cornstarch opened and was not dated. 3. Ten 16 ounce (oz) containers of beef base with no expiration dates 4. Seven 16 oz. containers of chicken base with no expiration dates. DM and RD acknowledged the items without a label indicating received on, use by or expiration dates. The RD 2stated all items should be labeled with contents, date received, a use by date or expiration date. RD 2 stated if food items are not labeled residents are at risk of becoming ill from bad food.During an interview on 2/27/26 at 2:55 P.M. the director of nursing (DON) stated all resident food items should be labeled according to policy to prevent foodborne illnesses. A review of the facility policy titled, Food Storage and Handling, revised 2/29/24, indicated, 1. Raw Meat/Poultry/Seafood Storage.b. Raw meat, poultry and seafood should be labeled, dated. 7. Frozen Fruit Storage. b label and date all food items. d. use within 6 months. 9. Fresh Vegetable Storage. f. label and date all food items. 13. Dry Storage Area. Label and date all storage products.