STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055394	A. Building B. Wing	02/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Claremont Care Center	219 E. Foothill Blvd Pomona, CA 91767

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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 failed to ensure five of five sampled residents (Resident 21, 61, 116, 117, and 35), were treated with dignity when:a. Licensed Vocational Nurse (LVN) 2 failed to knock on Resident 21 and 61, 116 and 117's doors prior to entering the resident's rooms.b. LVN 3 failed to draw (close) Resident 35's privacy curtains completely around Resident 35's bed during insulin (a medication, hormone that removes excess sugar from the blood, can be produced by the body or given artificially via medication) administration in Resident 35's abdomen (belly). This failure could potentially result in Residents 21, 61, 116, 117, and 35 feeling bothered or startled, in the residents feeling invaded and humiliated, and negatively impacting the resident's psychosocial [the emotional and social requirements that individuals must have to feel safe, supported, and capable of functioning well in their environment]) well-being.Findings:a. During a review of Resident 21's admission Record (AR), the AR indicated, Resident 21 was originally admitted to the facility on [DATE] and readmitted on [DATE] with multiple diagnoses including osteomyelitis (inflammation of bone or bone marrow, usually due to an infection) of vertebra (one of the bones that make up the spinal column), thoracic (relating to chest) region, and bacteremia (bacteria in your blood).During a review of Resident 21's History and Physical (H&P), dated 12/20/2025, the H&P indicated, Resident 21 was A & O x 4 (alert and oriented to person, place, time, and situation).During a review of Resident 21's Minimum Data Set (MDS - a resident assessment tool), dated 12/23/2025, the MDS indicated Resident 21's cognitive skills (ability to think and process information) for daily decision making were intact. The MDS indicated, Resident 21 was independent (resident completes the activity by themself with no assistance from a helper) and required partial/moderate assistance (helper does less than half of the effort) with ADL (activities of daily living).During a review of Resident 61's AR, the AR indicated, Resident 61 was admitted to the facility on [DATE] with multiple diagnoses including chronic obstructive pulmonary disease (COPD - a long standing group of lung disease that block airflow causing difficulty in breathing) with (acute, sudden) exacerbation (worsening), and urinary tract infection (UTI - an infection in the bladder/urinary tract), site not specified.During a review of Resident 61's History of Present Illness (H&P), dated 1/21/2026, the H&P indicated, Resident 61 had the capacity to understand and make decisions.During a review of Resident 61's MDS, dated [DATE], the MDS indicated Resident 61's cognitive skills for daily decision making were intact. The MDS indicated Resident 61 required substantial/maximal assistance (helper does more than half the effort) to supervision or touching assistance (helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity) with ADL.During a review of Resident 116's AR, the AR indicated, Resident 61 was admitted to the facility on [DATE] with multiple diagnoses including anxiety disorder (a mental health condition characterized by excessive, uncontrollable, and persistent fear or worry that interferes with daily life), unspecified, and old myocardial infarction (MI - heart attack).During a review of Resident 116's H&P, dated 2/9/2026, the H&P indicated, Resident 116 was frail but responsive to name.During a review of Resident 116's MDS, dated [DATE], the MDS indicated Resident 116 was dependent (helper does all of the effort) and required partial/moderate (continued on next page)

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

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	assistance with ADL.During a review of Resident 117's AR, the AR indicated, Resident 117 was admitted to the facility on [DATE] with multiple diagnoses including need for assistance with personal care, and bipolar disorder (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs), unspecified.During a review of Resident 117's MDS, dated [DATE], the MDS indicated Resident 117's cognitive skills for daily decision making were moderately impaired. The MDS indicated Resident 117 required substantial/maximal assistance to supervision or touching assistance with ADL.During an observation on 2/10/2026 between 10:00 AM and 10:55 AM, multiple staff (unidentified) were entering multiple resident's rooms without knocking [announcing themselves] on the doors.During an observation on 2/11/2026 at 7:46 AM, LVN 2 entered Resident 21 and 61's room without knocking on the door [or announcing self] to check on Resident 21 and 61's breakfast trays. LVN 2 exited the room and entered Resident 116 and 117's roomwithout knocking on the door, and collected Resident 116's breakfast tray. LVN 2 exited the room and put away the breakfast tray in a meal delivery cart. LVN 2 entered Resident 21 and Resident 61's room a second time without knocking on the door and collected Resident 61's breakfast tray.During an interview on 2/11/2026 at 7:52 AM with LVN 2, in the presence of Registered Nurse (RN) 1, LVN 2 stated staff (in general) should knock [on the doors] prior to entering resident rooms and knocking was important to protect the resident's privacy and dignity.During a concurrent interview on 2/12/2026 at 11:16 AM with Resident 61 and the Responsible Party (RP), Resident 61 stated, staff not knocking prior to entering Resident 61's room would scare the (expletive) out of Resident 61. The RP stated, staff (unidentified) sometimes knocked on the door and sometimes, they don't.During an interview on 2/12/2026 at 3:35 PM with the Director of Nursing (DON), the DON stated, knocking on a resident's door before entering their room was important to let the resident know staff was entering the room, for staff to ask permission to enter, and for dignity [purposes]. b. During a review of Resident 35's AR, the AR indicated, Resident 35 was admitted to the facility on [DATE] with multiple diagnoses including type 2 diabetes mellitus (DM - adult onset disorder characterized by difficulty in blood sugar control and poor wound healing) with other specified complication, and heart failure, unspecified.During a review of Resident 35's MDS, dated [DATE], the MDS indicated Resident 35's cognitive skills for daily decision making were intact. The MDS indicated Resident 35 was dependent and required setup or clean-up assistance (helper sets up or cleans up; resident completes activity) with ADL.During a review of Resident 35's Order Summary Report (OSR), active orders as of 2/12/2026, the OSR indicated, an active order for Lantus SoloStar (a type of long-acting insulin) subcutaneous (administered under the skin) solution pen-injector 100 unit/millimeters (ml, volume of liquid) two times a day for DM, dated 12/17/2026.During a review of Resident 35's Medication Administration Record (MAR), dated 2/1/2026 to 2/28/2026, the MAR indicated Lantus insulin was scheduled to be administered daily at 9:00 AM and at 5:00 PM. During an observation on 2/12/2026 at 8:36 AM, LVN 3 administered Resident 35's insulin in Resident 35's right upper quadrant of Resident 35's abdomen with Resident 35's privacy curtain drawn from Resident 35's head of the bed to the right corner of the foot of bed, Resident 5's abdomen was exposed. LVN 3 stated, LVN 3 should have drawn Resident 35's drape all the way around Resident 35's bed for privacy and dignity. During a review of the facility's policy and procedure (P&P) titled, Resident Rights-Dignity and Respect, revised 10/2025, the P&P indicated, it was the policy of the facility forall residents to be treated with kindness, dignity, and respect. The P&P indicated, residents should be examined and treated in a manner that maintained the privacy of their bodies. The P&P indicated, a closed door or drawn curtain shielded the resident from passers-by. The P&P indicated, staff should knock before entering the resident's room.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure quality of care for three of three sampled residents (Residents 2, 66 and 35) by failing:A. To follow physician's order when the license nurses administered insulin (a medication that removes excess sugar from the blood.) on one of three sample residents (Resident 2)'s left arm with a shunt. (a surgically created access point on the body for dialysis [a treatment to clean your blood when your kidney can't do it well.]) B. To ensure a Change of Condition (COC, a major unplanned deviation from the most recent status, when the change is identified the resident is evaluated and the changes are reported to the physician) assessment was completed for Resident 66 after a surgical debridement (the medical process of cleaning a wound by removing dead, damaged, or infected tissue, as well as foreign debris, to promote faster healing and prevent infection) of a callus (a thickened, hardened patch of skin that forms to protect a specific area of the body from repeated rubbing, pressure, or irritation) revealed an open diabetic (difficulty in blood sugar control and poor wound healing) foot ulcer (an open sore or wound, usually on the bottom of the foot, that develops in people with diabetes due to a combination of numb feet, poor blood circulation, and skin breakdown from pressure) was found on [DATE]. Additionally, the facility failed to notify Medical Doctor (MD, Resident 66's primary care physician) 2 of Resident 66's COC.C. To obtain a physician order prior to performing a fingerstick (a procedure that uses a medical device [a lancet] to prick the skin to check blood sugar) for Resident 35.These failures placed Residents 2, 66 and 35 at risk for serious complications, including bleeding and compromise of dialysis (a treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidney(s) have failed) access, delayed treatment, infection, impaired wound healing, and further clinical deterioration and Resident 35 feeling bothered and receiving unnecessary treatment.Findings: A. During a review of Resident 2's Face Sheet (admission record), the face sheet indicated the facility initially admitted a [AGE] year-old female on [DATE] and re-admitted on [DATE], with the diagnoses that included but not limited to end stage renal disease (irreversible kidney failure) , dependence on renal dialysis (a treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidneys have failed) and type 2 diabetes mellitus (a disorder characterized by difficulty in blood sugar control). During a review of Resident 2's minimum data set (MDS, a resident assessment tool), dated [DATE], indicated Resident 2 is getting dialysis. During a review of Resident 2's physician's order dated 2/2026. The physician's order indicated Resident 2 should not receive any needle stick on her left arm. During a review of Resident 2's Medication Administration Record (MAR), dated 2/2026. The MAR indicated license nurses used Resident 2' left arm to administered medication through needle injection on following dates and time: Insulin glargine (a long-acting insulin helps people with diabetes control their blood sugar.) Solution 100 unit/ml [DATE] 6:35 PM NovoLOG (a fast-acting insulin) Injection Solution 100 unit/ml (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	[DATE] 11:42 AM [DATE] 11:48 AM [DATE] 6:37 AM [DATE] 6:32 PM [DATE] 6:23 AM [DATE] 10:00 PM [DATE] 6:02 AM [DATE] 10:06 PM During an interview on [DATE] at 8:47 AM with Licensed Vocational Nurse (LVN)6, LVN 6 stated all physician's order should be reviewed before administered medication to a resident. If a resident is on hemodialysis, she will try to avoid the arm having shunt because injection on the shunt arm could result trauma to the resident. During a concurrent interview and record review on [DATE] at 9:07 AM, with LVN 5, Resident 2's physician's order dated 2/2026 was reviewed. The physician's order indicated, no needle stick on Resident 2's left arm. LVN 5 stated she was not aware of the order and had administered insulin injection on Resident 2's left arm. LVN 5 stated using Resident 2's left arm for injection will increase the risk of bleeding and cause trauma. During an interview on [DATE] at 9:50 AM with the Director of Nursing (DON), the DON stated that for any hemodialysis resident who is also on insulin injection, it is important that nurse check physician's order and avoid the arm with the shunt. The DON also stated their nurses should follow physician's order and avoid any harm to any resident. During a review of the facility's Policy and Procedure (P&P) titled, Medication administration, not dated. The P&P indicated medication should be administered as prescribed by the physician. B. During a review of Resident 66's admission Record (AR), the AR indicated the facility admitted Resident 66 on [DATE], with diagnoses including cellulitis (a skin infection that causes swelling and redness), pressure ulcer (a small open sore or wound generally found in the stomach or on the skin), the need for assistance with personal care, and Type 2 Diabetes Mellitus (DM, a disorder characterized by difficulty in blood sugar control and poor wound healing). During a review of Resident 66's MDS, dated [DATE], the MDS indicated Resident 66's cognition (the ability to think and process information) was intact. The MDS indicated Resident 66 required partial/moderate assistance (helper does less than half the effort) with activities of daily living (ADL-term used in healthcare that refers to self-care activities) and substantial/maximal assistance (helper does more than half the effort) with mobility. During a review of Resident 66's Nursing Order (NO), dated [DATE], the NO indicated a plan for debridement (the medical process of cleaning a wound by removing dead, damaged, or infected tissue, (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	as well as foreign debris, to promote faster healing and prevent infection) to Resident 66's right heel. During a review of Resident 66's Progress Note (PN), dated [DATE], the PN documentation indicated Resident 66 was seen at bedside for debridement and treatment of a complex callus on Resident 66's right foot. The PN indicated will debride callus today. The PN indicated non-selective active wound care (methods used to clean a wound that remove both dead [necrotic] tissue and healthy, living tissue in the process) to be provided by facility staff between visits. The PN indicated skilled nursing team to continue care as ordered. During a review of Resident 66's Care Plan Report (CPR), initiated [DATE], the CPR's focus indicated a right heel ulcer and on [DATE] Resident 66's callus was debrided exposing a diabetic fool ulcer on Resident 66's right heel. The CPR's goal indicated Resident 66's skin issue would begin the healing process by the next review date. During an interview on [DATE] at 10:27 AM, with LVN/Treatment Nurse (LVN) 7, LVN 7 stated following the surgical debridement to the right heel, the removal of the callus revealed an open diabetic foot ulcer requiring ongoing wound care treatment. LVN 7 stated and confirmed that a COC assessment was not completed. LVN 7 stated a COC assessment was needed because Resident 66's skin integrity status changed from an intact callus to an open wound, representing an alteration in medical condition requiring assessment, monitoring, and [new] interventions. LVN 7 stated completion of a COC assessment was essential to evaluate the extent of the wound, identify risk factors including infection and impaired healing related to DM, and to notify the resident's physician. LVN 7 stated that failure to complete the assessment limited comprehensive clinical evaluation of the resident's altered status and placed the resident at risk for delayed identification of complications, and impaired wound healing. During an interview and concurrent record review on [DATE] at 11:49 AM, with Registered Nurse (RN) 1, Resident 66's medical records were reviewed with RN 1, RN 1 stated when a resident's condition changed from intact skin to an open wound, a COC assessment was required. RN 1 stated completion of a COC assessment ensured a comprehensive nursing evaluation was performed, physician notification occurred, appropriate monitoring and interventions were initiated, and promoted clear interdisciplinary team (IDT, a group of experts from different fields [e.g., doctors, nurses, social workers] who work closely together, sharing knowledge to solve complex problems or care for a patient) communication. RN 1 stated there was no documented evidence MD 2 was notified of Resident 66's COC that occurred on [DATE]. RN 1 stated when there was a resident COC, the physician should be notified of the changes. During a review of the facility's P&P titled, Change in Condition dated 4/2025, the P&P's policy indicated the facility is to ensure each resident receives quality of care and services to attain and maintain the highest practicable physical mental and psychosocial well-being in accordance with the interdisciplinary comprehensive assessment and plan of care. The P&P indicated if, at any time, it is recognized by any one of the team members that the conditions or care needs of the residents have changed. the nurse will perform and document an assessment of the resident and identify need for additional interventions, considering implementation of existing orders or nursing interventions or through communication with the resident's provider using SBAR [COC] or similar process to obtain new orders or interventions. The P&P indicated the nurse will communicate the change to other departments as appropriate and each department notified will perform their own evaluation and assessment to determine if the change requires further intervention and implement actions accordingly. The nurse will transcribe the treatment and plan of care relative to the change of (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	condition on the resident Electronic Medical Record (EMR). The P&P indicated the IDT shall collaborate with the attending physician.to review risk indicators and the plan of care. The P&P indicated the nurse shall use his/ her clinical judgment and shall contact the physician based on the urgency of the situation. C. During a review of Resident 35's AR, the AR indicated Resident 35 was admitted to the facility on [DATE] with multiple diagnoses including type 2 diabetes mellitus (DM – adult-onset disorder characterized by difficulty in blood sugar control and poor wound healing) with other specified complication, and heart failure. During a review of Resident 35's MDS, dated [DATE], the MDS indicated Resident 35's cognitive skills for daily decision making were intact. The MDS indicated Resident 35 was dependent to required setup or clean-up assistance (helper sets up or cleans up; resident completes activity) with ADL. During a review of Resident 35's Order Summary Report (OSR), active orders as of [DATE], the OSR indicated an active order dated [DATE], for Lantus SoloStar (a type of long-acting insulin) subcutaneous (under the skin) solution pen-injector 100 unit/millimeters (ml, unit of volume) two times a day for DM. The OSR, did not indicate an order to check Resident 35's blood sugar for the Lantus SoloStar insulin ordered two times a day for DM. During a review of Resident 35's Medication Administration Record (MAR), dated 2/2026, the MAR indicated Lantus SoloStar insulin was scheduled to be administered daily at 9 AM and at 5 PM. During a review of Resident 35's Weights and Vitals Summary (WVS), effective date range: [DATE] to [DATE], the WVS indicated a blood sugar level of 127 mg/dL (milligrams per deciliter - a unit of measurement representing the concentration of blood sugar in a specific volume of blood) on [DATE] at 9 AM. During an observation on [DATE] at 8:05 AM, during medication administration, LVN 3 was preparing Resident 35's 9 AM scheduled medications. Resident 35 was lying in bed having breakfast. LVN 3 performed a fingerstick on Resident 35's right ring finger. LVN 3 stated, LVN 3 liked checking Resident 35's blood sugar since Resident 35 was getting Lantus, it's (insulin) a long acting. During an interview on [DATE] at 11:31 AM with Resident 35, Resident 35 stated Resident 35 was getting fingersticks around 5 [to] 6 times total in a day, including at 9 AM performed only by LVN 3. Resident 35 stated, being poked (fingerstick and insulin injections) many times in a day bothered Resident 35. During a concurrent interview and record review on [DATE] at 11:46 AM with LVN 3, Resident 35's OSR was reviewed. LVN 3 stated there was no order to check Resident 35's blood sugar for the Lantus 9 AM dose. LVN 3 stated, checking Resident 35's blood sugar for the Lantus 9 AM dose was not necessary and would not be following doctor's order and, that would be a mistake. LVN 3 stated, unnecessary fingersticks were something that residents (in general) would not like or enjoy and would be uncomfortable. During a concurrent interview and record review on [DATE] at 3:35 PM with the DON, Resident 35's OSR focusing on the orders for insulin with blood sugar checks were reviewed. The DON stated Resident 35 would be getting blood sugar checks four (4) times at 6:30 AM, 11:30 AM, 4:30 PM and at (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the clinical record was complete and accurate for three of three sampled residents (Resident 2, Resident 66, and Resident 113).This failure had the potential to result in inaccurate assessments, inconsistent and/or inaccurate treatments provided to the residents and negatively impact Resident 2 and 66, and Resident 113's physical well-being. Findings: 1a(i). During a review of Resident 2's Face Sheet (admission record), the face sheet indicated the facility initially admitted a [AGE] year-old female on 5/27/2023 and re-admitted on [DATE], with the diagnoses that included but not limited to end stage renal disease (irreversible kidney failure) , dependence on renal dialysis (a treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidneys have failed) and type 2 diabetes mellitus (a disorder characterized by difficulty in blood sugar control). During a review of Resident 2's minimum data set (MDS, a resident assessment tool), dated 11/1/2025, indicated Resident 2 is getting dialysis. During a review of Resident 2's Medication Administration Record (MAR), dated 2/2026, the MAR indicated the following dates and time Resident 2's insulin administered site was documented as on her Deltoid (muscle in the shoulder): NovoLOG (fast-acting insulin, medicine used by people with diabetes to help control blood sugar.) Injection Solution 100 unit/ml 2/3/2026 5:04 PM Insulin Glargine (long-acting insulin, medicine that helps people with diabetes control their blood sugar.) Solution 100 unit/ml 2/4/2026 5:06 PM During an interview on 2/11/2026 at 9:13 AM with Licensed Vocational Nurse (LVN) 4, LVN 4 stated deltoid is not a proper site for insulin injections because deltoid is muscle and insulin shot should be subcutaneous (under the skin) on the back of the arms and on stomach. During a concurrent interview and record review on 2/11/2026 at 9:50 AM with the Director of Nursing (DON), Resident 2's MAR dated 2/2026 was reviewed. The DON stated the documentation on Resident 2's MAR indicated that insulin shot was given on deltoid was wrong documentation. During an interview and on 2/13/2026 at 10:11 AM with Registered Nurse (RN), RN stated Resident 2 MAR has discrepancies. RN also stated false documentation is unacceptable, all documentation should be complete and accurate to reflect patient assessment. False documentation could lead to problems like medication error. 1a(ii). During a review of Resident 113's Face Sheet, the face sheet indicated the facility admitted Resident 113, a [AGE] year-old male, admitted on [DATE], with diagnoses that included end stage (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	renal disease (irreversible kidney failure) , dependence on renal dialysis (a treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidney(s) have failed) and type 2 diabetes mellitus (a disorder characterized by difficulty in blood sugar control). During a review of Resident 113's MDS, dated [DATE], indicated Resident 113 is getting dialysis. During a review of Resident 113's Care Plan (CP), date initiated 2/6/2026, the CP indicated no needle stick on Resident 113's left arm. During a review of Resident 113's MAR dated 2/2026. The MAR indicated the following dates and time Resident 113's insulin administered site was documented as on his Deltoid: NovoLOG Injection Solution 100 unit/ml 2/5/2026 4:08 PM 2/6/2026 4:02 PM 2/9/2026 4:10 PM 2/10/2026 4:11 PM 2/10/2026 8:21 PM During a review of Resident 113's MAR dated 2/2026. The MAR indicated the following dates and time Resident 113's insulin administered site was documented as on his left arm: NovoLOG Injection Solution 100 unit/ml 2/7/2026 5:24 PM 2/8/2026 12;22 PM During a concurrent observation and interview on 2/11/2026 at 8:10 AM with Resident 113 in Resident 113's room. Resident 113 was observed lying on the bed with a dialysis shunt on his left arm. Resident 113 stated nurse had been given his insulin injection on his stomach and his right arm; they never use his left arm or his shoulder. During an interview on 2/11/2026 at 9:13 AM with LVN 4, LVN 4 stated deltoid is not a proper site for insulin injections because deltoid is muscle and insulin shot should be subcutaneous on the back of the arms and on stomach. During a concurrent interview and record review on 2/11/2026 at 9:50 AM with the DON, Resident 113's MAR dated 2/2026 was reviewed. The DON stated the documentation on Resident 113's MAR indicated that insulin shot was given on deltoid was wrong documentation. During an interview on 2/13/2026 at 10:11 AM with RN, RN stated Resident 113's MAR has discrepancies. RN also stated that false documentation is unacceptable, all documentation should be complete and accurate to reflect patient assessment. False documentation could lead to problems (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	like medication error. During a concurrent interview and record review with LVN 3 on 2/13/2026 at 10:54 AM, Resident 113's CP initiated on 2/6/2026 and Resident 113's MAR dated 2/2026 were reviewed. The CP indicated no needle stick on Resident 113's left arm and MAR indicated Resident 113 was given medication through a needle injection on his left arm. LVN 3 stated, the documentation on the MAR was wrong, she did not use Resident 113's left arm for any medication injections. LVN 3 also stated she needs to be more careful when she does documentation. Wrong documentation could lead to medication errors, and poor resident outcomes. 1b. During a concurrent interview and record review on 2/13/2026 at 10:11 AM with RN, Resident 113's dialysis communication form. dated 2/12/2026 was reviewed. The dialysis communication form was not completed and missing the following information: Dialysis center name Covid-19 (a respiratory disease) confirm Case status Location of the dialysis Access site Level of consciousness status If the dialysis access site had dressing or not If the dialysis access site had Infection or not RN stated the dialysis communication form on 2/12/2026 was incomplete, and it should be complete. She also stated it is facility nurses' responsibility to make sure the dialysis communication form to be completed and accurate. RN also stated that incomplete documentation is unacceptable, all documentation should be complete and accurate to reflect resident's assessment. Incomplete documentation will affect communication between nurses and will increase the risk of medication error for residents. During a review of facility's policy and procedures (P&P) titled, Resident Assessment and Associated Process dated 4/2025, the P&P indicated resident assessment should be documented comprehensive and accurate. 2. During a review of Resident 66's admission Record (AR), the AR indicated the facility admitted Resident 66 on 4/4/2025, with diagnoses including cellulitis (a skin infection that causes swelling and redness), pressure ulcer (a small open sore or wound generally found in the stomach or on the skin), and the need for assistance with personal care. During a review of Resident 66's MDS, dated [DATE], the MDS indicated Resident 66's cognition (the ability to think and process information) was intact. The MDS indicated Resident 66 required partial/moderate assistance (helper does less than half the effort) with activities of daily living (ADL-term used in healthcare that refers to self-care activities) and substantial/maximal assistance (helper does more than half the effort) with mobility. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 66's Progress Note (PN), dated 12/25/2025, the PN indicated Resident 66 underwent surgical debridement (removal of dead, damaged, or infected tissue and foreign debris from a wound using instruments like a scalpel or scissors) of an ulcer located on the right heel. The PN indicated: Surgical debridement performed to the ulcer site. Plan for debridement continue as needed. Non-selective active wound care (methods used to clean a wound that remove both dead [necrotic] tissue and healthy, living tissue in the process) to be provided by facility staff between visits. Skilled nursing team to continue care as ordered. During a review of Resident 66's Order Summary Report (OSR), dated active as of 1/1/2026, The OSR reflected an active order with a start date of 12/25/2025 for: Right Heel Diabetic Ulcer – cleanse with normal saline (NS- a sterile mixture of 0.9% salt [sodium chloride] in water, designed to match the natural salt concentration in human blood), pat dry, apply collagen (a protein in the body) powder to the wound bed (the surface of the wound itself, specifically the exposed tissue at the base of a cut, sore, or ulcer) followed by calcium alginate (a natural, biodegradable gel that can hold shape and moisture) and cover with dry dressing QD (QD-once daily). During a review of Resident 66's Treatment Administration Record (TAR), dated 1/2026, under the TAR's Weekly Assessment – No Skin Impairment, the following entries were documented: 1/3/2026: Skin documented as intact. 1/10/2026: Skin documented as intact. 1/17/2026: Skin documented as intact. 1/24/2026: Skin documented as intact. The TAR indicated the weekly skin assessments reflected intact skin status on the above dates. During a review of Resident 66's PNs, dated 1/7/2026, 1/14/2026, 1/21/2026, and 2/4/2026, the PNs indicated Resident 66's wound had not resolved and remained open. During an interview and concurrent record review on 2/13/2026 at 10:36 AM, Resident 66's Treatment Administration Record (TAR), dated 1/2026, was reviewed with Licensed Vocational Nurse 7/Treatment Nurse (LVN 7). LVN 7 stated the weekly skin assessments were inaccurate and improperly documented. LVN 7 confirmed Resident 66's skin had remained open since the debridement and had not resolved. LVN 7 stated the documentation should have reflected that the wound remained open. LVN 7 stated accurate wound documentation was essential to ensure the correct wound care orders were followed, changes in condition were promptly identified, appropriate precautions were implemented, and for all staff to be aware of the resident's current wound status to provide consistent care. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 2/13/2026 at 11:49 AM, with RN 1, RN1 stated documentation [in resident medical records] should be accurate, timely, and reflective of the resident's actual condition. RN 1 explained that for wounds, it was essential to clearly document whether the skin was intact or open, the status of healing, and any changes observed. RN 1 stated proper and accurate wound documentation was critical to ensure appropriate treatment interventions, prevent infection, support care planning, and maintain continuity of care among staff. During a review of the facility's Job Description titled, Licensed Vocational Nurse dated 12/17/2021, the LVN job description indicated: Chart [document] nurses' notes in professional and appropriate manner that timely, accurately, and thoroughly reflect the care provided to the residents, as well as the resident's response to the care. Perform routine charting duties as required and in accordance with established charting and documentation policies and procedures and applicable state and federal regulations. During a review of the facility's Job Description titled, Registered Nurse Supervisor dated 12/17/2021, the RN supervisor job description indicated: Reviews nursing personnel medical record documentation to ensure that it is appropriately and accurately descriptive of the nursing care provided.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure one of three sampled resident (Resident 2)'s care plan (CP - provides direction on the type of nursing care an individual needs that includes goals of treatment, specific nursing interventions [actions, treatments, procedures, or activities designed to meet an objective] and an evaluation plan) was implemented when licensed nurses administered insulin (a medication that removes excess sugar from the blood.) on Resident 2's Left arm where Resident 2 had a shunt (a surgically created access point on the body for dialysis [a treatment to clean your blood when your kidney can't do it well.]) This failure had the potential to increase the risk of bleeding and cause trauma to Resident 2. Findings:During a review of Resident 2's Face Sheet, the face sheet indicated the facility initially admitted a [AGE] year-old female on 5/27/2023 and re-admitted on [DATE], with the diagnoses that included but not limited to end stage renal disease (irreversible kidney failure) , dependence on renal dialysis (a treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidneys have failed) and type 2 diabetes mellitus (a disorder characterized by difficulty in blood sugar control). During a review of Resident 2's minimum data set (MDS, a resident assessment tool), dated 11/1/2025, indicated Resident 2 is getting dialysis. During a review of Resident 2's CP, date initiated 2/6/2026, the CP indicated no needle stick on Resident 2's left arm.During a review of Resident 2's Medication Administration Record (MAR), dated 2/2026. The MAR indicated license nurses used Resident 2' left arm to administered medication through a needle injection on following date and time: Insulin glargine (a long-acting insulin helps people with diabetes control their blood sugar.) Solution 100 unit/ml 2/6/2026 6:35 PM NovoLOG (a fast-acting insulin) Injection Solution 100 unit/ml 2/2/2026 11:42 AM 2/4/2026 11:48 AM 2/6/2026 6:37 AM 2/7/2026 6:32 PM 2/8/2026 6:23 AM 2/8/2026 10:00 PM 2/9/2026 6:02 AM 2/9/2026 10:06 PM During a concurrent interview and record review on 2/11/2026 at 9:07 am with LVN 5, Resident 2's CP dated 2/2026 was reviewed. the CP indicated, no needle stick on Resident 2's left arm. LVN 5 stated she was not aware of the CP and had administered insulin injection on Resident 2's left arm. LVN 5 stated using Resident 2's left arm for injection will increase the risk of bleeding and cause trauma. During an interview on 2/13/2026 at 8:00 am with the director of nursing (DON), the DON stated nurse should follow resident's care plan, if nurses fail to follow or implement resident's care plan, then resident will have a poor outcome.During an interview on 2/13/2026 at 8:50 am with Quality Assurance (QA), QA stated resident's care plan needs to be implemented. QA also stated that for Resident 2, using her left arm to do insulin injections will increase the risk of bleeding or could even cause trauma.During a review of the facility's policy and procedure (P&P) titled, comprehensive person-centered care planning dated 4/2025, the P&P indicated facility should develop and implement resident's care plan.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure one of one sampled resident (Resident 43), who was unable to carry out activities of daily living (ADL - routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves) received the necessary services to maintain personal grooming as indicated in the facility's policy and procedure (P&P) titled, ADL, Services to carry out.This deficient practice had the potential to impact Resident 43's overall health and could socially and psychologically affect Resident 43. Findings:During a review of Resident 43's admission Record (AR), the AR indicated Resident 43 was admitted to the facility on [DATE] with multiple diagnoses including the need for assistance with personal care, unspecified dementia (a progressive state of decline in mental abilities), psychotic (relating to or affected with a psychosis, a severe mental condition in which thought, and emotions are so affected that contact is lost with reality) disturbance, mood disturbance, and anxiety (intense, excessive, and persistent worry and fear about everyday situations).During a review of Resident 43's Care Plan (CP), initiated 1/14/2026, the CP indicated Resident 43 had an ADL self-care performance deficit and indicated Resident 43 had impaired mobility, activity intolerance, and impaired cognition related to dementia.During a review of Resident 43's CP, initiated 1/15/2026, for Rehab [rehabilitation occupational therapy] OT, the CP indicated, Resident 43 was observed with ADL self-care performance deficit.During a review of Resident 43's History and Physical Examination (H&P), dated 1/16/2026, the H&P indicated, Resident 43 did not have the capacity to understand and make decisions.During a review of Resident 43's Minimum Data Set (MDS - a resident assessment tool), dated 1/18/2026, the MDS indicated, Resident 43's cognitive skills (ability to think and process information) for daily decision making were severely impaired (never/rarely made decisions). The MDS indicated Resident 43 was dependent (helper does all of the effort) and required supervision or touching assistance (helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity) with ADL.During a concurrent observation and interview on 2/10/2026 at 10:33 AM with Certified Nursing Assistant (CNA) 1, Resident 43 was lying in bed awake. Resident 43 was unkempt with greasy hair, had whitish flakes on Resident 43's head, and had chin whiskers. CNA 1 stated, Resident 43 had little whiskers and needed to be shaved and Resident 43's hair was a little oily and Resident 43's hair needed to be washed but Resident 43 was combative during care. CNA 1 stated, grooming was important for residents (in general) to look presentable and feel clean.During an interview on 2/12/2026 at 3:35 PM with the Director of Nursing (DON), the DON stated Resident 43 had oily hair and facial hair and Resident 43 needed grooming for health reasons and for dignity [purposes].During a review of the facility's P&P titled, ADL, Services to carry out, revised 10/2025, the P&P indicated, the facility had a policy that residents were given the appropriate treatment and services to maintain or improve his/her abilities. The P&P indicated residents who were unable to carry out ADL will receive necessary services to maintain including grooming.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 implement appropriate fall prevention interventions for one of two sampled residents (Resident 113), who was at high risk for falls and had a history of recent falls, when on [DATE], Resident 113 was observed leaning toward the left side of Resident 113's bed and Resident 113's mattress did not have equal sized side borders.This deficient practice had the potential to result in a recurrent fall and injury to Resident 113.Findings:During a review of the admission Record (AR), the AR indicated Resident 113 was admitted to the facility on [DATE] with diagnoses that included cerebral infarction (a type of stroke where blood flow to part of the brain is blocked, usually by a clot), difficulty with walking and, in need of assistance with personal care.During a review of Resident 113's History and Physical (H&P), dated [DATE], the H&P indicated Resident 113 had the capacity to understand and make decisions.During a review of Resident 113's Care Plan Report (CPR), initiated [DATE], the CPR indicated Resident 113 was at risk for falls related to [having an] actual fall [DATE] when Resident 113 slid slowly from the bed to [the floor]. The CPR did not indicate a goal for Resident 113. The CPR's interventions indicated Resident 113 needed a safe environment.During a review of Resident 113's Fall Risk Evaluation, dated [DATE], the fall risk evaluation indicated a fall risk score of 11 (a total score of 10 or greater indicates the resident is at high risk for falls).During a review of Resident 113's Situation, Background, Assessment, Recommendation [SBAR, a structured four-step communication framework used primarily in healthcare to quickly, clearly, and concisely convey critical resident information] Communication Form, dated [DATE] time at 12:17 AM, the SBAR indicated the resident was found on the floor next to his bed on his left side. The SBAR indicated Resident 113 verbalized that he was trying to turn to his side in bed but slid slowly to the ground.During a review of Resident 113's Change in Condition (CIC, an alteration in a resident's physical health that differs from their previous baseline) Follow Up Nurses Note, dated [DATE], the CIC's additional notes indicated the resident was found in [the] room on the floor next to his bed [on the] left side. Resident [113] was trying to turn to [the] side and slid down slowly. Body check was done noted no injury. MD [unidentified] was notified and fall management initiated using floor mat[s] at bedside.During a review of Resident 113's Minimum Data Set (MDS - a comprehensive assessment and screening tool), dated [DATE], the MDS indicated Resident 113 required partial to moderate assistance when lying, sitting, or transferring.During a concurrent observation and interview on [DATE] at 10:23 AM with Resident 113, in Resident 113's room, Resident 113 was leaning towards the left side of Resident 113's bed. Resident 113 stated Resident 113 had not been at the facility for too long and Resident 113 had already had a fall. Resident 113 stated Resident 113's mattress made Resident 113 lean to the left [side of the bed] and Resident 113 fell [to the floor]. There were no pillows on Resident 113's left side of the bed.During an interview on [DATE] at 11:30 AM with Resident 113, Resident 113 stated [on [DATE]] at 11PM Resident 113 was asleep and Resident 113 slid off the left side of Resident 113's bed. Resident 113 stated the left side of Resident 113's mattress had a border made of foam, but the border would not stay up, and the nursing staff placed pillows on that side so that when Resident 113 leaned toward the left, Resident 113 would not fall.During an interview and concurrent observation on [DATE] at 12:16 PM with LVN 7, in Resident 113's room, LVN 7 stated LVN 7 had not noticed Resident 113's mattress. Resident 113 pointed at the left side border of Resident 113's bed and stated, isn't up like on the right side. LVN 7 stated the left upper side of Resident 113's mattress did not have a border like the right side of the bed. LVN 7 stated LVN 7 would call the mattress company to check if the mattress needed to be repaired. LVN 7 [exited Resident 113's room and entered an unidentified resident's room who was lying on the same mattress type] the unidentified resident's mattress upper borders on both sides stayed up firm. LVN 7 stated LVN 7 did not know the importance [or purpose] (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	of Resident 113's mattress borders because they were all soft but [if firm] LVN 7 could see the border's use to prevent falls. During a review of the facility's policy and procedure (P&P) titled, Nursing, Resident Assessment - Fall Management System, revised [DATE], the P&P indicated the facility is committed to promoting resident autonomy by providing an environment that remains free of accident hazards as possible. The P&P indicated it is the policy of the facility to provide each resident with an appropriate assessment and interventions to prevent falls. The P&P indicated a review of the fall incident will include an investigation to determine probable causal factors [of the fall].

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure one of one sampled resident's (Resident 25) oxygen humidifier (a medical device used to add moisture to the air or oxygen [a colorless gas essential to living organisms] that a resident breathes to prevent nasal irritation for residents on oxygen therapy) bottle was labeled with a date as indicated in the facility's policy and procedures (P&P), titled Infection Control Policy/Procedure, Resident Care - Oxygen, Use of This deficient practice had the potential to result in Resident 25's humidifier becoming contaminated with bacteria (microscopic organism that can cause disease) and result in an infection to Resident 25.Findings:During a review of the admission Record (AR), the AR indicated Resident 25 was admitted to the facility on [DATE], with diagnoses that included chronic (long term) respiratory failure (CRF) with hypoxia (a dangerous medical condition where body tissues do not receive enough oxygen to maintain normal function) and chronic obstructive pulmonary disease (COPD - a long term group of lung diseases that clock airflow).During a review of Resident 25's Minimum Data Set (MDS - a standardized assessment and care screening tool), dated [DATE], the MDS indicated Resident 25's cognition (the ability to think and process information) was intact.During a review of Resident 25's Care Plan Report (CPR), initiated [DATE], the CPR indicated Resident 25 had oxygen therapy related to Congestive Heart Failure (CHF, a long term progressive condition where the heart muscle is too weak or stiff to pump blood efficiently, causing blood to back up and fluid to accumulate in the lungs, legs, and body) and respiratory illness. The CPR indicated Resident 25 was at risk for respiratory distress: change in respirations,During an observation on [DATE] at 11 AM, in Resident 25's room, Resident 25 was resting in bed, under the covers, and was receiving 2 liters (L, metric unit of volume) of oxygen via nasal cannula (NC, a lightweight, flexible, and non-invasive device used to deliver supplemental oxygen directly into a resident's nostrils via two small prongs) with a humidifier bottle. The humidifier bottle was not labeled with a date. During an interview on [DATE] at 11:26 AM with the License Vocational Nurse (LVN) 7, LVN 7 stated, the humidifier [disposable bottle] was changed weekly and as needed and the bottle should be labeled [with a date indicating the date it was changed]. LVN 7 stated the Director of Staff Development (DSD) changed [the humidifier bottles] and the NC [tubing] and the [licensed] nurses labeled [the humidifiers] with a date.During an interview on [DATE] at 11:32 AM with the DSD, the DSD stated the DSD and the RNs were responsible for changing the [resident's, in general] NC [tubing] and humidifier [bottles] every Thursday and as needed. The DSD stated Resident 25's NC [tubing] was dated [DATE]. The DSD stated the NC [tubing] and the humidifier [bottles] were changed (dated) together (at the same time) and Resident 25's humidifier was not labeled with a date (to indicate the date the humidifier was changed).During a review of the facility's P&P titled, Infection Control Policy/Procedure, Resident Care - Oxygen, Use of dated [DATE], the P&P indicated it is the policy of this facility to promote resident safety in administering oxygen. The P&P indicated the following guidelines will be observed in oxygen administration: If a reusable humidifier is used, it should be emptied, rinsed, dried, and refilled with sterile water daily. The person changing the water should label it [the humidifier] with a date (this P&P is followed by the facility for disposable humidifier bottles).

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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 maintain infection prevention and control practices for four of five sampled residents (Resident 66, Resident 120, Resident 21, and Resident 61) by failing to:a. Ensure a personal care toiletry item (shaving cream) located inside Resident 21 and Resident 61's shared restroom was labeled and stored properly.b. Implement a physician order for Enhanced Barrier Precautions (EBP- extra measures, like wearing gowns and gloves, used during high-contact care activities with residents who are at a higher risk of having or spreading germs that are hard to treat, like multidrug-resistant organisms [MDROs, bacteria that have become resistant to certain antibiotics [medication used to treat bacterial infections], and these antibiotics can no longer be used to control or kill the bacteria]) for Resident 66.This deficient practice had the potential to result in cross-contamination (the physical movement or transfer of harmful bacteria from one person, object or place to another) and the transmission of infectious microorganisms to Resident 66, Resident 120 (Resident 66's roommate), Resident 21, and Resident 61, the facility staff, and increased the risk of the spread of infection within the facility.Findings: a. During a review of Resident 21's admission Record (AR), the AR indicated Resident 21 was originally admitted to the facility on [DATE] and readmitted on [DATE] with multiple diagnoses including osteomyelitis (inflammation of bone or bone marrow, usually due to an infection) of vertebra (one of the bones that make up the spinal column), thoracic (relating to chest) region, and bacteremia (bacteria in your blood). During a review of Resident 21's History and Physical (H&P), dated 12/20/2025, the H&P indicated, Resident 21 was A&O x4 (alert and oriented to person, place, time and situation). During a review of Resident 21's Minimum Data Set (MDS - a resident assessment tool), dated 12/23/2025, the MDS indicated Resident 21's cognitive skills (ability to think and process information) for daily decision making were intact. The MDS indicated Resident 21 was independent with personal hygiene (the ability to maintain personal hygiene, including combing hair, shaving, applying make-up, washing/drying face and hands [excludes baths, showers, and oral hygiene). During a review of Resident 61's AR, the AR indicated, Resident 61 was admitted to the facility on [DATE] with multiple diagnoses including chronic obstructive pulmonary disease (COPD – a long standing lung disease causing difficulty in breathing) with (acute) exacerbation (sudden worsening or flare-up), and urinary tract infection (UTI – an infection in the bladder/urinary tract). During a review of Resident 61's H&P, dated 1/21/2026, the H&P indicated Resident 61 had the capacity to understand and make decisions. During a review of Resident 61's MDS, dated [DATE], the MDS indicated Resident 61's cognitive skills for daily decision making were intact. The MDS indicated Resident 61 required supervision or touching assistance (helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity) with personal hygiene. During an observation on 2/10/2026 at 10:16 AM, Resident 21 and Resident 61's room had EBP signage posted and a white colored trimmed 3-drawer personal protective equipment (PPE – clothing and equipment that is worn or used to provide protection against hazardous substances (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and/or environments) cart located outside of the shared room. During a concurrent observation and interview on 2/10/2026 at 10:21 AM with the Housekeeper (HK) inside Resident 21 and Resident 61's shared restroom, an unlabeled 1.5 oz (ounce – a unit of weight) can of [NAME] (brand name) shaving cream was on the sink. The HK stated the shaving cream was not labeled and the HK was going to throw away the shaving cream. During an interview on 2/10/2026 at 10:28 AM with Resident 61, Resident 61 stated Resident 61 used the restroom and the shaving cream, it's (shaving cream) been there a while. During an interview on 2/10/2026 at 10:33 AM with Certified Nursing Assistant (CNA) 1, CNA 1 stated, a shaving cream was a personal item and should be labeled with the resident's (in general) name and bed number and stored at the resident's bedside. CNA 1 stated, labeling personal care items was important not to get mixed up with other resident's belongings and for infection control, if not labeled, you don't know who it belongs to [purposes]. During an interview on 2/11/2026 at 7:30 AM with Resident 21, Resident 21 stated, Resident 21 could walk to the restroom and shaved, I can do everything for myself. During an interview on 2/13/2026 at 7:52 AM with the Infection Preventionist (IP), the IP stated, a shaving cream was a personal item and should be labeled with the resident's name and stored at the beside. The IP stated, labeling personal care items was important to know who the personal care item belonged to and personal care items should only be used for that person for their own use, to prevent any type of infection or cross-contamination (the physical movement or transfer of harmful bacteria from one person, object or place to another), for infection control [purposes]. During a review of the facility's policy and procedure (P&P) titled, Personal Care Items, reviewed 12/2025, the P&P indicated, the facility ensured proper hygiene, safety, and accountability regarding personal care items (such as shaving cream) provided to or brought in by individuals. The P&P indicated, personal care items must be labeled with residents' name and stored in designated personal storage areas. During a review of the facility's P&P titled, IPCP Standard and Transmission-Based Precautions, revised 12/2025, the P&P indicated, the facility implemented infection control measures to prevent the spread of communicable diseases and conditions. b. During a review of Resident 66's AR, the AR indicated the facility admitted Resident 66 on 4/4/2025, with diagnoses including cellulitis (a skin infection that causes swelling and redness), pressure ulcer (a small open sore or wound generally found in the stomach or on the skin), and the need for assistance with personal care. During a review of Resident 66's MDS, dated [DATE], the MDS indicated Resident 66's cognition (the ability to think and process information) was intact. The MDS indicated Resident 66 required partial/moderate assistance (helper does less than half the effort) with activities of daily living (ADL-term used in healthcare that refers to self-care activities) and substantial/maximal assistance (helper does more than half the effort) with mobility. During a review of Resident 120's AR, the AR indicated the facility admitted Resident 120 on 2/5/2026, with diagnoses including heart failure, type 2 diabetes mellitus (DM-a disorder (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	characterized by difficulty in blood sugar control and poor wound healing), and the need for assistance with personal care. During a record review of Resident 66's Order Summary Report (OSR), dated active as of 2/12/2026, the OSR indicated Resident 66 had an active order, dated 12/25/2025, for EBP indicating PPE required for high resident contact care activities. The order's indicated was a diabetic wound (a slow-healing open sore, most common on the feet, caused by high blood sugar that damages nerves and reduces blood flow). During a review of Resident 66's Progress Note (PN), dated 2/4/2026, the PN indicated a diagnosis of diabetic foot ulcer (an open sore or wound, usually on the bottom of the foot, that develops in people with diabetes due to a combination of numb feet, poor blood circulation, and skin breakdown from pressure) on the right heel. The PN indicated the wound remained open. During a review of Resident 120's MDS, dated [DATE], the MDS indicated Resident 120's cognition was intact. The MDS indicated Resident 120 required partial/moderate assistance with ADL and partial/moderate assistance with mobility. During an observation on 2/10/2026 at 11:10 AM, Resident 66's shared room had no EBP signage posted at the entrance or on the door. No EBP or PPE cart was observed at the doorway/hallway, and there was no visible indication that EBP were in place. During an interview on 2/10/2026 at 11:15 AM, Resident 66 stated Resident 66 had recently undergone a procedure to remove a callus on Resident 66's right foot, at which time a diabetic foot ulcer was identified. Resident 66 stated that the nurses had been providing daily wound care. Resident 66 stated Resident 66 had not observed staff wearing gowns when assisting Resident 66 with personal care. During an interview on 2/13/2025 at 9:45 AM, with the IP, the IP stated residents (in general) who had open wounds automatically required EBP to prevent the spread of infections and [this practice] protected both staff and residents. The IP stated a diabetic foot ulcer was an open wound and EBP should have been implemented immediately upon discovery and following a debridement (a procedure for cleaning and removal of dead, damaged, or infected tissue from a wound to promote healing) for Resident 66. The IP stated the IP had not been made aware of Resident 66's open wound and stated, this breakdown in communication was problematic. The IP stated the facility did not implement EBP in a timely manner for Resident 66, as ordered, and stated such delays increased the risk for infection transmission to Resident 120, other residents, and the facility staff. During an interview and concurrent record review on 2/13/2025 at 10:36 AM, Resident 66's Treatment Administration Record (TAR), dated 2/2026, was reviewed with LVN 7. The TAR indicated an active order for: Right heel diabetic ulcer – cleanse with normal saline (NS- a sterile mixture of 0.9% salt [sodium chloride] in water, designed to match the natural salt concentration in human blood), pat dry, apply collagen (a protein in the body) powder to the wound bed (the surface of the wound itself, specifically the exposed tissue at the base of a cut, sore, or ulcer) followed by calcium alginate (a natural, biodegradable gel that can hold shape and moisture) and cover with dry dressing QD (once daily). (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	LVN 7 stated Resident 66 continued to receive daily treatment for the right heel diabetic ulcer and stated the ulcer remained open and had not resolved. LVN 7 stated that based on the physician's order for EBP and the presence of an open wound, EBP should have been implemented and followed to prevent the spread of infection and to protect residents and [facility] staff. During an interview and concurrent record review on 2/13/2025 at 12:27 PM, Resident 66's PN, dated 12/25/2025, was reviewed with Licensed Vocational Nurse/Treatment Nurse (LVN) 7. The PN indicated Resident 66 was seen at bedside for debridement and treatment of complex callus [a thickened, hardened patch of skin that forms to protect a specific area of the body from repeated rubbing, pressure, or irritation] to [Resident 66's] right foot. The PN indicated, Surgical debridement was done to the ulcer site. LVN 7 stated that following the debridement, the ulcer was identified as an open wound requiring ongoing treatment. During a review of the facility's P&P titled, IPCP Standard and Transmission Based Precautions revised 12/2025, the P&P indicated: Enhanced Barrier Protection (EBP) was used in conjunction with standard precautions and expand the use of PPE through the use of gown and gloves during high-contact resident care activities that provide opportunities for indirect transfer of MDROs to staff hands and clothing then indirectly transferred to residents or from resident-to-resident. (e.g., residents with wounds. who were especially high risk of both acquisition of and colonization with MDROs. The P&P indicated wounds included, diabetic foot ulcers, unhealed surgical wounds, and venous stasis ulcers.

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep all essential equipment working safely. Based on observation, interview, and record review, the facility failed to ensure the plastic strip air curtain leading to the walk-in refrigerator in one of one kitchen (Kitchen 1) did not have a missing strip.This deficient practice had the potential to result in foodborne illness (disease caused by consuming contaminated food or drinks), to the residents consuming the food from the walk-in refrigerator, due to not maintaining consistent temperatures or the entry of insects, dust, and pollutants.Findings:During an initial tour observation of Kitchen 1 and concurrent interview on 2/10/2026 at 9:05 AM with the Dietary Services Supervisor (DSS), the walk-in refrigerator door leading into the walk-in freezer was observed directly next to Kitchen 1's exit door and lead to the outside of the facility. There was a plastic air curtain hanging on the refrigerator door that had a missing strip, resulting in a six-to-eight-inch gap. The DSS stated the air curtain was missing a strip and needed to be repaired. The DSS stated the air curtain helped maintain the cold air inside the refrigerator and without the strip, the temperature inside the refrigerator could quickly rise and could cause the food inside to go bad.During an interview with the Registered Dietician (RD), on 2/12/2026 at 3:03 PM, the RD stated kitchen equipment (used or not) should be functioning and in working condition.During an interview with the Administrator (ADM) on 2/13/2026, at 10:20 AM, the ADM stated the walk-in refrigerator was old, older than 40 years, and the air curtain was up and being used. The ADM stated the facility did not have a copy of the air curtain's maintenance manual. During an interview with the Maintenance Director (MDR) on 2/13/2026 at 10:49 AM, the MDR stated the MDR was informed, on 2/12/2026, of a missing air curtain strip in Kitchen 1.During a review of the facility's policy and procedure (P&P) titled Physical Environment-Equipment Maintenance, revised on 10/2025, the P&P indicated it was the policy of the facility to establish procedures for routine and non-routine care of equipment and to ensure that the equipment remained in good working order for resident and staff safety. The P&P indicated equipment instructions and manuals would be kept in the Maintenance Supervisor's Office.During a review of the facility's P&P titled Environmental-Maintenance Policy, reviewed on 10/2025, the P&P indicated a maintenance policy for [the facility] ensures that the building, equipment, and overall environment remain safe, clean, and functional for residents, staff, and visitors.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the call light (a device used by a resident to signal the need for assistance) system was within reach for two of two sampled residents (Resident 3 and Resident 115), as indicated on Resident 115's care plans (CP) and in accordance with the facility's policy and procedure (P&P) titled Call Light. This failure resulted in Resident 115 feeling discouraged and had the potential to result in unmet needs and inability to alert staff during an emergency for Residents 3 and115. Findings: A. During a review of the admission Record (AR), the AR indicated Resident 3 was admitted to the facility on [DATE], with diagnoses that included heart failure (a long standing condition where the heart muscle is too weak or stiff to pump blood efficiently, failing to meet the body's oxygen [a colorless gas essential to living organisms] needs), dementia (a progressive state of decline in mental abilities), Type 2 diabetes mellitus (DM – a disorder characterized by difficulty in blood sugar control and poor wound healing), difficulty in walking, and need for assistance with personal care. During a review of Resident 3's Care Plan Report (CPR), dated [DATE], the CPR indicated Resident 3 was at risk for falls related to impaired balance and mobility. The CPR's interventions indicated to be sure Resident 3's call light was within reach and to encourage the use of the call light to call for assistance as needed. During a review of Resident 3's History and Physical (H&P), dated [DATE], the H&P indicated Resident 3 had the capacity to understand and make decisions. During a review of Resident 3's Minimum Data Set (MDS – a comprehensive assessment and screening tool), dated [DATE], the MDS indicated Resident 3's cognitive (the ability to think and process information) ability was moderately impaired. During a concurrent observation and interview on [DATE] at 2:45 PM with Resident 3 in the resident's room, Resident 3 was sitting on his wheelchair. Resident 3 stated Resident 3 wanted a nurse and when asked where Resident 3's call light was, Resident 3 was unable to find the call light to call for assistance. During an interview on [DATE] at 2:47 PM with the Director of Nursing (DON), the DON stated the importance of having a call light within [a resident's, in general] reach was for the residents to use it when they had a need and have their needs met. During a review of the facility's P&P titled, Call Light, dated February 2023, the P&P indicated to leave the resident comfortable, ensure the call device is within resident's reach before leaving [the] room, and if the resident is unable to reach the call light, don't leave the resident unattended. B. During a review of Resident 115's AR, the AR indicated, Resident 115 was admitted to the facility on [DATE] with multiple diagnoses including other reduced mobility (ability to move oneself - or body parts freely, easily, and purposefully), and need for assistance with personal care. During a review of Resident 115's CPR titled, At risk for falls r/t (related to) impaired balance . initiated [DATE], the CPR indicated, one of the interventions was to ensure the call light was within (continued on next page)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	reach and encourage to use it for assistance as needed. During a review of Resident 115's H&P, dated [DATE], the H&P indicated, Resident 115 could make needs known but could not make medical decisions. During a review of Resident 115's OT [Occupational Therapy - treatment that helps you improve your ability to perform daily tasks] Evaluation & Plan of Treatment (OTE), dated [DATE], the OTE indicated, Resident 115 had impaired strength on both upper extremities (the upper arm, forearm, and hand). During a review of Resident 115's MDS, dated [DATE], the MDS indicated Resident 115's cognitive skills (ability to think and process information) for daily decision making were moderately impaired (decisions poor; cues/supervision required). The MDS indicated, Resident 115 was dependent (helper does all of the effort) with activities of daily living (ADL – routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). The MDS indicated, Resident 115 was always incontinent (no episodes of continent [ability to control] bowel movements). During a concurrent observation and interview on [DATE] at 11:42 AM, with Resident 115, Resident 115 was lying in bed. Resident 115 had moderate contractures (a stiffening/shortening at any joint, that reduces the joint's range of motion) on both upper extremities. Resident 115's touch call pad (a touch sensitive call light) was slightly tucked underneath a pillow on the left bed siderail by Resident 115's left shoulder. Resident 115 was asking, can you help me? Resident 115 stated, Resident 115 was not able to use and press the call light and would just yell, I try my best, when Resident 115 needed to call for help and Resident 115 felt, it's hard when Resident 115 was unable to use the call light. During a concurrent observation and interview on [DATE] at 11:48 AM with Licensed Vocational Nurse (LVN) 1, Resident 115's touch call pad was tucked underneath a pillow by the left bed siderail and Resident 115's left shoulder. LVN 1 stated Resident 115's call light was by Resident 115's left shoulder. LVN 1 stated Resident 115's call light should be within Resident 115's reach so Resident 115's needs could be answered promptly. During an interview on [DATE] at 3:35 PM with the DON, the DON stated, resident's (in general) call lights should be within resident's reach for residents to call when residents need assistance [from staff]. During a review of the facility's P&P titled, Call Light, date revised 2/2023, the P&P indicated, the facility had a policy to provide the resident a means of communication with nursing staff. The P&P indicated, to ensure the call device was within resident's reach before leaving room and if the resident was unable to reach the call light, don't leave the resident unattended.