

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

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055364	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/09/2026
NAME OF PROVIDER OR SUPPLIER Long Beach Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 3401 Cedar Avenue Long Beach, CA 90807	
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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	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** Based on observation, interview, and record review, the facility failed to ensure staff assisted residents at eye level during mealtimes for three of four sampled residents (Residents 85, Resident 70 and Resident 119. These failures had the potential for Residents 85, Resident 70, and Resident 119 to not be treated with dignity and respect. Findings: Based on observation, interview, and record review, the facility failed to ensure staff assisted residents at eye level during mealtimes for three of four sampled residents (Residents 70, Resident 85 and Resident 119). These failures had the potential for Residents 85, Resident 70 and Resident 119 not to be treated with dignity and respect. Findings: During a review of Resident 70's admission Record, the admission Record indicated Resident 70 was admitted on [DATE] to the facility with diagnoses including Parkinson's Disease with dyskinesia (a progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movements) difficulty in walking, and lack of coordination. During a review of Resident 70's Minimum Data Set (MDS- resident assessment tool) dated 6/28/2026, the MDS indicated Resident 70 had moderately impaired cognitive skills (person has trouble remembering things, making decisions, concentrating, and learning new things) and required partial/moderate assistance (helper does less than half the effort) with eating. The MDS indicated Resident 70 had impaired vision (sees large print, but not regular print in newspapers or books). During an observation on 7/7/2026 at 1:03 p.m. in Resident 70's room, Certified Nursing Assistant (CNA) 12 was sitting on a highchair while feeding Resident 70 with his meal. Resident 70 was lying in his bed in an upright position. During an interview on 7/7/2026 at 2:27 p.m. with Certified Nursing Assistant (CNA) 12, CNA 12 stated Resident 70 is unable to feed himself and requires assistance from the staff. CNA 12 stated (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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to complete a change of condition (COC) and notify the physician timely when two of five sampled residents (Residents 75 and 15) had a significant change of condition in physical status when: 1. staff reported Resident 75's repeated refusals to walk during Restorative Nursing Aide (RNA, nursing aide program that help residents to maintain their function and joint mobility) treatment and a decline in walking distance. 2. staff reported Resident 15's repeated refusals to put on left ankle foot orthoses ankle foot orthosis (AFO, an orthotic device designed to correct or address problems with the ankle and foot) during RNA treatment. These deficient practices resulted in Resident 75 and Resident 15 experiencing a change in physical condition without informing the physician timely and a delay in providing alternative interventions and treatments. Findings: 1. During a review of Resident 75's admission Record, the admission Record indicated Resident 75 initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including, but not limited to acquired absence of left leg below knee, acquired absence of right leg below knee, and difficulty in walking. During a review of Resident 75's Minimum Data Set (MDS, resident assessment tool) dated 5/25/2026, the MDS indicated Resident 75 was cognitively intact (sufficient judgement, planning, organization to manage average demands in one's environment). The MDS indicated Resident 75 had no functional range of motion (ROM, full movement potential of a joint) limitations in the upper extremity (UE, shoulder, elbow, wrist, hand) and had limitations on both sides of the lower extremity (LE, hip, knee, ankle, foot). The MDS indicated Resident 75 required set up assistance with eating, oral hygiene and substantial assistance with bathing, lower body dressing and walking 150 feet. The MDS indicated Resident 75 required partial assistance with sit to stand, sit to lying, and chair to bed transfers. During a review of Resident 75's Order Summary Report dated 7/8/2026, the Order Summary Report indicated an order dated 4/20/2025 may participate in Restorative Nursing Program as necessary. During a review of Resident 75's Care Plan Report, the Care Plan Report indicated a care plan revised 7/11/2025 that Resident 75 had the potential to benefit from participation in restorative nursing related to maintain current function. The care plan goal indicated Resident 75 will maintain current level of function through the review date. The care plan intervention/tasks revised on 5/27/2025 indicated to monitor resident on restorative program for tolerance of the program; ambulation (walking) using front-wheeled walker (FWW, type of mobility aid with wide base of support and two wheels in the front) right and left below knee prosthesis (artificial part of the body) as tolerated with skin checks once a day three times a week. During a review of Resident 75's June 2026 Documentation Survey Report (DSR), the DSR indicated Resident 75 walked between 280 feet and 600 feet from 6/1/2026 to 6/20/2026. The DSR indicated Resident 75 refused ambulation on 6/24/2026, 6/29/2026, and 6/30/2026. During a review of Resident 75's July 2026 DSR, the DSR indicated Resident 75 refused RNA ambulation on 7/1/2026, 7/3/2026, 7/4/2026, and walked 25 feet on 7/6/2026, and 75 feet on 7/7/2026. During an observation and interview on 7/6/2026 at 10:15 AM, Resident 75 was sitting in a wheelchair and able to self-propel the wheelchair from the hallway to Resident 75's room. Resident 75 stated he received a new left leg prosthesis a few weeks ago and almost fell using the new left leg prosthesis a couple of weeks ago when walking with staff. Resident 75 stated the left leg was feeling better and started to walk again this week. During an interview on 7/8/2026 at 12:08 PM with Restorative Nursing Aide (RNA 1), RNA 1 stated about two weeks ago Resident 75 was walking with Restorative Nursing Aide (continued on next page)		

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Report, the Care Plan Report indicated a care plan initiated 6/12/2024 that Resident 15 had the potential to benefit from participation in restorative nursing related to maintain current function. The care plan goal indicated Resident 15 will maintain current level of function. The care plan interventions/tasks indicated the following: RNA program for LUE passive range of motion (PROM, movement at a given joint with full assistance from another person) once a day three times a week as tolerated, initiated on 6/12/2024; RNA program for splinting using left AFO as tolerated with skin check once a day three times a week; RNA program for LLE active assistive range of motion (AAROM, movement at a given joint with a person's own effort and assistance from an external force or another person) exercises as tolerated once a day, three times a week; RNA program for RLE PROM exercises as tolerated once a day, three times a week; RNA program for RUE AAROM once a day, three times a week as tolerated. During a review of Resident 15's June 2026 Documentation Survey Report, the Documentation Survey Report indicated Resident 15 refused RNA program for splinting using left AFO as tolerated with skin check on 6/9/2026, 6/11/2026, 6/16/2026, 6/18/2026, 6/27/2026, and 6/30/2026. During a review of Resident 15's July 2026 Documentation Survey Report, the Documentation Survey Report indicated Resident 15 refused RNA program for splinting using left AFO as tolerated with skin check on 7/4/2026 and 7/7/2026. During an observation and interview on 7/7/2026 at 12:44 PM in Resident 15's room, Restorative Nursing Aide (RNA 2) completed RNA treatment with Resident 15. RNA 2 completed AROM and AAROM on RUE and AAROM and PROM on Resident 15's right hip, knee, and ankle and left arm and legs. RNA 2 stated Resident 15 refused to wear the AFO for the left foot. RNA 2 stated Resident 15's left ankle did not really move up and down. RNA 2 stated she documented that Resident 15 refused to wear the left AFO and reported to the charge nurse. RNA 2 stated maybe the AFO caused discomfort, or it may not fit and that was why Resident 15 was refusing the AFO. During an interview and record review on 7/8/2026 at 10:23 AM with Registered Nurse Supervisor (RN 1), RN 1 stated if a resident on RNA refused to wear a splint after the third refusal, a change of condition assessment should be completed, and the facility should notify the physician. RN 1 reviewed Resident 15's RNA treatment records and stated Resident 15 refused putting on the left AFO three times in a row (6/27/2026, 6/30/2026, 7/4/2026). RN 1 stated a COC should have been completed on 7/4/2026 after the third refusal. RN 1 stated there was a delay in completing a COC for Resident 15's continued refusals in wearing the AFO during RNA treatment. RN 1 stated the purpose of a COC was to document the resident's new condition and baseline and to monitor the resident to see if he was improving or declining in that new condition. RN 1 stated there could be a delay in care if staff delayed completing a COC assessment. RN 1 stated nursing staff should have assessed Resident 15 earlier to see why Resident 15 was refusing to wear the left AFO and if Resident 15 had pain and if a Physical Therapy (a rehabilitation profession that restores, maintains, and promotes optimal physical function) evaluation was needed to evaluate the splint. During an interview on 7/8/2026 at 3:26 PM with the Director of Nursing (DON), the DON stated the RNA program was for residents who required maintenance and were at high risk for decline in activities of daily living and contractures. DON stated if a resident on RNA had multiple refusals to put on a splint, this was considered a COC, and a COC should be completed immediately. DON stated if a COC was not completed timely, then appropriate interventions could be delayed, and the resident could continue to decline. During a review of the facility's policies and procedures (P&P) revised 12/2009, titled, Application and Monitoring of Orthoses, Supports, Braces, and Splints, the P&P indicated report any concerns, refusals, skin issues, discomfort, or damaged equipment to the nurse and therapy department. During a review of the facility's P&P revised 3/2018, titled, Acute Condition Changes - Clinical Protocol, the P&P indicated the staff and physician will discuss possible causes of (continued on next page)		

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	limitation in the left arm because it was not documented in the OT evaluation. OT 2 stated OTs measured ROM to address contractures or limitations in ROM, because ROM affected activities of daily living, functional mobility such as the ability to comb your hair. OT 2 stated measuring and documenting ROM on an OT evaluation also provided a baseline measurement so that OT could see if there was any improvement or decline in a resident's ROM. During a record review of the facility's policies and procedures (P&P) revised 12/2009, titled, Therapy Evaluation and Discharge Summary, the P&P indicated to ensure timely, complete, and compliant therapy documentation that supports medical necessity, resident-centered care and regulatory compliance. During a record review of the facility's policies and procedures (P&P) revised 7/2017, titled, Resident Mobility and Range of Motion Policy, the P&P indicated the facility will assess, monitor, and support each resident's mobility and range of motion to maintain or improve function and prevent avoidable decline, complications and deficiencies related to mobility. 1b. During a review of Resident 5's June 2026 Documentation Survey Report (DSR), the DSR indicated required documentation for Restorative Nursing: LUE elbow extension splint and resting hand splint two hours as tolerated once a day three times a week were 1. Amount of minutes spent providing splint or brace assistance, 2. Did the resident complain of or show signs of pain or discomfort? The DSR did not indicate documentation of application and removal of Resident 5's LUE elbow extension splint or LUE resting hand splint. During an interview and record review on 7/7/2026 at 9:20 AM with Restorative Nursing Aide (RNA 1), RNA 1 reviewed the electronic RNA documentation for splinting and RNA 1 stated for RNA splinting tasks, the electronic documentation system only asked how long RNA staff spent putting on and taking off the splints, but not when the splints were applied and removed. RNA 1 stated there was nowhere to document when RNAs applied and removed a splint. RNA 1 stated it was important to document how long a splint was worn because a splint could cause skin blisters or skin issues if it was worn too long or if a resident could not tolerate the splint for the time ordered, then it could mean a resident could have too much tone or something was happening with a resident. RNA 1 stated none of the residents with RNA splinting had a place to document when a splint was applied and removed. During an interview on 7/7/2026 at 3:06 PM with Occupational Therapist (OT 2), OT 2 stated therapists monitored a resident and established a safe wear time for residents wearing splints, because residents could have skin issues if a splint was worn for too long. OT 2 stated once a resident was able to safely tolerate a splint, then therapy would transition to RNA to put on the splint. OT 2 stated therapists need to tell RNAs how to put on splints, how long to put on a splint, and where to put the splint. OT 2 stated it was important for RNAs to monitor how long a resident wore a splint, because the time wearing the splint could tell you if there was an issue with the fit of the splint. During an interview and record review on 7/8/2026 at 10:23 AM with Registered Nurse Supervisor (RN 1), RN 1 reviewed Resident 5's RNA records and stated the RNA documentation did not track or document when the left elbow splint or left resting hand splint was applied and removed each day during RNA treatment. RN 1 stated the RNA documentation only required documentation on how many minutes an RNA spent putting on or taking off a splint. RN 1 stated it was important for RNAs to document when a splint was applied and removed, because splinting could cause pain and decreased skin circulation. RN 1 stated documentation was communication and if RNA staff did not document how long a resident wore a splint, then you could lose information for communication about the resident. During an interview on 7/8/2026 at 3:26 PM with the Director of Nursing (DON), DON stated residents on the RNA program were at high risk for decline in ADLs and contractures and helped to maintain a resident's function. DON stated RNAs should document when a splint was applied and removed. DON stated the documentation should show if a resident took off a splint early, because the splint wear time (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Long Beach Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 3401 Cedar Avenue Long Beach, CA 90807	
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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	tolerance could change from the initial assessment and it could be a change of condition if a resident's tolerance for wearing a splint changed. DON stated it was important for RNAs to monitor and document when a splint was applied and removed, because it was in indication if a resident was tolerating a splint or if the resident experienced any changes. DON stated the facility needed to change the RNA documentation because the facility needed to document how long each resident was wearing a splint. During a record review of the facility's policies and procedures (P&P) revised 12/2009, titled, Application and Monitoring of Orthoses, Supports, Braces, and Splints, the P&P indicated to ensure orthoses, supports, braces, and splints are applied safely and monitored appropriately by RNAs in accordance with physician orders, therapy recommendations, and the resident's care plan. The P&P indicated document: device applied/removed, date and time, resident tolerance, skin condition, any concerns reported. 2. During a review of Resident 15's admission Record, the admission Record indicated Resident 15 admitted to the facility on [DATE] with diagnoses including but not limited to hemiplegia (weakness to one side of the body) and hemiparesis (inability to move one side of the body) following cerebral infarction (blockage of the flow of blood brain, causing or resulting in brain tissue death) affecting right dominant side, Type 2 Diabetes Mellitus (a disorder characterized by difficulty in blood sugar control and poor wound healing). During a review of Resident 15's Minimum Data Set (MDS, resident assessment tool) dated 5/25/2026, the MDS indicated Resident 15 was cognitively intact and did not exhibit any behaviors in rejection of care. The MDS indicated Resident 15 had functional limitation in range of motion (ROM, full movement potential of a joint) on one side of the upper extremity (UE, shoulder, elbow, wrist, hand) and on one side of the lower extremity (LE, hip, knee, ankle, foot). The MDS indicated Resident 15 required set up with eating and oral hygiene, required substantial/maximal assistance in bathing, dressing, sit to lying, and chair to bed transfers. During a review of Resident 15's Order Summary Report dated 7/8/2026, the Order Summary Report indicated an order dated 4/22/2025 for may participate in restorative nursing program as necessary. During a review of Resident 15's Care Plan Report, the Care Plan Report indicated a care plan initiated 6/12/2024 that Resident 15 had the potential to benefit from participation in restorative nursing related to maintain current function. The care plan goal indicated Resident 15 will maintain current level of function. The care plan interventions/tasks indicated the following: RNA program for splinting using left AFO as tolerated with skin check once a day three times a week. During an observation and interview on 7/7/2026 at 12:44 PM in Resident 15's room, Restorative Nursing Aide (RNA 2) completed RNA treatment with Resident 15. RNA 2 completed AROM and AAROM on RUE and AAROM and PROM on Resident 15's right hip, knee, and ankle and left arm and legs. RNA 2 stated Resident 15 refused to wear the AFO for the left foot. RNA 2 stated Resident 15's left ankle did not really move up and down. During an interview and record review on 7/7/2026 at 9:20 AM with Restorative Nursing Aide (RNA 1), RNA 1 reviewed the electronic RNA documentation for splinting and RNA 1 stated for RNA splinting tasks, the electronic documentation system only asked how long RNA staff spent putting on and taking off the splints, but not when the splints were applied and removed. RNA 1 stated there was nowhere to document when RNAs applied and removed a splint. RNA 1 stated it was important to document how long a splint was worn because a splint could cause skin blisters or skin issues if it was worn too long or if a resident could not tolerate the splint for the time ordered, then it could mean a resident could have too much tone or something was happening with a resident. RNA 1 stated none of the residents with RNA splinting had a place to document when a splint was applied and removed. During an interview on 7/7/2026 at 3:06 PM with Occupational Therapist (OT 2), OT 2 stated therapists monitored a resident and established a safe wear time for residents wearing splints, because residents could have skin issues if a splint was (continued on next page)		

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	worn for too long. OT 2 stated once a resident was able to safely tolerate a splint, then therapy would transition to RNA to put on the splint. OT 2 stated therapists need to tell RNAs how to put on splints, how long to put on a splint, and where to put the splint. OT 2 stated it was important for therapy to tell RNAs how long to put on a splint to keep the same interventions and time to maintain a resident's function. OT 2 stated it was important for RNAs to monitor how long a resident wore a splint, because the time wearing the splint could tell you if there was an issue with the fit of the splint. During an interview and record review on 7/8/2026 at 10:23 AM with Registered Nurse Supervisor (RN 1), RN 1 stated an RNA program was for residents who needed help with ROM and mobility. RN 1 stated RNAs receive instruction on what treatments to perform from therapy and the RNA tasks should include what splints to put on and how long to put on a splint. RN 1 reviewed Resident 15's RNA documentation records and stated the RNA documentation for the task for putting on a left AFO did not include how long Resident 15 should put on the left AFO. RN 1 stated the RNA task should include how long to put on the left AFO, because RNA treatment was an order that had to be executed and should be written. RN 1 stated RNA or nursing staff should not have to guess how long Resident 15 should wear the left AFO and the time should be written so every staff knew what RNA treatment should be completed. RN 1 stated if the wear time for the left AFO was not written, the RNAs could put on the left AFO for too short of a time or for too long and the facility could not measure the efficacy of the splints. RN 1 stated the RNA documentation also did not track or document when the left AFO was applied and removed each day. RN 1 stated the RNA documentation only required documentation on how many minutes an RNA spent to put on or take off a splint. RN 1 stated it was important for RNAs to document when the splint was applied and removed, because splinting could cause pain and decreased skin circulation. During an interview on 7/8/2026 at 3:26 PM with the Director of Nursing (DON), DON stated residents on the RNA program were at high risk for decline in ADLs and contractures and helped to maintain a resident's function. DON stated the RNA task should indicate how long a resident should put on a splint during RNA, because the RNAs need to know how long to put on a splint. DON stated if there was no wear time indicated in the RNA task, the contracture could worsen because the tolerance for the splint could have changed and could show that a therapist needed to re-evaluate the splint. DON stated the RNA should also document when a splint was applied and removed. DON stated the documentation should show if a resident took off a splint early, because the splint wear time tolerance could change from the initial assessment and it could be a change of condition if a resident's tolerance for wearing a splint changed. DON stated it was important for RNAs to monitor and document when a splint was applied and removed, because it was in indication if a resident was tolerating a splint or if the resident experienced any changes. DON stated the facility needed to change the RNA documentation because the facility needed to document how long each resident was wearing a splint. During a record review of the facility's policies and procedures (P&P) revised 12/2009, titled, Application and Monitoring of Orthoses, Supports, Braces, and Splints, the P&P indicated to ensure orthoses, supports, braces, and splints are applied safely and monitored appropriately by RNAs in accordance with physician orders, therapy recommendations, and the resident's care plan. The P&P indicated devices shall be used only as ordered and directed in the resident's care plan. The P&P indicated apply and remove the device according to therapy instructions and the care plan. The P&P indicated document: device applied/removed, date and time, resident tolerance, skin condition, any concerns reported.		

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to protect the residents' right to be free from physical abuse for one of three sampled residents (Resident 160) when Resident 110 kicked Resident 160 on 6/27/2026. This failure resulted in Resident 110 kicking Resident 160 and had the potential for Resident 160 to feel unsafe and unprotected. Findings: During a review of Resident 110's admission Record, the admission Record indicated Resident 110 was admitted to the facility on [DATE] with diagnoses including congestive heart failure (CHF- a heart disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling) and mental and behavioral disorders. During a review of Resident 110's Minimum Data Set (MDS- a resident assessment tool) dated 6/29/2026, the MDS indicated Resident 110's cognition (ability to think, understand, learn, and remember) was intact. The MDS indicated Resident 110 required setup assistance (helper assists only prior to or following the activity) with activities of daily living (ADLs- activities such as bathing, dressing, and toileting a person performs daily). During a review of Resident 160's admission Record, the admission Record indicated Resident 160 was admitted to the facility on [DATE] with diagnoses including schizophrenia (a mental illness that is characterized by disturbances in thoughts) and severe intellectual disabilities (when a person has very limited reasoning, learning, and problem-solving skills). During a review of Resident 160's MDS dated [DATE], the MDS indicated Resident 160's cognition was moderately impaired. The MDS indicated Resident 160 was dependent (helper does all the effort) with ADLs. During an interview on 7/7/2026 at 3:16 p.m., with Housekeeper (HK) 1, HK 1 stated he saw Resident 110 kick Resident 160. During a phone interview on 7/8/2026 at 12:47 p.m., with Registered Nurse (RN) 3, RN 3 stated HK 1 told her he witnessed Resident 110 kick Resident 160. RN 3 stated when she spoke with Resident 110, Resident 110 admitted to kicking Resident 160 because he thought Resident 160 took his snacks and phone. During a review of the facility's policy and procedure (P&P) titled, Residents Rights, revised 5/2025, the P&P indicated, This organization is committed to protecting and promoting the rights, dignity, privacy, independence, and well-being of all residents. Every resident shall be treated with respect and fairness and shall enjoy their rights without discrimination, harassment, abuse, neglect, or retaliation. The P&P indicated, Residents have the right to live in a safe, secure, and healthy environment. Residents have the right to be free from physical, emotional, verbal, sexual, or financial abuse.		

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the Notice of Proposed Transfer/Discharge form was provided to the Office of the State Long-Term Ombudsman (public advocate for residents in long-term care facilities) at the time of transfer to the General Acute Care Hospital (GACH) for one of three sampled residents (Resident 12). This deficient practice had the potential of Resident 12 being denied additional protection from being inappropriately discharged and access to an advocate who could inform them of their options and rights. Findings: During a review of Resident 12's admission Record, the admission Record indicated Resident 12 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including hypertension (HTN- high blood pressure) and cerebrovascular accident (CVA- stroke, loss of blood flow to a part of the brain). During a review of Resident 12's Minimum Data Set (MDS- a resident assessment tool) dated 6/20/2026, the MDS indicated Resident 12's cognition (ability to think, understand, learn, and remember) was severely impaired. The MDS indicated Resident 12 was dependent (helper does all the effort) with activities of daily living (ADLs- activities such as bathing, dressing, and toileting a person performs daily). During an interview on 7/8/2026 at 10:28 a.m., with Licensed Vocational Nurse (LVN) 8, LVN 8 stated the licensed nurses are responsible for completing and providing the Ombudsman with the Notice of Transfer/Discharge at the time the resident is transferred. LVN 8 stated the Ombudsman needs to be notified of a residents transfer and discharge, so they are not only aware but also to ensure the transfer is safe. During a concurrent interview and record review on 7/9/2026 at 8:48 a.m., with Registered Nurse (RN) 2, Resident 12's Notices of Proposed Transfer/Discharge were reviewed. RN 2 stated Resident 12's Notice of Proposed Transfer/discharge date d 3/24/2026 was faxed to the Ombudsman on 7/7/2026 (105 days later). RN 2 stated Resident 12's Notice of Proposed Transfer/discharge date d 5/16/2026 was faxed to the Ombudsman on 7/7/2026 (52 days later). RN 2 states both Notices of Proposed Transfer/Discharge should have been faxed to the Ombudsman at the time of transfer/discharge to ensure it's a safe transfer/discharge. During an interview on 7/9/2026 at 2:01 p.m., with the Director of Nursing (DON), the DON stated Resident 12's Notice of Proposed Transfer/Discharge form should have been completed and faxed to the Ombudsman immediately when Resident 12 was transferred to the GACH. The DON stated it is important the Ombudsman is made aware at the time of transfer to ensure it is appropriate. During a review of the facility's policy and procedure (P&P) titled, Transfer or Discharge, revised 4/2025, the P&P indicated, Transfers and discharges must meet specific criteria and require resident/representative notification, orientation, and documentation in the medical record.		

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Assess the resident when there is a significant change in condition **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure one of one sampled residents (Resident 9), change of condition ([COC] a sudden, clinically important deviation from a patient's baseline in physical, cognitive (ability to think, understand, learn, and remember) behavioral, or functional status which without immediate intervention, may result in complications or death) was documented when Resident 9's Dilantin (medication used to control and prevent seizures) (phenytoin) level is 10 to 20 microgram/milliliter (mcg/mL-measures mass and volume) dropped to less than 2.This deficient practice had the potential to result in a delay of care and services for Resident 9.Findings:During a review of Resident 9's admission Record (a document containing demographic and diagnostic information) (Face Sheet- front page of the chart that contains a summary of basic information about the resident), the Face Sheet indicated Resident 9 was originally admitted to the facility on [DATE] and readmitted to the facility on [DATE] with diagnoses of but not limited to epilepsy (recurrent unprovoked seizures), hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body), hemiparesis (muscle weakness or a partial loss of movement on one side of the body), and paranoid schizophrenia (a mental illness that is characterized by disturbances in thought).During a review of Resident 9's History and Physical (H&P), dated 3/11/2026, the H&P indicated Resident 9 had the capacity to understand and make decisions. The H&P indicated Resident 9 was recently hospitalized at a General Acute Care Hospital (GACH) from 3/7/2026 to 3/10/2026 due to a high Dilantin level.During a review of Resident 9's Minimum Data Set (MDS-a resident assessment tool), dated 4/23/2026 the MDS indicated Resident 9 had the ability to express ideas and wants. The MDS indicated Resident 9 needed substantial to maximal assistance with toileting showering, dressing, personal hygiene, and transferring.During a review of Resident 9's Order Summary, the Order Summary indicated on 5/12/2026 Resident 9 had an order for Dilantin 100 milligram (mg- metric unit of measurement, used for medication dosage and/or amount) to be given three times a day for seizures.During a record review on 7/08/2026 at 1:33 p.m. with Licensed Vocational Nurse (LVN) 1, Resident 9's Lab Result Report, dated 5/12/2026, was reviewed. The Lab Result Report indicated Resident 9's Dilantin level was less than 2. LVN 1 stated the doctor was informed of the Dilantin level but there was no change of condition documented for a Dilantin level less than 2.During a concurrent interview and record review on 7/09/2026 at 10:37 a.m. with Registered Nurse (RN) 2, Resident 9's Lab Result Report, dated 5/12/2026, was reviewed, the Lab Result Report indicated Resident 9's Dilantin level was less than 2 (normal Dilantin level is 10 to 20). RN 2 stated we missed that lab result. RN 2 stated the licensed nurses should have documented a COC immediately for Dilantin less than 2 and informed the resident and the resident's family.During a review of resident 9's Care Plan Titled, Resident 9 has a Seizure Disorder Related to Stroke, date initiated 1/19/2024, the Care Plan indicated a goal the resident would maintain lab values within therapeutic range per medical doctor (MD) thorough review date. The Care Plan indicated interventions and tasks to obtain and monitor lab diagnostic work as ordered.During a review of the facility's policy and procedure (P&P), titled Acute Condition Changes - Clinical Protocol date revised 3/2018, the P&P indicated, . Before contacting a physician about someone with an acute change of condition, the nursing staff will collect pertinent details to report to the physician; for example, the history of present illness and previous and recent test results for comparison. The staff will monitor and document the resident/patient's progress and responses to treatment, and the physician will adjust treatment accordingly. The physician will help the staff monitor a resident/patient with a recent acute change of condition until the problem or condition has resolved or stabilized.		

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	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 ensure the Minimum Data Set (MDS- a resident assessment tool) for one of three sampled residents (Resident 92) was accurate by failing to code Resident 92's fall on 3/24/2026. The MDS assessment conducted on 5/6/2026 indicated the resident did not have any falls. This failure had the potential to negatively affect Resident 92's plan of care and placed Resident 92 at risk for future falls and injuries. Findings: During a review of Resident 92's admission Record, the admission Record indicated Resident 92 was initially admitted on [DATE] and was readmitted on [DATE] to the facility with diagnoses including end stage renal disease (ESRD-irreversible kidney failure) hemiplegia (weakness on one side of the body) and hemiparesis affecting right dominant side (total paralysis of the arm, leg, and trunk on the right side of the body), dependence on renal dialysis (a treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidney(s) have failed) and gastrostomy (a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems). During a review of Resident 92's MDS dated [DATE], the MDS indicated Resident 92 had severely impaired cognitive skills (a person has trouble with basic brain functions like thinking, learning and remembering) for decision making. The MDS indicated Resident 92 was dependent on staff with dressing, toileting hygiene, bathing and personal hygiene. During a review of Resident 92's Change of Condition (COC- a sudden, clinically important deviation from a patient's baseline in physical, cognitive [ability to think, understand, learn, and remember] behavioral, or functional status which without immediate intervention, may result in complications or death) dated 3/24/2026 at 6:36 p.m., the COC indicated Resident 92 was found lying on the floor face down beside the bed and sustained a bump on right temporal (temple) area, abrasion (scrape) on the right hip and back. The COC indicated the physician and family member were notified. During a review of Resident 92's MDS dated [DATE], the MDS indicated the resident had no history of falls since admission, reentry (readmission) or prior assessment. During a concurrent interview and record review on 7/9/2026 at 10:13 a.m. with Registered Nurse (RN) 1, Resident 92's COC dated 3/24/2026 and MDS Section J (section in the MDS that document specific health issues and symptoms that directly impact resident's overall quality of life) dated 5/6/2026 were reviewed. RN 1 stated Resident 92 was found on the floor face down with right temporal bruise but without changes in level of consciousness (LOC- how awake and alert a person is). RN 1 stated the MDS indicated Resident 92 had no falls since admission or reentry. RN 1 stated the fall that occurred on 3/24/2026 was not coded correctly. RN 1 stated MDS assessment should be accurate to prevent recurrence of fall for better resident's care. During a concurrent interview and record review on 7/9/2026 at 11:23 a.m. with the Director of Minimum Data Set (DMDS), Resident 92's MDS dated [DATE] and COC dated 3/24/2026 were reviewed. The DMDS stated the MDS dated [DATE] did not reflect the fall of Resident 92 on 3/24/2026. The DMDS stated the fall that happened on 3/24/2026 should be reflected on the MDS conducted on 5/6/2026. The DMDS stated Resident 92's MDS assessment should be accurate to provide a true assessment or picture of the resident's condition. During an interview on 7/9/2026 at 3:02 p.m. with the Director of Nursing (DON), the DON stated Resident 92 had an episode of fall this year. The DON stated inaccurate MDS assessment would lead to inaccurate care planning that could affect Resident 92's care. During a review of facility's policy and procedure (P&P) titled, Comprehensive Assessments, revised 10/2023, the P&P indicated error in assessment is an assessment where resident's overall clinical status is not accurately represented or miscoded and results in an inappropriate plan of care.		

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a preadmission screening resident review (PASARR A screening to ensure a person is appropriately placed and receives needed services before entering a nursing facility) Level II was completed for two of three sampled residents (Resident 10 and Resident 16). This deficient practice had the potential to result in an inappropriate placement and delay of needed services for Resident 10 and Resident 16. Findings: During a review of Resident 10's admission Record, the admission Record indicated Resident 10 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including schizophrenia (a mental illness that is characterized by disturbances in thought) and bipolar disorder (mood swings that range from the lows of depression to elevated periods of emotional highs). During a review of Resident 10's PASARR Level I screening dated 5/9/2026, the PASARR Level I screening indicated Resident 10 had serious mental illness and a PASARR Level II screening was required. No PASARR Level II found. During a review of Resident 10's Minimum Data Set (MDS- a resident assessment tool) dated 6/22/2026, the MDS indicated Resident 10's cognition (ability to think, understand, learn, and remember) was intact. The MDS indicated Resident 10 was dependent (helper does all the effort with activities of daily living (ADLs- activities such as bathing, dressing, and toileting a person performs daily). During a concurrent interview and record review on 7/8/2026 at 10:38 a.m., with the Minimum Data Set Assistant (MDSA), Resident 10's PASARR Level I dated 6/22/2026 was reviewed. The MDSA stated Resident 10's PASARR Level I screening was positive and a Level II PASARR II was required. The MDSA reviewed the Notice of Attempted Evaluation for a Level II PASARR screening that stated it was not completed because the facility staff were unresponsive in two or more separate attempts. The MDSA stated this should not have happened because the PASARR screening determines what the residents may need and assists with creating the residents plan of care. During an interview on 7/9/2026 at 2:01 p.m., with the Director of Nursing (DON), the DON stated it was important the PASARR screenings were done accurately to identify if the resident was appropriately placed at this facility and provide the residents with additional resources. During a review of the facility's policy and procedure titled, PASRR Policy revised March 2019, the P&P indicated, The facility shall ensure that all residents are screened for mental illness (MI) through the PASRR process prior to admission and as required post-admission, in compliance with federal and state regulations. The P&P indicated If Level I is positive, the facility must refer to the state PASRR authority for Level II evaluation. Level II determines need for nursing facility services and need for specialized services. 2. During a review of Resident 's Face Sheet (front page of the chart that contains a summary of basic information about the resident), the Face Sheet indicated, Resident 16 was originally admitted to the facility on [DATE] and readmitted on [DATE]. Resident 16's was admitted to the facility with diagnoses including Schizoaffective disorder depressive type (is a chronic mental health condition combining schizophrenia symptoms (like hallucinations [hearing things not based in reality] or delusions [believing things not based on reality]) with major depressive episodes), type 2 diabetes mellitus (body's inability to process sugar) with diabetic polyneuropathy (nerve damage caused by chronically high blood sugar levels and metabolic stress), metabolic encephalopathy (a general term for brain dysfunction caused by chemical imbalances or toxins in the body). During a review of Resident 16's MDS, dated 06/01/2026, the MDS indicated, Resident 16 was severely cognitively impaired (indicating serious challenges with orientation (remembering dates/time) and short-term memory). The MDS indicated, Resident 16 required setup or clean-up assistance (helper sets up; resident completes (continued on next page)		

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	activity. Helper assists only prior to or following the activity) from staff with eating, oral hygiene, and upper body dressing. During a concurrent interview and record review on 07/08/2026 at 9:12 a.m. with the MDSA, Resident 16's PASRR level I screening dated 12/01/2025 was reviewed. The PASARR Level 1 screening indicated that a severe mental illness, and a level II Mental Health Evaluation was required. The Notice of Evaluation for Level II screening completion dated 12/03/2025 indicated level II assessment was not completed due to Facility staff were unresponsive to two or more separate attempts of communication within 48hours of the Level I screening. As a result of the facility's lack of response, the PASRR Level II case was subsequently closed without completion of the required evaluation. The MDSA acknowledged the importance of timely tracking and follow-up of PASARR evaluations to ensure residents receive appropriate services. The MDSA stated the facility will assign a staff member specifically responsible for tracking PASRR referrals and follow-ups to prevent future occurrences. The MDSA stated staff education/in-service will be provided immediately regarding PASRR tracking and follow-up procedures. During a review of the facility's policy and procedure titled, PASARR Policy revised March 2019, the P&P indicated, The facility shall ensure that all residents are screened for mental illness (MI) through the PASRR process prior to admission and as required post-admission, in compliance with federal and state regulations. The P&P indicated If Level I is positive, the facility must refer to the state PASRR authority for Level II evaluation. Level II determines need for nursing facility services and need for specialized services.		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure one of one sampled residents (Resident 9), had a care plan created, initiated, and implemented for the use of Dilantin (medication used to control seizures). This deficient practice had the potential to result in the side effects not being identified and addressed. Findings: During a review of Resident 9's admission Record (a document containing demographic and diagnostic information) (Face Sheet- front page of the chart that contains a summary of basic information about the resident), the Face Sheet indicated Resident 9 was originally admitted to the facility on [DATE] and readmitted to the facility on [DATE] with diagnoses of but not limited to epilepsy (recurrent unprovoked seizures), hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body), hemiparesis (muscle weakness or a partial loss of movement on one side of the body), and paranoid schizophrenia (a mental illness that is characterized by disturbances in thought). During a review of Resident 9's History and Physical (H&P), dated 3/11/2026, the H&P indicated Resident 9 had the capacity to understand and make decisions. The H&P indicated Resident 9 was recently hospitalized at a General Acute Care Hospital (GACH) from 3/7/2026 to 3/10/2026 due to a high Dilantin level. During a review of Resident 9's Minimum Data Set (MDS-a resident assessment tool), dated 4/23/2026 the MDS indicated Resident 9 had the ability to express ideas and wants. The MDS indicated Resident 9 needed substantial to maximal assistance with toileting, showering, dressing, personal hygiene, and transferring. During a review of Resident 9's Order Summary, the Order Summary indicated on 5/12/2026 Resident 9 had an order for Dilantin 100 milligram (mg- metric unit of measurement, used for medication dosage and/or amount) to be given three times a day for seizures. During an interview on 7/8/2026 at 10:42 a.m. with Certified Nursing Assistant (CNA) 11, CNA 11 stated Resident 9 was hospitalized a couple of months ago for an elevated Dilantin level. During a concurrent interview and record review on 7/08/2026 at 1:33 p.m. with Licensed Vocational Nurse (LVN) 1, Resident 9's Care Plans were reviewed. LVN 1 stated Resident 9 was hospitalized on [DATE] for elevated Dilantin level of 28.4. LVN 1 stated Resident 9 does not have a Care Plan for Dilantin. LVN 1 stated Resident 9 should have a Care Plan for Dilantin. LVN 1 stated Care Plan are important to follow for positive outcomes and monitor for no decline in the residents condition. During a concurrent interview and record review on 07/09/2026 at 10:37 a.m. with Registered Nurse (RN) 2, Resident 9's Care Plans were reviewed. RN 2 stated she does not see a Care Plan for Dilantin documented in resident 9's chart. RN 2 stated Resident 9 should have a care plan for Dilantin. The RN 2 stated the care plans are the responsibility of the licensed staff. During a review of the facility's policy and procedure (P&P), titled Care Plans, Comprehensive Person-Centered care plan revised 3/2022, the P&P indicated, A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. The interdisciplinary team (IDT), in conjunction with the resident and his/her family or legal representative, develops and implements a comprehensive, person-centered care plan for each resident. The comprehensive, person-centered care plan is developed within seven (7) days of the completion of the required MDS assessment (Admission, Annual or Significant Change in Status), and no more than 21 days after admission.		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	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, and record review, the facility failed to revise the care plans for two of four sampled residents (Resident 102 and 161) by:Failing to revise the at risk for falls care plan dated 3/27/26 for Resident 102 who was found lying on the floor on 4/22/26.Failing to revise the care plan for Resident 161 to reflect the current plan of care for Resident 161's ruptured blister on the left hip that started on 5/26/26.These deficient practices had the potential for Residents 102 and 161 to not receive the appropriate care and/or services.Findings:1.During a review of Resident 102's admission Record (face sheet) dated 7/6/2026, the admission record indicated, Resident 102 was admitted to the facility on [DATE] with diagnoses including legally blind (a person's eyesight is so limited that they can't see well enough to do everyday tasks, even with glasses) depression (feelings of sadness and emptiness) and history of falling.During a review of Resident 102's Minimum Data Set (MDS- a standardized assessment and care screening tool). The MDS indicated, Resident 102 had moderate cognitive impairment (memory). The MDS indicated, Resident 102 was totally dependent (staff does all the work) with activities of daily living (ADL's such as bathing, dressing and toileting).During a review of Resident 102's History & Physical (H&P) dated 5/30/2026, the H&P indicated, Resident 102 had fluctuating capacity to understand and make decisions.During a review of Resident 102's Change of Condition evaluation (COC) dated 4/22/2026, the COC indicated, Resident 102 was found lying on the floor.During a review of Resident 102's care plan titled, At risk for fall related to leaning to the left while seated in the wheel chair dated 3/27/2026. The care plan was not revised and updated to reflect Resident 102 had an actual fall on 4/22/2026.During an interview on 7/8/2026 at 9:51 a.m. with Licensed Vocational Nurse 5 (LVN 5), LVN 5 stated Resident102 was found on the floor on 4/22/2026 and that the risk for falls care plan was not updated to reflect Resident 102 was found on the floor. LVN 5 stated the care plan needed to be revised after each fall to prevent future falls and to minimize injuries 2.During a review of Resident 161's admission Record dated 7/9/26, the admission record indicated, Resident 161 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including depression (feelings of sadness and emptiness) diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing) and Bipolar disorder (a mental health condition that causes extreme mood swings that include emotional highs [mania] and lows[depression] that make it difficult to carry out day-to-day tasks and activities).During a review of Resident 161's MDS, the MDS indicated, Resident 161's cognition was intact. The MDS indicated, Resident 161 was totally dependent with ADL's. The MDS indicated, Resident 161 had an unhealed pressure injury (localized, pressure-related damage to the skin and/or underlying tissue usually over a bony prominence).During a review of Resident 161's History & Physical (H&P) dated 5/07/2026, the H&P indicated, Resident 161 had fluctuating capacity to understand and make decisions.During a review of Resident 161's Change of Condition evaluation (COC) dated 5/25/2026, the COC indicated, Resident 161 had scattered open blisters on the left buttock.During a review of Resident 161's care plan titled Scattered open blisters on left buttock dated 5/26/26. The care plan indicated, to provide treatment as ordered and to have a wound consult.During a review of Resident 161's Order Summary Report dated 6/9/2026, the order summary report indicated, Resident 161 had orders for a left hip ruptured blister, clean with normal saline (NS) pat dry pack with calcium alginate (wound dressing) apply Santyl (removes dead tissue) in the deeper area and cover with waterproof adhesive foam dressing change every day and as needed.During a (continued on next page)		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	review of Resident 161's Wound Consult assessment dated [DATE], the wound assessment indicated, Resident 161 had a new ruptured blister to the left hip. The wound assessment indicated, to clean the ruptured blister with normal saline (NS) pat dry pack with calcium alginate (wound dressing) apply Santyl (debrides wounds) in the deeper area and cover with waterproof adhesive foam dressing change every day and as needed. During an interview on 7/9/2026 at 10:58 a.m. with Treatment Nurse 1 (TXN 1), TXN 1 stated she should have revised Resident 161's care plan to reflect Resident 161's left hip ruptured blister and the current plan of the care Resident 161 was receiving for the left hip ruptured blister. TXN 1 stated she made a mistake by not revising the care plan to reflect the care that Resident 161 was receiving. TXN 1 stated the care plan is a guide for the nurse on how to provide care to the Resident. TXN 1 stated there was a potential for the wound to worsen when the plan of care is not accurate. During an interview on 7/9/26 at 11:32 p.m. with the Director of Nurses (DON), the DON stated care plans need to have the interventions revised when there are changes in the level of care the residents will be receiving. The DON stated care plans are the guide the nurses use when providing care to the resident. The DON stated there was a potential for residents to decline when the plan of care is not revised to reflect the interventions the residents should be receiving. During a review of the facility's policy and procedure (P&P) titled Care Plans, Comprehensive Person-Centered dated 3/2022, the P&P indicated a comprehensive, person-centered care plan that includes measurable objectives and a timetable to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. The P&P indicated the care plan interventions are derived from a through analysis of the information gathered as part of the comprehensive assessment.		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	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 ensure two of four sampled residents' (Resident 32 and Resident 113) fingernails were trimmed and free from accumulation of unknown substances underneath their fingernails. This failure resulted in Resident 32 and Resident 113's fingernails to have irregular edges, accumulation of dark brown substance under the fingernails, and had the potential to cause infection and impaired skin integrity. Findings: During a review of Resident 32's admission Record, the admission Record indicated Resident 32 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including rheumatoid arthritis (a chronic progressive disease- causing inflammation in the joints and resulting in painful deformity and immobility) and muscle weakness. During a review of Resident 32's Minimum Data Set (MDS- a resident assessment tool) dated 4/21/2026, the MDS indicated Resident 32's cognition (ability to think, understand, learn, and remember) was severely impaired. The MDS indicated Resident 32 required moderate assistance (helper does less than half the effort) with activities of daily living (ADLs- activities such as bathing, dressing, and toileting a person performs daily). During a review of Resident 113's admission Record, the admission Record indicated Resident 113 was admitted to the facility on [DATE] with diagnoses including hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) and hypertension (HTN- high blood pressure). During a review of Resident 113's MDS dated [DATE], Resident 113's cognition was moderately impaired. The MDS indicated Resident 113 was dependent (helper does all the effort) with ADLs. During an observation and interview on 7/6/2026 at 9:28 a.m., in Resident 113's room, Resident 113's fingernails were observed to be untrimmed with some dark brown deposits underneath the fingernails. Resident 113 stated she would like her fingernails trimmed. During an observation on 7/6/2026 at 9:58 a.m., in Resident 32's room, Resident 32's fingernails were observed to be untrimmed with some dark brown deposits underneath the fingernails. During a concurrent observation and interview on 7/7/2026 1:01 p.m., with Certified Nurse Assistant (CNA) 5, in Resident 32's room, CNA 5 stated Resident 32's fingernails were long and needed to be trimmed. CNA 5 stated it was important to keep the residents' fingernails clean and trimmed to prevent bacteria from building up under their fingernails and to prevent them from scratching themselves. During a concurrent observation and interview on 7/7/2026 at 1:22 p.m., with CNA 6, in Resident 113's room, CNA 6 stated Resident 113's fingernails were long and dirty and should be kept clean and short because bacteria can form under their fingernails and they could cut themselves from scratching (continued on next page)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	which could potentially result in an infection. During an interview on 7/8/2026 at 11:33 a.m., with the Infection Prevention Nurse (IPN), The IPN stated it was important resident nails are kept trimmed and clean because the residents could scratch themselves which could cause an infection. During an interview on 7/9/2026 at 2:01 p.m., with the Director of Nursing (DON), the DON stated cleaning and trimming fingernails was one of the CNA tasks and is required to be done when a resident's fingernails are observed as being long and unclear. The DON stated long, dirty fingernails can result in infection if a resident scratch themselves and breaks skin. During a review of the facility's policy and procedure (P&P) titled, Fingernails/Toenails, Care of, revised 2/2018, the P&P indicated, The purpose of this procedure are to clean the nail bed, to keep nails trimmed, and to prevent infections. Nail care included daily cleaning and regular trimming. Trimmed and smooth nails prevent the resident from accidentally scratching and injuring his or her skin.		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	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 clarify and follow physician orders for one of three sampled residents (Resident 134) by failing to: Clarify frequency (number of times) for administration of Resident 134's Nicotine patch (medicated adhesive patch that you stick to your skin to help you quit smoking). Clarify frequency for administration of Resident 134's Diclofenac (medication used to treat pain). Check Resident 134's blood sugar three times daily per doctor's orders. These deficient practices had the potential to cause medication errors and/or inadequate treatment for Resident 134 and placed Resident 134 at risk for increased pain, hypoglycemia, and hyperglycemia. Findings: During a review of Resident 134's admission Record, the admission Record indicated Resident 134 was admitted to the facility on [DATE]. During a review of Resident 134's History and Physical (H&P) dated 6/29/2026, the H&P indicated Resident 134 was recently hospitalized for Diabetic Ketoacidosis (DKA- a life-threatening diabetes complication when your body doesn't have enough insulin to turn sugar into energy causing an imbalance) Diabetes Mellitus (DM- a disorder characterized by difficulty in blood sugar control and poor wound healing) and hypertension (HTN- high blood pressure). The H&P indicated Resident 134's cognition (ability to think, understand, learn, and remember) was intact. During a concurrent interview and record review on 7/8/2026 at 3:18 p.m., with Registered Nurse (RN) 1, Resident 134's orders and Blood Sugar Summary were reviewed. RN 1 stated Resident 134 had orders to check fingerstick blood sugars three times a day. RN 1 stated the orders to check Resident 134's blood sugars three times a day were not being followed but should have been to prevent Resident 134 from developing DKA, hypoglycemia (low blood sugar), or hyperglycemia (high blood sugar). RN 1 reviewed Resident's 134's blood sugar vitals summary and stated Resident 134's blood sugars were only being checked one or two times a day. During a concurrent interview and record review on 7/8/2026 at 4:19 p.m., with Licensed Vocational Nurse (LVN) 4, Resident 134's Inpatient Discharge Instructions and Medication Administration Record (MAR) were reviewed. LVN 4 stated the Inpatient Discharge Instructions (from the GACH) were the admitting orders they followed when a resident is admitted. LVN 4 stated Diclofenac 1% topical gel to apply four times a day and Nicotine 14 milligrams (mg- unit of measurement) to apply once a day in the morning were put in as PRN (as needed) but ordered by the admitting doctor as scheduled. LVN 4 stated the admitting orders were put in incorrectly. During an interview on 7/9/2026 at 2:01 p.m. with the Director of Nursing (DON), the DON stated a Nicotine patch is not ordered as PRN. The DON stated it was important Resident 134 received the Nicotine patch daily as ordered because he could have potentially gone through nicotine withdrawals. The DON stated Resident 134 not receiving the pain medication cream could cause Resident 134 to experience uncontrolled pain. The DON stated the nurses should be following doctors' orders for checking Resident 134's blood sugar three times a day because not doing so could result in uncontrolled diabetes and DKA. During a review of the facility's policy and procedure (P&P) titled, Following Physician Orders, revised 4/2018, the P&P indicated, To ensure all physician/practitioner orders are accurately received, reviewed, implemented, documented, and monitored in a timely manner to provide safe and effective resident care.		

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure incontinence care (the help provided to manage the accidental leaking of urine and stool) was provided in a timely manner for one of two sampled residents (Resident 63), who was left soiled for an extended period. Resident 63 asked the staff to have his incontinence briefs (diaper) changed at 7:10 a.m. on 7/6/2026 and was changed and cleaned on 7/6/2026 at 11:00 a.m. This failure had the potential to result in psychosocial distress, frustration, discomfort and increased risk of skin impairment. Findings: During a review of Resident 63's admission Record, the admission Record indicated Resident 63 was admitted on [DATE] to the facility with diagnoses including chronic obstructive pulmonary disease (COPD- group of lung disease that block the airflow which can cause difficulty of breathing), osteoarthritis (protective cartilage on the ends of your bone breaks down, causing pain, swelling and problems moving the joint), hypertension (high blood pressure) and congestive heart failure (CHF- a heart disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling). During a review of Resident 63's Minimum Data Set (MDS- a resident assessment tool) dated 4/14/2026, the MDS indicated Resident 63 had an intact cognition (thought process) and required substantial/maximal assistance (helper does more than half the effort) with toileting hygiene, bathing, and upper body dressing. The MDS indicated Resident 63 is incontinent (losing control over your bladder and bowels, resulting in accidental leaks) of stool and urine. During a review of Resident 63's Care Plan titled, Resident has ADL Self-Care Deficit, undated, the Care Plan indicated interventions including answering the resident's call light promptly and keeping the resident clean, dry and change as needed. During an observation on 7/6/2026 at 10:46 a.m. in Resident 63's room, Resident was talking loudly to an unknown staff in his room. During a concurrent observation and interview on 7/6/2026 at 11:09 a.m., with CNA 2 in Resident 63's room, curtains were closed. CNA 2 stated she was providing incontinent care to Resident 63. During a concurrent observation and interview in Resident 63's room on 7/6/2026 at 1:09 p.m. with Resident 63, Resident 63 stated he called the staff at around 7:00 a.m. today (7/6/2026) and Certified Nursing Assistant (CNA) 1 answered his call light. Resident 63 stated he told the CNA 1 he needed his incontinence brief (diaper) to be changed because it was soiled with urine and stool. Resident 63 stated that he had to climb in his wheelchair so he could tell the staff to change him. Observed a cushion pad on the wheelchair with fresh and old stains of fecal matter. Resident 63 stated he felt upset and not feeling well sitting on incontinence brief soiled with stool for hours. During an interview on 7/6/2026 at 1:10 p.m. and subsequent interview on 7/6/2026 at 2:32 p.m. with CNA 1, CNA 1 stated she answered Resident 63's call light at around 7:10 a.m. on 7/6/2026. CNA 1 stated Resident 63 was complaining that his incontinence brief had not been changed that morning (7/6/2026). CNA 1 stated she did not change Resident 63's incontinence brief (diaper) because she had residents that she had to take care of and Resident 63 was not assigned to her. CNA 1 stated she told Licensed Vocational Nurse (LVN) 5 around 7:15 a.m. on 7/6/2026 during the huddle (staff gather at the start of a shift to share important residents' updates, prevent health problems and ensure everyone knows their daily care goals) that Resident 63 needed to change his soiled incontinence brief. CNA 1 stated Resident 63 was upset because the resident had to wait for 2 hours for someone to help him last night. CNA 1 stated Resident 63 would not be happy if his soiled incontinence brief was not changed in a timely manner. During an interview on 7/6/2026 at 1:40 p.m. with CNA 2, CNA 2 stated she asked Resident 63 (continued on next page)		

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	if he would want to be changed on 7/6/2026 at 10:30 a.m. CNA 2 stated Resident 63 was on his wheelchair and returned to his bed by himself. CNA 2 stated Resident 63's soiled incontinence brief was changed around 11:00 a.m. (7/6/2026). During an interview on 7/6/2026 at 1:43 p.m. and subsequent interview on 7/8/2026 at 11:32 a.m. with LVN 5, LVN 5 stated she told CNA 1 to change Resident 63's soiled incontinence brief. LVN 5 stated when she entered Resident 63's room on 7/6/2026 at 7:30 a.m., Resident 63 was not smiling, very quiet and not talking to her. LVN 5 stated there was a staff member who called in sick that day and the RN Supervisor had to revise the staff assignment, that is why no CNA was assigned to him yet at around 7:30 a.m. on 7/6/2026. LVN 5 stated Resident 63 should have been cleaned and soiled incontinence brief was changed right away when the resident used his call light to request a staff to help him. LVN 5 stated Resident 63 should not be left soiled with urine and stool for a long time. LVN 5 stated Resident 63 had a behavior and could get frustrated and be verbally aggressive if not changed in a timely manner. LVN 5 stated Resident 63 could develop skin breakdown and his angry behavior could escalate. During an interview on 7/9/2026 at 10:50 a.m. with Registered Nurse (RN) 1, RN 1 stated Resident 63 would be angry and could affect his dignity, skin breakdown and cause overall discomfort if Resident 63's soiled incontinence brief was not changed in a timely manner. During an interview on 7/9/2026 at 1:00 p.m. with the Director of Staff Development (DSD), DSD stated all staff are expected to answer the call light as soon as possible to ensure resident's safety. DSD stated any CNA not even assigned to the resident can assist in helping changed soiled incontinence brief of residents. DSD stated not changing soiled incontinence brief in timely manner could cause skin redness, moisture associated skin damage (MASD-inflamed, irritated or erosion of the skin caused by prolonged exposure to various forms of moisture such as sweat, urine, stool) and wounds. DSD stated Resident 63 could get emotional, angry, and feel disrespected for not being attended by the staff. During an interview on 7/9/2026 at 3:20 p.m. with the Director of Nursing (DON), the DON stated increased risk of falling, skin impairment and increased risk for escalating Resident 63's angry behavior if Resident 63 was not cleaned and changed his soiled incontinence brief in a timely manner. DON stated the CNA and LVN should have cleaned and changed the resident's soiled incontinence brief when Resident 63 verbalized his need to be changed. During a review of facility's policy and procedure (P&P) titled, Activities of Daily Living (ADLs), Supporting, revised 4/2025, the P&P indicated appropriate care and services are provided to residents who are unable to carry out ADLs (activities of daily living- activities such as bathing, dressing and toileting a person performs daily).		

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	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 two sampled residents (Resident 17) who received hemodialysis (a medical procedure to remove fluid and waste products from the body) had an emergency kit (medical supplies used to stop uncontrolled bleeding from a hemodialysis site if it got accidentally dislodged) at resident's bedside. This failure had the potential for delayed intervention during accidental dislodgment and bleeding on Resident 17. Findings: During a review of Resident 17's admission Record, the admission Record indicated Resident 17 was admitted on [DATE] to the facility with diagnoses including end stage renal disease (ESRD- irreversible kidney failure), dependence on renal dialysis (a treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidney(s) have failed), and diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing). During a review of Resident 17's Minimum Data Set (a resident assessment tool) dated 6/23/2026, the MDS indicated Resident 17 had intact cognition (thought process) and required supervision or touching assistance (helper provides verbal cues or contact guard assistance as resident completes the activity) with transfer to and from a bed to a chair, oral hygiene, toileting hygiene, upper body dressing and personal hygiene. During a review of Resident 17's Order Summary Report dated 5/23/2026, the Order Summary Report indicated to have an Emergency Kit by the bedside of the resident. During a review of Resident 17's Care Plan titled, Resident has End Stage Renal Disease requiring hemodialysis, initiated 3/18/2026, the Care Plan indicated interventions including having an emergency kit by the bedside and monitoring, documenting and reporting as needed for signs and symptoms of bleeding, hemorrhage (heavy or uncontrolled bleeding), and bacteremia (presence of bacteria in the blood). During a concurrent observation and interview on 7/6/2026 at 2:17 p.m. in Resident 17's room, Resident 17 did not have a dialysis emergency kit in his room. Resident 17 stated he had a dialysis catheter (soft, flexible tube inserted into a large vein to provide temporary or long-term access to the bloodstream) in his chest and undergoes dialysis every Tuesday, Thursday and Saturday. During a concurrent observation and interview on 7/7/2026 at 1:10 p.m. in Resident 17's room with Licensed Vocational Nurse (LVN) 5, LVN 5 stated there was no emergency kit at Resident 17's bedside drawer and room. LVN 5 stated the emergency kit should always be ready for Resident 17 use in case of bleeding from the dialysis site. During an interview on 7/9/2026 at 11:11 a.m. with Registered Nurse (RN) 1, RN 1 stated an emergency kit should always be readily available because Resident 17 was a high risk for uncontrolled bleeding from the dialysis site. RN 1 stated if Resident 17 had uncontrolled bleeding from the hemodialysis site, the emergency kit should be readily available in case of emergency. During an interview on 7/9/2026 at 3:12 p.m. with the Director of Nursing (DON), the DON stated if Resident 17 was actively bleeding from the dialysis site, the staff would not be able to stop the bleeding right away because the emergency kit was not available for use. During a review of facility's policy and procedure (P&P) titled, Hemodialysis Residents, revised 11/2019, the P&P indicated the facility will provide a safe, and appropriate care to the residents to improve their outcome in coordination with dialysis center.		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	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:1. Administer one of five residents' (Resident 73's) multivitamin with minerals in accordance with physician's orders.2. Ensure Resident 77's medications, namely diclofenac gel (a medication used to treat inflammation and pain), aformoterol (a medication used to treat breathing difficulty due to chronic obstructive pulmonary disease [COPD - a chronic lung disease causing difficulty in breathing]) and levalbuterol (a medication used to treat breathing difficulty due to asthma [a chronic lung disease causing inflammation and muscle tightness around airways]) were available in stock, affecting one of five residents.3. Dispose of and maintain documentation for disposal of Resident 77's unused and/or expired levalbuterol and aformoterol nebulizing solutions used by respiratory therapists as per facility's policy and procedure (P&P) titled, Policy - Respiratory Medication Disposal, undated, and Discarding and Destroying Medications, dated 06/2025. These deficient practices failed to provide medications in accordance with the physician's orders or professional standards of practice, ensure disposal and accurate documentation of disposal of medications, and had the potential to result in medication misuse, diversion, inadequate pain management and treatment for vitamin and mineral deficiencies, breathing problems and hospitalization for Residents 73 and 77. Findings: 1. During a review of Resident 73's admission Record (a document containing demographic and diagnostic information) dated 7/8/2026, the admission record indicated Resident 73 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included but not limited to anemia (a condition where the body does not have enough healthy red blood cells), alcohol abuse and unspecified cirrhosis (a condition in which liver is scarred and permanently damaged) of liver. During a review of Resident 73's History and Physical (H&P) dated 5/27/2026, the H&P indicated Resident 73 had fluctuating capacity to understand and make decisions. During a review of Resident 73's Minimum Data Set ([MDS], a resident assessment tool) dated 5/29/2026, the MDS indicated Resident 73's cognition (mental action or process of acquiring knowledge and understanding through thought and senses) was severely impaired. The MDS indicated Resident 73 needed moderate assistance from the facility staff for performing activities of daily living (ADLs - routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves) such as upper body dressing, maximal assistance for eating, oral hygiene, lower body dressing and personal hygiene, and dependent on facility staff for toileting hygiene, showering and putting on or taking off footwear. During an observation on 7/7/2026 between 9:55 a.m. and 10:18 a.m., Licensed Vocational Nurse (LVN) 2 prepared five medications to be administered to Resident 73. LVN 2 prepared tablets to be administered with apple sauce. a. One drop of Dorzolamide (a medication in the form of eye drops used to treat high pressure in the eyes) 2 percent (%) - a unit of measurement for strength of medication) in the right eye. b. One drop of Brimonidine (a medication in the form of eye drops used to treat high pressure in the eyes) 0.15% in both eyes. c. One capsule of gabapentin (a medication used to treat nerve pain or seizures (a sudden, uncontrolled electrical disturbance in the brain which can cause uncontrolled jerking, blank stares, and loss of consciousness) 100 milligrams ([mg] metric unit of measurement, used for medication dosage and/or amount) d. One tablet of lamotrigine (a medication used to treat mood disorder and seizures) 100 mge. One tablet of multivitamin (a combination of vitamins used to treat vitamin deficiency and support recovery and healing) During the medication administration in Resident 73's room, Resident 73 spit out multivitamin and lamotrigine. During a (continued on next page)		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	review of Resident 73's Order Summary Report (a document containing a summary of all active physician orders) dated 7/8/2026, the order summary report indicated but not limited to the following physician orders: Multivitamin adult tablet (Multiple Vitamins-Minerals), give 1 tablet by mouth one time a day for supplement, order date 8/17/2024, start date 8/18/2024. During a review of Resident 73's Plan Report, initiated date 9/6/2022, target date 8/8/2026, the care plan indicated, Resident 73 had anemia related to medication side effects, gastrointestinal bleed, at risk for weakness and fatigue. Interventions: administer medications as ordered, folic acid, thiamine HCl tablet, multivitamin adult tablet (multiple vitamins-minerals). During an interview on 7/7/2026 at 2:22 p.m. with LVN 2, LVN 2 stated she administered the wrong multivitamin to Resident 73. LVN 2 stated Resident 73 was supposed to receive multivitamin with minerals, but he received multivitamin without minerals. LVN 2 stated this was a medication error. During an interview on 7/8/2026 at 1:41 p.m. with the Director of Nursing (DON), the DON stated it was important to follow physician orders while administering medications to make sure that resident received vitamins and supplements for wound healing in case the resident had pressure sores and for overall healing process. 2. & 3. During a review of Resident 77's admission Record, dated 7/8/2026, the admission record indicated Resident 77 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included but not limited to chronic obstructive pulmonary disease with (acute) exacerbation, acute respiratory failure with hypoxia and low back pain. During a review of Resident 77's MDS, dated [DATE], the MDS indicated Resident 77's cognition was intact. The MDS indicated Resident 77 needed supervision level assistance from the facility staff for performing ADLs such as eating and oral hygiene, and moderate assistance for toileting hygiene, showering, upper body dressing and putting on or taking off footwear. During a concurrent observation and interview on 7/7/2026 at 10:23 a.m. with LVN 2, LVN 2 prepared seven medications to be administered to Resident 77. LVN 2 checked Resident 77's blood pressure and stated blood pressure reading was 111/83, systolic blood pressure [SBP - measures the pressure in the arteries when the heart contracts to pump blood] at 111) and (diastolic blood pressure [DBP - measures the pressure in the arteries when the heart muscle relaxes between beats] at 83 and heart rate (HR) was at 84 beats per minute. LVN 2 stated Resident 77 complained of pain in leg at pain level of 6 out of 10. LVN 2 stated Resident 77 asked for diclofenac gel but the instructions on it was for the hand and Resident 77 did not want to take an oral pain medication. a. One tablet of metformin (a medication used to treat high blood glucose level) 500 mg. One tablet of methocarbamol (a medication used to treat muscle spasms) 750 mg. One tablet of quetiapine (a medication used to treat mood disorders) 400 mg. One capsule of duloxetine (a medication used to treat mood disorders and neuropathy [nerve pain]) 60 mg. One tablet of Olmesartan (a medication used to treat high blood pressure) 20 mg with instructions to hold if SBP is less than 100 or HR is less than 60. One capsule of vitamin D3 (a vitamin used to treat low levels of vitamin D) 125 microgram ([mcg] a unit of measurement for mass) (5000 international units). One tablet of multivitamin with minerals. During a medication reconciliation review on 7/7/2026, Resident 77's Order Summary Report dated 7/8/2026 indicated but not limited to following physician orders: Diclofenac sodium external gel 1% topical, apply to left hand topically every 6 hours as needed for mild pain, apply 4 gram ([gm] a unit of measurement for mass) topically every 6 hours if needed, not to exceed 16 gm per day, order date 6/28/2026, start date 6/28/2026. During a review of Resident 77's Medication Administration Record (MAR - a daily documentation record used by a licensed nurse to document medications and treatments given to a resident) dated 7/1/2026 to 7/7/2026, the MAR indicated albuterol tartrate inhalation nebulization solution 15 mcg per 12 milliliters ([mL] a unit of measurement for volume) with instructions: 2 mL, inhale orally via nebulizer two times a day for shortness of breath (sob) / (continued on next page)		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	wheezing, was documented as administered 12 times. During a review of Resident 77's MAR dated 7/1/2026 to 7/7/2026, the MAR indicated levalbuterol hydrochloride (HCl) inhalation nebulization solution 1.25 mg/0.5 mL, with instructions: 1 inhalation inhale orally four times a day for respiratory therapy, was documented as administered 25 times. During an interview on 7/7/2026 at 2:25 p.m. with LVN 2, LVN 2 stated she informed the physician about Resident 77's complaining of pain in lower left leg and she could not apply diclofenac gel because the instructions for it (diclofenac gel) was only for left hand. LVN 2 stated she did not have diclofenac gel in stock for Resident 77 and would need to order from the pharmacy. LVN 2 then stated it was part of facility's house stock and was able to receive from central supply and would be able to apply the gel for Resident 77 next time. LVN 2 stated there was a risk that Resident 77's would remain in discomfort and pain because diclofenac gel was not available in stock. During an interview on 7/7/2026 at 2:25 p.m. with LVN 2, LVN 2 stated nursing did not have aformoterol and levalbuterol in her (LVN 2's) medication cart because nursing did not administer these medications for Resident 77. LVN 2 stated aformoterol and levalbuterol breathing treatments fell under the respiratory therapist program so the respiratory therapists would administer breathing treatments for Resident 77. During an interview on 7/7/2026 at 2:38 p.m. with the Pulmonary Services Director (PSD), PSD stated he could check for Resident 77's aformoterol and levalbuterol in Respiratory Cart 1 and Respiratory Cart 2. During an inspection of Respiratory Carts 1 and 2, PSD could not find Resident 77's aformoterol and levalbuterol and stated, they must have run out of the medication, and it was pending pharmacy delivery. PSD then stated aformoterol was supposed to be administered by nursing and levalbuterol administered by RT. During a concurrent interview and record review on 7/7/2026 at 2:38 p.m. with the PSD, Resident 77's MAR, dated 7/7/2026 was reviewed. The MAR indicated aformoterol was documented as administered by Respiratory Therapist (RT) 1 and levalbuterol was documented as administered by another RT (name key not provided to verify). PSD then stated due to the short expiration of within 14 days after opening the foil package of nebulizing solution, the RT staff ordered medications on 10th day before expiration. PSD stated the RT staff would discard and dispose the unused nebulizing solution by emptying it in the sink. PSD stated he did not have documentation for disposal of respiratory medications and that he needed to check the facility's policy. During a concurrent interview and record review on 7/7/2026 at 2:38 p.m. with the PSD, RT 1's daily documentation or progress note of respiratory treatment administration for Resident 77, dated 7/7/2026 7:41 a.m. was reviewed. The progress note indicated, Hand-held nebulizer (HHN) treatment administered with unit-dose albuterol (a medication used to treat breathing difficulty due to asthma or COPD) / Atrovent ([Generic name - ipratropium bromide] a medication used to treat breathing difficulty due to asthma or COPD) via mask, followed by chest physiotherapy (CPT). no shortness of breath observed at this time. The PSD stated RT 1 documented albuterol and Atrovent on the progress note which were incorrect medications because the administered medications should have been aformoterol and levalbuterol. The PSD stated RT 1 had left for the day. Surveyor attempted to reach RT 1 via phone with no response from RT 1. The PSD stated if they ran out of the aformoterol and levalbuterol for Resident 77 and medications were not administered, then the risk was very minimal, and it's mostly on therapeutic side not life-threatening side. We are helping resident with CPT, incentive spirometry, positive expiratory pressure valve therapy. The PSD stated, these are prophylactic (prevention) therapies and aiding them with the treatments. During an interview on 7/8/2026 at 10:23 a.m. with the PSD stated he would need to review the policy again. The PSD stated the facility received the medications from pharmacy at 5:45 p.m. and medications were administered on 7/7/2026. During an interview on 7/8/2026 at 1:41 p.m. with the DON, the DON stated it was important to always have the medications (continued on next page)		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	in stock and follow physician orders for all medications ordered. DON stated it was important to make Resident 77 comfortable for pain relief and important to have the diclofenac gel available to give ADL care. The DON stated the charge nurses should be checking if there was an 'as needed' medication ordered and it should be available in stock. During an interview on 7/8/2026 at 1:41 p.m. with the DON, the DON stated it was important to document the correct medications on record that were administered. The DON stated respiratory therapists should have a bin to dispose of any unused or expired medications and should be documented when medications were disposed of, according to facility's policy. The DON stated it was important to document disposal of medications to prevent medication misuse and diversion. During a phone interview on 7/8/2026 at 3:01 p.m. with Registered Pharmacist (RPH) 1 at Pharmacy (PH) 1, RPH 1 stated Resident 77's aformoterol was delivered on 6/29/2026 for quantity of 30 vials, 15 days' supply and they could be stored in the refrigerator. RPH 1 stated aformoterol could also be stored at room temperature for up to 6 weeks, and if it was removed from refrigerator, it should be marked with the date when moved from the fridge and could be used for up to 6 weeks. RPH 1 stated once the individual aformoterol vials in the foil pack were opened, they should be used right away after opening. RPH 1 stated Resident 77's levalbuterol was delivered on 6/29/2026 for a quantity of 30 vials and on 7/7/2026 for a quantity of 30 vials. RPH 1 stated levalbuterol should be stored at room temperature and once the foil package was opened, it should be used within 2 weeks. During an interview on 7/8/2026 at 4:02 p.m. with the PSD, when the surveyor tried to follow up regarding Resident 77's aformoterol and levalbuterol, the PSD stated he did not talk about Resident 77's aformoterol and the only medication in question was levalbuterol. Surveyor reminded him of the conversation and record review on 7/7/2026 regarding RT 1's documentation of administration of aformoterol for Resident 77. The PSD then stated he would need to check in Respiratory Therapy Cart 1 and Respiratory Therapy Cart 2. During a concurrent inspection and interview on 7/8/2026 at 4:02 p.m. with the PSD of the Respiratory Carts 1 and 2, the PSD stated there was no aformoterol for Resident 77 in Respiratory Carts 1 and 2, but there was one box of levalbuterol for Resident 77. The PSD stated the aformoterol could be in East Station Medication Cart. During a concurrent inspection and interview on 7/8/2026 at 4:14 p.m. with LVN 9 of the East Station Medication Cart, LVN 9 stated there was no aformoterol for Resident 77 in the cart. During an interview on 7/8/2026 at 5:09 p.m. with the PSD, the PSD stated he was able to find five packets of aformoterol for Resident 77 in North Station Medication Room after checking with RT 1. During a concurrent interview and record review on 7/8/2026 at 5:09 p.m. with the PSD, the package with aformoterol in North Station Medication Room was inspected. There were five packets of aformoterol 15 microgram ([mcg] a unit of measurement for mass) per 2 milliliters ([mL] a unit of measurement for volume) stored at room temperature in a cabinet, in a clear bag without a pharmacy label, without an open date. The clear bag had a typed note on white label that indicated Resident 77's first and last name and aformoterol. The PSD stated he did not realize that and he (PSD) would conduct a one-on-one education with RT 1 and respiratory therapy staff regarding medication storage, labeling and disposal according to facility's policy and manufacturer specifications. During a review of the facility's P&P titled, Administering Medications, dated 04/2019, the P&P indicated, Medications are administered in accordance with prescriber orders, including any required time frame. During a review of the facility's P&P titled, Policy - Respiratory Medication Disposal, undated, the P&P indicated, Respiratory medications shall be disposed of safely when discontinued, expired, contaminated, or no longer needed. Disposal shall protect resident safety, prevent misuse. requirements. The P&P indicated, Non-controlled respiratory medications shall be disposed of in designated pharmaceutical waste containers according to facility procedures. The P&P indicated, Disposal of medications shall (continued on next page)		

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For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	be documented according to facility policy, including the medication name, date of disposal, quantity (when applicable), and staff signature(s), if required. During a review of the facility's P&P titled, Discarding and Destroying Medications, dated 06/2025, the P&P indicated, Non-controlled and are disposed of in accordance with state regulations and federal guidelines regarding disposition of non-hazardous medications. The P&P indicated, The medication disposition record contains, as a minimum the following information: a. Resident's name; b. Name and strength of the medication.h. Signature of witnesses. The P&P indicated, Completed medication disposition records are kept on file in the facility for at least two (2) years or as mandated by state law governing the retention and storage of such records.		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure safe and secure storage and labeling of one of five residents' (Resident 77's) aformoterol (a medication used to treat breathing difficulty due to chronic obstructive pulmonary disease [COPD - a chronic lung disease causing difficulty in breathing]) nebulizing solution, found in one of one inspected medication rooms (North Station Medication Room), as per manufacturer specifications and facility's policy and procedure (P&P) titled, Medication Labeling and Storage, dated 02/2023 and Administration and Ordering of Respiratory Medications Policy, undated. These deficient practices had the potential to result in Resident 77 receiving medications that had become expired, ineffective or toxic due to improper storage and labeling possibly leading to adverse effects such as respiratory distress and hospitalization, and medication misuse and diversion. Findings: During a review of Resident 77's admission Record (a document containing demographic and diagnostic information), dated [DATE], the admission record indicated Resident 77 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included but not limited to chronic obstructive pulmonary disease with (acute) exacerbation and acute respiratory failure with hypoxia (low level of oxygen in body tissues). During a review of Resident 77's Minimum Data Set ([MDS], a resident assessment tool), dated [DATE], the MDS indicated Resident 77's cognition (mental action or process of acquiring knowledge and understanding through thought and senses) was intact. The MDS indicated Resident 77 needed supervision level assistance from the facility staff for performing activities of daily living (ADLs - routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves) such as eating and oral hygiene, and moderate assistance for toileting hygiene, showering, upper body dressing and putting on or taking off footwear. During a concurrent observation and interview on [DATE] at 10:23 a.m. with Licensed Vocational Nurse (LVN) 2, LVN 2 prepared seven medications to be administered to Resident 77 that did not include levalbuterol and aformoterol nebulizing solutions. During a review of Resident 77's Medication Administration Record (MAR - a daily documentation record used by a licensed nurse to document medications and treatments given to a resident) dated [DATE] to [DATE], the MAR indicated aformoterol tartrate inhalation nebulization solution 15 microgram ([mcg] a unit of measurement for mass) per 12 milliliters ([mL] a unit of measurement for volume) with instructions: 2 mL, inhale orally via nebulizer two times a day for shortness of breath (sob) / wheezing, was documented as administered 12 times. During an interview on [DATE] at 2:25 p.m. with LVN 2, LVN 2 stated nursing did not have aformoterol and levalbuterol in her (LVN 2's) medication cart because nursing did not administer these medications for Resident 77. LVN 2 stated that aformoterol and levalbuterol were usually administered by respiratory therapists to Resident 77. During a concurrent inspection and interview on [DATE] at 2:38 p.m. with the Pulmonary Services Director (PSD) of Respiratory Carts 1 and 2, PSD could not find Resident 77's aformoterol and stated, they must have run out of the medication, and it was pending pharmacy delivery. During a phone interview on [DATE] at 3:01 p.m. with Registered Pharmacist (RPH) 1 at Pharmacy (PH) 1, RPH 1 stated Resident 77's aformoterol was delivered on [DATE] for quantity of 30 vials, 15 days' supply and they could be stored in the refrigerator. RPH 1 stated aformoterol could also be stored at room temperature for up to 6 weeks, and if it was removed from refrigerator, it should be marked with the date when moved from the fridge and could be used for up to 6 weeks. RPH 1 stated once the (continued on next page)		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	individual afomoterol vials in the foil pack were opened, they should be used right away after opening. During a concurrent inspection and interview on [DATE] at 4:02 p.m. with the PSD of Respiratory Carts 1 and 2, the PSD stated there was no afomoterol for Resident 77 in Respiratory Carts 1 and 2. The PSD stated the afomoterol could be in East Station Medication Cart. During a concurrent inspection and interview on [DATE] at 4:14 p.m. with LVN 9 of the East Station Medication Cart, LVN 9 stated there was no afomoterol for Resident 77 in the cart. During an interview on [DATE] at 5:09 p.m. with the PSD, the PSD stated he was able to find five packets of afomoterol for Resident 77 in North Station Medication Room after checking with Respiratory Therapist (RT) 1. During a concurrent interview and record review on [DATE] at 5:09 p.m. with the PSD, the package with afomoterol in North Station Medication Room was inspected. There were five packets of afomoterol 15 mcg / 2 mL stored at room temperature in a cabinet, in a clear bag without a pharmacy label, without an open date. The clear bag had a typed note on white label that indicated Resident 77's first and last name and afomoterol. The PSD stated he did not realize that and he (PSD) would conduct a one-on-one education with RT 1 and respiratory therapy staff regarding medication storage, labeling and disposal according to facility's policy and manufacturer specifications. During a phone interview on [DATE] at 11:28 a.m. with RPH 1, RPH 1 stated one box of afomoterol had 6 pouches (5 vials in each pouch). RPH 1 stated the afomoterol box should be labeled with a pharmacy label with information such as pharmacy name, resident name, drug name, strength, quantity, instructions, doctor's name and pharmacy phone number. RPH 1 stated the facility should not repackage or change the label on medications. RPH 1 stated the facility, and licensed staff should maintain the original package for afomoterol or other medications, as sent from the pharmacy. During an interview on [DATE] at 12:18 p.m. with the DON, the DON stated, once the pharmacy delivered medications, the nursing staff would first verify how the medications should be labeled and stored and if the medications were for breathing treatment, the nursing staff would hand them over to the respiratory therapists and they would store them properly. The DON stated the facility should not repackage or change package or label of medications. The DON stated it was important to ensure medications were properly stored and labeled with a pharmacy label, and if it did not have instructions and if the medication was expired, then there would be a risk that the resident could have an ill effect or might not be treated for the condition. The DON stated in case of afomoterol that was not properly labeled and stored, there was a risk that the resident could have respiratory distress and might need to go to the hospital because the resident did not get proper treatment due to improper storage and labeling. During a review of the facility's P&P titled, Administration and Ordering of Respiratory Medications Policy, undated, the P&P indicated, All medications shall be administered using the Five Rights of medication administration and documented in the resident's medical record. The P&P indicated, 7. Storage. Respiratory medications shall be stored securely according to manufacturer recommendations and facility policy. Medications shall be kept in their original labeled containers. Responsibility. Licensed Nurses. Respiratory Therapy Staff (if applicable). Director of Nursing. During a review of the facility's P&P titled, Medication Labeling and Storage, dated 02/2023, the P&P indicated, The facility stores all medications and biologicals in locked compartments under proper temperature, humidity and light controls. The P&P indicated, Medications and biologicals are stored in the packaging, containers or other dispensing systems in which they are received. Only the issuing pharmacy is authorized to transfer medications between containers. The P&P indicated, Medications requiring refrigeration are stored in a refrigerator located in the medication room at the nurses' station or other secured location. The P&P indicated, Medication Labeling. 1. Labeling of medications and biologicals. pharmaceutical practices. 2. The medication label includes, at a minimum: a. medication (continued on next page)		

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

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	name (generic and/or brand); b. prescribed dose; c. strength; d. expiration date, when applicable; e. resident's name; f. route of administration; and g. appropriate instructions and precautions. The P&P indicated, Only the dispensing pharmacy may label or alter the label on a medication container or package. Medications may not be transferred between containers.		

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F 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide routine and 24-hour emergency dental care for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to assess and follow up with the necessary dental services for one of two sampled residents (Resident 63). This failure had the potential to put Resident 63 at risk for inability to chew effectively leading to weight loss and mouth discomfort. Findings: During a review of Resident 63's admission Record, the admission Record indicated Resident 63 was admitted on [DATE] to the facility with diagnoses including chronic obstructive pulmonary disease (COPD- group of lung disease that block the airflow which can cause difficulty of breathing), osteoarthritis (protective cartilage on the ends of your bone breaks down, causing pain, swelling and problems moving the joint), hypertension (high blood pressure) and congestive heart failure (CHF- a heart disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling). During a review of Resident 63's Minimum Data Set (MDS- a resident assessment tool) dated 4/14/2026, the MDS indicated Resident 63 had an intact cognition (thought process) and required substantial/maximal assistance (helper does more than half the effort) with toileting hygiene, bathing, and upper body dressing. During a review of Resident 63's Care Plan titled, Resident 63 has no teeth in the upper and multiple missing teeth in the lower jaw and the resident had no partial dentures, undated, the Care Plan indicated interventions such as coordinating arrangements for dental care and referring to the dentist for evaluation. During a review of Resident 63's Social Services Initial Psychosocial Assessment, dated 5/8/2026, the Social Services Initial Psychosocial Assessment indicated ancillary services (refer to the medical, diagnostic, and therapeutic treatments that support primary care) for vision, dental, hearing, and podiatry (medical care and treatment of feet) was left blank and was not completed. During an observation on 7/7/2026 at 9:18 a.m. in Resident 63's room, Resident 63 had missing upper and lower teeth. During a concurrent interview and record review on 7/8/2026 at 10:52 a.m. with Social Services Assistant (SSA) 1, Resident 63's electronic chart was reviewed. SSA 1 stated there was no dental mobile consult done or pending. During a concurrent interview and record review on 7/8/2026 at 11:09 a.m. with the Director of Social Services (DSS), Resident 63's Social Services Initial Psychosocial Assessment was reviewed. DSS stated he was responsible for doing admission assessment on all residents. DSS stated Resident 63's Social Services Initial Psychosocial assessment dated [DATE] was not completed. DSS stated Social Services Initial Psychosocial Assessment should be completed to capture necessary ancillary services Resident 63 would need. DSS stated if the initial social services psychosocial assessment is not completed, the residents' needs for dental services will not be met or identified. During an interview on 7/8/2026 at 3:22 p.m. with Licensed Vocational Nurse (LVN) 5, LVN 5 stated Resident 63 had missing teeth on the upper and lower mouth. LVN 5 stated Resident 63's could develop mouth discomfort and could affect resident's ability to chew his food leading to weight loss if resident's dental needs were not identified and assessed during admission by the social service. During an interview on 7/9/2026 at 3:25 p.m. with the Director of Nursing (DON), DON stated it is important to complete initial psychosocial service assessment of Resident 63 to ensure dental needs are identified because gaps in his teeth could affect his ability to chew and could affect his care. During a review of facility's Job Description for Social Services Specialist, revised 11/2024, the Job Description of Social Services Specialist indicated the Social Services Specialist will ensure the residents receive necessary evaluation for vision, hearing, mental health, and dental needs and follow up as required.		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility's Respiratory Therapist (RT) 1 failed to ensure medical records for one of five sampled residents (Resident 77) were accurate by failing to accurately document on progress notes that afomoterol (a medication used to treat breathing difficulty due to chronic obstructive pulmonary disease [COPD - a chronic lung disease causing difficulty in breathing]) and levalbuterol (a medication used to treat breathing difficulty due to asthma [a chronic lung disease causing inflammation and muscle tightness around airways]) nebulizing solutions were administered to Resident 77 instead of documenting that albuterol (a medication used to treat breathing difficulty due to asthma or COPD) and Atrovent ([Generic name - ipratropium bromide] a medication used to treat breathing difficulty due to asthma or COPD) were administered on 7/7/2026. This deficient practice resulted in inaccurate and unclear medical documentation, had the potential to cause misunderstanding among facility's licensed care staff, inaccurate care planning, medication errors and/or result in inappropriate breathing treatments for Resident 77. Findings: During a review of Resident 77's admission Record (a document containing demographic and diagnostic information), dated 7/8/2026, the admission record indicated Resident 77 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included but not limited to chronic obstructive pulmonary disease with (acute) exacerbation and acute respiratory failure with hypoxia (low level of oxygen in body tissues). During a review of Resident 77's Minimum Data Set ([MDS], a resident assessment tool), dated 6/30/2026, the MDS indicated Resident 77's cognition (mental action or process of acquiring knowledge and understanding through thought and senses) was intact. The MDS indicated Resident 77 needed supervision level assistance from the facility staff for performing activities of daily living (ADLs - routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves) such as eating and oral hygiene, and moderate assistance for toileting hygiene, showering, upper body dressing and putting on or taking off footwear. During a concurrent observation and interview on 7/7/2026 at 10:23 a.m. with Licensed Vocational Nurse (LVN) 2, LVN 2 prepared seven medications to be administered to Resident 77 that did not include levalbuterol and afomoterol nebulizing solutions. During a review of Resident 77's Medication Administration Record (MAR - a daily documentation record used by a licensed nurse to document medications and treatments given to a resident) dated 7/1/2026 to 7/7/2026, the MAR indicated afomoterol tartrate inhalation nebulization solution 15 mcg per 12 milliliters ([mL] a unit of measurement for volume) with instructions: 2 mL, inhale orally via nebulizer two times a day for shortness of breath (sob) / wheezing, was documented as administered 12 times. During a review of Resident 77's MAR dated 7/1/2026 to 7/7/2026, the MAR indicated levalbuterol hydrochloride (HCl) inhalation nebulization solution 1.25 mg/0.5 mL, with instructions: 1 inhalation inhale orally four times a day for respiratory therapy, was documented as administered 25 times. During an interview on 7/7/2026 at 2:25 p.m. with LVN 2, LVN 2 stated nursing did not have afomoterol and levalbuterol in her (LVN 2's) medication cart because nursing did not administer these medications for Resident 77. LVN 2 stated afomoterol and levalbuterol breathing treatments fell under the respiratory therapist program so the respiratory therapists would administer breathing treatments for Resident 77. During an interview on 7/7/2026 at 2:38 p.m. with the Pulmonary Services Director (PSD), PSD stated he could check for Resident 77's afomoterol and levalbuterol in Respiratory Cart 1 and Respiratory Cart 2. During an inspection of Respiratory Carts 1 and 2, PSD could not find Resident 77's afomoterol and (continued on next page)		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	levalbuterol and stated, they must have run out of the medication, and it was pending pharmacy delivery. PSD then stated aformoterol was supposed to be administered by nursing and levalbuterol administered by RT.During a concurrent interview and record review on 7/7/2026 at 2:38 p.m. with the PSD, Resident 77's MAR, dated 7/7/2026 was reviewed. The MAR indicated aformoterol was documented as administered by Respiratory Therapist (RT) 1 and levalbuterol was documented as administered by another RT (name key not provided to verify).During a concurrent interview and record review on 7/7/2026 at 2:38 p.m. with the PSD, RT 1's daily documentation or progress note of respiratory treatment administration for Resident 77, dated 7/7/2026 7:41 a.m. was reviewed. The progress note indicated, Hand-held nebulizer (HHN) treatment administered with unit-dose albuterol (a medication used to treat breathing difficulty due to asthma or COPD) / Atrovent ([Generic name - ipratropium bromide] a medication used to treat breathing difficulty due to asthma or COPD) via mask, followed by chest physiotherapy (CPT).no shortness of breath observed at this time. The PSD stated RT 1 documented albuterol and Atrovent on the progress note which were incorrect medications because the administered medications should have been aformoterol and levalbuterol. The PSD stated RT 1 had left for the day. Surveyor attempted to reach RT 1 via phone with no response from RT 1. The PSD stated if they ran out of the aformoterol and levalbuterol for Resident 77 and medications were not administered, then the risk was very minimal, and it's mostly on therapeutic side not life-threatening side; these are prophylactic (prevention) therapies and aiding them with the treatments.During an interview on 7/8/2026 at 1:41 p.m. with the DON, the DON stated it was important to always have the medications in stock and follow physician orders for all medications ordered. The DON stated it was important to document the correct medications that were administered. During a review of the facility's policy and procedure (P&P) titled, Administration and Ordering of Respiratory Medications Policy, undated, the P&P indicated, All medications shall be administered using the Five Rights of medication administration and documented in the resident's medial record. The P&P indicated, 5. Documentation - The nurse or respiratory therapist shall document: medication administered, date and time, dose and route.notification of the physician for significant changes or adverse reactions.During a review of the facility's P&P titled, Administering Medications, dated 04/2019, the P&P indicated, As required or indicated for a medication, the individual administering the medication records in the resident's medical record: a. the date and time the medication was administered; b. the dosage; .g. the signature and title.drug.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide and implement an infection prevention and control program. Based on observation and interview, the facility failed to implement and maintain infection control when Certified Nurse Assistant (CNA) 7 failed to perform hand hygiene in between resident's care and prior to entering and exiting resident rooms. These failures had the potential to result in cross contamination (physical movement or transfer of harmful bacteria from one person, object, or place to another) and place residents at risk for spread of infection. Findings: During a concurrent observation and interview on 7/7/2026 at 12:44 p.m., with CNA 7, CNA 7 was observed passing lunch trays while going room to room without performing hand hygiene. CNA 7 stated she did not perform hand hygiene because she was rushing and forgot. CNA 7 stated she should have performed hand hygiene to prevent the spread of germs which could result in the residents getting sick. During an interview on 7/8/2026 at 11:33 a.m., with Infection Prevention Nurse (IPN), IPN stated staff should be performing hand hygiene each time they grab a meal tray and when entering and exiting a room. IPN stated hand hygiene is important in the prevention of transmitting any type of infection and prevention of the staff and residents from getting sick. During an interview on 7/9/2026 at 2:01 p.m., with the Director of Nursing (DON), DON stated the staff are expected to perform hand hygiene before handling meal trays, before entering a resident's room, and when exiting a resident's room to prevent the spread of germs and infection. During a review of the facility's policy and procedure (P&P) titled, Handwashing/Hand Hygiene, revised 10/2023, the P&P indicated, This facility considers hand hygiene the primary means to prevent the spread of healthcare-associated infections. All personnel are expected to adhere to hand hygiene policies and practices to help prevent the spread of infections to other personnel, residents, and visitors. Hand hygiene is indicated after touching a resident's environment.		