STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055376	A. Building B. Wing	02/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Huntington Drive Health and Rehabilitation Center	400 W. Huntinton Dr. Arcadia, CA 91007

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility staff failed to promote dignity and respect for five (5) of six (6) sampled residents (Residents 37, 51, 79, 24 and 47) reviewed for dignity by failing to:1. Close the curtain while providing care to Resident 37 on 2/23/2026 and 2/24/2026. Resident 37's body was visible to other residents and staff in the room during care.2. Address Resident 51 by the resident's preferred name rather than using the term Mama on 2/25/2026.3. Knock on the door before entering Resident 79's room on 2/26/2026.4. Ensure Resident 24's pants were not wet with urine while Resident 24 sat on his wheelchair in the hallway on 2/23/2026 and did not ensure Resident 24 did not smell like urine in the hallway on 2/24/2026.5. Ensure Resident 47's foley catheter (thin, flexible tube inserted through the urethra [tube that carries urine from the bladder out of the body] into the bladder to continuously drain urine into an external bag) drainage bag was covered with a dignity bag (a discreet pouch designed to cover a urinary drainage bag).These deficient practices had the potential to negatively affect Residents 37, 51, 79, 24, and 47's senses of self-worth and self-esteem which could result in problems with emotional and mental well-being. Findings: 1. During a review of Resident 37's admission Record, the admission Record indicated Resident 37 was admitted to the facility on [DATE] and re-admitted on [DATE], Resident 37's diagnoses included epilepsy (a chronic brain disorder characterized by recurrent, unprovoked seizures [are brief episodes of abnormal electrical activity in the brain that can cause a variety of symptoms, including involuntary movements, loss of consciousness, and changes in behavior]), major depressive disorder (or also called clinical depression, it affects how you feel, think and behave and can lead to a variety of emotional and physical problems) and dementia (a progressive state of decline in mental abilities) During a review of Resident 37's Minimum Data Set (MDS, a resident assessment tool) dated 1/9/2026, the MDS indicated Resident 37 had severely impaired cognitive skills (mental action or process of acquiring knowledge and understanding) for daily decision making. The MDS indicated Resident 37 was dependent (helper does all of the effort, resident does none of the effort to complete the activity) in toileting hygiene, shower/ bathe self, upper and lower body dressing, putting on/ taking off footwear, personal hygiene, sit to lying, lying to sitting on the side of the bed, sit to stand and chair/ bed-to-chair transfer. During an observation on 2/23/2026 at 3:57 PM in Resident 37's room, Certified Nurse Assistant 7 (CNA 7) was changing Resident 37's brief. Resident 37's privacy curtain was halfway open and was not fully pulled to cover Resident 37's body. Resident 37's hip and bilateral legs were visible upon entering Resident 37's room and were also visible to other residents inside the room. Resident 37's roommate was observed staring at Resident 37 while the staff was providing care for the resident. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview on 2/24/2026 at 12:08 PM with CNA 2 inside Resident 37's room, CNA 2 was changing Resident 37's brief and providing morning care. Resident 37's privacy curtain was halfway open and was not fully pulled to cover Resident 37's body. Resident 37's left chest was exposed and not covered by the towel, making it visible to other residents in the room. CNA 2 stated she pulled the curtain down to Resident 37's waist to prevent Resident 37 from reaching for and grabbing the curtain. During an interview on 2/24/2026 at 3:28 PM with CNA 7, CNA 7 stated she did not pull the curtain fully to cover Resident 37. CNA 7 stated they need to close the curtain completely to cover the resident's body when providing care to the residents, to ensure privacy and dignity. During an interview on 2/24/2026 at 3:48 PM with LVN 1, LVN 1 stated they need to close the curtain fully to provide privacy and dignity for Resident 37. During a review of the facility's Policy and Procedure (P&P) titled, Dignity, revised 2/2021, the P&P indicated resident shall be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life, and feelings of self-worth and self-esteem. Staff promote, maintain and protect resident privacy, including bodily privacy during assistance with personal care and during treatment procedures. 2. During a review of Resident 51's admission Record, the admission Record indicated Resident 51 was admitted to the facility on [DATE] and re-admitted on [DATE], Resident 51's diagnoses included sepsis (a life-threatening condition that occurs when the body's immune system overreacts to an infection), chronic kidney disease (CKD, is a condition in which the kidneys are damaged and cannot filter blood as well as they should), Gastroesophageal reflux disease (GERD, happens when stomach acid flows back up into the esophagus and causes heartburn [a painful, burning feeling in the middle of your chest]) During a review of Resident 51's MDS, dated [DATE], the MDS indicated the resident's cognitive skills for daily decision making were severely impaired. The MDS indicated Resident 51 was dependent on shower/bathe self and putting on/ taking off footwear. The MDS indicated Resident 51 also needed substantial/ maximal assistance (helper does more than half the effort. helper lifts, holds trunk or limbs, and provides more than half the effort) in toileting hygiene, lower body dressing, roll left and right, sit to lying, lying to sitting on the side of the bed, sit to stand, chair/ bed-to-chair transfer, toilet transfer and tub shower transfer. During a concurrent observation on 2/25/2026 at 6:09 AM with LVN 5 inside Resident 51'S room, Resident 51 was awake and lying on her bed. LVN 5 stated, Hold the cup Honey (to Resident 51), you can bring this cup to your mouth. Resident 51 took her medication, LVN 5 stated, Alright Honey, do you want more water? During an interview on 2/25/2026 at 6:13 AM with LVN 5, LVN 5 stated they should not call the residents Honey. LVN 5 stated all the residents, including Resident 51, should be addressed with their first and last names, unless the residents preferred to be addressed differently. LVN 5 stated, to maintain the residents' dignity, they should not use labels when addressing residents. During a concurrent observation on 2/25/2026 at 1:15 PM in Resident 51's room, Resident 51 was awake and lying on her bed. Resident 51 turned on her call light. CNA 3 came inside Resident 51's room and asked Resident 51, Do you want something Mama? Resident 51 requested to move the (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	overbed table and was observed pushing it with CNA3. CNA 3 stated to Resident 51 Good job Mama! Thank you, Mama. During an interview on 2/25/2026 at 1:18 PM with CNA 3, CNA 3 stated, Yes, I called her (Resident 51) Mama. CNA 3 stated she does not know how to address Resident 51. CNA 3 stated they were not supposed to label residents to maintain dignity and respect. During a concurrent observation and interview on 2/25/2026 at 1:20 PM in Resident 51's room, Resident 51 was sitting on her bed watching television. Surveyor asked Resident 51 if it was okay for the staff to call her Honey or Mama. Resident 51 did not answer and looked at the surveyor and shook her head. During a review of the facility's P&P titled, Dignity, revised 2/2021, the P&P indicated Staff speak respectfully to residents at all times, including addressing the resident by his or her name of choice and not labeling or referring to the resident by his or her room number, diagnosis, or care needs. 3. During a review of Resident 79's admission Record, the admission Record indicated Resident 79 was admitted to the facility on [DATE] and re-admitted on [DATE], Resident 79's diagnoses included encephalopathy (a disturbance of brain function), diabetes mellitus (DM, is a metabolic disease, involving inappropriately elevated blood glucose levels) and gastrostomy tube (G-tube, is a tube inserted through the belly that brings nutrition directly to the stomach). During a review of Resident 79's MDS, dated [DATE], the MDS indicated the Resident 79's cognitive skills for daily decision making were moderately impaired. The MDS indicated Resident 79 was dependent on oral hygiene, toileting hygiene, shower/bathe self, upper and lower body dressing, putting on/ taking off footwear, personal hygiene, roll left and right, sit to lying, and lying to sitting on the side of the bed. During an observation on 2/26/26 at 8:36 AM inside Resident 79's room, Resident 79 was lying on her bed, sleeping. admission Coordinator (ADC) walked into Resident 79's room without knocking on the door. ADC was observed proceeding into Resident 79's bedside while looking around the resident's room without acknowledging the resident. During an interview on 2/26/2026 at 8:37 AM with ADC, ADC stated she did not knock on the door before entering Resident 79's room because Resident 79 was sleeping. ADC stated the staff need to knock on the door before going into any residents' room and introduce themselves, so the residents are aware of who is entering. ADC stated it was part of residents' rights and also to maintain dignity and respect. During a review of the facility's undated P&P titled, Dignity, revised 2/2021, the P&P indicated Residents' private space and property are respected at all times. Staff do not handle or move a resident's personal belongings without the resident's permission. Staff are expected to knock and request permission before entering residents' rooms. 4. During a review of Resident 24's admission Record, the admission Record indicated Resident 24 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included obstructive and reflux uropathy (a blockage in the urinary system that stops urine from flowing out of the body), other hydronephrosis (swelling of the kidneys caused by a backup of urine that cannot properly drain into the bladder due to blockage or obstruction), and benign prostatic hyperplasia with (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	lower urinary tract symptoms (enlargement of the prostate gland). During a review of Resident 24's MDS, dated [DATE], the MDS indicated Resident 24 was assessed having moderately impaired cognitive skills for daily decision making. The MDS indicated Resident 24 required supervision or touching assistance (helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity) with toileting hygiene, personal hygiene, sit to stand, and toilet transfer. The MDS indicated Resident 24 required partial/moderate assistance (helper does less than half the effort, helper lifts, holds, or supports trunk or limbs but provides less than half the effort) with shower/bathe self, lower body dressing, and putting on/taking off footwear. The MDS indicated Resident 24 had an indwelling catheter (a tube inserted into the bladder to help drain urine). During a concurrent observation and interview on 2/23/2026, at 12:04 PM, in the hallway outside the dining room, Resident 24 was observed sitting in his wheelchair with his eyes closed. Resident 24's pants were soiled with urine. Several unknown facility staff walked by Resident 24 but did not assist Resident 24 back to his room to change him. The Minimum Data Set Coordinator (MDS 1) stated Resident 24's pants were soiled and wheeled Resident 24 back to his room. During a concurrent observation and interview on 2/27/2026, at 10:14 AM, outside Resident 24's room, Resident 24 was observed sitting in his wheelchair outside his room. Resident 24 smelled like urine. Resident 24 stated he was aware that he smelled like urine. Resident 24 stated facility staff were too lazy to smell the urine and keep telling him to wait. Resident 24 stated sitting outside his room smelling like urine made him feel indecent. The Maintenance Supervisor 1 (MS 1) stood next to Resident 24 and stated Resident 24 smelled like urine. MS 1 stated Resident 24 should have been changed as soon as staff noticed he smelled like urine. During an interview on 2/24/2026, at 4 PM, MDS 1 stated facility staff should change the residents' clothing when soiled. MDS 1 stated facility staff were also responsible for making sure the residents were not sitting in soiled clothing in the hallway. MDS 1 stated facility staff should have helped Resident 24 when he smelled like urine outside his room. MDS 1 stated the residents' self-esteem could go down if facility staff did not clean the resident who smelled like urine right away. 5. During a review of Resident 47's admission Record, the admission Record indicated Resident 47 was initially admitted to the facility on [DATE] and was readmitted on [DATE] with diagnoses that included urinary tract infection, dysphagia (difficulty or discomfort in swallowing), and orthostatic hypotension (a sudden temporary drop in blood pressure that concerns when standing up from a sitting or lying position). During a review of Resident 47's Minimum Data Set (MDS- a resident assessment tool), dated 1/2/2026, the MDS indicated Resident 47 was assessed having moderately impaired (decisions poor, cues/supervision required) cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making. The MDS indicated Resident 47 was dependent (helper does all of the effort) with oral/toileting hygiene, shower/bathe self, upper/lower body dressing, and sit to lying. The MDS indicated Resident 47 had an indwelling catheter. During a review of Resident 47's Order Summary Report, dated 2/24/2026, the Order Summary Report indicated a physician order, with a start date of 1/16/2026, for foley catheter (f/c) French (Fr- circumference of f/c tube) 16/10 cubic centimeter (cc- unit of measurement for small liquid doses) to bladder sphincter dyssynergia (BSD- a condition where the bladder contracts but the sphincter (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	remains closed) due to diagnosis of obstructive uropathy (a condition where the normal flow of urine is blocked anywhere along the urinary tract). During a concurrent observation and interview on 2/23/2026, at 9:25 AM, with Certified Nursing Assistant 9 (CNA 9), in Resident 47's room, Resident 47 was awake in bed. Resident 47's foley catheter drainage bag was touching the floor and was not covered with a dignity bag (a discreet pouch designed to cover a urinary drainage bag). CNA 9 stated foley catheter drainage bags should not touch the floor and should always be covered with a dignity bag. During a review of the facility's policy and procedure (P&P), titled, Dignity, revised on 2/2021, the P&P indicated residents are treated with dignity and respect at all times. The P&P further indicated demeaning practices and standards of care that compromise dignity are prohibited. Staff are expected to promote dignity and assist residents by helping the Resident keep urinary catheter bags covered. During a review of the facility's P&P, titled, Dignity, revised 2/2021, the P&P indicated demeaning practices and standards of care that compromise dignity are prohibited. Staff are expected to promote dignity and assist residents by promptly responding to a resident's request for toileting assistance.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation interview and record review, the facility failed to provide reasonable accommodation of resident needs by ensuring 2 of four (4) sampled residents (Residents 29 and 43) call light device (one of the major communication technologies that links nursing home staff to the needs of residents) was within reach and answered timely. This failure had the potential to cause a delay in care for Resident 43 and 29 and prevent the residents from receiving the necessary care and services, which could lead to illness or serious injury.Findings: 1.During a review of Resident 29's admission Record, the admission Record indicated Resident 29 was initially admitted to the facility on [DATE] with diagnosis of type 2 diabetes mellitus (a disease that occurs when there is a problem in the way the body regulates and uses sugar as fuel), hypertension (high blood pressure), dependence on renal dialysis (a life-sustaining, long-term requirement for individuals with end-stage renal disease (ESRD, kidneys no longer function well enough to sustain life). During a review of Resident 29's Minimum Data Set (MDS, a resident assessment tool), dated 2/4/2026, the MDS indicated Resident 29's cognitive skills (processes of thinking and reasoning) for daily decision making was moderately impaired cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making were moderately impaired. The MDS indicated that Resident 29 was partial/moderate assistance (helper does less than half the effort. helper lifts, holds, or supports trunk or limbs, but provides less than half the effort) on oral hygiene (The ability to use suitable items to clean teeth), upper body dressing (the ability to dress and undress above the waist), Personal hygiene(the ability to maintain personal hygiene, including combing hair, shaving, applying makeup, washing/drying, face and hands (excludes baths, showers, and oral hygiene), lying to sitting on side of bed (the ability to move from lying on the back to sitting on the side of the bed and with no back support), Chair/bed-to-chair transfer (the ability to transfer to and from a bed to a chair or wheelchair). During a review of Resident 29's care plan date initiated 2/3/2026, the care plan indicated Resident 29 was at risk for fall risk for falls with injury related to limited mobility fracture, history of falls. The care plan indicated the residents need a working and reachable call light. During an observation and interview on 2/23/2026 at 10:14 AM in the presence of License Vocational Nurse (LVN 3), LVN 3, Resident 29's call light was observed at the left side of the bed facing down towards the floor. Resident 29 was trying to reach her call light and stated she could not reach it. Resident 29 also stated that call lights at night shift are not being answered. 2.During a review of Resident 43's admission Record, the admission Record indicated Resident 43 was initially admitted to the facility on [DATE] with diagnosis of major depressive disorder (disorder (a mental health disorder characterized by persistently depressed mood or loss of interest in activities, causing significant impairment in daily life), anxiety disorder (persistent and excessive worry that interferes with daily activities), bipolar disorder (mental disorder characterized by episodes of mania [extreme highs] and depression [extreme lows]). During a review of Resident 43's MDS, dated [DATE], the MDS indicated Resident 43's cognitive skills for daily decision making were cognitively intact. The MDS also indicated Resident 43 was partial/moderate assistance on Upper body dressing, personal hygiene and roll left and right (the ability to roll from lying on back to left and right side and return to lying on back on the bed). During a review of Resident 43's care plan date initiated 1/14/2022, the care plan indicated potential for fall or injury related to impaired physical mobility due to abnormalities of gait and mobility. The care plan also indicated that staff should orient Resident 43 to the use of the call light, keep the call light within reach, and answer call lights promptly. During concurrent observation and interview on 2/23/2026 at 10:46 AM at the hallway, Room A's call light was observed to be on. License Vocational Nurse (LVN 6) was talking to the resident's family, and two license nurses were sitting at the nursing station. The call light sound was heard, and the light was visibly seen from the hallway. LVN 6 stated that the two nurses at the nursing station should have answered the call light; (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	however, they did not respond. During an interview on 2/23/2026 at 10:50 AM with Resident 43, Resident 43 stated, nurses don't usually answer the call light. I got used to it. I have to wait until nurses' answer. During an interview on 2/25/2026 at 1:31 PM with the Director of Staff and Development (DSD), the DSD stated the call lights are the call light was the resident's way of communication, and to alert the facility staff when the resident needs assistance. It should be within reach all the time. DSD also stated The residents might feel ignored, needs not meet, residents emotional state will be affected. There's no excuse. The DSD also stated call lights are supposed to be answered as soon as possible. During an interview on 2/26/2026 at 9:19 AM with the Registered Nurse (RN 1), RN1 stated that all call lights need to be answered. RN1 also stated that at the nursing station there is a call light board where staff can hear and see the light and sound when residents press their call light. RN1 also stated that answering call light promptly is important for the safety of the residents. If call lights are not answered, residents may feel ignored and this could also lead to potential harm such as falls. During a review of facility's Policy and Procedure (P&P) titled Call Light, revised date 1/2024, the P&P indicated that the residents are provided with a mean to call staff for assistance through a communication system that directly alert member or a centralized workstation. The purpose of this procedure is to ensure timely response to the residents' requests and needs. The P&P also indicated that upon admission, and as needed the resident call light shall be kept within reach. The P&P also indicated that the staff must answer the resident's call light in a timely manner.

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure two (2) of four (4) sampled residents (Residents 104 and 107) reviewed for activities of daily living (ADL) were provided care and services to maintain good grooming and personal hygiene by failing to:Provide toileting assistance to Resident 104 when residents asked to use the restroom and and was instructed by facility staff to urinate in the resident's diaper. 2.a. Provide toileting assistance to Resident 107 when resident needed to urinate and was instructed by facility staff to urinate in the resident's diaper.2b. Give Resident 107 a bath from 2/18/2026 to 2/23/2026.These deficient practices have the potential for Residents 104 and 107 to develop skin issues/complications and affect the residents' quality of life and self-esteem.Findings: During a review of Resident 104's admission Record, the admission Record indicated Resident 104 was admitted to the facility on [DATE] with diagnoses that included lack of coordination, abnormalities in gait (the manner or pattern of how someone walks, runs, or moves on foot) and mobility, and fracture of second lumbar vertebra (one of the bones that make up the spinal column). During a review of Resident 104's Minimum Data Set, (MDS- a resident assessment tool), dated 2/25/2026, the MDS indicated Resident 104 had moderate impairment in Cognitive skills (mental action or process of acquiring knowledge and understanding) for daily decision making. The MDS also indicated Resident 104 was dependent (helper does all the effort) on toileting hygiene, shower and putting on/taking off footwear and required substantial/maximal assistance with lower body dressing. The MDS further indicated Resident 104 required partial/moderate assistance (helper does less than half the effort) with upper body dressing and setup assistance (helper sets up; resident completes activity) with oral hygiene. During an interview on 2/24/2026 at 9:15 AM, Family Member 1 (FAM 1) for Resident 104 stated that on the night of 2/23/2026 the resident pressed his call light and requested assistance to use the restroom. FAM 1 stated the Certified Nursing Assistant (CNA, not identified) staff told the resident he could urinate in his diaper instead of assisting him to the restroom. FAM 1 further stated that Resident 104 expressed concerns about the care he received and stated he wanted to go home. During a concurrent observation and interview on 2/24/2026 at 10:22 AM, Resident 104 was observed lying in bed with a diaper (under brief). The resident stated that on the night of 2/23/2026, he pressed on his call light and requested assistance to use the restroom. He stated the CNA did not respond for more than an hour, and he had already urinated in his diaper before the staff arrived. The resident stated the CNA told him he could urinate in his diaper. Resident 104 reported he remained in a wet diaper throughout the night and was changed the following morning. The resident stated he only needed assistance with undoing his diaper so he could use his urinal and was disappointed with the care provided. He stated he had expressed to Family Member 1 a desire to go home due to his concerns. Resident 104 further stated that the same situation occurred on the night of 2/22/2026, when no staff responded to his call light, and he remained in a wet diaper the entire night. During an interview on 2/24/2026 at 4:43 PM, Registered Nurse 1 (RN 1) stated that residents may feel embarrassed when they experience accidents, especially because many struggles with loss of independence. RN 1 stated residents should not be told they can urinate in their diapers and should be treated with respect and dignity. (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 2/26/2026 at 12:14 PM, Licensed Vocational Nurse 3 (LVN 3) stated that telling Resident 104 he could urinate in his diaper and leaving him wet is a dignity concern. LVN 3 stated that such actions could cause the resident to feel unhappy with the care provided and to feel that staff do not care about him. During a review of the facility's Policy and Procedure (P&P) titled, Supporting Activities of Daily Living, revised 3/2018, the P&P indicated that resident will be provided with care, treatment and services as appropriate to maintain or improve their ability to carry out ADL. 2. During a review of Resident 107's admission Record, the admission Record indicated Resident 107 was admitted to the facility on [DATE] with diagnoses that included displaced midcervical fracture of right femur (injury where the neck of the upper thigh bone is broken and misaligned), abnormalities of gait and mobility (change from a normal, smooth, and effortless walking pattern), and muscle weakness. During a review of Resident 107's admission Assessment, dated 2/18/2026, the admission Assessment indicated Resident 107 was continent (able to voluntarily control) bladder and bowel functions. During a review of Resident 107's Minimum Data Set (MDS- a resident assessment tool), dated 2/23/2026, the MDS indicated Resident 107 was assessed having intact memory and cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making. The MDS indicated Resident 107 required partial/moderate assistance (helper does less than half the effort) with toileting hygiene, shower/bathe self, lower body dressing, personal hygiene, and toilet transfer. The MDS indicated Resident 107 required supervision or touching assistance with sit to lying, sit to stand, and walking 10 feet (ft- unit of measurement). The MDS indicated Resident 107 was independent (Resident completes the activity by themselves with no assistance from a helper) with eating. During a review of a facility form titled, Documentation Survey Report v2 (clinical documentation for ADLs), from 2/1/2026 to 2/28/2026, the Documentation Survey Report indicated Resident 107 did not receive a bath from 2/18/2026 to 2/22/2026. During a review of the Nurse's Station (NS) Shower Schedule, the Shower Schedule for Room B (room [ROOM NUMBER]) was scheduled every Monday and Friday. During an interview, on 2/23/2026, at 11:37 AM, with Resident 107, Resident 107 stated she was admitted to the facility the evening of 2/18/2026. Resident 107 stated she was put in a room that did not have its own bathroom when she was admitted to the facility. Resident 107 stated that an unknown Certified Nursing Assistant (CNA) instructed her to just pee (urinate) in her diaper the night of 2/18/2026, when she requested assistance to go to the bathroom. Resident 107 stated this made her feel bad and degraded and wanted to leave the facility the next day. During the same interview, on 2/23/2026, at 11:37 AM, with Resident 107, Resident 107 stated she has not bathed or showered since she was admitted to the facility. Resident 107 stated when she asked an unknown CNA if she could get a bath, the CNA told her she had to wait until 2/23/2026. Resident 107 stated not bathing for five days made her feel horrible and made her not want to entertain visitors because she felt dirty. (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview, on 2/25/2026, at 10:48 AM, with Certified Nursing Assistant 4 (CNA 4), CNA 4 stated Resident 107 was scheduled to shower every Monday and Friday. CNA 4 stated Resident 107 should have been given a bath or shower on 2/20/2026 if Resident 107 was admitted on [DATE]. CNA 4 stated facility staff should not wait until the scheduled shower day to give residents a shower. CNA 4 stated CNAs should accommodate the residents request for a bath on the same day they request it. CNA 4 stated not giving the residents a bath can make them feel that no one cares about them. During the same interview, on 2/25/2026, at 10:48 AM, with CNA 4, CNA 4 stated it was not acceptable for facility staff to tell Resident 107 to pee in her diaper because Resident was continent as was able to walk to the bathroom with assistance. CNA 4 stated facility staff should have assisted Resident 107 to the bathroom or offered her a bedpan (a shallow shaped container used as a portable toilet for people who cannot reach a bathroom) instead. During an interview, on 2/25/2026, at 2:34 PM, with the Director of Staff Development (DSD), DSD stated Resident 107 should have been given or offered a bath on 2/20/2026. DSD stated it was not okay for a resident to wait five days to get a bath in the facility. DSD stated it was not good for Resident 107's morale that she felt dirty and did not want any visitors. During the same interview, on 2/25/2026, at 2:34 PM, with DSD, DSD stated newly admitted residents were not allowed to get up from bed until an evaluation was done by the physical therapist. DSD stated if this was the case, the unknown CNA should have offered Resident 107 a bedpan when she needed to urinate. DSD stated facility staff should not tell a resident to pee in her diaper. DSD stated urinating in bedpan was more dignified than telling a resident to urinate in her diaper. During a review of the facility's policy and procedure (P&P), titled, Activities of Daily Living, Supporting, revised on 3/2018, the P&P indicated, Appropriate care and services will be provided for residents who are unable to carry out ADLs independently, with the consent of the Resident and in accordance with plan of care, including appropriate support and assistance with hygiene (bathing, dressing, grooming, and oral care).

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the residents bed were at the lowest position for two (2) of four (4) residents (Resident 81 and 86) reviewed for accidents, as indicated on the care plan. This deficient practice has the potential to cause injury and/or fall to Resident 81 and 86.Findings: 1. During a review of Resident 81's admission Record, the admission Record indicated Resident 81 was admitted to the facility on [DATE] with diagnosis that included Parkinson's disease (a progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movements). During a review of Resident 81's Minimum Data Set (MDS- a resident assessment tool), dated 2/2/2026, the MDS indicated Resident 81 had an intact cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making. The MDS also indicated Resident 81 was dependent (helper does all the effort) with putting on/taking off footwear and required substantial/maximal assistance (helper does more than half the effort) with toileting and personal hygiene, shower, upper and lower body dressing. The MDS further indicated Resident 81 required setup assistance (helper sets up; resident completes activity) with eating and oral hygiene. During a review of Resident 81's Fall Risk Assessment (a nursing tool that uses a scoring system to evaluate resident's risk of fall) dated 2/2/2026, the fall risk assessment indicated Resident 81 was at risk for fall. During a review of Resident 81's Care Plan initiated on 2/3/2021 and revised on 2/5/2026, it indicated the resident has the potential for fall/injury related to impaired physical mobility and history of fall with an approach plan of ensuring the resident's bed was at the lowest level and checking resident's environment for any hazards that can affect the resident's safety. During an observation on 2/23/2026 at 9:58 AM, Resident 81 was asleep in bed with both right and left middle section of the bedside rails up with the bed height left at approximately three (3) feet from the floor. During a concurrent observation and interview on 2/25/2026 at 12:57 PM, Licensed Vocational Nurse (LVN 2) stated Resident 81's bed was not and should have been placed in the lowest position (when the bed motor automatically stops and no longer moves downward) to prevent injuries from falling. LVN 2 also stated the facility staff should always lower the bed to the lowest level.2. During a review of Resident 86's admission Record, the admission Record indicated Resident 86 was initially admitted to the facility on [DATE] and was readmitted on [DATE] with diagnoses that included epilepsy (brain activity that cause sudden uncontrollable electrical disturbance in the brain and sometimes loss of awareness), hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) and hemiparesis (muscle weakness or partial paralysis on one side of the body) following cerebral infarction (a medical condition that occurs when brain tissue dies due to a lack of blood flow and oxygen). During a review of Resident 86's Fall Risk Assessment (a nursing tool that uses a scoring system to evaluate resident's risk of fall) dated 11/20/2025, the fall risk assessment indicated Resident 86 was at risk for fall.During a review of Resident 86's MDS, dated [DATE], the MDS indicated Resident 86 had intact cognitive skills for daily decision making. The MDS also indicated Resident 86 was dependent with shower and required substantial/maximal assistance with toileting and personal hygiene, lower body dressing and with putting on/taking off footwear. The MDS further indicated Resident 86 required partial/moderate assistance (helper does less than half the effort) with upper body dressing and required setup assistance with eating and oral hygiene. During an observation on 2/23/2026 at 8:12 AM, Resident 86 was in bed awake with both right and left middle section of the bedside rails up with the bed height left at approximately 3 feet from the floor.During a review of Resident 86's Care Plan initiated on 11/30/2022 and revised on 8/26/2025 indicated the resident was at risk for fall/injury related to seizure disorder with an approach plan of ensuring the resident's bed was at the lowest level and checking resident's environment for any hazards that can affect the resident's safety. During an interview on 2/25/2026 at 1:08 PM, (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Registered Nurse 1 (RN 1) stated Residents 81 and 86's beds should be at the lowest position. During an interview on 2/26/2026 at 11:24 AM, the Director of Nursing (DON) stated the residents' beds should be in the lowest position for the residents' safety and to prevent injuries related to fall. During a review of the facility's policy and procedure (P&P) titled, Falls and Fall Risk, Managing, revised 3/2018, the P&P indicated that based on previous evaluation and current data, the staff will identify interventions related to the residents specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling. The P&P also stated that environmental factors that contribute to the risk of falls included incorrect bed height or weight.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 provide the necessary proper care and services for two (2) of two sampled residents (Resident 24 and Resident 47) reviewed for indwelling catheter (a tube that allows urine to continuously drain from the bladder) as indicated in the facility's policy and procedure (P&P) by failing to ensure: Resident 47's indwelling catheter drainage bag (a bag used to collect urine from an indwelling catheter) was not touching the floor.This deficient practice resulted in contamination of Resident 47's care equipment and placed Resident 47 at risk for infection. 2a. Facility staff emptied Resident 24's leg bag at least twice a day in accordance with the manufacturer's instructions .This deficient practice resulted in Resident 24's leg bag to constantly getting disconnected from the foley catheter (thin, flexible tube inserted through the urethra [tube that carries urine from the bladder out of the body] into the bladder to continuously drain urine into an external bag) and cause urine spills. b. Facility staff used aseptic technique(a technique that involves rigorous hand hygiene, wearing non-sterile gloves, and preventing contamination of the catheter/bag connectors) when Resident 24's leg bag was changed on 2/25/2026. c. Facility staff followed Resident 24's physician order to insert a 16 French (Fr- circumference of f/c tube) 16/10 cubic centimeter (cc- unit of measurement for small liquid doses) foley catheter. Resident 24 had an 18 Fr foley catheter on 2/25/2026. d. Resident 24's indwelling catheter was securely anchored with a securement device to prevent potential pulling and accidental dislodgement. These deficient practices can result in accidental dislodgement and urinary tract infections (UTI- an infection in any part of the urinary system) for Resident 24. Findings: During a review of Resident 47's admission Record, the admission Record indicated Resident 47 was initially admitted to the facility on [DATE] and was readmitted on [DATE] with diagnoses that included urinary tract infection, dysphagia (difficulty or discomfort in swallowing), and orthostatic hypotension (a sudden temporary drop in blood pressure that concerns when standing up from a sitting or lying position). During a review of Resident 47's Minimum Data Set (MDS- a resident assessment tool), dated 1/2/2026, the MDS indicated Resident 47 was assessed having moderately impaired (decisions poor, cues/supervision required) cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making. The MDS indicated Resident 47 was dependent (helper does all of the effort) with oral/toileting hygiene, shower/bathe self, upper/lower body dressing, and sit to lying. The MDS indicated Resident 47 had an indwelling catheter. During a review of Resident 47's Order Summary Report, dated 2/24/2026, the Order Summary Report indicated a physician order, with a start date of 1/16/2026, for foley catheter Fr 16/10 cc to bladder sphincter dyssynergia (BSD- a condition where the bladder contracts but the sphincter remains closed) due to diagnosis of obstructive uropathy (a condition where the normal flow of urine is blocked anywhere along the urinary tract). During a concurrent observation and interview on 2/23/2026, at 9:25 AM, with Certified Nursing Assistant 9 (CNA 9), in Resident 47's room, Resident 47 was awake in bed. Resident 47's foley catheter drainage bag was touching the floor and was not covered with a dignity bag (a discreet pouch designed to cover a urinary drainage bag). CNA 9 stated foley catheter drainage bags should not touch the floor. During an interview on 2/24/2026, at 3:28 PM, with Treatment Nurse 1 (TN 1), TN 1 stated bacteria can enter Resident 47's foley catheter drainage bag which can cause an infection if the drainage bag touches the floor. TN 1 stated a basin should be placed underneath the drainage bag to prevent the bag from touching the floor. TN 1 stated the drainage bag should also cover the drainage bag to prevent other staff and visitors from seeing Resident 47's urine. TN 1 stated CNAs and Licensed Nurses were responsible for making sure Resident 47's drainage bag was not touching the floor. During a review of the facility's P&P titled, Catheter Care, Urinary Level III, revised on 8/2022, the P&P, under Infection Control, indicated to be sure the catheter tubing and drainage bag are kept off the floor During a (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	review of Resident 24's admission Record, the admission Record indicated Resident 24 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included obstructive and reflux uropathy (a blockage in the urinary system that stops urine from flowing out of the body), unilateral inguinal hernia (when the abdominal tissue pushes through a weak spot in the abdominal muscles on one side of the groin, creating a huge bulge), and benign prostatic hyperplasia with lower urinary tract symptoms (enlargement of the prostate gland). During a review of Resident 24's MDS, dated [DATE], the MDS indicated Resident 24 was assessed having moderately impaired cognitive skills for daily decision making. The MDS indicated Resident 24 required supervision or touching assistance (helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity) with toileting hygiene, personal hygiene, sit to stand, and toilet transfer. The MDS indicated Resident 24 required partial/moderate assistance (helper does less than half the effort, helper lifts, holds, or supports trunk or limbs but provides less than half the effort) with shower/bathe self, lower body dressing, and putting on/taking off footwear. The MDS indicated Resident 24 had an indwelling catheter. During a review of Resident 24's Order Summary, dated 2/24/2026, the Order Summary Report indicated a physician order for the following:F/C Fr 16/10 cc to BSD due to diagnosis of obstructive uropathy, with a start date of 1/10/2026Change foley catheter Fr 16/10 cc and bag as needed (prn) if leaking, plugged, or pulled out, obstruction, excessive sedimentation or when the closed system is compromised, once a month every 1 month starting on the 16th for 28 days for f/c change.Change foley catheter leg bag every Sunday and prn when leaking. During a concurrent observation and interview on 2/24/2026, at 10:14 AM, Resident 24 was observed sitting in his wheelchair outside his room. Resident 24 stated he smelled like urine because facility staff did not always empty his urine bag when it was full. Resident 24 stated sometimes he has to empty his own urine bag because his leg bag gets disconnected when it is too full. During an interview on 2/24/2026, at 3:33 PM, with TN 1, TN 1 stated Resident 24's leg bag was ordered to be changed every Sunday or as needed but she frequently changes it because it would always get disconnected. TN 1 stated Resident 24's leg bag getting disconnected was an ongoing problem because Resident 24 moves too much or tries to empty his own leg bag. TN 1 stated Resident 24 empties his leg bag because CNAs do not regularly empty Resident 24's leg bag and it gets too full. TN 1 stated Resident 24 should not empty his leg bag without assistance or supervision because Resident 24 has limited mobility and could fall and or injure himself when he stands and undresses himself before emptying his leg bag. During an interview on 2/25/2026, at 8:41 AM with CNA 5, CNA 5 stated Resident 24 empties his leg bag when it is full and when staff does empty it right away. CNA 5 stated there where incidents when she started her shift at 7 AM that Resident 24's leg bag was full and not emptied during the night. CNA 5 stated Resident 24's leg bag would get disconnected from the foley catheter when it was full of urine. CNA 5 stated Resident 24's leg bag should be emptied at least twice a shift to prevent the leg bag from getting disconnected from the foley catheter. During a concurrent observation and interview on 2/25/2026, at 11:16 AM, TN 1 and TN 2 informed Resident 24 that Resident 24's leg bag was going to be changed. TN 1 and TN 2 donned (to put on) non-sterile gloves (clean, single-use gloves that have not undergone sterilization to remove all microorganisms) and gowns and entered Resident 24's room. TN 1 removed Resident 24's diaper and TN 2 stated Resident 24 had an 18 Fr (red) foley catheter inserted. TN 1 and TN 2 stated Resident 24's foley catheter was not secured with a device. TN 2 held Resident 24's foley catheter as TN 1 twisted and disconnected the leg bag from Resident 24's foley catheter. TN 1 flushed the foley catheter with 60 milliliters (ml- unit of measurement) of normal saline and connected the new leg bag to Resident 24's foley catheter. TN 1 did not clean the area where the foley catheter connected with the leg bag before disconnecting and connecting the new leg bag. During an interview on 2/25/2026, at 11:16 AM with TN 1 and TN 2, TN 1 and TN 2 stated aseptic technique should be followed when changing the leg bag and during foley catheter care. TN 1 stated she did not but should have cleaned the foley catheter connection site before disconnecting and connecting the new leg bag. TN 1 stated not cleaning the (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	foley catheter tubing could cause Resident 24 to get a urinary tract infection. TN 2 stated they have never secured Resident 24's foley catheter to prevent it from getting accidentally pulled. TN 1 stated she did not know why an 18 Fr foley catheter instead of a 16 Fr as ordered was inserted into Resident 24. TN 1 stated it was important for Resident 24 to wear the right foley size because it could cause Resident 24 discomfort if it was too big. During an interview on 2/26/2026, at 3:27 PM, with the Director of Nursing (DON), the DON stated Resident 24's leg bag should be emptied every shift of as needed when full. The DON stated TN 1 and TN 2 should have followed the aseptic technique and cleaned Resident 24's foley catheter connection site with alcohol before disconnecting. The DON stated Resident 24's foley catheter should have been secured with a device to prevent accidental dislodgement and tugging on the bladder which could cause bleeding and pain. During a review of the facility's P&P, titled, Indwelling (Foley) Catheter Insertion, Male Resident, revised 8/2022, the P&P indicated to secure the catheter tubing and/or bag to resident with approved catheter securement device. During a review of the facility's P&P, titled, Catheter Care, Urinary Level III, revised 8/2022, the P&P indicated the following:Empty the collection bag at lease every eight (8) hours using a separate, clean collection container for each resident. Avoid splashing and prevent contact of the drainage spigot with the non-sterile container.Ensure the catheter remains secured with a securement device to reduce friction and movement at the insertion site.Use aseptic technique when handling or manipulating the drainage system. During a review of the Medline Leg Bag Manufacturer's Instructions, the Manufacturer's Instructions indicated the following:To change leg bag: Wash hands with soap and water. Pinch off the catheter tube above the leg bag connection so urine does not leak out. Be careful not to pull on the catheter. Disconnect catheter tube from leg bag using a twisting motion while keeping the catheter tube pinched. A catheter plug may be used to keep the foley from draining, otherwise place a towel underneath the catheter to collect any drips. Clean catheter funnel and leg bag connection port with isopropyl alcohol, wiping away from the opening. Insert drain bag port into catheter funnel. Minimize number of times you switch between bags to reduce risk of infection.Empty leg bag when half-full, or at least twice a day.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide oxygen therapy (treatment that provides supplemental, or extra oxygen) as indicated on the physician's order for two (2) of two sampled residents (Resident 71 and 15) reviewed for respiratory/oxygen. This deficient practice had the potential to place Resident 71 and 15 at risk for shortness of breath and/or hypoxia (low levels of oxygen in the body tissues) which could lead to irreversible damages of health and/or death. Findings:1. During a review of Resident 71's admission Record, the admission Record indicated Resident 71 was admitted to the facility on [DATE] and re-admitted on [DATE]. The admission record indicated Resident 71's diagnoses included respiratory failure (a serious condition that makes it difficult to breathe on your respiratory system [organs/ structures in the body that allow you to breath such as lungs]), pulmonary edema (when fluid collects in the air sacs of the lungs, making it difficult to breathe) and history of pneumonia (a lung infection). During a review of Resident 71's Minimum Data Set (MDS, a resident assessment tool), dated 2/17/2026, the MDS indicated Resident 71 had severely impaired cognitive skills (mental action or process of acquiring knowledge and understanding) for daily decision making. The MDS indicated Resident 71 was dependent (helper does all of the effort, resident does none of the effort to complete the activity) in toileting hygiene, shower/ bathe sit-to stand, self, upper and lower body dressing, putting on/taking off footwear, sit to lying, and sit-to stand. During an observation on 2/23/2026 at 8:45 AM in Resident 71's room, Resident 71 was awake in bed. Resident 71's oxygen tubing was observed around her head and the nasal cannula (NC) was on the resident's neck. The oxygen concentrator was running with the oxygen at 2 liters per minute (lpm) with humidifier. During a concurrent interview and record review on 2/24/2026 at 3:34 PM with Licensed Vocational Nurse 3 (LVN 3), the Physician Order (PO) dated 2/13/2026 was reviewed. The PO indicated oxygen at 2 lpm via nasal cannula continuously every shift for shortness of breath and pneumonia. LVN 3 stated the nasal cannula was not on Resident 71's nostrils; the oxygen tubing and nasal cannula were positioned on top of her head. The nasal cannula should be placed on her nostrils because Resident 71 can experience low oxygen saturation (the percentage of oxygen in a person's blood. It shows how well oxygen is being carried from the lungs to the rest of the body.) During a concurrent interview and record review on 2/24/2026 at 3:40 PM with LVN 3, Resident 71's Care Plan (CP) for altered respiratory status / difficulty of breathing, revised on 2/16/2026 was reviewed. The CP indicated interventions were to administer oxygen per order and monitor for effectiveness. LVN 3 stated the CP was not followed, because the nasal cannula fell out from Resident 71's nostrils, therefore the resident was not receiving oxygen as ordered. During a concurrent observation on 2/25/2026 at 6:53 AM with LVN 4 in Resident 71's room, Resident 71 was sleeping and the nasal cannula was not on the resident's nostrils. The nasal cannula was observed hanging on the right upper bed rail (is a safety device [typically a metal or plastic bar] attached to the side of a bed to prevent falls, aid in repositioning, and provide support when getting in or out of bed). During an interview on 2/25/2026 at 6:55 AM, LVN 4 stated Resident 71 needed to have the nasal cannula on her nostrils and receive oxygen continuously to prevent the resident from experiencing low oxygen levels. 2. During a review of Resident 15's admission Record, the admission Record indicated Resident 15 was admitted to the facility on [DATE] and re-admitted on [DATE]. Resident 15's diagnoses included chronic respiratory failure (occurs when a person does not have enough oxygen in the blood) with hypoxia, asthma (a condition in which the airways narrow and swell and may produce extra mucus), and morbid obesity (weight more than 100 pounds over the ideal body weight and experiencing severe health effects) During a review of Resident 15's MDS, dated [DATE], the MDS indicated Resident 15 had intact cognitive skills for daily decision making. The MDS indicated Resident 15 needed substantial/ maximal assistance (helper does more than half the effort. helper lifts, holds trunk or limbs, and provides more than half the effort) in toileting hygiene, shower/ (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	bathe self, upper and lower body dressing, putting on/ taking off footwear, roll left and right, sit to lying, lying to sitting on the side of the bed and chair/ bed-to-chair transfer. During a record review of Resident 15's PO, dated 3/10/2025, the PO indicated oxygen at 3 lpm via nasal cannula continuously for diagnosis of respiratory failure. During a record review of Resident 15 CP for oxygen therapy related to respiratory illness, acute and chronic respiratory failure with hypercapnia (occurs when a patient with a pre-existing, long-term condition that causes high carbon dioxide levels experiences a sudden, acute worsening of the condition), dated 1/16/2025, the CP indicated Resident 15 has oxygen via nasal prongs(cannula)/mask at 3 lpm continuously. During an observation on 2/26/2026 at 9:14 AM in Resident 15's room, Resident 15 was lying supine on the bed. The nasal cannula was on top of Resident 15's upper lip and not on her nostrils. Oxygen concentrator was running with the oxygen at 3 lpm. During an observation on 2/26/2026 at 9:15 AM with LVN 4 in Resident 15's room, Resident 15 was awake and lying supine on the bed. LVN stated she had to fix the placement of the nasal cannula so it could be in Resident 15's nostrils for the resident to receive oxygen as ordered. During an interview on 2/26/2026 at 9:21 AM, LVN 4 stated Resident 15's nasal cannula should always be checked for proper placement because if it was not positioned properly on her nostrils, Resident 15 can have a lower oxygen level. During a record review of facility's Policy and Procedure (P&P) titled, Oxygen Administration, revised 10/2010, the P&P indicated,11.Securely anchor the tubing so that it does not rub or irritate the Resident's nose, behind the Resident's ears, etc.12. Check the mask, tank, humidifying jar, etc., to be sure they are in good working order and are securely fastened.13. Observe the resident upon set up and periodically thereafter to be sure oxygen is being tolerated.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. Based on interview and record review, the facility failed to ensure competencies and skills sets to provide nursing and related services were completed for two (2) of four (4) nursing staff in accordance with the facility assessment and policy and procedures (P&P). This deficient practice had the potential to cause increased risk for improper resident assessments, and inadequate documentation which could negatively impact the quality of care provided to the residents.Findings: 1. During a concurrent interview and record review on 2/25/2026 at 2:26 PM with Director of Staff Development (DSD), Treatment Nurse (TN1, a licensed vocational nurse) employee records were reviewed. DSD stated TN 1 was hired on 10/17/2022. DSD stated TN1 did not have documented evidence of completed competency and training for Foley catheter (tube that drains urine from the bladder into a drainage bag) care. During an interview on 2/25/2026 at 2:06 PM with TN 1, TN 1 stated she was not evaluated for Foley catheter care. During an interview on 2/25/2026 at 2:19 PM with TN 2, TN 2 stated she does not remember if she was evaluated for Foley care. 2. During a concurrent interview and record review on 2/26/2026 at 10:49 PM with DSD, TN 2 (a licensed vocational nurse) employee records were reviewed. DSD stated TN 2 was hired on 9/22/2021. DSD stated TN2 did not have documented evidence of completed competency for Foley catheter care. DSD also stated the competencies and training for Foley catheter care, intermittent catheterization (procedure where thin (catheter) temporarily inserted to the bladder to drain urine and then removed after the bladder is empty) , and indwelling catheter (tube inserted into the bladder to drain urine and left in place for period of time) should have been completed in accordance with the facility assessment. During an interview with the DSD on 2/26/2026 at 11:52AM, the DSD stated licensed nurses' competencies including indwelling catheter care are completed upon hire and as needed to ensure residents are provided the proper care. During a record review of the Facility Assessment, dated 9/1/2025, the Facility Assessment indicated under Areas Facility Assessment Informed: Training, Competencies that Action to be taken this year was to provide training on Medication Pass, Foley Care . training. During a review of facility's P&P titled, Staffing, Sufficient and Competent Nursing, revised 8/2022, the P&P indicated that the facility provides sufficient number of nursing staff with the appropriate skills and competencies necessary to provide nursing and related care and services for all residents in accordance with resident care plans and the facility assessment. The P&P also indicated the competency is a measurable pattern of knowledge, skills, abilities, behaviors, and other characteristics that an individual needs to perform work roles or occupational functions successfully. All nursing staff must meet the specific competency requirements of their respective licensure and certifications as defined by state law.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. Based on observation, staff interviews, and review of facility records, the facility failed to correctly measure the calorie and sugar content of breakfast meals for 14 of 14 residents who were ordered to receive a fortified diet (an enhanced meal meant to provide extra protein, calories, and nutrients).This deficient practice had the potential for residents on fortified diet to not receive the increased nutrients, protein and calories required which could result in malnutrition or weight loss.Findings:During a review of the facility's menu from 2/22/2026 to 2/28/2026, the menu indicated hot or cold cereal was served for breakfast on 2/24/2026.During a review of the facility's menu, titled, Super Cereal (fortified cream of wheat), the menu indicated the following ingredients:Evaporated milk 5/8 cup (c)Water 1 1/8 quart (qt- unit of measurement for volume of liquid)Dry milk powder 1/2 cRolled oats 2 1/2 cEvaporated milk 1 3/4 cMargarine 1 1/4 cLight brown sugar 10 ounce (oz- unit of measurement for weight in cooking)Granulated sugar 3/4 cDuring a review of the facility's menu, titled, Super Cereal Method, the menu indicated the following:Choose type of cereal to be prepared for the day. Prepare as close to serving time as possible and keep covered until served. This will prevent the cereal from drying.In a stockpot of kettle combine the 1st amount of evaporated milk and the dry milk powder; mix well and bring to boil.Add cereal and cook for 5 minutes.Add remaining ingredients and stir until creamy. Cereal should thicken and be creamy but not sticky. (diabetic diets: omit the sugar)Place cooked cereal in a 4 inch dep steamtable pan, serve with a 6 oz ladle per portion. During an observation on 2/25/2026, at 7:03 AM, in the kitchen, during the serving of breakfast lunch trays, Dietary [NAME] (DC) was informed by an unknown kitchen staff that the cream of wheat needed to be fortified. DC opened one 12 fluid ounce (fl oz- unit of measurement for liquid capacity) can of evaporated milk and poured the entire can of evaporated milk into the stock pot containing cream of wheat. DC opened one 16 oz bag of brown sugar with a knife and poured half of the contents into the same stock pot containing cream of wheat. DC also added a splash of vanilla flavor in the stock pot. DC did not measure the brown sugar before adding it to the cream of wheat. DC stated she did not know the recipe indicated to add granulated sugar to the recipe.During an interview, on 2/25/2026, at 10:42 AM, with DC, DC stated she was not familiar with the menus in the facility and would sometimes have to look for the menus. DC stated she did not look at or follow the facility's fortified cream of wheat (super cereal) menu for this morning. DC stated she cooked the fortified cream of wheat based on the menu that she learned from the previous facility where she worked before. DC stated she did not measure the brown sugar before she added it to the cream of wheat. DC stated she did not check if the amount of evaporated milk in the can was the same amount indicated in the menu. DC stated she added the vanilla flavor to make the cream of wheat smell better. DC stated not following the menu could cause residents to get sick. DC stated not following the menu can cause the blood sugars of the diabetic residents to go up.During a concurrent interview and record review, on 2/25/2026, at 1:20 PM with the Registered Dietician (RD), the facility's menu for Super Cereal was reviewed. RD stated residents were ordered fortified diets because they needed extra calories and weight management. RD stated the menu for super cereal indicated to add 1 3/4 cups of evaporated milk to the cereal. RD stated DC added 12 oz of evaporated milk from the can which was equivalent to only 1 1/2 cups. RD stated DC did not add enough evaporated milk to the fortified super cereal. RD stated the recipe was not followed when DC poured approximately half the bag of brown sugar into the pan. RD stated it was okay for kitchen staff to eyeball recipe measurements if the kitchen staff was skilled enough. RD stated she was unsure if the policy indicated it was okay to eyeball measurements but stated it was safer for kitchen staff to get the exact measurement of the ingredient. RD stated DC should have added granulated sugar to the cream of wheat as indicated in the recipe. RD stated DC did not follow the recipe when DC added vanilla flavor to the cereal. RD stated it was important to follow the recipe to ensure proper nutrition (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	was being provided to the staff. RD stated not following the recipe could cause food intolerances, weight loss, malnutrition, or skewed laboratory results. RD stated DC should have used and followed the menu for Super Cereal.During an interview on 2/26/2026, at 9:03 AM with the Dietary Supervisor (DS), the DS stated DC should have followed the recipe for super cereal. DS stated DC should not have poured the bag of brown sugar directly into the pot and should have used a measuring cup to measure the brown sugar. DS stated it was important for DC to follow the recipe so the residents can meet the required calories and nutritional value of the food.During a review of the facility's policy and procedure, titled, Standardized Recipes, revised 4/2017, the policy indicated, standardized recipes shall be developed and used in the preparation of foods.

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, facility failed to provide food that accommodated food preferences and offer meal substitutes of the same nutritive values for two (2) of two sampled residents (Resident 107 and Resident 75) reviewed for food. This deficient practice had the potential to result in decreased meal intake and can lead to weight loss and malnutrition (when the body does not get the right amount of nutrients, either too little or too much, causing health problems).Findings:During a review of Resident 107's admission Record, the admission Record indicated Resident 107 was admitted to the facility on [DATE] with diagnoses that included displaced midcervical fracture of right femur (injury where the neck of the upper thigh bone is broken and misaligned), abnormalities of gait and mobility (change from a normal, smooth, and effortless walking pattern), and muscle weakness. During a review of Resident 107's Minimum Data Set (MDS- a resident assessment tool), dated 2/23/2026, the MDS indicated Resident 107 was assessed having intact memory and cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making. The MDS indicated Resident 107 required partial/moderate assistance (helper does less than half the effort) with toileting hygiene, shower/bathe self, lower body dressing, personal hygiene, and toilet transfer. The MDS indicated Resident 107 was independent (Resident completes the activity by themselves with no assistance from a helper). During an interview on 2/23/2026, at 11:37 AM, Resident 107 stated facility staff had not asked her what foods she liked or disliked since she was admitted to the facility on [DATE]. Resident 107 stated she did not eat red meat and pork, but the kitchen staff have been serving her red meat and pork since she was admitted . Resident 107 stated she wrote her food dislikes on her meal ticket every time she was served red meat or pork, but the facility kept sending her pork and red meat. Resident 107 stated she started asking family members to bring her food because she needed to eat and the facility did not listen to her food preferences. During an observation of Resident 107's lunch food tray on 2/23/2026, at 1:20 PM, Resident 107 was served spaghetti with meat in red sauce, green beans and garlic bread. During a concurrent interview and record review on 2/23/2026 at 1:20 PM, with Resident 107, Resident 107's lunch Meal Ticket was reviewed. Resident 107's Meal Ticket indicated Resident 107 was served spaghetti with meat sauce for lunch. The Meal Ticket did not indicate Resident 107's preferred beverage and what foods she liked or disliked. The Meal Ticket had a handwritten note that stated Resident 107 liked fish, chicken, hot water, and 2% milk and disliked red meat and pork. Resident 107 stated she once again wrote what food and beverage she liked and disliked on the meal ticket because she was served red meat for lunch. Resident 107 stated she did not understand why the facility kept serving her red meat and pork when she always wrote her food preferences on the meal ticket. Resident 107 said the staff should see and take note of what she preferred to eat since she writes it on her meal ticket and leaves it on the tray. Resident 107 stated facility staff knew when she did not eat her food but never asked her the reason why. Resident 107 stated facility staff did not offer her an alternate meal when she did not eat her food. During a concurrent interview and record review, on 2/25/2026, at 9:21 AM, with the MDS Coordinator, Resident 107's Interdisciplinary Team (IDT- a group of healthcare professionals from different disciplines who collaborate to provide comprehensive and coordinated care for a resident) meeting, dated 2/19/2026 was reviewed. MDS stated Resident 107's IDT form did not indicate any of Resident 107's food preferences. During a concurrent interview and record review, on 2/25/2026, at 9:21 AM with MDS Coordinator, Resident 107's Dietary Profile/Preference form was reviewed. MDS Coordinator stated Resident 107's Dietary Profile/Preference form, which indicated that Resident 107 disliked pork, bacon, sausage, ham, beef, coffee, and cold cereal, was not documented and signed by DS until 2/24/2026. MDS Coordinator stated the Dietary Supervisor (DS) was the staff responsible for assessing and documenting the (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	residents' Dietary Profile/Preference form. MDS Coordinator, stated Resident 107's Dietary Profile/Preference form should have been assessed upon admission or sooner than 2/24/2026 to make sure she received food that she could eat and liked. During an interview on 2/25/2026, at 9:32 AM, the DS stated the residents' dietary preferences and allergies were assessed within 24 hours after admission. DS stated if a resident was admitted in the middle of the night, then the dietary assessment was done the following day. DS stated she did not assess Resident 107's dietary preference until five days after she was admitted to the facility because she was too busy. DS stated it was important to assess the residents' dietary preference upon admission to prevent residents from getting food that they did not like. During an interview on 2/25/2026, at 9:53 AM, the Registered Dietician (RD) stated DS had three days or 72 hours to assess and note Resident 107's dietary preference and restrictions. RD stated DS should have assessed Resident 107's dietary preference by 2/21/2026 if she was admitted to the facility on [DATE]. RD stated residents will feel frustrated and lose weight if residents do not eat the food in the facility. RD stated facility staff should have offered Resident 107 a substitute meal or asked Resident 107 the reason why she did not eat her food. During a review of Resident 75's admission Record, the admission Record indicated Resident 75 was initially admitted to the facility on [DATE] and was readmitted on [DATE] with diagnoses that included polyosteoarthritis (a form of arthritis affecting five or more joints), dysphagia (difficulty in swallowing), and chronic pain syndrome (a condition where pain lasts for more than 3 to 6 months often persisting long after an initial injury or illness has healed). During a review of Resident 75's MDS, dated [DATE], the MDS indicated Resident 75 was assessed having intact memory and cognitive skills for daily decision making. The MDS indicated Resident 75 was independent with eating, oral/toileting hygiene, sit to lying, and toilet transfer. The MDS indicated Resident 75 required setup or clean-up assistance (helper sets up or cleans up; Resident completes activity) with shower/bathe self and personal hygiene. During a concurrent observation and interview on 2/23/2026, at 2:45 PM, with Resident 75 in Resident 75's room, a plate of uneaten sandwich with light brown bread was observed at the foot of Resident 75's bed. Resident 75 stated the sandwich was her lunch and she did not eat it because she only ate white bread. Resident 75 stated she did not eat or return the plate because she wanted to show DS that the kitchen continues to give her wheat bread even after she informed DS that she only ate white bread. During an observation on 2/24/2026, at 12:49 PM, Resident 75's lunch was observed. Resident 76 was served a sandwich with light brown bread covered in plastic. Resident 75 stated she was served wheat bread instead of white bread. Resident 75 returned the tray to an unknown Certified Nursing Assistant (CNA) and informed the CNA she did not eat wheat bread. During an interview on 2/25/2026, at 9:40 AM, DS stated she was informed by Resident 75 a month ago that Resident 75 only wanted to eat white bread because it was easier for her to digest. DS stated she has not updated Resident 75's food preference in her meal ticket. DS stated she should have updated resident 75's meal ticket to prevent the kitchen staff from serving wheat bread. DS stated Resident 75 should not have been given white bread. DS stated she did not know why Resident 75 was served wheat bread on 2/23/2026 and 2/24/2026. DS stated not giving Resident 75 the food she preferred could make her feel upset and sad and not eat her meals, which could lead to unplanned weight loss. During an interview on 2/25/2026, at 10:01 AM, the RD stated DS should have updated Resident 75's meal ticket and dietary profile when she was informed by Resident 75 that she preferred to only eat white bread. RD stated this could have prevented Resident 75 from getting served wheat bread. RD stated serving the residents food that they disliked could lead to frustration and feeling ignored by the facility. During a concurrent interview and record review on 2/26/2026, at 1:21 PM, with MDS Coordinator, Resident 75's care plans were reviewed. MDS Coordinator stated Resident 75 did not have a care plan addressing Resident 75's dietary preferences. MDS Coordinator stated Resident 75 should have had a care plan addressing her dietary preference, so facility staff were aware of what resident 75 liked and did not like to eat. During a review of the facility's Policy and Procedure (P&P), titled, Resident Food Preferences, revised on (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	7/2017, the P&P indicated the following:Individual food preferences will be assessed upon admission and communicated to the interdisciplinary team. Modifications to diet will only be ordered with the resident's or representative's consent.Upon the resident's admission (or within twenty-four hours after his/her admission) the dietician or nursing staff will identify a resident's food preferences.When possible, staff will interview the Resident directly to determine current food preferences based on history and life patterns related to food and mealtimes.Nursing staff will document the residents' food and eating preferences in the care plan. During a review of the facility's P&P titled, Nutritional Assessment, revised on 10/2017, the P&P indicated the following:The dietician, in conjunction with the nursing staff and healthcare practitioners, will conduct a nutritional assessment for each resident upon admission (within current baseline assessment timeframes) and as indicated by a change in condition that placed the resident at risk for impaired nutrition.The nutritional assessment will be conducted by the multidisciplinary team and shall identify at least following components: food preferences and dislikes (including flavors, textures, and forms.Individualized care plans shall address, to the extent possible the resident's personal preferences.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to prepare and store food in a sanitary manner in accordance with facility policy by failing to ensure:Soaps and cleaning solutions were not combined with food items.Kitchen equipment and surfaces were free from food debris and cleaned after use.Food items stored in the refrigerator were labeled and dated.Opened food item in the freezer was properly sealed.Multiple clear bags of brown bread in the dry storage room were labeled.Dietary [NAME] (DC) changed gloves and performed hand hygiene in between documentation, checking the food temperature during the tray line assembly, food preparation, and before serving the residents' meal trays.DC's apron did not come in contact with the residents' clean plates and DC did not touch the center of the clean plates during tray line assembly. These deficient practices had the potential to result in chemical and pathogen (germ) exposure to residents' food and placed the residents at risk for developing foodborne illness (food poisoning- any illness resulting from consuming food or drinks contaminated with harmful bacteria, viruses, parasites, or chemicals) with symptoms including an upset stomach, stomach cramps, nausea, vomiting, diarrhea, and fever and could lead to other serious medical complications and hospitalization.Findings:During a concurrent observation of the kitchen and interview, on 2/23/2026, at 7:45 AM, with the Dietary Supervisor (DS) the following were observed:One (1) green and 1 red bucket containing liquid with used white towels were observed next to an uncovered bin containing yellow and red potatoesDried yellow debris on the inside door and black debris on the bottom of Oven 1 (OV 1)Seven (7) unlabeled and undated bags of half sandwiches in Refrigerator 1 (REF 1)1 unlabeled bag of sandwich in REF 1.1 opened bag of frozen chicken dumplings tied at the top with a clear plastic wrap in Freezer 1 (FRZ 1)Multiple clear plastic bags of unlabeled brown bread inside the dry storage room. DS stated the red and green bucket should not have been placed next to the potatoes. DS stated the 8 sandwich bags inside REF 1 were the residents' snacks. DS stated the bags should have been labeled and dated with the preparation date. DS stated the opened bag of chicken dumplings should not have been tied with a clear plastic wrap. DS stated the bag of chicken dumplings should have been placed and sealed in a storage bag before it was returned back inside FRZ 1. DS stated the bags of bread were wheat bread and should have been labeled as soon as they were delivered to the facility. During an observation of the kitchen tray line assembly on 2/25/2026, at 6:57 AM, the following were observed:DC held a thermometer with gloved hands and checked the temperatures of each food item on the steam table. After checking the temperature of each food item, DC wrote the temperature on the food temperature log. DC did not change her gloves and wash her hands between checking the food temperature and holding the pen and paper.DC checked the temperature of the oatmeal on top of the stove with gloved hands. DC held the thermometer and pen in her right hand. DC's right hand was inside the pot of oatmeal. DC did not remove her gloves and wash her hands after checking the oatmeal's temperature and returned to the steam table to continue with tray line assemblyWith the same gloved hands, DC used the metal can opener to open a can of evaporated milk and poured the evaporated milk in a large stock pot. DC turned the oven burner knob and cracked two raw eggs into a small metal skillet. DC did not remove her gloves and wash her hands after holding the can of evaporated milk, turning the oven burner knob, and cracking two raw eggsDC's black apron touched the residents' clean plates when she scooped the eggs and sausage from the steam table.DC's gloved hand touched the center of the residents' plates each time she slid the plates across the tray line table. During an interview on 2/25/2026, at 10:42 AM, with DC, DC stated she did not change her gloves and wash her hands after she touched the pen and before she checked the food temperature with the thermometer. DC stated the pen was dirty and not changing her gloves after touching the pen could contaminate the food. DC stated she always checked and wrote the food temperature in the food temperature log by herself. DC stated bacteria could get passed to the residents when she did not change her gloves after opening (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the can, turning the oven knob, and cracking the eggs. During the same interview on 2/25/2026, at 10:42 AM with DC, DC stated her apron was dirty and should not have touched the residents' plates. DC stated bacteria on her apron could get on the plate and contaminate the residents' food. DC stated the inside or top of the plate should not be touched because it can contaminate the plate. DC stated plates should only be touched on the side or edge of the plate. DC stated contaminated plates and food could cause the residents to get sick and end up in the hospital. During an interview on 2/25/2026, at 1:20 PM, with the Registered Dietician (RD), RD stated it was not acceptable for DC's apron to touch the food or the plate. RD stated the apron touching the plate could cause bacteria to end up on the food and to the residents which could cause and spread a gastrointestinal (GI- stomach and intestines) infection. RD stated DC should have changed her gloves after touching the pen and before checking the temperature of the food. RD stated DC should have asked for assistance and the process of checking the temperature of the food should have been performed by two kitchen staff: one staff to check the temperature and the other staff to write the temperature in the log. RD also stated DC should not have had the pen in the same hand as the thermometer when she checked the temperature of the oatmeal because it was dirty and could fall into the pot. RD stated not changing gloves after opening the can of evaporated milk, touching the oven knob, and cracking the eggs ran the risk of cross contamination (the process by with bacteria are unintentionally transferred from one substance or object to another with harmful effect). During the same interview on 2/25/2026, at 1:20 PM with RD, RD stated plates should only be touched on the bottom or the edge and not on the inside or center. RD stated food items in the kitchen should be labeled and dated. RD stated it was important for food items to be labeled to know what the items were and to prevent residents from ingesting inappropriate food or foods they were allergic to. RD stated it was important to write the used by date on the food to know the expiration date of the food. RD stated the red bucket found in the bottom shelf next to the potatoes contained sanitizer and the green cleaning bucket contained soap and water. RD stated buckets containing chemicals used for cleaning should be placed away from food items to prevent splashes and contamination. RD stated she was not sure what the policy was for storing the opened frozen chicken dumpling in the freezer but stated the bag should not have been tied with a clear plastic wrap and placed back in the freezer. RD stated best practice for storing open food items in the freezer was to place the opened bag in a sealed bag to prevent frostbite or spoilage which could cause GI upset. RD stated OV 1 should have been cleaned after use to prevent malfunction and grease built up. During an interview on 2/26/2026, at 9:03 AM, with DS, DS stated DC should have checked to see if her apron was loose to prevent it from touching the plates during tray line assembly. DS stated contaminated food and plates could cause residents to get sick and end up in the hospital. DS stated kitchen staff should not wait until the weekly deep cleaning to clean the oven. DS stated the ovens in the kitchen should be cleaned every day and as soon as something was spilled during use. DS stated OV 1 should have been cleaned right after it got dirty. DS stated it was important to always keep kitchen equipment clean and sanitized to prevent contamination and to be able to continue cooking. During a review of the facility's policy and procedure (P&P), titled, Food Receiving and Storage, revised 11/2022, the P&P indicated the following:Foods shall be received and stored in a manner that complies with safe food handling practices.All food stored in the refrigerator or freezer are covered, labeled, and dated (use by date).Wrappers of frozen foods must stay intact until thawing.Soaps, detergents, cleaning compounds or similar substances will be stored in separate storage areas from food storage and labeled clearly. During a review of the facility's P&P, titled, Sanitization, revised 11/2022, the P&P indicated the following:The food service area is maintained in a clean and sanitary manner.All utensils, counters, shelves and equipment are kept clean, maintained in good repair and are free from breaks, corrosion, open seams, cracks and chipped areas that may affect their use of proper cleaning. Seals, hinges and fasteners are kept in good repair.All equipment, food contact surfaces and utensils are cleaned and sanitized using heat or chemical sanitizing solutions. During a review of the facility's P&P, titled, Preventing Foodborne Illness- Employee (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Hygiene and Sanitary Practices, revised 11/2022, the P&P indicated the following:Food and nutrition services employees follow appropriate hygiene and sanitary procedures to prevent the spread of foodborne illness.Employees must wash their hands:before coming in contact with any food surfaces;after handling raw meat, poultry or fish and when switching between working with ray food and working with ready-to-eat food;after handling soiled equipment of utensils;during food preparation, as often as necessary to remove soil and contamination and to prevent cross contamination when changing tasks; and/orafter engaging in other activities that contaminate the handsGloves are considered single-use items and must be discarded after completing the task for which they are used. Gloves are removed, hands are washed and gloves replaced: between handling ray meats and ready-to-eat foods

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to maintain safe, clean, comfortable sanitary and home-like environment for three (3) of four (4) sampled residents (Resident 15, 29 and 37) reviewed for environment by failing to ensure: 1.a. Resident 15's room was free of soiled diaper and a used cup containing chocolate on the floor.1.b. Resident 15's electric fan was free of sticky gunk (any thick, sticky, greasy, or slimy substance, often representing unwanted, dirty, or unidentifiable residue). 2. Resident 29's floor was free of used wet wipes. 3. Resident 37's curtain was free of brownish colored stains. These deficient practices caused an unsanitary environment for Resident 15, 29 and 37 and had the potential to result in the spread of diseases and infection.Findings: 1. During a review of Resident 15's admission Record, the admission Record indicated Resident 15 was initially admitted to the facility on [DATE] with diagnosis of type 2 diabetes mellitus (a disease that occurs when there is a problem in the way the body regulates and uses sugar as fuel), depression (severe feelings on sadness and hopelessness), and hypertension (high blood pressure). During a review of Resident 15's Minimum Data Set (MDS, a resident assessment tool), dated 2/9/2026, the MDS indicated Resident 15's cognitive skills (processes of thinking and reasoning) for daily decision making was moderately impaired skills for daily decision making were moderately impaired. The MDS indicated Resident 15 was dependent (helper does all the effort. Residents do none of the effort to complete the activity. Or the assistance of two or more helpers is required for the resident to complete the activity) on lower body dressing (the ability to dress and undress below the waist), personal hygiene (the ability to maintain personal hygiene, including combing hair, shaving, applying makeup, washing/drying face and hands (excludes baths, showers, and oral hygiene). During observation on 2/23/2026 at 9:35 AM at Resident 15's room, a used diaper was observed on the floor under the head of Resident 15's head of bed, and a cup containing chocolate was also observed on the floor. In addition, the electric stand fan in Resident 15's room had sticky gunk at the bottom part and base of the electric stand fan. 2. During a review of Resident 29's admission Record, the admission Record indicated Resident 29 was initially admitted to the facility on [DATE] with diagnosis of type 2 diabetes mellitus, hypertension, dependence on renal dialysis (a life-sustaining, long-term requirement for individuals with end-stage renal disease [ESRD, kidneys no longer function well enough to sustain life] or severe acute kidney failure, as their kidneys can no longer filter waste or excess fluid). During a review of Resident 29's MDS, dated [DATE], the MDS indicated Resident 29's cognitive skills for daily decision making was moderately impaired skills for daily decision making were moderately impaired. The MDS indicated that Resident 29 was partial/moderate assistance (helper does less than half the effort. helper lifts, holds, or supports trunk or limbs, but provides less than half the effort) on oral hygiene, upper body dressing, personal hygiene, lying to sitting on side of bed (the ability to move from lying on the back to sitting on the side of the bed and with no back support), and chair/bed-to-chair transfer (the ability to transfer to and from a bed to a chair or wheelchair). During a review of Resident 29's care plan, date initiated 2/3/2026, the care plan indicated Resident 29 was at risk for fall with injury related to limited mobility, fracture, and a history of falls. The care (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	plan also indicated that the residents require a safe environment with even floors free from spills and/or clutter and adequate, glare-free light. During observation on 2/25/2026 at 6:01 AM in Resident 29's room, two (2) used disposable perineal wipes were on the floor. The perineal wipes appeared crumpled and partially soiled with brown-colored residue. During an interview on 2/25/2026 at 1:21 PM with the Director of Staff and Development (DSD), the DSD stated that a used diaper, a cup containing chocolate, used perineal wipe left on the floor, and electric fan with sticky gunk were not acceptable. The DSD also stated that the residents' room should be free of clutter and should be maintained in a clean condition. During a concurrent interview and record review on 2/25/2026 at 1:25 PM with the DSD, the facility's Policy and Procedures (P&P) titled Cleaning and Disinfection of Environmental Surfaces, revised date 8/2019, was reviewed. The DSD stated the P&P indicated that the environmental surfaces will be disinfected or cleaned on a regular basis when surfaces are visibly soiled. The DSD also stated the P&P indicated that walls, blinds, and window curtains in the resident areas will be cleaned when these surfaces are visibly contaminated or soiled. The DSD stated that the presence of odor and dirt does not promote healthy environment for residents' wellbeing. The DSD also stated that the facility's P&P was not followed. During an interview on 2/26/2026 at 9:33 AM with the House Keeping (HK 1), HK 1 stated that the surfaces and the floors should be cleaned and disinfected every day. HK1 also stated that residents should be provided with a safe, clean and comfortable environment. 3. During a review of Resident 37's admission Record, the admission Record indicated Resident 37 was admitted to the facility on [DATE] and re-admitted on [DATE], Resident 37's diagnoses included epilepsy (a chronic brain disorder characterized by recurrent, unprovoked seizures [are brief episodes of abnormal electrical activity in the brain that can cause a variety of symptoms, including involuntary movements, loss of consciousness, and changes in behavior]), major depressive disorder (or also called clinical depression, it affects how you feel, think and behave and can lead to a variety of emotional and physical problems) and dementia (a progressive state of decline in mental abilities) During a review of Resident 37's Minimum Data Set (MDS, a resident assessment tool) dated 1/9/2026, the MDS indicated Resident 37 had severely impaired cognitive skills (mental action or process of acquiring knowledge and understanding) for daily decision making. The MDS indicated Resident 37 was dependent (helper does all of the effort, resident does none of the effort to complete the activity) in toileting hygiene, shower/ bathe self, upper and lower body dressing, putting on/ taking off footwear, personal hygiene, sit to lying, lying to sitting on the side of the bed, sit to stand and chair/ bed-to-chair transfer. During an observation on 2/23/2026 at 3:58 PM inside Resident 37'S room, CNA 7 was changing Resident 37's briefs. Resident 37's curtain had a brownish colored stain. CNA 7 stated Resident 37's curtain was dirty from Resident 37's hands. Resident 37 grabs and pulls the curtain when they were changing her. Resident 37 was on left side lying position when observed trying to reach and grab the curtains while being changed. During an interview on 2/24/2026 at 3:29 PM with CNA 7, CNA 7 stated Resident 37's curtain had food stains, it was the brown colored stains. Resident 37 kept on grabbing and pulling the curtains. CNA 7 (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	stated they need to keep Resident 37's environment clean because of infection control. During an interview on 2/24/2026 at 3:53 PM with LVN 1, LVN 1 stated they need to keep the Resident's room or environment clean, to prevent spread of germs and infection. During an interview on 2/26/2026 at 2:08 PM with Director of Staff Development (DSD), DSD stated we need to keep the environment clean for the residents, to make sure residents will not get sick and for infection control. During a review of the facility's Policy and Procedure (P&P) titled, Homelike Environment, revised 2/2021, the P&P indicated residents are provided with a safe clean, comfortable and homelike environment and encouraged to use their personal belongings to the extent possible. The facility staff and management maximize, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting. These characteristics include: a. clean, sanitary and orderly environment

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to inform one (1) of 22 sampled residents (Resident 86) the risks and benefits of the use of bilateral bedside rails (a metal or plastic bars attached to the sides of the bed) in accordance with the facility's policy. This deficient practice had the potential for Resident 86 not to be able to exercise their right to choose his treatment plan.Findings: During a review of Resident 86's admission Record, the admission Record indicated Resident 86 was initially admitted to the facility on [DATE] and was readmitted on [DATE] with diagnoses that included epilepsy (brain activity that cause sudden uncontrollable electrical disturbance in the brain and sometimes loss of awareness), hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) and hemiparesis (muscle weakness or partial paralysis on one side of the body) following cerebral infarction (a medical condition that occurs when brain tissue dies due to a lack of blood flow and oxygen). During a review of Resident 86's Minimum Data Set (MDS- a resident assessment tool), dated 11/25/2025, the MDS indicated Resident 86 had intact cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making. The MDS also indicated Resident 86 was dependent (helper does all the effort) on showering and required substantial/maximal assistance (helper does more than half the effort) with toileting and personal hygiene, lower body dressing and with putting on/taking off footwear. The MDS further indicated Resident 86 required partial/moderate assistance (helper does less than half the effort) with upper body dressing and required setup assistance with eating and oral hygiene. During an observation on 2/23/2026 at 8:12 AM, Resident 86 was in bed with bilateral middle section of the bedside rails up. Resident 86 refused to answer any questions asked. During a concurrent interview and record review on 2/24/2026 at 4:31 PM, Registered Nurse 1 (RN 1) stated Resident 86 did not have an informed consent (voluntary agreement to accept treatment and/or procedures after receiving education regarding the risks, benefits, and alternatives offered) for bilateral bedside rails use. RN 1 also stated an informed consent should have been obtained prior to use of bedside rails to ensure Resident 86 understood the risk and benefits of its use. During a concurrent interview and record review on 2/26/2026 at 10:33 AM, the MDS Coordinator stated Resident 86 a consent prior to use of the bedside rail because the resident should be informed of the risk and benefits of its use. MDS Coordinator stated this includes the potential risk for entrapment (a dangerous situation where a resident gets stuck in the gaps between the mattress, bed frame, or side rails) During an interview on 2/26/2026 at 11:11 AM, the Director of Nursing (DON) stated Resident 86 did not have an informed consent for the use of bedside rails. The DON also stated a consent should have been obtained before initiating side rails so that Resident 86 was aware of the risk involved. During a review of the facility's Policy and Procedure (P&P) titled, Bed Safety and Bed Rails, revised 8/2022, the P&P indicated that before using bed rails for any reason, the staff shall inform the resident or resident representative about the benefits and potential hazards associated with bed rails and obtain informed consent. During a review of the facility's P&P titled, Resident Rights, revised 2/2021, the P&P indicated that Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the residents' right to be informed of, and participate in, his or her care, planning and treatment.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 Level 1 Preadmission Screening and Resident Review (PASRR, initial screening for all applicants to Medicaid-certified nursing facilities [meets federal and state standards for care and is approved to receive payment from Medicaid {a government health insurance program that provides free or low-cost coverage to eligible low-income individuals and families} for services provided to eligible residents] for possible serious mental disorder [MD, a health condition characterized by clinically significant alterations in thinking, mood, or behavior associated with distress and/or impaired functioning], intellectual disability [ID, a condition characterized by significantly subaverage intellectual functioning and substantial limitations in adaptive behavior] or a related condition, which is completed prior to admission to a nursing facility) was completed and was accurate for two (2) of six (6) sampled residents (Resident 71 and 81) reviewed for PASARR, in accordance with the facility's policy. This deficient practice had the potential to result in inappropriate placement of Resident 71 and 81 and had the potential for not receiving the necessary and appropriate level of treatment and evaluation in the facility.Findings: 1. During a review of Resident 71's admission Record, the admission Record indicated Resident 71 was admitted to the facility on [DATE] and re-admitted on [DATE]. The admission record indicated Resident 71's diagnoses included depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), psychosis (a mental disorder characterized by a disconnection from reality), and dementia (a progressive state of decline in mental abilities) During a review of Resident 71's Minimum Data Set (MDS, a resident assessment tool), dated 2/17/2026, the MDS indicated Resident 71 had severely impaired cognitive skills (mental action or process of acquiring knowledge and understanding) for daily decision making. The MDS indicated Resident 71 was dependent (helper does all of the effort, resident does none of the effort to complete the activity) toileting hygiene, shower/ bathe, sit-to stand, self, upper and lower body dressing, putting on/taking off footwear, sit to lying, and sit-to stand. During a review of Resident 71's PASARR dated, 1/13/2026, the PASARR indicated Level I was negative for serious mental illness. The PASARR indicated Resident 71 was not diagnosed with serious mental illness and was not taking any psychotropic (any medication capable of affecting the mind, emotions, and behavior) medications. During a review of Resident 71's Physician's Order (PO) Summary, dated 2/24/2026, the PO Summary indicated Resident 71 was prescribed: 1. On 1/14/2026, Duloxetine (Cymbalta, used to treat depression and anxiety [is a feeling of fear, dread, and uneasiness]) 60 milligrams (MG, unit of mass) by mouth one time a day for depression manifested by (m/b) expressing feelings of sadness. 2. On 1/30/2026, Olanzapine (Zyprexa, is an antipsychotic that can treat schizophrenia [a serious mental illness that affects how a person thinks, feels, and behaves] and bipolar disorder [a mental illness that causes unusual shifts in a person's mood, energy, activity levels, and concentration]) 2.5MG by mouth as needed for psychosis at bedtime m/b refusing care and agitation. During a concurrent interview and record review on 2/25/2026 at 2:15 PM with the Director of Nursing (DON), the PASRR dated 1/13/2026 was reviewed. The DON stated PASARR indicated Resident 71 (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was not diagnosed with serious mental illness and was not taking any psychotropic medications. The DON stated the PASARR was completed at the General Acute Hospital (GACH). The DON stated Resident 71's PASARR was incorrectly filled out because it should have indicated that Resident 71 had a diagnoses of psychosis, dementia, and depression. The DON stated Resident 71 was also taking Olanzapine and Duloxetine at the GACH and were continued at the facility. During an interview on 2/25/2026 at 2:18 PM with the DON, DON stated it was important to have an accurate PASARR to ensure Resident 71 was placed in the right facility and be provided with the appropriate care. 2. During a review of Resident 81's admission Record, the admission Record indicated Resident 81 was admitted to the facility on [DATE] with diagnoses that included major depressive disorder and unspecified psychosis. During a review of Resident 81's MDS, dated [DATE], the MDS indicated Resident 81 had intact cognitive skills for daily decision making. The MDS also indicated Resident 81 was dependent with putting on/taking off footwear and required substantial/maximal assistance (helper does more than half the effort) with toileting and personal hygiene, shower, upper and lower body dressing. The MDS further indicated Resident 81 required setup assistance (helper sets up; resident completes activity) with eating and oral hygiene. During a review of Resident 81's Medical Records, Residents 81's medical records indicated a negative PASARR 1 screening on 2/3/2021 despite diagnosis of mental illness. Residents 81's PASSAR 1 screening sections were not filled out completely, which included an assessment of mental illness (refers to a serious mental illness that cause significant functional limitations that warrants a deeper Level II [a comprehensive evaluation conducted by the appropriate state-designated authority that determines whether an individual has MD, ID or a related condition as defined above, determines the appropriate setting for the individual, and recommends what, if any, specialized services and/or rehabilitative services the individual needs]) evaluation before nursing facility During a concurrent interview and record review on 2/25/2026 at 3:40 PM, the Director of Nursing (DON) stated Resident 81 had an incomplete and inaccurate PASSAR level 1 screening because the PASARR did not reflect the resident's psychiatric diagnoses. The DON also stated the facility should have reviewed the PASSAR level 1 screening from General Acute Care Hospital (GACH) for completeness and accuracy. The DON further stated Resident 81 should have been re-screened for PASSAR level 1 upon admission to ensure the screening was accurate and Resident 81 was appropriately placed in a proper environmental setting. During a review of the facility's Policy and Procedure (P&P) titled, admission Criteria, revised 3/2019, the P&P indicated that all new admissions and readmissions are screened for mental disorders (MD), intellectual disabilities (ID) or related disorders (RD) per the Medicaid Pre-admission Screening and Resident Review (PASARR) process. The P&P also stated that the facility conducts a Level I PASARR screen for all potential admissions, regardless of payer source, to determine if the individual meets the criteria for a MD, ID or RD. &P further indicated that if the level I screen indicates that the individual may meet the criteria for a MD, ID, or RD, he or she is referred to the state PASARR representative for the Level IE (evaluation and determination) screening process.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility staff failed to keep one (1) of six (6) sampled residents (Resident 37) reviewed for Activities of Daily Living (ADLs, are activities related to personal care including bathing or showering, dressing, getting in and out of bed or a chair, walking, using the toilet, and eating) face and blanket clean and free of food particles on 2/26/2026, as indicated on the facility's dignity policy. This deficient practice had the potential to result in a negative effect on Resident 37's quality of life and self-esteem.Findings:During a review of Resident 37's admission Record, the admission Record indicated Resident 37 was admitted to the facility on [DATE] and re-admitted on [DATE], Resident 37's diagnoses included epilepsy (a chronic brain disorder characterized by recurrent, unprovoked seizures [are brief episodes of abnormal electrical activity in the brain that can cause a variety of symptoms, including involuntary movements, loss of consciousness, and changes in behavior]), major depressive disorder (or also called clinical depression, it affects how you feel, think and behave and can lead to a variety of emotional and physical problems) and dementia (a progressive state of decline in mental abilities) During a review of Resident 37's Minimum Data Set (MDS, a resident assessment tool) dated 1/9/2026, the MDS indicated Resident 37 had severely impaired cognitive skills (mental action or process of acquiring knowledge and understanding) for daily decision making. The MDS indicated Resident 37 was dependent (helper does all of the effort, resident does none of the effort to complete the activity) in toileting hygiene, shower/ bathe self, upper and lower body dressing, putting on/ taking off footwear, personal hygiene, sit to lying, lying to sitting on the side of the bed, sit to stand and chair/ bed-to-chair transfer. During a concurrent observation and interview on 2/26/2026 at 8:44 AM with Licensed Vocational Nurse 1 (LVN 1), Resident 37 was sitting on her bed with breakfast tray in front of her. Resident 37 had a white liquid coming out of her mouth and running down her chin, and there was white cream-like substance on her blanket and on the towel placed on her chest. Certified Nurse Assistant 8 (CNA 8) entered the room and took out Resident 37's breakfast tray. LVN 1 looked at Resident 37 and stated Resident 37 was dirty and that she would call CNA 8 to clean Resident 37. During a concurrent observation and interview on 2/26/2026 at 8:50 AM with CNA 8, inside Resident 37's room, CNA 8 stated it was not acceptable for Resident 37 to have food coming out of her mouth, running down her chin, or to have food debris on her blanket because it affects her dignity. CNA 8 also stated they should always keep Resident 37 clean. During a review of the facility's Policy and Procedure (P&P) titled, Dignity, revised 2/2021, the P&P indicated residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene.2. Appropriate care and services will be provided for residents who are unable to carry out AOLs independently, with the consent of the residents and in accordance with the plan of care, including appropriate support and assistance with:a. hygiene (bathing, dressing, grooming, and oral care)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure hemodialysis (a treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidney(s) have failed) emergency kit (E-Kit, an emergency supply kit used for residents who received hemodialysis) was readily accessible at the bedside for one (1) of two (2) sampled residents (Resident 29) reviewed for dialysis. This failure may result in the inability to manage Resident 29's bleeding from hemodialysis access site in the event of complications such as uncontrolled bleeding.Findings: During a review of Resident 29's admission Record, the admission Record indicated Resident 29 was initially admitted to the facility on [DATE] with diagnosis of type 2 diabetes mellitus (a disease that occurs when there is a problem in the way the body regulates and uses sugar as fuel), hypertension (high blood pressure), dependence on renal dialysis hemodialysis with end-stage renal disease (ESRD, medical condition in which a person's kidneys cease functioning on a permanent basis leading to the need for a regular course of long-term dialysis or a kidney transplant to maintain life). During a review of Resident 29's Minimum Data Set (MDS, a resident assessment tool), dated 2/4/2026, the MDS indicated Resident 29's cognitive skills (processes of thinking and reasoning) for daily decision making was moderately impaired cognitive (mental action or process of acquiring knowledge and understanding) skills for daily decision making were moderately impaired. The MDS also indicated that Resident 29 was assessed to need partial/moderate assistance (helper does less than half the effort. helper lifts, holds, or supports trunk or limbs, but provides less than half the effort) on oral hygiene (ability to use suitable items to clean teeth), upper body dressing (the ability to dress and undress above the waist), personal hygiene (the ability to maintain personal hygiene, including combing hair, shaving, applying makeup, washing/drying, face and hands [excludes baths, showers, and oral hygiene]), lying to sitting on side of bed (the ability to move from lying on the back to sitting on the side of the bed and with no back support), and with changing position chair/bed-to-chair transfer (the ability to transfer to and from a bed to a chair or wheelchair). During a record review of Resident 29's Order Summary dated 2/24/2026, the Order Summary indicated dialysis (hemodialysis) schedule, Tuesday, Thursday, and Saturday. During a record review of Resident 29's Care Plan, initiated 2/24/2026, the care plan indicated Resident 29 has renal insufficiency related to dialysis. The care plan also indicated, if bleeding occurs from the arteriovenous shunt (AV shunt- surgically created connection between artery[blood vessel that carries blood away from the heart] and a vein [blood vessel that carries return blood to the heart] in the arm that allows doctors to remove and return blood during dialysis treatment), staff are to apply pressure to the site. During an observation on 2/23/2026 at 10:17 AM in Resident 29's room, there was no dialysis E-Kit found in the resident's room. During a concurrent interview and record review in 2/23/2026 at 10:25 AM with the License Vocational Nurse (LVN) 3, LVN 3 stated there was no dialysis E-Kit found in Resident 29's room. During an interview and record review with the Director of Nursing (DON) on 2/24/2026 at 4:47 PM, the facility's Policy and Procedures (P&P) titled, End Stage Renal Disease, Care of a Resident With, dated 9/2010 was reviewed. The DON stated the P&P did not but should have indicated that a dialysis E- Kit be at bedside because it is the facility's practice to have a dialysis E-Kit easily accessible in case of emergency bleeding. During an interview on 2/25/2026 at 2:00 PM with Director of Staff and Development (DSD), DSD stated the dialysis E-Kit should be easily accessible in the residents' rooms, consisting of clamps (used to control bleeding), tape, gauze, and torniquet (tight band or strap).

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide pharmaceutical services including procedures to ensure the accurate acquiring, administering of drugs and biologicals to meet the needs for two (2) of 22 sampled residents (Residents 89, and 2) in accordance with the facility's policy and procedure (P&P) by failing to ensure: 1. Resident 89's Bactrim double strength ([DS] type of antibiotic medication used to treat infection) tablet 800-160 milligrams (mg-unit of measurement) and Prevymis oral (medicine used to prevent viral infection) tablet 480 mg were not left at bedside.This deficient practice had the potential for Resident 89 not to receive the medication which could delay the resident being free from infection and the deficient practice also increased the risk for diversion (the transfer of a controlled substance or other medication from a lawful to an unlawful channel of distribution or use) and accidental exposure to harmful medications in the event that other residents take it. 2.a.Licensed Vocational Nurse 1 (LVN 1) follow the facility's policy on insulin (a hormone that removes excess sugar from the blood, can be produced by the body or given artificially via medication) administration to depress the plunger and remove the needle after approximately five (5) seconds wait after administering Insulin Aspart (Novolog, fast acting insulin) on 2/25/2026.This deficient practice had the potential for Resident 2 not to receive the full does of insulin which could result in inadequate blood sugar management which can cause hyperglycemia (elevated blood sugar level) or hypoglycemia (low blood sugar level)2.b. LVN 1 used two (2) identifiers (the individual's name, an assigned identification number, date of birth or another person-specific identifier) prior to administering medications to Resident 2 on 2/25/2026.This deficient practice had the potential for medication errors (any preventable event that may cause or lead to inappropriate medication use) result in harm to Resident 2. Findings: 1. During a review of Resident 89's admission Record, the admission Record indicated the resident was initially admitted to the facility on [DATE] and readmitted [DATE] with diagnoses of type 2 diabetes mellitus (a disease that occurs when there is a problem in the way the body regulates and uses sugar as fuel), hypertension (high blood pressure) and dysphagia (difficulty swallowing). During a review of Resident 89'S Minimum Data Set (MDS – a resident assessment tool), dated 2/18/2026 the MDS indicated the resident was cognitively intact (ability to think, remember, and reason) with cognitive skills for daily decision making. Resident 89 needed partial/moderate assistance (Helper does less than half the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort) with personal hygiene (the ability to maintain personal hygiene, including combing hair, shaving, applying makeup, washing/drying face and hands), and was independent (Resident completes the activity by themself with no assistance from a helper) with eating. During a review of Resident 89's Self-Administration of Medication Evaluation, dated 2/14/2026 at 8:17 PM, the Self- Administration of Medications Evaluation indicated that the resident does not want to self-administer medication. During a review of Resident 89's Order Summary Report, dated 2/25/2026, the Order Summary Report indicated a physician's order on 2/17/2026 for Bactrim DS oral tablet 800-160 mg. The order summary also indicated a physician's order on 2/17/2026 for Prevymis oral tablet 480 mg. During an observation on 2/23/2026 at 11:03 AM in resident 89's room, a clear plastic medication cup (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	at the bedside table was observed with one pink colored medication and one white medication. Both tablets were cut in half. During a concurrent interview and record review on 2/25/2026 at 2:11 PM with the Director of Staff and Development (DSD), the facility's Policy and Procedures (P&P) titled Self-Administration of Medication revised 2/2021, was reviewed. The DSD stated the P&P indicated residents have the right to self-administer medications if the interdisciplinary team (IDT, involving two or more disciplines or fields of study)has determined that it is clinically appropriate and safe for the resident to do so. The DSD stated that as part of the comprehensive evaluation, the IDT would assess each resident's cognitive and physical abilities to determine whether self-administration of medication is safe and clinically appropriate for the resident. DSD also stated medications should not be left at the resident's bedside if resident does not meet criteria for self-administration due to the risk of medication error, overdosing, and diversion. During an interview on 2/26/2026 at 1:55 PM with the Licensed Vocational Nurse (LVN 1), the LVN1 stated she left Resident 89's Bactrim DS Oral Tablet 800-160 mg and Prevymis Oral Tablet 480 mg at Resident 89's bedside because the resident stated she would take them later. LVN 1 also stated that she should not have left the medication at the bedside. LVN 1 also stated that this practice increased the risk for medication error. 2. During a review of Resident 2's admission Record, the admission Record indicated Resident 2 was admitted to the facility on [DATE] and re-admitted on [DATE]. Resident 2' s diagnoses included transient ischemic attack (TIA, is a temporary blockage of blood flow to the brain), hydronephrosis (swelling of the kidney), urinary tract infection (UTI, is an infection in any part of the urinary system), and Diabetes mellitus (DM, is a metabolic disease, involving inappropriately elevated blood glucose levels) During a review of Resident 2's MDS, dated [DATE], the MDS indicated Resident 2 had intact cognitive skills for daily decision making. The MDS indicated Resident 2 was dependent (helper does all of the effort, resident does none of the effort to complete the activity) in toileting hygiene, and shower/ bathe self. The MDS also indicated Resident 2 needed partial and moderate assistance in upper body dressing, roll left and right, sit to lying, lying to sitting on the side of the bed, sit to stand, chair/ bed-to-chair transfer, toilet transfer, tub shower transfer, and walk 10 feet. a. During an observation on 2/25/2026 at 9:01 AM with LVN 1 in Resident 2's room, LVN 1 prepared Resident 2's Insulin Aspart Inject 10 units subcutaneously (SQ, is a shot that delivers medicine into the fatty tissue layer just under the skin, above the muscle, using a short, small needle for slow, steady absorption) before meals and at bedtime for DM. LVN 1 informed Resident 2 that she will administer his insulin. LVN1 wiped Resident 2's abdomen with alcohol pads and injected the insulin on Resident 2's right upper abdomen and withdrew the needle right away without waiting for 5 seconds. During an interview on 2/25/2026 at 9:14 AM with LVN 1, LVN 1 stated she withdrew the needle too fast. LVN 1 stated she should have waited 5 seconds before withdrawing the needle because the insulin needed time to get absorbed in Resident 2's abdomen. During an interview on 2/26/2026 at 11:14 AM with the Director of Nursing (DON), DON stated when licensed staff administer insulin, the staff should check the correct dose/ unit insulin, check expiration date, and the correct site. The DON stated the licensed staff should wait 5 seconds before withdrawing the needle to make sure the insulin is absorbed into the resident's body. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During review of the facility's policy and procedure (P&P) titled, Insulin Administration, revised on 9/2014, the P&P indicated, depress the plunger and remove the needle after approximately five (5) seconds. b. During an observation on 2/25/2026 at 9:03 AM with LVN 1, LVN 1 prepared Resident 2's medications scheduled at 9AM administration which consisted of the following: Vitamin C (supplement) Aspirin (a common, over-the-counter medication used to relieve mild-to-moderate pain, reduce fever[an abnormally high body temperature], and decrease inflammation [the body natural response to injury or infection]) for cardiovascular accident (CVA, commonly known as a stroke, a loss of blood flow to part of the brain, which damages brain tissue caused by blood clots and broken blood vessels in the brain) prophylaxis Cephalexin (used to treat a wide variety of bacterial infections, including skin, ear, respiratory, and urinary tract infections) for UTI Cranberry tablet (supplement) Multivitamin-minerals (supplement) Cholecalciferol (Vitamin D3, used to treat or prevent vitamin D deficiency, helping the body absorb calcium for healthy bones, muscles, and immunity) for wound healing Calcium carbonate (used as a dietary supplement to increase low calcium levels and as an antacid to relieve heartburn, indigestion, and upset stomach by neutralizing stomach acid) for hyperacidity (a condition where the stomach produces excessive acid) Bethanechol (a medication that stimulates your bladder to help you urinate) for urinary incontinence (involuntary or accidental leakage of urine, commonly referred to as a loss of bladder control) Clearlax (medication for constipation [infrequent, difficult, or painful bowel movements, usually fewer than three times a week]) Famotidine (medication for gastrointestinal upset [temporary discomfort in the digestive tract {stomach and intestines} commonly caused by inflammation, infections, or dietary issues]) Levetiracetam (medication for seizure [a sudden, uncontrolled burst of electrical activity in the brain]) Rivaroxaban (medication for atrial fibrillation [Afib, is an irregular and often very rapid heartbeat]) During an observation on 2/25/2026 at 9:09 AM in Resident 2's room, LVN 1 entered the room and informed Resident 2 that she would give him his 9 AM medications. Resident 2 was sitting in his wheelchair, and in a rush to go to the rehabilitation room. LVN 1 did not check any of Resident 2's identifiers. LVN 1 did not check resident's armband before handing Resident 2 his 9 AM medications. During an interview on 2/25/2026 at 9:35 AM with LVN 1, LVN 1 stated she did not check Resident (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2's armband before administering the resident's medications. LVN 1 stated she should have checked Resident 2's armband before administering medications because it is part of the seven (7) rights of medication administration. During an interview on 2/26/2025 at 11:15 AM with the Director of Nursing (DON), DON stated before administering medications to the residents, the licensed staff should always have 2 resident identifiers. The licensed staff should verify the medication order in the electronic medication administration record (eMAR, is the digital version of the traditional paper medication administration records used in healthcare facilities) while preparing the medications and also checking the resident's armband before administering the medications. During review of the facility's P&P titled, Medication Administration- General Guidelines, dated on 10/2017, the P&P indicated Residents are identified before medications are administered. Methods of identification include: a. checking identification band b. checking photographs attached to medical record; and c. if necessary, verifying resident identification with other facility personnel. B. Administration1) Medications are administered only by licensed nursing, medical, pharmacy or other personnel authorized by state laws and regulations to administer medications.2a Medications are administered in accordance with written orders of the attending physician. 4) Medications are administered at the time they are prepared. Medications are not pre-poured.5) Medications arc administered without unnecessary interruptions.6) The person who prepares the dose for administration is the person who administers the dose

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident?s drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to monitor the use of anticoagulant therapy (a medical treatment using drugs, called blood thinners, to prevent or treat dangerous blood clots [thrombi] by slowing down the blood's clotting process, stopping existing clots from growing, and preventing new ones from forming) for one (1) of five (5) sampled residents (Residents71) reviewed for unnecessary medications, in accordance with the facility's policy and the resident's care plan by failing to monitor resident for side effects of anticoagulant medication, bruising, bleeding, and hematoma (localized collection of blood outside a blood vessel that has leaked into surrounding tissues and clotted). This deficient practice had the potential for Resident 71 to experience complications from the use of anticoagulant therapy which could place the resident at risk for injury and harm.Findings:During a review of Resident 71's admission Record, the admission Record indicated Resident 71 was admitted to the facility on [DATE] and re-admitted on [DATE]. The admission record indicated Resident 71's diagnoses included respiratory failure (a serious condition that makes it difficult to breathe on your respiratory system [organs/ structures in the body that allow you to breathe such as lungs]), hypertension (high blood pressure), and atrial fibrillation (Afib, is an irregular and often very rapid heartbeat) During a review of Resident 71's Minimum Data Set (MDS, a resident assessment tool), dated 2/17/2026, the MDS indicated Resident 71 had severely impaired cognitive skills (mental action or process of acquiring knowledge and understanding) for daily decision making. The MDS indicated Resident 71 was dependent (helper does all of the effort, resident does none of the effort to complete the activity) in toileting hygiene, shower/ bathe sit-to stand, self, upper and lower body dressing, putting on/taking off footwear, sit to lying, and sit-to stand. During a concurrent interview and record review on 2/25/2026 at 10:38 AM with MDS Coordinator, Resident 71's Physician Orders (PO) dated 2/13/2026 was reviewed. The PO indicated Apixaban (a medication used to help prevent strokes or blood clots in people who have atrial fibrillation [a condition in which the heart beats irregularly, increasing the chance of clots forming in the body and possibly causing strokes]) Give 1 tablet by mouth two times a day for Afib. MDS Coordinator stated there was no PO order for monitoring for signs and symptoms (s/s) of bleeding while Resident 71 was on Apixaban. During a concurrent interview and record review on 2/25/2026 at 10:40 AM with MDS Coordinator, Resident 71's Care Plan (CP) for cerebral vascular accident (CVA or stroke, is an interruption in the flow of blood to cells in the brain) dated 1/15/2026 and the resident's medical records were reviewed. The CP Interventions indicated: Administer anticoagulant medications as ordered by physicians. Monitor for side effects and effectiveness. Administer anticoagulant medication per order. Monitor for side effects of medication, bruising, bleeding, hematoma (localized collection of blood outside a blood vessel that has leaked into surrounding tissues and clotted). Any noted notify the physician.The MDS Coordinator stated that the care plan (CP) interventions were not followed or implemented for Resident 71 because there were no orders or documented evidence in Resident 71's chart indicating that staff were monitoring the resident for side effects of the anticoagulant medication, bruising, bleeding, and hematoma. During a concurrent interview and record review on 2/25/2026 at 10:41 AM with MDS Coordinator, Resident 71's Nurse's Progress Notes (NPN) dated 2/1/2026 to 2/23/2026 were reviewed. MDS Coordinator stated the NPN contained no documentation of monitoring Resident 71 for side effects of the anticoagulant medication, bruising, bleeding, and hematoma. MDS 1 stated that if there was no documentation, it means it was not done. During a review of the facility's Policy and Procedure (P&P) titled, Anticoagulation- Clinical Protocol revised 11/2018, the P&P indicated, the staff and physician will monitor for possible complications in individuals who are being anticoagulated and will manage related problems.If an individual was on anticoagulation therapy showing signs of excessive bruising, hematuria, hemoptysis, or other evidence of bleeding, the nurse will discuss the situation with the physician before giving the next scheduled dose of anticoagulant.

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Dispose of garbage and refuse properly. Based on observation, interview, and record review, the facility failed to ensure one (1) of one trash can was covered with a lid while not in use in accordance with the facility's policy and procedure (P&P). This deficient practice had the potential to spread odors and bacteria (germ), cause contamination (presence of a germs, chemicals, or dirt in a place making it unsafe) and attract vermin (animals that are believed to be harmful, carry diseases such as rodents, parasitic worms, or insects) which may cause disease and other health issues to residents residing in the facility, staff, and the community.Findings: During a concurrent observation of the kitchen and interview on 2/23/2026, at 7:47 AM, with the Dietary Supervisor (DS), one large gray trash can was observed next to the steam table (a table with slots to hold food containers which are kept hot by steam). DC confirmed the trash can had trash inside and was not covered with a lid. During an interview on 2/25/2026, at 1:20 PM, with the Registered Dietician (RD), the RD stated trash cans should always be covered for pest control (the process of managing, reducing, or eliminating unwanted insects, rodents, and other organisms that threaten human health) and to prevent cross contamination (the process by which bacteria are unintentionally transferred from one substance or object to another with harmful effect) in the kitchen. During a follow-up interview, on 2/26/2026, at 9:03 AM, with DS, DS stated the trash should be covered at all times when not in use. DS the policy for trash can in the kitchen was not followed. During a review of the facility's P&P, titled, Food-Related Garbage and Refuse Disposal, revised 10/2017, the P&P indicated the following:Food-related garbage and refuse are disposed of in accordance with current state laws.All garbage and refuse containers are provided with tight-fitting lids or covers and must be kept covered when stored or not in continuous use.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure standard infection prevention control practices (a set of practices that prevent or stop the spread of infections and or diseases in the healthcare setting) were followed for two (2) of 22 sampled residents (Resident 37 and Resident 4) on Enhanced Barrier Precautions (EBP, refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and glove use during high contact resident care activities) by failing to ensure:Certified Nursing Assistant 2 (CNA 2) was wearing a gown while providing bed bath and dressing to Resident 37. Licensed Vocational Nurse 1 (LVN 1) changed gloves between tasks and wore a gown while administering medications to Resident 4 via resident's gastrostomy tube (G-tube, is a tube inserted through the belly that brings nutrition directly to the stomach).These deficient practices have potential to place the residents and staff at risk for infection.Findings:1. During a review of Resident 37's admission Record, the admission Record indicated Resident 37 was admitted to the facility on [DATE] and re-admitted on [DATE], Resident 37's diagnoses included epilepsy (a chronic brain disorder characterized by recurrent, unprovoked seizures [are brief episodes of abnormal electrical activity in the brain that can cause a variety of symptoms, including involuntary movements, loss of consciousness, and changes in behavior]), major depressive disorder (or also called clinical depression, it affects how you feel, think and behave and can lead to a variety of emotional and physical problems) and dementia (a progressive state of decline in mental abilities) During a review of Resident 37's Minimum Data Set (MDS, a resident assessment tool) dated 1/9/2026, the MDS indicated Resident 37 had severely impaired cognitive skills (mental action or process of acquiring knowledge and understanding) for daily decision making. The MDS indicated Resident 37 was dependent (helper does all of the effort, resident does none of the effort to complete the activity) in toileting hygiene, shower/ bathe self, upper and lower body dressing, putting on/ taking off footwear, personal hygiene, sit to lying, lying to sitting on the side of the bed, sit to stand and chair/ bed-to-chair transfer. During an observation on 2/24/2026 at 12:08 PM with CNA 2 in Resident 37's room, CNA 2 was observed not wearing a gown while providing bed bath and dressing to Resident 37. Resident 37 was observed with wound dressing on the left foot. During an observation on 2/24/2026 at 12:10 PM, CNA 2 was seen without a gown while in Resident 37's room. CNA 2 entered and exited the room multiple times to place dirty linen in the dirty linen cart, which was parked in the hallway. CNA 2 then took a bag of clean linen from the clean linen cart and returned to Resident 37's room. During an interview on 2/24/2026 at 12:12 PM with CNA 2, CNA 2 stated she forgot to wear the gown. CNA 2 stated she should be wearing PPE (personal protective equipment - clothing and equipment that is worn or used to provide protection against hazardous substances and/or environments) because she was providing bed bath and dressing to Resident 37. CNA2 stated Resident 37 had wound on her left foot and resident was on EBP. During an interview on 2/26/2026 at 9:40 AM with the Director of Staff Development (DSD), the DSD stated that staff should wear PPE when caring for residents in the EBP room due to infection control requirements. The DSD added that if staff do not wear PPE, they can cause crossˆcontamination when caring for other residents. 2. During a review of Resident 4's admission Record, the admission Record indicated Resident 4 was admitted to the facility on [DATE] and re-admitted on [DATE], Resident 4's diagnoses included hemiplegia (paralysis of one side of the body) and hemiparesis (weakness on one side of the body) following cerebral infarction (refers to damage to tissues in the brain due to a loss of oxygen to the area) affecting the left side of the body, Gastroesophageal reflux disease (GERD, happens when stomach acid flows back up into the esophagus and causes heartburn [a painful, burning feeling in the middle of your chest]) and diabetes mellitus (DM, is a metabolic disease, involving inappropriately elevated blood glucose levels) During a review of Resident 4's MDS, dated [DATE], the MDS indicated the resident's cognitive skills (continued on next page)

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	055376	A. Building B. Wing	02/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Huntington Drive Health and Rehabilitation Center	400 W. Huntinton Dr. Arcadia, CA 91007

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	for daily decision making were severely impaired. The MDS indicated Resident 4 was dependent on eating, oral hygiene, toileting hygiene, shower/bathe self, upper and lower body dressing, and putting on/ taking off footwear. The MDS indicated Resident 51 also needed substantial/ maximal assistance (helper does more than half the effort. helper lifts, holds trunk or limbs, and provides more than half the effort) in roll left and right, sit to lying, lying to sitting on the side of the bed, sit to stand, chair/ bed-to-chair transfer, toilet transfer and tub shower transfer. During an observation on 2/26/2026 at 8:10 AM in Resident 4's room, LVN 1 was not wearing a disposable gown when she entered the resident's room. LVN 1 pulled the curtain while wearing disposable gloves, then disconnected Resident 4's Gˆtube from the tubeˆfeeding connection. LVN 1 touched Resident 4's blanket and shirt, then connected the flush syringe to Resident 4's Gˆtube without changing her disposable gloves. LVN 1 proceeded to checking the residual on Resident 4's Gˆtube while still wearing the same disposable gloves. LVN 1 then pulled the curtain on the left side of Resident 4's bed using the same gloves. During an observation on 2/26/2026 at 8:28 AM in Resident 4's room, LVN 1 pulled Resident 4's curtain after checking the resident's blood pressure and pulse, using the same disposable gloves. LVN 1 then pulled the medication cart using her left gloved hand without changing her gloves.During an observation on 2/26/2026 at 8:35 AM in Resident 4's room, LVN 1 changed her disposable gloves, then pulled Resident 4's curtain and took a flush syringe from a plastic bag. LVN 1 connected the flush syringe to Resident 4's Gˆtube without changing her gloves. During an observation on 2/26/2026 at 8:35 AM in Resident 4's room, LVN 1 did not change her disposable gloves after administering medications. LVN 1 touched Resident 4's shirt and pulled the resident's curtain without changing her gloves. During an interview on 2/26/2026 at 8:50 AM, LVN 1 stated she did not change her gloves between tasks. LVN 1 also stated that she should not have touched Resident 4's curtains and should have changed her gloves when changing tasks due to infection control requirements. During review of the facility's policy and procedure (P&P) titled, Enhanced Barrier Precautions updated on 8/2022, the P&P indicated, 1. Enhanced barrier precautions (EBPs) are used as an infection prevention and control intervention to reduce the spread of multi-drug-resistant organisms (MDROs) to residents.2. EBPs employ targeted gown and glove use during high contact resident care activities when contact precautions do not otherwise apply.a. Gloves and gowns are applied prior to performing the high contact resident care activity (as opposed to before entering the room).3. Examples of high-contact resident care activities requiring the use of gowns and gloves for EBPs include:a. dressing.b. bathing/showering.c. transferring.d. providing hygiene.e. changing linen.f. changing briefs or assisting with toileting.g. device care or use (central line, urinary catheter, feeding tube, tracheostomy/ventilator, etc.); andh. wound care (any skin opening requiring a dressing).5. EBPs are indicated (when contact precautions do not otherwise apply) for residents with wounds and/or indwelling medical devices regardless of MDRO colonization. During review of the facility's P&P titled, Handwashing/ Hand Hygiene revised on 11/2023, the P&P indicated,4. Single-use disposable gloves should be used:c. when in contact with a resident, or the equipment or environment of a resident, who is on contact precautions.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. Based on interview and record review, the facility failed to maintain documentation of screening, education, offering and current Influenza (a contagious respiratory illness caused by influenza viruses that infect the nose, throat, and lungs) vaccination status for one (1) of four (4) sampled staff member (CNA 1) reviewed for infection prevention, control, and immunizations. This deficient practice had potential to miss potential gaps in identifying, tracking, implementing strategies to increase vaccination rates among staff, which helps to protect vulnerable residents.Findings:During a concurrent interview and record review on 2/25/2026 at 2 PM, Covid-19 and Influenza staff vaccination record for 2026 was reviewed. Infection Prevention Nurse (IPN) stated Certified Nursing Assistant 1 (CNA 1) refused Influenza vaccination but did not have a documentation of the consent which indicated the staff declined both vaccinations. The IPN also stated records of the staff vaccination was to keep track of staffs' vaccination status and to identify staffs who are required to wear mask when they are in resident care areas and protect the residents. During an interview on 2/25/2026 at 2:45 PM, the Director of Nursing (DON) stated the facility should maintain a record of the Covid-19 and influenza vaccination status of all staff and it helps to keep track when the staff are due for their Influenza vaccinations. The DON also stated the facility should keep records of staffs who was offered and declined vaccinations to ensure the staff were offered the vaccines again, in case the staff changed their minds. During another interview on 2/26/2026 at 12:22 PM, the IPN stated the documentation of staff vaccination is important to implement more precautions for the staff who are not vaccinated and monitor their infection vulnerability since they are at a higher risk for contracting respiratory illnesses and protect the residents from contracting respiratory illness from those staff. During a review of the facility's policy and procedure (P&P) titled, Employee Infection and Vaccination, revised 3/2022, the P&P indicated that vaccinations that are declined by the employee will be documented on the applicable declination form and placed in the employees' health record.

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. Based on interview and record review, the facility failed to maintain documentation of screening, education, offering and current Coronavirus disease (Covid-19, an infectious disease caused by the SARS-CoV-2 virus that causes respiratory illness primarily affecting lungs and breathing) vaccination status for one (1) of four (4) sampled staff member (CNA 1) reviewed for infection prevention, control, and immunizations. This deficient practice had potential to miss potential gaps in identifying, tracking, implementing strategies to increase vaccination rates among staff, which helps to protect vulnerable residents.Findings: During a concurrent interview and record review on 2/25/2026 at 2 PM, Covid-19 and Influenza staff vaccination record for 2026 was reviewed. Infection Prevention Nurse (IPN) stated Certified Nursing Assistant 1 (CNA 1) refused Covid-19 vaccination but did not have a documentation of the consent which indicated the staff declined both vaccinations. The IPN also stated records of the staff vaccination was to keep track of staffs' vaccination status and to identify staffs who are required to wear mask when they are in resident care areas and protect the residents. During an interview on 2/25/2026 at 2:45 PM, the Director of Nursing (DON) stated the facility should maintain a record of the Covid-19 and influenza vaccination status of all staff and it helps to keep track when the staff are due for their Covid-19 vaccinations. The DON also stated the facility should keep records of staffs who was offered and declined vaccinations to ensure the staff were offered the vaccines again, in case the staff changed their minds. During another interview on 2/26/2026 at 12:22 PM, the IPN stated the documentation of staff vaccination is important to implement more precautions for the staff who are not vaccinated and monitor their infection vulnerability since they are at a higher risk for contracting respiratory illnesses and protect the residents from contracting respiratory illness from those staff. During a review of the facility's policy and procedure (P&P) titled, Employee Infection and Vaccination, revised 3/2022, the P&P indicated that vaccinations that are declined by the employee will be documented on the applicable declination form and placed in the employees' health record.