STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055402	A. Building B. Wing	03/06/2026

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River City Post Acute	2540 Carmichael Way Carmichael, CA 95608

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure two of 36 sampled residents (Resident 12 and Resident 3) were free from chemical restraints (the use of medications to manage resident's behaviors or restrict their freedom) when:Resident 12 was treated with quetiapine (Seroquel, a psychotropic medication used to treat mental illness) without an adequate indication for its use, andResident 3 received quetiapine without supporting evidence of a bipolar disorder (a mental disorder characterized by mood swings alternating between emotional highs and lows) diagnosis.These failures resulted in Resident 12 and Resident 3 continuing to receive unnecessary psychotropic medications, increasing their risk of unwanted side effects such as drowsiness. 1.A review of the admission record indicated the facility admitted Resident 12 in 2024 with multiple diagnoses which included left sided paralysis following stroke and depression. Resident 12's clinical records indicated that during her stay in the facility, the resident was diagnosed with dementia (a progressive decline in mental abilities). A review of the quarterly Minimum Data Set (MDS, a federally mandated resident assessment tool) dated 6/30/25 indicated Resident 12 scored 15 out of 15 in a Brief Interview for Mental Status (BIMS), which indicated she had no cognitive impairment. The MDS assessment indicated Resident 12 did not have delusions, hallucinations or disorganized thinking. A review of the quarterly MDS assessment dated [DATE] indicated Resident 12 scored 15 out of 15 in a Brief Interview for Mental Status and did not have delusions, hallucinations or disorganized thinking. A review of Resident 12's clinical record contained a psychiatrist (a medical doctor specializing in mental disorders) note dated 10/14/25. The psychiatrist documented, Evaluation and management of ongoing yelling behaviors, agitation, and mood instability in the context of underlying depression, anxiety, and insomnia [inability to sleep]. The psychiatrist note indicated that Resident 12 continued to display agitation and yelling behavior, which may be associated with her advanced age and/or cognitive decline. The psychiatrist noted that Resident 12's symptoms may also be triggered by environmental changes or routine disruptions. A further review of psychiatrist's note revealed, [Resident 12's name] often feels frustrated and angry, especially feeling like she has little control over her life. Also struggling with poor hearing and eyesight makes it difficult for her to fully engage with her environment and socialize with her peers, leaving her more isolated. There was no documented evidence that psychiatrist diagnosed Resident 12 with psychosis or any other mental disorder. A review of the MDS assessment dated [DATE], indicated Resident 12 experienced a change in (continued on next page)

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

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	condition and was placed on hospice services (compassionate care for people who are near the end of life). The MDS assessment indicated Resident 12 had no behaviors of delusions, disorganized thinking, or hallucinations. A review of Order Summary Report (OSR) for Resident 12 indicated, Seroquel [quetiapine] Oral Tablet 100 mg (milligram, a unit of measurement); Give 1 tablet.two times a day for unspecified psychosis MB [manifested by]: agitation, shaking the SR [siderails], cursing and yelling. The OSR indicated a start date for Seroquel 10/29/25. A review of Resident 3's Medication Administration Record (MAR) indicated that the resident was administered Seroquel 100 mg twice a day continuously in the morning and evening from of 10/29/25. During an observation on 3/3/26 at 10:11 a.m., Resident was observed sleeping in her bed and unavailable for interview. During an observation on 3/3/26 at12:26 p.m., Resident 12 was in bed, calm, occasionally opened her eyes, but did not respond to greeting. No screaming or yelling behaviors were noted. During an observation on 3/3/26 at 4:03 p.m., Resident 12 was observed in bed sleeping. During an observation on 3/4/26 at 9:21 a/m., Resident was in bed sleeping. During an observation on 3/4/26 at 3:45 p.m., Resident 12 was in bed sleeping. During an observation on 3/5/26 at 10:26 a.m., Resident 12 was in bed sleeping. During an interview on 3/5/26 at 10:25 a.m., with Certified Nursing Assistant 6 (CNA 6), CNA 6 stated Resident 12 had impaired vision and hearing and confusion due to dementia. CNA 6 stated Resident 12 did not have hallucinations, delusions and was not a danger to self or others. CNA 6 stated Resident 12 occasionally refused personal care and sometimes had yelling behaviors and rattled side rails during provision of personal care. CNA 6 stated, She usually calms down and allows me to provide care if I start singing and talking to her. She likes when I explain to her who I am and what I will be doing. During an interview on 3/5/26 at 10:35 a.m., with Licensed Nurse 9 (LN 9), LN 9 stated she took care of Resident 12 frequently. LN 9 stated Resident 12 had never had hallucinations or delusions. LN 9 stated Resident 12 was not aggressive and not a danger to self or others. LN 9 added, Not combative but occasionally refuses to be changed or repositioned so might push CNA.Lots of behaviors - yelling, shaking/rocking side rails, cursing. LN 9 stated that when Resident 12 started her yelling episodes, staff would leave the resident and come back when resident calmed down. LN 9 agreed that yelling behaviors could be related to unmet physical needs and because of dementia Resident 12 might not be able to express when she was in pain, hungry, or needed to be repositioned. During an interview on 3/5/26 at 10:54 a.m., CNA 7 stated she was familiar with Resident 12 and her care needs. CNA 7 stated that Resident 12 had yelling, screaming, and occasionally cursing behaviors, but was not a danger to self or others and had no physical behaviors. CNA 7 added, She will start yelling and screaming.when she's uncomfortable or in pain. Once she is medicated for pain, she will cooperate. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 3/5/26 at 11:06 a.m., with Medical Director (MD), the MD stated that Resident 12 had visual impairment, was hard of hearing (HOH), and had personality changes due to advanced dementia. The MD stated that Resident 12 had no hallucinations or delusions. The MD stated that Resident 12 had lots of verbal behaviors, including verbal outbursts, cursing, saying mean things to staff, and refusing care. The MD denied Resident 12's yelling and refusing care posed danger to self or others. The MD agreed that Resident 12's verbal yelling behaviors could be related to unmet physical needs, medical conditions, or dementia-related behaviors. The MD stated that hospice physician prescribed antipsychotic medication Seroquel to manage Resident 12's behaviors and then added, I don't think it's very effective, she's still having behaviors per nursing. She would wake up and start screaming, curse at the staff, refuse care. The MD stated that Resident 12's advanced age, impaired vision and hearing could contribute to resident's agitation and yelling. During an interview on 3/5/26 at 11:31 a.m., with Assistant of Director of Nursing 2 (ADON 2), the ADON stated that Resident 12 was receiving hospice care and was prescribed several medications for anxiety, depression, and agitation. ADON 2 did not respond when asked if Resident 12's yelling and cursing behaviors were related to her dementia and if there were episodes of Resident 12's exhibiting dangerous behaviors or self-harm. ADON 2 acknowledged that Resident 12 was heavily sedated for the past three days of observation which could be an effect of Seroquel. ADON stated that hospice was managing Resident 12's medications. During a follow up interview and record review on 3/5/26 at 12:27 p.m., the MD was asked if Seroquel was approved treatment by U.S. Food and Drug Administration (FDA, a federal agency that ensures the safety and effectiveness of drugs and treatments) for residents with dementia. The MD replied, She is on hospice, and I don't know why they prescribed it. Facility staff apparently reporting to hospice that resident continue having symptoms and they continue adding new medications or increasing dosages. The MD reviewed documented indications for Seroquel administration, including yelling, screaming banging side rails, and acknowledged that Resident 12 did not have hallucinations or delusions. The MD added, I don't see that starting Seroquel helped her symptoms. The MD stated that she oversaw Resident 12's management by hospice services. The MD added further, If we know that medication is not helping and causing harm.we review her medications. A review of FDA's 'Highlights of Prescribing Information for Seroquel indicated, Warning: Increased mortality in Elderly patients with Dementia.Antipsychotic drugs are associated with an increased risk of death.[Seroquel] is not approved for elderly patients with Dementia-Related Psychosis. During a telephone interview on 3/5/26 at 3:15 p.m., with Pharmacy Consultant (PC), the PC stated that Resident 12 was getting Seroquel for psychosis. The PC stated that Seroquel was not approved treatment by FDA for Resident 12's diagnosis of psychosis. The PC stated there was not scientific data listed for off label use (the practice of prescribing certain medications not included on the officially approved label) of Seroquel. A review of the facility's policy and procedures (P & P) titled Psychotropic Medication Use, dated 2/2025, indicated, Residents do not receive psychotropic medications that are not clinically indicated and necessary to treat a specific condition documented in the medical record. Adequate indication for use refers to the identified, documented clinical rationale for administering medication that is based on. Manufacturers recommendations, clinical practice guidelines, clinical standards of practice, medication references, clinical studies. 2. A review of Resident 3's medical records titled admission Record, indicated that Resident 3 was a (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	[AGE] year-old resident re-admitted to the facility in September of 2025 with diagnoses which included major depressive disorder (more than just feeling sad), anxiety, dementia, and bipolar disorder. Resident 3's MDS, completed on 12/30/25, indicated a BIMS (Brief Interview of Mental Status) of 15 in Section C, meaning Resident 3 was performing normally in terms of memory and orientation with no significant cognitive impairment detected. In addition, Section E of the annual MDS assessments on 9/26/25 as well as the quarterly assessments on 6/5/25, 9/2/25, and 12/30/25 further indicated Resident 3 exhibited no indicators of psychosis, such as hallucinations (sensory experience of something not present); delusions (an impression or belief not based on reality); or verbal or physical behavioral symptoms directed toward others. Review of Resident 3's Physician's Orders, indicated an order dated 12/5/25 for quetiapine 25 mg (milligram, unit of measure) twice a day for m/b [manifested by] aggressive outburst related to bipolar. Resident 3's Medication Administration Record (MAR) indicated that the resident was administered quetiapine 25 mg twice daily continuously in the morning and evening with a start date of 12/5/25. During the documented observations listed below, Resident 3 was found in bed asleep: 3/3/26 at 10:49 a.m. 3/4/26 at 8:47 a.m. 3/4/26 at 3:28 p.m. DailyMed, a nationally recognized drug reference, indicated that quetiapine's potential adverse effects and warnings included motor and sensory instability, dizziness, drowsiness, and increased risk of falls and fractures. A review of Resident 3's, daily evaluation for behavior/cognitive monitoring for a period of 2/8/26 to 3/4/26 was not completed by the staff and left blank every day. During an interview on 3/5/26 at 11:48 a.m. with the ADON 2, regarding the daily evaluation for behavior/cognitive monitoring, ADON 2 was not sure why the daily assessment was not completed by the staff and she stated the best practice was to fill out every section. During an interview on 3/5/26 at 12:09 p.m. with MD, MD stated, that a 25 mg twiceˆdaily dose of quetiapine is not even effective for treating bipolar disorder at this point. The MD was unsure when the bipolar diagnosis was added to the resident's record. Furthermore, the MD stated that staff should have completed the daily behavior/cognitive assessments. She was unsure of the source of the resident's behaviors or whether they were related to dementia, but she felt the resident was safe to care for and the resident was not combative. MD also stated that a psychiatric referral [being sent to a mental health expert] order was placed one or two weeks after resident's readmission and bipolar diagnosis was probably added after the referral. During an interview on 3/5/25 at 3:09 p.m. with PC, PC stated, that a recommendation was made in midˆFebruary 2026 to the resident's MD to consider discontinuing the use of quetiapine, since the (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	dose was not appropriate for bipolar disorder, or to provide a clinical rationale for its use. A review of Resident 3's psychiatric referral report, dated 10/14/25, indicated Resident 3's diagnosis was major depressive disorder. During an interview on 3/6/26 at 10:24 a.m. with the MD, after reviewing the psych referral report, the MD stated the report was confusing and did not indicate that the resident had bipolar disorder. The MD further stated the report needed to be clarified, and based on the report, the diagnosis list should have been updated to remove the bipolar diagnosis from the resident's chart. During an interview on 3/6/26 at 9:40 a.m. with LN 12, LN 12 stated, resident was a sweet lady and only got upset when she had to wait for something, but she was not a danger to herself or other residents. LN 12 felt safe providing care for her. During an interview on 3/6/26 at 9:45 a.m. with CNA 10, CNA 10 stated they felt safe providing care for the resident. CNA 10 stated that the resident was very nice and sometimes she had a lot of pain related to her medical condition. During a review of the facility's policy and procedure (P&P) titled, Psychotropic Medication Use, dated 2/2015, the P&P indicated, Residents do not receive psychotropic medications that are not clinically indicated and necessary to treat a specific condition documented in the medical record.Adequate indication for use refers to the identified, documented clinical rationale for administering medication that is based on: an assessment of the resident's condition and therapeutic goals.Psychotropic medication may be considered appropriate when: a resident's behavioral symptoms present a danger to the resident or others.

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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. Based on observation, interview, and record review, the facility failed to provide needed care and treatment according to professional standards of practice for three of 36 sampled residents (Resident 15, Resident 90 & Resident 156) when:Resident 15 did not receive bowel care as ordered.This failure resulted in Resident 15 experiencing abdominal discomfort from constipation. 2. Resident 90 did not receive physical therapy as ordered by the physician.This failure had to the potential for Resident 90 to experience a decline in mobility 3. Wound care nurse failed to follow physician orders for Resident 156 during wound care treatmentThis failure had the potential for Resident 156's wounds to worsen.1. A review of Resident 15's admission Record indicated Resident 15 was admitted to the facility in July 2008 with multiple diagnoses including chronic obstructive pulmonary disease (respiratory disease that restricts air flow and causes breathing difficulties), diabetes (high blood sugar resulting from the body's inability to produce or properly use insulin), peripheral vascular disease (narrowed or blocked blood vessels outside the heart), and atrial fibrillation (an irregular and very rapid heart rhythm). A review of Resident 15's Minimum Data Set (MDS- federally mandated assessment tool), Cognitive Patterns, dated 12/16/25, indicated Resident 1 had a Brief Interview for Mental Status (BIMS- tool to assess cognition) score of 8 out of 15 that indicated Resident 15 had moderately impaired cognition. Further review of Resident 15's MDS, Bowel and Bladder, dated 12/26/25, indicated Resident 15 was always incontinent of bowel. A review of Resident 15's Medication Administration Record [MAR] for 2/1/26 to 2/28/26 indicated orders: Bowel regimen: (1) MOM [Milk of Magnesia- a laxative} 30 cc [cubic centimeters- measure of volume] po [by mouth] Q [every] 24 hrs [hours] PRN [as needed] constipation if no BM [bowel movement] x 3 days . Bowel regimen: (2) Dulcolax suppository [a rectal laxative] 10 mg [milligrams] per rectum QD [every day] PRN for constipation if MOM is ineffective . Bowel regimen: (3) Fleets enema [a rectal laxative] 133 ml [milliliters] per rectum Q 3 Day PRN for constipation if Dulcolax is ineffective . A review of Resident 15's MAR for February 2026 indicated Resident 15 received MOM on 2/12/26 and it was effective, received MOM on 2/23/26 and it was ineffective, received Dulcolax suppository on 2/26/26 and it was effective. A review of Resident 15's MAR for March 2026 indicated Resident 15 did not receive the bowel care regimen in March 2026. A review of Resident 15's POC [Plan of Care] Response History for 2/21/26 to 3/5/26, indicated Resident 15 had a bowel movement on 2/26/ 26 and 3/3/26. Resident 15 did not have a bowel movement between 2/26/26 and 3/3/26 and did not receive bowel care regimen. During an interview on 3/3/26 at 8:41 a.m. with Resident 15, Resident 15 stated she had not had a bowel movement in two weeks. Resident 15 stated she was given MOM but it did not work. Resident (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	15 stated she had pain and discomfort in the abdominal area. During a concurrent interview and record review on 3/5/26 at 9:42 a.m. with the Assistant Director of Nursing (ADON) 2, the ADON 2 acknowledged that Resident 15 had a bowel movement on 2/26/26 and on 3/3/26. The ADON 2 acknowledged that Resident 15 did not receive any bowel care regimen between 2/26//26 and 3/3/26. ADON 2 stated the bowel care regimen is initiated if no bowel movement for 72 hours. The ADON 2 stated the bowel regimen is to start with MOM, then use Dulcolax suppository, then use enema. The ADON 2 stated Resident 15, Should have had bowel care initiated. The ADON 2 stated a Certified Nursing Assistant (CNA) may have forgotten to document Resident 15's bowel movement but further stated if it was not documented it did not happen. When asked what the harm was if adequate bowel care was not performed, the ADON 2 stated the resident was at risk for complications from constipation including pain and discomfort. A review of the facility's Policy and Procedure (P&P) titled Physicians Orders, effective 3/22/22, indicated .Medication orders will include the following: .Name of the medication .dosage .frequency .The route and the condition/diagnosis for which the medication is ordered . Documentation pertaining to physician orders will be maintained in the resident's medical record . P&P requested for Bowel Care on 3/5/26 but was not provided. 2. During an interview on 3/3/26, at 9:46 a.m., with Resident 90, Resident 90 stated, she was concerned about her mobility because she had not had physical therapy or any form of exercise since she can remember. During a review of Resident 90's Brief Interview for Mental Status (BIMS: a screening tool used in long-term care to assess cognitive function, specifically orientation and short-term memory. Scores of 13–15 indicate intact cognition) dated 1/8/26, BIMS score indicated, 15 indicating Resident 90 was cognitively intact. During a review of Resident 90's MDS Section GG ((Functional Abilities and Goals) is a standardized assessment tool within the Minimum Data Set (MDS) 3.0, implemented by the Centers for Medicare & Medicaid Services (CMS) to measure a patient's need for assistance with self-care and mobility) dated 1/15/25, indicated, Mobility. Supervision or touching assistance - Helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity. Assistance may be provided throughout the activity or intermittently.Substantial/maximal assistance - Helper does MORE THAN HALF the effort. Helper lifts or holds trunk or limbs and provides more than half the effort.Dependent - Helper does ALL of the effort. Resident does none of the effort to complete the activity. Or the assistance of 2 or more helpers is required for the resident to complete the activity.Sit to lying.Substantial/maximal assistance.lying to sitting on side of bed.substantial/maximal assistance.chair/bed-to-chair transfer.Dependent. MDS GG indicated, Resident 90 requires assistance with upper and lower body mobility and assistance with dressing herself. During a review of Resident 90's Order Summary Report dated 3/5/26, report indicated, an order for, RECOMMENDED PHYSIOTHERAPY [physical therapy] FOR FOOT AND LEFT SHOULDER ROM [range of motion]. Prescriber Written Active 09/22/2025. During an interview on 3/5/26, at 10:08 a.m., with Director of Rehab Services (DOR), DOR stated, the process for residents receiving physical therapy is initiated by the physician order. DOR stated, for (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	long term residents should be getting a joint mobility screening annually which is a hands on screening (joint mobility screening is a proactive, standardized assessment used by rehabilitation professionals to identify joint restrictions, asymmetries, and movement limitations) if a resident had a rehab screening and a change in mobility it would also trigger a joint mobility screening. During a concurrent interview and record review on 3/5/26, at 10:15 a.m., with DOR, Resident 90's medical record was reviewed. Resident 90's Order Summary Report dated 3/5/26, report indicated, an order for, RECOMMENDED PHYSIOTHERAPY [physical therapy] FOR FOOT AND LEFT SHOULDER ROM [range of motion]. Prescriber Written Active 09/22/2025. Residents 90's therapy evaluations were reviewed. Resident 90's therapy evaluations indicated, Resident 90 was not seen by the therapy department since they have been providing therapy services to the facility beginning 4/30/25. DOR stated, Resident 90 has not received physical therapy from the facility. DOR stated, the physician order was entered incorrectly and did not trigger the therapy department to see Resident 90 to being on physical therapy. DOR stated, according to the progress notes, nursing staff noticed a decline of Resident 90's wheelchair mobility which is what triggered the physician to order physical therapy. During an interview on 3/5/26 at 11:33 a.m., with Assistant Director of Nursing 1 (ADON) 1, ADON 1 stated, If the physician writes an order, the nursing department will call or notify Physical Therapy about the new order for Physical Therapy. ADON 1 stated, I do not see any notification in Resident 90's medical record that the therapy department was notified of the order. During a review of Resident 90's medical record, record indicated, Resident 90 did not receive ordered physical therapy from 9/22/25-3/5/26. 3. During an interview on 3/3/26, at 12:58 p.m., with Resident 156, Resident 156 stated, she is concerned about the wound care treatment she gets for her feet, because the staff do not change her dressings every day. During an observation on 3/3/26, at 1:05 p.m., in Resident 156's room, Treatment Nurse (TN) 1 was observed performing treatments to Resident 156's lower legs and toes. Resident 156's left 2nd toe was seen with drainage, wound appeared wet. Resident 156's right 2nd toe was seen with drainage, wound appeared wet. TN 1 was observed to not use betadine on any of Resident 156's wounds. During a concurrent interview and record review on 3/3/26, at 1:22 p.m., Resident 156's Treatment Administration Record (TAR) was reviewed. The TAR indicated, an order for LEFT FOOT 2ND TOE TRAUMA: CLEANSE W/NSS [normal saline solution], PAT DRY. BETADINE TO TOE, OTA every day shift, and RIGHT FOOT 2ND DIGIT TRAUMA: CLEANSE W/NSS, PAT DRY. BETADINE TO TOE, OTA [open to air] every day shift. TN 1 stated, I did not apply betadine to the left or right second toe, the order states to apply it. TN 1 stated, we are supposed to follow the order, the reason for using betadine is to assist in drying out the wound. During an interview on 3/6/26, at 11:02 a.m., with Medical Director (MD), MD stated it is her expectation that nursing staff follow wound care orders. MD stated, the betadine is mostly used to help dry out the wound if it stays wet.

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate foot care. Based on observation, interview, and record review, the facility failed to ensure residents receive necessary care to maintain their highest practicable physical and psychosocial well-being for one of 36 sampled residents (Resident 79), when Resident 79, who required podiatrist care (a specialized physician who managed foot health, including cutting and trimming toenails) was observed with long yellow toenails.This failure had the potential to affect Resident 79's foot health contributing to injury and/or infection and negatively impact Resident 79's psychosocial well-being.A review of the admission record indicated the facility admitted Resident 79 in 2024 with multiple diagnoses, including diabetes mellitus (DM - a disorder characterized by difficulty in blood sugar control) and generalized weakness.A review of the most recent quarterly Minimum Data Set (MDS: federally required assessment) dated 12/17/25 indicated Resident 79's speech was clear and she was able to understand others. The assessment indicated that Resident 79 scored 11 out of 15 in a Brief Interview for Mental Status which indicated she had moderate cognitive impairment.A review of Resident 79's clinical records contained a physician order dated 12/18/25, order indicated, Social Services: Patient is requesting podiatry for Diabetic foot/nail care. A review of physician order dated 2/3/26 contained an order for podiatry services for treatment of toenails and other foot problems every 61 days as needed.A review of Resident 79's clinical record contained a document that the resident's last visit for toenail care was conducted by podiatrist on 10/21/25, (over 4 months ago). The document indicated that Resident 79's nails were painful, long, yellow, brittle and thickened. There was no documented evidence that Resident 79 was seen by podiatrist as requested by physician's 12/18/25 order.During an observation and interview on 3/3/26 at 8:40 a.m., Resident 79 was resting in bed awake. Resident 79 answered appropriately to all questions and stated that she required lots of assistance from the staff. Resident 79's toenails were noted yellow in color, long with sharp uneven edges. Resident 79 stated, I don't like them to be that long.They are so.sharp, I need them to be cut. Resident 79 explained that due to her diagnosis of diabetes, she required a podiatrist. Resident 79 explained that she had not seen a podiatrist for several months. Resident 79 added, I put my name on the list with SS [social services] over and over and have not seen [podiatrist] yet.During an interview in Resident 79's room on 3/4/26 at 3:30 p.m., a Certified Nursing Assistant 8 (CNA 8) confirmed that Resident 79's toe nails were long with sharp edges and needed to be trimmed. CNA 8 explained that during showers or bed bath, the CNAs were required to document on showers sheets if residents' nails/toenails needed to be trimmed. CNA 8 stated that nurses reviewed shower sheets every day and will either trim or notify social services to have a podiatry toenail care.During an observation and interview in Resident 79's room on 3/4/26 at 3:45 p.m., LN 10 explained that residents with diabetes required a podiatrist to trim their toenails. LN 10 validated that Resident 79's nails were long and sharp and needed to be trimmed. During a concurrent interview and record review on 3/4/26 at 3:50 p.m., with Social Services Assistant (SSA), SSA reviewed Resident 79's clinical records and validated that the physician ordered the podiatrist to see resident every 2 months or as needed. The SSA reviewed Resident 79's clinical records and stated that the last time Resident 79 was seen by podiatrist was on 10/21/25. The SSA reviewed the list of residents seen by podiatrist on 2/3/26 and stated that Resident 79's name was not on the list.During a concurrent interview and record review on 3/5/26 at 8:05 a.m., with Administrator (ADM), the ADM stated that residents with diabetes were referred to podiatrist for toenails trimming. The ADM explained that nurses were required to check showers sheets every time the resident was given a shower or bed bath and if the resident had long toenails, the nurse would contact SS and request the podiatry visit for toenails trimming. Upon reviewing Resident 79's shower sheets dated 2/14/26 and 2/25/26, the ADM acknowledged that both shower sheets indicated that the resident's toenails needed to be clipped.A review of the facility's policy titled, Fingernails/Toenails, Care of, dated 2/2018, indicated, The purpose of this procedure are to clean the nails bed, to keep nails trimmed and to prevent infections. (continued on next page)

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Nail care includes daily cleaning and regular trimming.Trimmed and smooth nails prevent the resident from accidentally scratching and injuring his or her skin.During an interview on 3/5/26 at 8:10 a.m., with the ADM and Social Services Director (SSD), the SSD validated that the last time Resident 79's toenails were cut over 4 months ago. The SSD stated that Resident 79 missed the 2/3/26 podiatrist's visit due to being hospitalized and the next time the podiatrist will see facility's residents in April. The SSD added, She will be added on the list for his [podiatrist] next visit. When the SSD was asked if it was not too long for Resident 79 to wait for her toenails to be trimmed from October 2025 to April 2026, the SSD added, We will have another look at her toenails and see if she can be seen as an outpatient.During an interview of Resident 79's family member (FM) on 3/6/26 at 1:28 p.m., the FM stated that Resident 79 had been waiting for her toenails clipping for a long time. The FM stated, We have to ask multiple times to her toenails trimmed. Not seen podiatrist since October last year .but nothing was done.A review of the facility's policy titled, Social Services, dated 9/2021, indicated, Our facility provides medically-related social services to assure that each resident can attain or maintain his/her highest practicable physical, mental, or psychosocial well-being.Medically-related social services are provided to maintain or improve each resident's ability to control everyday physical needs. The policy indicated that social services staff were responsible for making referrals and obtaining needed services from outside entities.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough food/fluids to maintain a resident's health. Based on observation, interview, and record review, the facility failed to ensure one out of 36 sampled residents (Resident 46) received the appropriate services needed to maintain acceptable parameters of nutritional status when: 1. Significant unplanned weight loss of 12.4 lbs (pounds, a unit of measurement), 9.1 percent (%) occurred from January 31, 2026, to February 28, 2026. 2. The recommendation made during the Interdisciplinary Care Conference (IDT) conducted on February 20, 2026, of adding an Oral Nutritional Supplement (ONS) for Resident 46 was not ordered or implemented. These failures placed Resident 46 at risk for nutrional decline and further unplanned weight loss. 1. A review of Resident 46's Facesheet, indicated he was admitted to the facility in January 2026, with diagnoses that included: cerebral infarction (blockage of an artery in the brain which lead to tissue death), hemiplegia (severe or complete paralysis on one side of the body), dysphagia (difficulty swallowing), retention of urine (inability to fully or partially empty bladder), schizophrenia (a severe mental disorder). It was noted that Resident 46 was his own responsible party. A review of Resident 46's Minimum Data Set (MDS; an assessment tool), dated 1/18/26, indicated Brief Interview of Mental Status (BIMS) score was 99 which indicated Resident 46 was unable to complete the interview. A review of Resident 46's Weight and Vitals Summary, from January 2026 to February 2026, indicated the following: January 13, 2026 - 137.6 lbs January 17, 2026 - 138.8 lbs January 24, 2026 - 137.8 lbs January 31, 2026 - 136.4 lbs February 7, 2026 - 136 lbs February 14, 2026 - 128.8 lbs February 21, 2026 - 127.6 lbs February 28, 2026 - 124 lbs Resident 46 had a total weight loss of 13.6 lbs/9.9% since admission, and 12.4 lbs/9.1% within the last month, indicating a significant weight loss of more than 5% within 30 days. A review of Resident 46's Physician's Orders, dated 2/16/26 indicated Resident 46 was on a regular soft bite sized texture diet, thin consistency, one to one feeding, with extra time to swallow. During an interview on 3/4/26 at 3:30 p.m. with Certified Nursing Assistant (CNA 1), CNA 1 indicated that Resident 46 required assistance with every meal and most meals were consumed in his room with staff. During a telephone interview on 3/6/26 at 10:02 a.m. with Resident 46's family member, the family member indicated she was worried about the weight loss Resident 46 had experienced since his admission. Resident 46's family member further indicated he had not experienced weight loss prior to admission. 2. A review of a record titled, Nurse's Progress Note, dated 2/16/26, indicated a referral to RD (Registered Dietician). A review of a record titled, IDT, dated 2/20/26, indicated Resident 46 was not meeting Estimated Energy Requirement (EER; the number of calories a person needs per day to maintain their weight and basic body functions) due to recent weight loss trend. The record further indicated recommendations were made to add ONS to be consumed daily to better meet EER. The record showed the treatment team present during this IDT was the Assistant Director of Nursing (ADON 1), ADON 2, and RD. A review of Resident 46's Physician's Orders, dated 3/6/26, indicated Resident 46 did not have ONS ordered. During a telephone interview on 3/5/26 at 10:15 a.m. with RD, RD confirmed IDT meeting was done on 2/20/26 which pertained to weight loss and the recommendation was to add an ONS for Resident 46. RD confirmed that the ONS was not ordered or implemented. RD further confirmed Resident 46 continued to have weight loss after the date of the IDT. During an interview on 3/5/26 at 10:34 a.m. with ADON 1, ADON 1 confirmed the most recent weight taken for Resident 26 was on 2/28/26 and he weighed 124 lbs. ADON 1 stated the expectation, when a recommendation is discussed during IDT is that it is ordered and implemented in a timely fashion. ADON 1 further stated the consequence of the delay in implementing the ONS was Resident 46 continued to lose weight. During a follow-up interview on 3/6/26 at 12:38 p.m. with RD, RD stated, his expectation for implementing recommendations is within 24 hours of the recommendation. RD further stated implementing the recommendation within 24 hours could have minimized Resident 46's weight loss. RD further stated since there were several people present at the IDT; everyone may have assumed the other would have implemented the order. A review of the facility's policy and procedure (undated) titled, Weight Management, indicated, In the (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	event of a patterned or significant, unplanned weight loss of at least 5% in 30 days, the following interventions will be carried out.The dietetics professional will assess the resident.and make recommendations in the resident's medical record.Orders may be obtained for nutritional supplements or other interventions.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. Based on observation, interview, and record review, the facility failed to ensure the medication error rate did not exceed 5% for 2 of 3 sampled residents (Residents 4 and 104).For Resident 4, a licensed nurse did not administer the resident's multivitamin in accordance with the Physician Orders.For Resident 104, a licensed nurse did not administer the resident's:a. folic acid, an essential vitamin for cell growth and red blood cell formation; andb. calcium, a mineral important for strong bones and overall health, as ordered by the physician.As a result, 3 errors were identified out of 31 opportunities for error during the observation of medication administration; the facility medication error was 9.68%.1. During an observation of medication administration on 3/3/26 at 8:15 a.m., Licensed Nurse (LN) 11 was observed to prepare and administer Resident 4's morning medications which did not include Resident'4 multivitamin-minerals tablet.During an interview on 3/3/26 at 8:25 a.m., LN 11 stated she did not have a bottle of multivitamins on her medication cart to complete Resident 4's morning medication pass. During the continued interview, LN 11 asked the Infection Prevention Nurse (IPN) to bring her a bottle of multivitamins from the medication room. The IPN stated that the medication was not available in the medication room.Reconciliation of the observation of medication administration with Resident 4's current Physician Orders showed an order dated 5/24/25 for multivitaminˆminerals, to give one tablet by mouth daily.Review of Resident 4's March Medication Administration Record (MAR) contained a nursing note dated 3/3/26 at 8:46 a.m. indicating, multivitaminˆmineral oral.not available.During an interview on 3/5/26 at 11:03 a.m. with the Assistant Director of Nursing (ADON) 1, the ADON 1 stated, the multivitamin-mineral medication bottle should have been available for resident use prior to the medication pass observation. A review of facility policy and procedure (P&P) titled, Administering Medications V 2.1, undated, the P&P stated, Medications are administered in a safe and timely manner, and as prescribed.2. a. During an observation of medication administration on 3/3/26 at 9:01 a.m., LN 3 was observed to prepare and administer Resident 104's morning medications which included a 400 mcg (microgram, unit of measure) folic acid tablet.Reconciliation of the observation of medication administration with Resident 104's current Physician Orders indicated an order, dated 9/20/25, for folic acid 1 mg (milligram, unit of measure) to give one tablet by mouth daily.A review of Resident 104's MAR for 3/3/26 indicated that folic acid 1 mg tablet was given to Resident 104.During an interview on 3/3/26 at 2:20 p.m. with LN 3, LN 3 stated that folic acid 400 mcg house supply bottle was used during the medication administration pass observation. LN 3 stated, the resident used to have a blister pack for folic acid sent to the facility from the pharmacy, but resident ran out last week. LN 3 acknowledged the wrong strength of medication was given to the resident.During an interview on 3/5/26 at 11:03 a.m. with ADON 1, ADON 1 stated, the right dosage of medication should have been used to reduce the chance of drug interactions and side effects.2. b. During an observation of medication administration on 3/3/26 at 9:01 a.m. LN 3 was observed to prepare and administer Resident 104's morning medications which did not include the resident's calcium 500 mg.During an interview on 3/3/26 at 9:02 a.m. with LN 3, LN 3 stated, only higher strength calcium plus vitamin D were available for use, and the physician needed to be contacted.Reconciliation of the observation of medication administration with Resident 104's current Physician Orders indicated an order, dated 12/2/24, for calcium 500 mg to give one tablet by mouth daily in the morning.During an interview on 3/3/26 at 2:22 p.m. with LN 3, LN 3 stated, I contact the physician and changed the order to calcium 600 plus 10 mcg of vitamin D, so we could use our current house supply.During an interview on 3/5/26 at 11:03 a.m., with ADON 1, ADON 1 stated, the calcium 500 mg medication bottle should have been available for resident use prior to the medication pass observation. A review of facility policy and procedures (P&P) titled, Administering Medications V 2.1, undated, the P&P stated, Medications are administered in a safe and timely manner, and as prescribed.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to implement its policy and procedure for a census of 162 when:Three bottles of atropine eye drops, medication used to treat various eye conditions, 1% (percent, unit of measure), requiring roomˆtemperature storage, were stored in the refrigerator, creating a potential risk for drug degradation and reduced effectivenessOpened inhalers (used to administer medication by breathing in) in the medication cart were not dated, which put residents at risk of receiving expired or outdated medication1. During a concurrent observation and interview with Licensed Nurse (LN) 13 on [DATE] at 2:25 p.m. in Medication Room Hall 1, three bottles of atropine 1% were stored in the refrigerator at 38 degrees F (Fahrenheit, unit of measure for temperature) per refrigerator thermometer. LN 13 stated, the eye drop bottles needed to be stored at 68-77 degrees F per the bottle's storage requirement.During an interview on [DATE] at 11:10 a.m. with the assistant Director of Nursing (ADON) 1, ADON 1 stated, potency of eye drops could be negatively affected.During a review of atropine's storage requirements printed on the manufacturer's label, the label indicated, stored at 68 to 77 F.2. During an inspection of medication cart 2 hall 7 on [DATE] at 10:16 a.m., two multidose opened inhalers, budesonide/formoterol, combination of two medications used for breathing issues, 160/4.5 mcg (microgram, unit of measure) were observed to be stored in the medication cart without open date labels.During an interview on [DATE] at 10:16 a.m. with LN 11, LN 11 acknowledged that both used medication boxes did not have open date labels to determine the products' expiration dates.During an interview on [DATE] at 11:14 a.m. with ADON 1, ADON 1 stated the open dates needed to be documented on the multidose inhalers to know the products' expiration dates. Open multidose inhalers are exposed to pathogens and can cause issues related to infection control and will not be effective if used beyond their expiration dates.A review of the manufacturers' labels for storage on the boxes indicated, discard within 3 months after removing from foil pouch.During a review of the facility's policy and procedure (P&P) titled, Administering Medications, dated, 4/2019, the P&P indicated, The expiration/beyond use date on the medication label is checked prior to administering. When opening a multi-dose container, the date opened is recorded on the container.Medications are administered in a safe and timely manner.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure food was stored in a sanitary manner when:1. Multiple cups, bowls and a large colander were found stored upright and exposed to the air, dust and splatter in the kitchen and when, 2. The activities refrigerator had no working thermometer, foods were not dated when opened, and chocolate ice cream drippings and debris were observed on the bottom of the freezer.These failures increased the risk for food borne illness. 1.During an initial tour observation on 3/3/26 at 8:19 a.m., two large trays of coffee cups, a nest of 6 mixing bowls and colander were stored upright on a bottom shelf in the kitchen open to air, dust and splatter.During a concurrent observation and interview on 3/3/26 at 8:20 a.m. with Dietary Aid (DA) 2, DA 2 verified two large trays of coffee cups were stored upright, open to the air, dust and splatter and said, They are supposed to be turned upside down to protect them from dust. During a concurrent observation and interview on 3/3/26 at 8:36 a.m. with [NAME] 1, [NAME] 1 verified set of six nesting bowls and one large colander were stored upright under and [NAME] out slightly from the kitchen counter on a bottom shelf. [NAME] one said, They should be turned face down.During an interview on 3/5/26 at 11:48 a.m. with the Corporate Registered Dietitian (CRD), the CRD was asked her expectations for the storage of cups and bowls and said, The cups and mixing bowls should be stored face down.During a review of the facility policy and procedure (P&P) titled Warewashing, revised 12/24, the P&P indicated All dishware will be air dried and properly stored.2. During a concurrent observation of the activities refrigerator and interview with the Recreation Director (AD) on 3/6/26 at 7:51 a.m., the AD verified there were two 20 ounce and two 24 ounce containers of chocolate sauce open but not labeled with an open date in the refrigerator, and a thermometer that registered 75 degrees. Inside the freezer was a five gallon container of chocolate ice cream, without an open date, with brown streaks running down the sides of the carton, with brownish smears on the bottom and sides of the freezer and additional debris on floor of the freezer. The AD verified the freezer observation and also said, It looks like the [refrigerator] thermometer is broken.During an interview on 3/6/26 at 9:21 a.m. with the Dietary Manager (DM), the DM was asked her expectations of the activities refrigerator used for food consumed by residents and said, Items in the refrigerator and freezer should be labeled with the open date and use by date. There should be a working thermometer in both the refrigerator and freezer. They should be cleaned once a week or ASAP if there is spillage.During a review of the facility policy and procedure (P&P) titled Refrigerators and Freezers, revised 11/22, the P&P indicated All food is appropriately dated. Received dates (date of delivery) are marked.on individual items.and use by dates are indicated once food is opened.freezers are kept clean, free of debris.on a scheduled basis and more often as necessary.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure infection control practices were implemented for 8 sampled residents (Resident 95, Resident 56, Resident 54, Resident 17, Resident 153, Resident 126, Resident 133, and Resident 173) and residents who use shower room in hallway 6 and 7 when: 1. Resident 95 had a visibly blood-soiled dressing left on arteriovenous fistula site (AVF; a surgically created connection between an artery and a vein, usually in the arm, that allows easy access to the blood stream for dialysis-a treatment that uses a machine to clean waste and extra fluid from the blood when a person's kidneys were no long able to do it) and 2. There were unsanitary conditions in the showers of hallway 6 and 7, and 3. Resident 56's nebulizer (a machine to convert respiratory medication into a mist for direct entry into the lungs) mask and tubing were not stored properly to maintain cleanliness, and 4. Resident 54's enteral feeding pump (medical device used to deliver nutrition, fluids, and medication directly into the digestive tract) and the wall behind the feeding pump had multiple droplets and stains of brown substance resembling tube feeding formula and Resident 54's suction machine (medical device used to remove excess fluids from a person's airway or mouth) and cannister were soiled and suction cannister was dated 12/8/25, and 5. The facility failed to ensure residents were assisted or prompted to clean their hands before meals for sampled residents (Residents 17, 153, 126, 133, and 173). These failures had the potential to increase the risk of infection and cross-contamination (movement or transfer of harmful bacteria from one person, object, or place to another) among the residents. 1. A review of Resident 95's Facesheet, indicated he was admitted to the facility in January 2026, with diagnoses that included: end stage renal (an adjective for kidney) disease (the final stage of chronic kidney disease where kidneys no longer function on their own), dependence on kidney dialysis, heart failure (a condition where the heart was too weak or stiff to pump enough oxygen-rich blood to meet the body's needs). A review of Resident 95's Minimum Data Set (MDS; an assessment tool), dated 1/20/26, indicated Brief Interview of Mental Status (BIMS) score was 15 out of 15 which indicated Resident 95 was cognitively intact. A review of a record titled Physician's Orders, dated 1/5/26 indicated, Resident 95 received dialysis treatments every Monday, Wednesday, and Friday. During a concurrent observation and interview on 3/3/26 at 9:20 a.m. in Resident 95's room, Resident 95 was observed laying in bed awake with a blood-soiled dressing on his left upper arm. Resident 95 stated the dressing covered his AVF site and it was applied yesterday afternoon after his dialysis treatment. Resident 95 further stated he wanted the dressing changed since it was dirty. During a concurrent observation and interview on 3/3/26 at 9:38 a.m. in Resident 95's room, with Licensed Nurse (LN 1), LN 1 confirmed that the dressing applied over Resident 95's AVF site was soiled with blood and should have been changed. LN 1 further stated a dressing over a dialysis access site was usually removed two hours after a resident returned from the dialysis treatment center (a specialized medical facility for dialysis). LN 1 also stated the dressing was left on since yesterday (3/2/26) when Resident 95 had dialysis. During a concurrent observation and interview on 3/3/26 at 9:45 a.m. in Resident 95's room, with LN 2, LN 2 confirmed the dressing was soiled with blood. LN 2 further stated when staff observed any soiled dressing, the expectation would have been a new dressing applied. LN 2 also stated there was a risk of infection when dressings were left soiled. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 3/4/26 at 3:30 p.m. with LN 4, LN 4 stated there was no set protocol on what a nurse was supposed to do when a resident returned to the facility after dialysis with a dressing over AVF site. During an interview on 3/5/26 at 10:34 a.m. with Assistant Director of Nursing (ADON 1), ADON 1 stated the consequences of a soiled dressing not changed immediately, and left on Resident 95 overnight, was an increased risk of infection. A review of the facility's policy and procedure (P&P) titled, End-Stage Renal Disease, Care of a Resident, revised September 2010, indicated, Staff caring for residents with end stage renal disease, including residents receiving dialysis care outside the facility, shall be trained in the care and special needs of these residents. A review of the facility's P&P titled, Policies and Procedures Infection Prevention and Control, dated December 2023, indicated, All personnel are trained on infection prevention and control policies and procedures upon hire and periodically thereafter. 2. During an interview on 3/5/26 at 3:47 p.m. with Resident 154, Resident 154 stated the shower in hallway 6 was always dirty. Resident 154 further stated he had to wrap his shoes or feet in plastic before he went into the shower because he had a wound. A review of Resident 154's Facesheet, indicated he was admitted to the facility in November 2025, with diagnoses that included: cellulitis (serious bacterial infection affecting the deeper layers of the skin) of the of left lower limb, and amputation of right great toe. A review of Resident 154's MDS dated [DATE], indicated BIMS score was 15 out of 15 which indicated Resident 154's cognitive function was intact. During a concurrent observation and interview on 3/6/26 at 11:04 a.m. in the shower of hallway 7, with Housekeeping Supervisor (HS), pink colored residue was observed built up in all corners of the shower room. HS confirmed the build up and stated it could have been soap. HS further stated the expectation was the shower would be free from any debris, build up, mold, or odor. HS also stated the consequences of any mold, build up, or dust in the shower could have led to respiratory issues for residents, infection control concerns, and cross contamination. During an interview on 3/6/26 at 11:17 a.m. with Housekeeping Assistant (HA 2), HA 2 stated, showers were expected to be free of mold and build up. HA 2 further stated that there was a risk of infection for residents if they showered in a dirty shower room. During an interview on 3/6/26 at 11:22 a.m. with ADON 1, ADON 1 stated the expectation was that showers should be clean, checked routinely and hygienic for residents to prevent the risk of infection. A review of the facility's undated P&P titled, Seven Step Daily Washroom Cleaning, indicated, When damp mopping floors pay close attention to any possible build up along corners and edges, use your disinfectant and scraper to remove any potential build up in these areas to maintain a clean and sanitary surface. During an observation of shower room in Hall 6 on 3/6/26 at 10:23 a.m., accompanied by Director of Maintenance (DOM) and HS, pink and black slimy substance was observed on the tile and side skirting (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	in the corners of the shower room. The DOM validated that the tile and skirting were dirty and stated, Seems like [it had] not being pressure-washed for a while. The HS added,[It] needs to be bleach sprayed, pressure washed, and scaped. The HS stated, We have no showers on Sundays, and it is expected that housekeeping staff pressure wash it every Sunday or more often. 3. A review of Resident 56's admission Record Indicated Resident 56 was admitted to the facility in December 2023 with multiple diagnoses including congestive heart failure (the heart does not pump blood as efficiently as it should), diabetes (high blood sugar caused by the body's inability to produce or properly use insulin), Parkinsonism (neurological condition causing tremors, muscle rigidity, and poor balance), and pulmonary hypertension (high blood pressure in the lung arteries causing the heart to work harder). A review of Resident 56's MDS, Cognitive Patterns, dated 2/25/26, indicated Resident 56 had long and short-term memory problems and was severely cognitively impaired to make decisions regarding daily living. A review of Resident 56's Order Listing Report indicated an order dated 1/23/26, Albuterol Sulfate Inhalation Nebulization Solution [bronchodilator medication used to treat wheezing and shortness of breath] .via nebulizer every 4 hours as needed for wheezing, SOB [Shortness of Breath] . A review of Resident 56's Medication Administration Record [MAR], for 3/1/26 to 3/30/26, indicated Albuterol Sulfate Inhalation Nebulization Solution .3 ml [milliliters] inhale orally via nebulizer every 4 hours as needed for wheezing, SOB-Start Date-01/24/2026 . During a concurrent observation and interview on 3/3/26 at 10:12 a.m. with Licensed Nurse (LN) 8, LN 8 confirmed Resident 56's nebulizer mask and tubing were uncovered, laying in nightstand drawer, and covered with used tissues. LN 8 acknowledged the nebulizer mask and tubing should have been in a black mesh bag to keep it clean when not in use. LN 8 stated if the mask and tubing were not kept in a bag, they cannot be used and should be replaced. LN 8 stated if mask and tubing were not stored properly it could put resident at risk for infection. A review of the facility's Policy and Procedure (P&P) titled Oxygen and Nebulizer Tubing, revised 11/11, indicated .The purpose of this procedure is to guide prevention of infection associated with respiratory therapy tasks and equipment .Infection Control Considerations Related to Medication Nebulizers/Continuous Aerosol: .Save the circuit [nebulizer tubing and mask] in plastic bag, marked with date and resident's name, between uses .Discard the administration set up every seven (7) days . 4. A review of Resident 54's admission Record indicated Resident 54 was admitted to the facility in March 2021 with multiple diagnoses including respiratory failure, epilepsy (brain disorder characterized by seizures), cerebral infarction (stroke-blocked flow to the brain causing brain cell death), dysphagia (difficulty swallowing), and gastrostomy (surgical opening into the stomach through the abdomen to insert a feeding tube to supply nutrition, hydration and medication). A review of Resident 54's MDS, Cognitive Patterns, dated 12/9/25 indicated Resident 54 had long and short-term memory problems and was severely cognitively impaired to make decisions regarding daily living. A review of Resident 54's Order Summary Report indicated an order dated 2/24/25 .Enteral Feed (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Order [liquid nutrition delivered directly into the digestive system] two times a day TF [tube feeding] rate to Glucerna 1.5 [tube feeding formula] @ [at] 55 ml/hr x [times] 20 hrs [hours] . A review of Resident 54's Medication Administration Record [MAR] for 3/1/26 to 3/30/26, indicated Keep suction machine at bedside. Suction PRN [as needed] to clear the airway of blood saliva, vomit, or other secretions. every shift for monitor- Start Date- 04/18/2025 . During a concurrent observation and interview on 3/3/26 at 8:41 a.m. with Resident 54, observed Resident 54 in bed with feeding pump next to bed. Observed feeding pump and wall behind feeding pump splattered with multiple droplets and brown stains that resembled the tube feeding formula being used. Observed suction machine and cannister on nightstand. Suction machine and cannister were soiled with brown and black stains. The suction cannister was dated 12/8/25. Resident 54 stated she needs to be suctioned sometimes. During a concurrent observation and interview on 3/3/26 at 11:09 a.m. with LN 8 in Resident 54's room, LN 8 confirmed that Resident 54's feeding pump and the wall behind the feeding pump were splattered with droplets of tube feeding formula. LN 8 stated, It is not acceptable. LN 8 confirmed that Resident 54's suction machine and cannister were soiled and needed to be cleaned. LN 8 confirmed the suction cannister was dated 12/8/25. LN 8 stated she did know how often the suction cannisters needed to be changed but probably should have been changed since it was dirty. During an interview on 3/5/26 at 9:42 a.m. with the Assistant Director of Nursing (ADON) 2, the ADON 2 viewed a picture of Resident 54's feeding pump, the wall behind the pump, and the suction machine and cannister, then stated, Someone failed to do their job to keep the equipment tidy. The ADON 2 stated if the feeding pump, walls, and suction machine are soiled there is a danger of infection and should be kept clean. When asked how often the suction machine cannister should be changed, the ADON 2 stated she was not sure and would need to check the policy. A review of the facility's P&P titled Enteral Feedings-Safety Precautions, revised 11/18, indicated .The facility will remain current in and follow accepted best practices in enteral nutrition .Preventing contamination .Maintain strict aseptic techniques at all times when working with enteral nutrition systems and formulas . A review of the facility's P&P titled Suctioning, revised 8/14, indicated .The purpose of this procedure is to help prevent nosocomial [infection acquired in healthcare facilities] associated with suctioning and to prevent transmission of such infections to residents and staff .Suction machines must be available at the bedside of residents who require suctioning because they cannot clear nasal, oral, and/or respiratory secretions by themselves .Wipe the machine with disinfectant to remove soil, as necessary . The suction collection cannister should be emptied and cleaned daily and changed or decontaminated as necessary . A review of the facility's P&P titled Dignity, revised 10/25, indicated .Each resident is cared for in a manner that promotes and enhances individuality, a sense of well-being, satisfaction with life, and feelings of self-worth and self-esteem . A review of the facility's P&P titled Resident Rights, revised 10/25, indicated .Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to; . a dignified existence . (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5. During an observation on 3/3/26 at 12:17 p.m., in the dining room, staff performed hand hygiene for themselves using hand sanitizer from dispensers in the hall outside of the dining room. There were nine residents in the dining room awaiting lunch. There were no hand sanitizer dispensers on any dining tables. At 12:19 p.m., residents were served their meals and began eating. No residents were observed performing or assisted in performing hand hygiene before eating. During an interview on 3/3/26 at 12:22 p.m., in the dining room with Resident 17 and Resident 133, Residents 17 and 133 stated they did not wash their hands before eating. During an interview on 3/3/26 at 12:41 p.m., with Resident 17 and Resident 133 in the dining room, Resident 17 stated he did not wash his hands before eating because it was not offered, They never provide sanitizer or hand wipes to wash my hands before eating. Resident 133 stated the towelettes would be nice to have regularly. Both Resident 17 and Resident 133 stated they had never been offered wipes before today and that they preferred their hands washed before eating. Resident 133 stated even though I washed my hands in my room, I still have to wheel myself in my wheelchair to the dining room before eating. During an interview on 3/3/26 at 1:08 p.m., with Resident 153, Resident 153 stated that although I use the wall sanitizer dispenser located in the hallway to sanitize my hands, I must wheel myself into the dining room afterward for meals. Resident 153 stated They need to have some kind of towelettes with the meals to wash my hands before eating. During a concurrent observation and interview on 3/5/26 at 8:30 a.m., with Resident 173 and Resident 126 in Residents 173 and 126's room, there was no hand sanitizer dispensers present. Breakfast trays were present and the breakfast was eatenby both residents. Resident 173 stated he/she was not prompted or assisted in hand hygiene and no towelettes were on the meal tray. Resident 173 stated he/she did not perform hand hygiene. Resident 126 stated he/she did not wash his/her hands nor was he/she prompted to and no hand sanitizer or wipes were available. Resident 126 stated there was no hand wipes or sanitizer available for residents before meals. During an interview on 3/5/26 at 9:38 a.m. with Dietary Aide 1 (DA 1) in the kitchen, the DA 1 stated trays include food, drinks, silverware, napkin, and diet ticket, and stated, We do not provide sanitizing wipes. We don't have them. During an interview on 3/5/26 at 9:46 a.m, with Licensed Nurse 6 (LN 6) in the hallway, LN 6 stated [There is] nothing on the trays for hand hygiene LN 6 stated Certified Nursing Assistants (CNAs) should prompt and assist residents with hand hygiene and should provide it when needed. During an interview 3/5/26 at 9:48 a.m., with CNA 4 in the hallway, CNA 4 stated residents are not given anything for hand hygiene and are generally not prompted, stating it depends on the individual CNA. During an interview on 3/5/26 at 1:15 p.m., with the Assistant Director of Nursing 1 (ADON 1) in the ADON 1 office, the ADON 1 stated that residents should be prompted and assisted in hand hygiene, especially before meals. The ADON 1 stated hand wipes would be kept in a utility room near the nurses station and that staff does not chart resident performing or refusing hand hygiene with meals. The ADON 1 stated, We need to improve on resident hand hygiene. During an interview on 3/5/26 at 3:38 p.m., with the Director of Staff Development, the DSD stated (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	there was no resident hand hygiene training at the facility and provided the most recent staff training materials and the most recent training roster that only addressed employee handwashing. A review of facility training course syllabus for classroom presentation on Hand Hygiene and Proper Handwashing Technique dated 1/8/26, indicated Objective, To review with staff proper hand washing technique and key hand hygiene tips. The materials did not include procedures for assisting or prompting residents with hand hygiene before meals. During an interview on 3/6/26 at 8:03 a.m., with the Central Supply Technician (CST) in the Central Supply Office, the CST stated hand sanitizer was supplied to wall dispensers and medication carts, treatment carts, and nursing stations. The CST stated that moist towelettes were supplied to nursing station utility rooms, but not to the kitchen or for meal trays. The CST stated the dining room tables and meal trays were not supplied with sanitizer or wipes. A review of the facility P&P titled, Handwashing/Hand Hygiene dated 9/18/23 indicated, This facility considers hand hygiene the primary means to prevent the spread of infections. and Use an alcohol-based hand rub. before meals. The P&P indicates, Hand hygiene products and supplies. shall be readily accessible for staff use to encourage compliance with hand hygiene policies.

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observation, interview and record review, the facility failed to provide care in an environment that maintained and enhanced residents' dignity and respected their individuality, when a white board at the Nursing Station of Hall 6 identified two residents by their room numbers referring them as FEEDERS.This failure had the potential to compromise residents' dignity by exposing residents' care needs.During an observation on 3/3/26 at 4:05 p.m., a white board on the wall at the Nursing Station of Hall 6 had two resident rooms that were labeled as FEEDERS.During a concurrent observation and interview on 3/4/26 at 3:15 p.m., with Licensed Nurse 3 (LN 3) and LN 4, a whiteboard in Hallway 6 listed two resident rooms as FEEDERS. LN 3 & LN 4 stated, staff wrote important information on white board and updated it daily. When the Department asked LN 3 and LN 4 regarding feeders, LN 4 explained, These are the residents that need to be assisted with feeding, one-on-one. LN 3 and LN 4 did not provide any answer when asked if it was appropriate to label and identify residents as feeders.During a concurrent observation and interview on 3/4/26 at 3:35 p.m., the whiteboard in Hallway 6 was observed. the Assistant of Director of Nursing (ADON) 1 validated that FEEDERS indicated residents who required help with feeding. The ADON 1 agreed that labeling residents as FEEDERS could be demeaning because it reduced a person to a task rather than recognizing them as individuals and undermined residents' dignity. The ADON 1 stated, posting FEEDERS in a visible area was inappropriate because it exposed residents health information.A review of the facility's policy titled, Dignity, dated 10/25, indicated, Each resident is cared for in a manner that promotes and enhances individuality, a sense of being well-being.feelings of self- worth and self -esteem. Staff speak respectfully to residents at all times, including addressing the resident by their name.and not labeling or referring to the resident by their room number, diagnosis or care needs. Signs indicating the residents clinical status or care needs are not openly posted.

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. Based on observation, interview, and record review the facility failed to allow two of 36 sampled residents (Resident 19 & Resident 153) to make choices about aspects of their life in the facility that are significant to them when:The facility did not offer or assist Resident 19 to eat in the dining room for breakfast, andThe facility failed to allow Resident 153 to keep snacks in his room.These failures had the potential to affect Resident 19 and Resident 153's mental health and overall wellbeing. 1.During an observation on 3/3/26, at 9:00 a.m., Resident 19 was sitting in bed with his breakfast tray on his bedside table. During an interview on 3/3/26, at 9:00 a.m., with Resident 19, Resident 19 stated, he ate his breakfast in bed and would rather eat in the dining room. Resident 19 stated, he has asked the facility to eat in there and for assistance wheeling himself with his wheelchair, but they do not assist him and stated they kick me out of the dining room. Resident 19 stated, the people who need help to eat are usually in the dining room. During an observation on 3/6/26, at 7:20 a.m., in Hallway 1, the dining cart carrying resident's breakfast trays was observed in the hallway. During an observation on 3/6/26, at 7:21 a.m, in Resident 19's room, Resident 19 was observed sitting in bed. During an interview on 3/6/26, at 7:21 a.m., with Resident 19, Resident 19 stated, he was not offered to eat in the dining room today. During an interview on 3/6/26, at 7:32 a.m., with Licensed Nurse (LN) 8, LN 8 stated, Residents in Hallway 1 who need assistance to eat are brought to the dining room, and Residents who are independent eat in their room. During a review of Resident 19's Care plan dated 8/23/25, Care plan indicated, While in the facility, resident states that it is important that s/he has the opportunity to engage in daily routines that are meaningful relative to their preferences. During a review of the facility's policy and procedure (P&P) titled, Resident Rights, dated 2025, the P&P indicated, Employees shall treat all residents with kindness, respect, and dignity. 1. Federal and State laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to: . e. self-determination [the ability or power to make decisions for yourself]. 2. A review of the admission record indicated the facility admitted Resident 153 in 2025 with multiple diagnoses which included left leg below knee amputation, anxiety and depression. A review of the Minimum Data Set (MDS, a federally mandated resident assessment tool) dated 1/23/26 indicated, Resident 153 scored 13 out of 15 in a Brief Interview for Mental Status, which indicated he was cognitively intact. The MDS assessment addressing Resident 153's daily preferences indicated that it was very important for Resident 153 to take care of his personal belongings and things. (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview on 3/3/26 at 10:08 a.m., Resident 153 was sitting in a wheelchair in his room. Resident 153 was pleasant, calm and stated he did not have any concerns with his care. Resident 153 had a water jug on his bedside table and no food leftovers or snacks were observed on Resident 153's bedside table and nightstand. During an observation on 3/3/26 at 3:40 p.m., Resident 153 was seen in his wheelchair in the hall. Resident 153 stated, I am very upset what happened today- the staff had confiscated all of my snacks- cookies, chips, candies, a few of water bottles, other drinks, salt, pepper, and hot sauce to add to the food. Resident 153 looked very anxious and stated, Nothing perishable, nothing to spoil, all snacks. They were sealed in Ziplock bags or original packages in my drawer and if you walked in, you'd never guessed that I had snacks, unless you checked my nightstand drawers. Resident 153 rolled into his room, opened closet door and showed an empty cardboard box. Resident 153 continued, Some of my snacks were in a box inside the closet. CNA [Certified Nursing Assistant] came and took everything. I am very upset and frustrated of this - it cost money and they will probably toss it out. Resident 153 stated, that CNA explained that the social services requested to have all of his snacks removed from his nightstand and closet. During a continued interview with Resident 153 in his room on 3/3/26 at 3:40 p.m., Resident 153 stated, They keep telling me that in order for my wounds to heal, I need to eat good, and I get hungry after dinner so I just have snacks and now they took it away. Resident 153 stated, when he was admitted , the admission staff explained that he could not keep perishable food at bedside. Resident 153 added, Nothing about snacks, these are not perishables, and they were inside the drawers. Resident 153 stated, he was very upset about this incident and felt like his rights to keep snacks at bedside were not respected and not honored. During an interview on 3/3/26 at 4:03 p.m., with CNA 5, CNA 5 stated, residents were allowed to keep snacks, chips, candies, and drinks at bedside as long as they are stored closed and, in the drawer, or closet. During an interview on 3/3/26, at 4:06 p.m., Licensed Nurse 3 (LN 3), who was also a charge nurse for the unit stated that during admission, staff explained facility rules to residents regarding food brought from home. LN 3 added, Perishable food needs to be dated and refrigerated. Snacks, including cookies, chips, candies - as long as they are covered and not opened to air, it's okay to keep at bedside.Keeping snacks in zip lock bag is okay. During a concurrent observation and interview on 3/3/26, at 4:32 p.m., with Social Services Assistant (SSA), observed two green shopping bags half-filled on the floor in social services office. The SSA picked up the bags from the floor and explained that the bags contained box with cookies, several small bags with gummy candies in small, sealed pouches, snack size boxes with raisins, chips in closed bag, a few water bottles and other drinks. Inside one of the bag was a piece of paper with Resident 153's name on it. SSA validated that the snacks were contained inside boxes, bags, and closed Ziplock bag. The SSA stated, one of the CNAs brought bags to the office less than two hours ago. SSA was not able to explain the reason for taking Resident 153's snacks and drinks away and did not provide the answer when asked why Resident 153 could not keep snacks at his bedside. A review of Resident 153's physician progress note dated 3/3/26 at 11:05 p.m., indicated, Patient was seen.He told me [he] got very upset because some of his belongings were removed from his room.Because he was so upset, patient was planning to leave the facility tomorrow.Upset about not having access to his snacks.Social services was made aware. (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/3/26 at 4:40 p.m., the Administrator (ADM) stated, Residents have rights to keep snacks in their drawers or containers as long as they are covered. The ADM added, I am not aware who took it from [Resident 153], but the resident should be able to keep it at bedside. A review of the facility's policy titled, Resident Rights, dated 10/2025, indicated, Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to.self-determination [to make their own choices about their life] .exercise their rights as a resident of the facility.Be supported by the facility in exercising their rights.Retain and use personal possessions to the maximum extent space and safety permit.

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Encode each resident?s assessment data and transmit these data to the State within 7 days of assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to complete a Minimum Data Set (MDS: a federally mandated, standardized, and comprehensive assessment tool used in nursing homes to evaluate the functional, medical, and psychological status of residents) assessment for one of four sampled residents (Resident 142) when Resident 142 was discharged on 9/22/25 and facility staff did not complete the Discharge MDS assessment. During a review of Resident 142's facesheet, facesheet indicated, Resident 142 was admitted on [DATE], and discharged from the facility on 9/22/25.During a concurrent interview and record on 3/5/26, at 1:51 p.m., with MDS Nurse 2 (MDS 2), Resident 142's Medical record was reviewed. The Medical record indicated, Resident 142 did not have a discharge MDS assessment completed. MDS 2 stated, the discharge MDS assessment was not completed, we have 14 days from discharge to complete the discharge MDS assessment, and we missed this one.During a review of the MDS Resident Assessment Instrument 3.0 (RAI: tool used to instruct staff how to perform and complete the MDS) dated [DATE] indicated, Discharge assessments consist of discharge return anticipated and discharge return not anticipated. Must be completed within 14 days after the discharge date .During a review of the facility's Policy & Procedure (P&P) titled, MDS Completion and Submission Timeframes, dated 2023, the P&P indicated, Our facility will conduct and submit resident assessments in accordance with current federal and state submission timeframes.b. Timeframes for completion and submission of assessments is based on the current requirements published in the Resident Assessment Instrument Manual

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
River City Post Acute	2540 Carmichael Way Carmichael, CA 95608

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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 Based on interview and record review, the facility failed to ensure one of 36 sampled residents (Resident 18) received a required mental health evaluation for an identified mental disorder.This failure had the potential to result in Resident 18 not receiving needed mental health care and services.A review of the admission record indicated the facility admitted Resident 18 in 2025 with multiple diagnoses, which included bipolar disorder (a mental health disorder characterized by extreme mood swings, alternating between emotional highs and lows). During a record review of Resident 18's Preadmission Screening and Resident Review [PASRR- a comprehensive evaluation tool used to identify persons with mental illness, intellectual or developmental disabilities] Level 1 Screening Evaluation, dated 12/18/25, indicated Resident 18 had a diagnosed mental disorder for which the resident was prescribed psychotropic medications (drugs that affect a person's mental activity, mood, and behavior.) The screening form indicated that Resident 18's Level I was positive, and a Level II was required to be completed by the state mental health evaluation.A review of Resident 18's clinical records indicated, no level II evaluation was completed.During an interview on 3/5/26 at 8:20 a.m., the Social Services Director (SSD) explained that a resident with mental diagnosis and/or who received psychotropic medications and was positive for Level I, is required to have a Level II screening for which they were referred to the state department of health services (DHS). The SSD added, We contact DHS and they come and evaluate the resident.they give us recommendations for psychiatric referral or any special activities that might be offered to resident. The SSD stated that PASRR Level II evaluations guided the plan of care for residents with mental disorders.During a follow up interview and record review with SSD on 3/5/26 at 2:22 p.m., the SSD reviewed Resident 79's PASSR dated 12/18/25 and validated that the resident was positive for Level II. The SSD stated the facility did not follow up with DHS and Resident 18 was not assessed for the need of special services for her mental illness. The SSD stated that Resident 18 may have missed special services that she needed and missed benefits she could have received from DHS.During an interview on 3/6/26 at 8:51 a.m., the Administrator (ADM) stated that it was important for residents with mental illnesses to receive Level II screening to make sure the residents received appropriate care and specialized services.A review of the facility's PASSRR Completion Policy, dated 9/2024, indicated, The center will make sure that all admissions have the appropriate Patient Assessment and Resident Review (PASSR) completed. Administrator is accountable for monitoring the process for completing the necessary paperwork for the admission.

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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. Based on observation, interview, and record review, the facility failed to develop and/or implement a comprehensive care plan for two of thirty-six sampled residents (Resident 46 and Resident 88) when: 1. Resident 46's communication board care plan was not implemented by staff. 2. Resident 88 did not have a Care Plan that indicated he needed to wear a helmet when out of bed. These failures placed Resident 46 at the risk of care needs not being met and Resident 88 at risk of fall and injury. 1. A review of Resident 46's Facesheet, indicated he was admitted to the facility in January 2026, with diagnoses that included: cerebral infarction (blockage of an artery in the brain which lead to tissue death), hemiplegia (severe or complete paralysis on one side of the body), dysphagia (difficulty swallowing), retention of urine (inability to fully or partially empty bladder), schizophrenia (a severe mental disorder). It was noted that Resident 46 was his own responsible party. A review of Resident 46's Care Plans, dated 1/13/2026, indicated, The resident has difficulty communicating verbally to express needs and speaks a non-English language.A communication board is in the resident's room to aid with communication. The interventions listed in the CP indicated, .Accessible to communication board for resident to be able to communicate his needs with staff. A review of Resident 46's Minimum Data Set (MDS; an assessment tool), dated 1/18/26, indicated Brief Interview of Mental Status (BIMS) score was 99 which indicated Resident 46 was unable to complete the verbal interview. In an interview on 3/4/26 at 3:10 p.m. with Licensed Nurse (LN 3), LN 3 stated she used Google Translate (a software that translates language) to help communicate with Resident 46. In an interview on 3/4/26 at 3:30 p.m. with Certified Nursing Assistant (CNA 1), CNA 1 stated she knew when Resident 46 needed help because he kicked the pillows or blanket in bed. In a concurrent observation and interview on 3/5/26 at 8:10 a.m. in Resident 46's room, LN 5 confirmed that there was no communication board at the bedside. LN 5 further stated she communicated with Resident 46 with yes or no answers. During an observation on 3/5/26 at 8:20 a.m. in Resident 46's room, CNA 2 helped Resident 46 with breakfast and provided care with no communication board. During a follow up interview on 3/5/26 at 9:45 a.m. with LN 5, LN 5 stated if a Care Plan (CP; a comprehensive, written guide, outlining a resident's personal health needs, goals, and specific treatments) for communication board was initiated, the expectation was the communication board needs to be at bedside. LN 5 further stated miscommunication was possible if it was not used. During an interview on 3/5/26 at 10:34 a.m. with Assistant Director of Nursing (ADON 1), ADON 1 stated the expectation was the communication board should have always been available during Resident 46's care. ADON 1 further stated Resident 46's needs would not have been met if unable to communicate effectively. ADON 1 was unable to provide a policy that covered communication boards. A review of the facility's policy and procedure titled, Care Planning Interdisciplinary Team, dated 8/25/21, indicated, Our facility's Interdisciplinary Team is responsible for the development of an (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	individualized comprehensive care plan for each resident. 2. A review of Resident 88's admission Record indicated Resident 88 was admitted to the facility in April 2024 with multiple diagnoses including cerebral infarction, hemiplegia and hemiparesis (weakness on one side of the body), and intracerebral hemorrhage (bleeding inside the brain). A review of Resident 88's MDS, Cognitive Patterns, dated 12/20/25, indicated Resident 88 had a BIMS score of 3 out of 15 that indicated Resident 88 was severely cognitively impaired. Further review of Resident 88's MDS, Functional Abilities, dated 12/20/25, indicated Resident 88 required substantial assistance for bed mobility and transfers from bed to chair. A review of Resident 88's hospital Internal Medicine admission Adult History & Physical, dated 4/19/24, indicated .h/o [history of] ICH [Intracranial Hemorrhage- bleeding inside the skull] and CVA [Cerebrovascular Accident- disrupted blood flow to the brain causing brain cell death] . s/p [status post] decompressive hemicraniectomy [removal of large portion of the skull to relieve pressure on the brain] . A review of Resident 88's After Hospital Summary, dated 4/19/24 to 4/30/24, indicated .Activity .Continue to wear helmet when out of bed . A review of Resident 88's order dated 4/30/24, indicated Resident to be Out of bed with helmet every shift for craniectomy . A review of Resident 88's Care Plan, dated 9/23/25, indicated [Resident 88] is at risk for recurrent falls/ self-injury r/t [related to] impaired mobility/gait/balance, weakness, he desires his independence impulsive behavior does not wait or seek assistance with transfer .Interventions . Assist resident getting in and out of bed . Assist resident with ambulation . Place call light within reach while in bed .Remind resident to use call light when attempting to ambulate or transfer . A review of Resident 88's Care Plan, dated 10/13/24, indicated Resident exhibits and/or is at risk for seizure activity related to head injury .Interventions .Maintain safe environment . These Care Plans do not indicate need to wear helmet when out of bed as an Intervention. A review of Resident 88's Care Plan, dated 3/4/26, indicated Resident has forgetful behavior of taking off the Helmet when OOB [out of bed] .Interventions .Monitor resident for behavior of wearing or not wearing the Helmet while OOB as per order .Remind the resident of wearing Helmet when OOB as safety measure r/t DX [diagnosis] . During an observation on 3/3/26 at 12:01 p.m. in the dining room, Resident 88 was sitting at a table in his wheelchair and was not wearing his helmet. During a concurrent observation and interview on 3/3/26 at 3:38 p.m. with Resident 88, observed Resident 88 sitting at the edge of the bed with his wheelchair at the end of the bed and helmet hanging from the back of the wheelchair. Observed Resident 88 stand up and begin to turn to sit in wheelchair. Resident 88 appeared unsteady and appeared to have right-sided weakness. Resident 88 then turned and sat back down on the edge of the bed. When asked if he wears his helmet, Resident 88 stated, Occasionally. When asked if anyone has told him to wear his helmet, he stated no one has told him to wear it. Resident 88 stated he has fallen a few times but does not remember if he was (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	hurt. During a concurrent interview and record review on 3/5/26 at 9:03 a.m. with the Assistant Director of Nursing (ADON) 2, the ADON 2 stated Resident 88 has a history of a brain injury and is supposed to wear a helmet when he gets out of bed, but he takes it off. ADON 2 stated Resident 88 has helmet because he is at risk for seizures. ADON 2 stated Resident 88 needs assist when getting out of bed and whoever is assisting him should put on the helmet. ADON 2 acknowledged Resident 88's helmet order only indicated he needs to wear it when out of bed but does indicate if it was applied or refused, just if it was observed on or off. The ADON 2 stated she will check to see if Resident 88 has a care plan for wearing the helmet or taking it off himself. During an interview on 3/5/26 at 10:41 a.m., with the Medical Director (MD), the MD stated she began seeing Resident 88 in July 2025. The MD stated Resident 88 had brain trauma and cerebellar strokes which affected his balance. The MD stated Resident 88 is missing part of his skull and needs to wear a helmet when out of bed due to his imbalance. Nurses should be documenting if Resident 88 is wearing the helmet or not. During an interview on 3/5/26 at 11:31 a.m. with the ADON 2, the ADON 2 provided the Care Plan, dated 3/4/26, Resident has forgetful behavior of taking off the Helmet when OOB. Requested Care Plan prior to 3/4/26 addressing helmet usage. It was not provided. A review of the facility's Policy and Procedure (P&P) titled Care Planning-Interdisciplinary Team, effective date 8/25/21, indicated .Our facility's Interdisciplinary Team is responsible for the development of an individualized comprehensive care plan for each resident .The care plan is based on the resident's comprehensive assessment and is developed by an Interdisciplinary Team . A review of the facility's P&P titled 'Fall Management, dated 5/26/21, indicated .Patients will be assessed for falls risk . Those determined to be at risk will receive appropriate interventions to reduce risk and minimize injury . Identify patient's fall risk by reviewing the Nursing Documentation .Develop individualized plan of care .

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. Based on observation, interview, and record review, the facility failed to arrange needed services for one of thirty-six sampled residents (Resident 88) when Resident 88 did not receive neurology (physician focused on treating disorders of the nervous system including the brain) or neurosurgical (surgical specialty focused on treating disorders of the nervous system including the brain) follow up services after admission to the facility.This failure placed Resident 88 at risk for increased disability and decreased functional status. A review of Resident 88's admission Record indicated Resident 88 was admitted to the facility in April 2024 with multiple diagnoses including cerebral infarction (blockage of a blood vessel in the brain causing cell death), hemiplegia (paralysis on one side of the body) and hemiparesis (weakness on one side of the body), and intracerebral hemorrhage (bleeding inside the brain). A review of Resident 88's Minimum Data Set (MDS-federally mandated assessment tool), Cognitive Patterns, dated 12/20/25, indicated Resident 88 had a Brief Interview for Mental Status (BIMS- tool to assess cognition) score of 3 out of 15 that indicated Resident 88 was severely cognitively impaired. Further review of Resident 88's MDS, Functional Abilities, dated 12/20/25, indicated Resident 88 required substantial assistance for bed mobility and transfers from bed to chair. A review of Resident 88's hospital Internal Medicine admission Adult History & Physical, dated 4/19/24, indicated .h/o [history of] ICH [Intracranial Hemorrhage] and CVA [Cerebrovascular Accident- stroke, disrupted blood flow to the brain causing brain cell death] . Pt [patient] admitted 2/21-4/8 [2024] s/p [status post] decompressive hemicraniectomy [removal of large portion of the skull to relieve pressure on the brain] and hematoma evacuation [pooled blood removed] . also found to have multifocal embolic appearing strokes [multiple blood clots block blood vessels in different parts of the brain] . A review of Resident 88's hospital After Hospital Summary, for 4/19/24 to 4/30/24, indicated .Follow-up Appointments: Here is a list of your recommended follow-up plan. Please reach out to these clinics to confirm your appointment or with any questions for each specialist: .Neurosurgery .Neurology . A review of Resident 88's hospital Skilled Nursing Facility Admit Orders, dated 4/30/24, indicated .Recommended follow up appointments: .Neurosurgery .Neurology .A review of Resident 88's Physician-History and Physical note, dated 8/29/25, indicated .Establish care .significant past medical history of left basal ganglia [brain area responsible for motor control] ICH (2/2024) s/p decompressive hemicraniectomy with hematoma evacuation . Outpatient specialty follow-ups (Neurology .) as feasible .A review of Resident 88's order by facility Medical Director, dated 9/4/25 indicated, .Neuro follow-up .A review of Resident 88's order by facility Medical Director dated 1/18/26 indicated, .Neurologists consult for CVD [cerebrovascular disease] Seizure Disorder with Social Services . During an interview on 3/5/26 at 9:03 a.m. with the Assistant Director of Nursing (ADON) 2, the ADON 2 stated, Resident 88 has a history of a brain injury and is at risk for seizures. When asked if Resident 88 had follow up appointment for neurology consult, the ADON 2 stated she did not see any follow- up appointments arranged. The ADON 2 contacted the Social Services Director who confirmed that no neurology follow up had been initiated. During an interview on 3/5/26 at 10:41 a.m. with the Medical Director (MD), the MD stated she began seeing Resident 88 in July 2025. MD stated Resident 88 had brain trauma and strokes. The MD stated Resident is missing part of his skull from decompressive hemicraniectomy in 2024. The MD stated she did not know if Resident 88 had a neurology follow up consult but should have been seen by neurology. The MD stated she was not aware if Resident 88 was supposed to have neurology consult upon admit to the facility and was not aware of any further procedure he may need. The MD stated it would have been worthwhile to contact neurology or neurosurgery to see what the appropriate care upon admission was and what follow up needed to be done. The MD stated, It would be reassuring to know if neuro [neurology] agrees with current management of [Resident 88]. The MD stated she documented in her note on 8/29/25 to follow up with neurology. The MD stated the facility needs to make sure they have the appropriate records, appropriate follow up arranged, and that documents are scanned in the (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	electronic record. During a concurrent interview and record review on 3/6/26 at 2:10 p.m. with the Social Services Assistant (SSA), Resident 88's orders for neurology consult were reviewed. The SSA stated that she was unable to locate a referral for neurology consult for Resident 88. The SSA stated it is the Social Services Department's responsibility to follow up on referrals for consults. A review of the facility's Policy and Procedure (P&P) titled, Social Services, revised 9/21, indicated . Our facility provides medically-related social services to assure that each resident can attain or maintain his/her highest practicable physical, mental, or psychosocial well-being .The social worker/social services staff are responsible for .making referrals and obtaining needed services from outside entities .

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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 that one of 36 residents (Resident 4), received necessary assistance with tooth brushing and mouth care in accordance with the resident's assessed needs, care plan, and facility policy.This failure resulted in ongoing poor oral hygiene, decayed dentition, and unmet assessed Activity of Daily Living (ADL) needs for Resident 4.A review of Resident 4's admission record indicated Resident 4 was originally admitted to the facility on [DATE]. Resident 4 had a history of transient ischemic attack (when blood flow to part of the brain is temporarily blocked) and cerebral infarction (interruption in the flow of oxygen and nutrients to a specific area of the brain, causing brain cells to die), diabetes mellitus type 2 (a chronic condition in which the body doesn't use insulin properly, causing high blood sugar), chronic kidney disease (kidneys are losing the ability to clean waste and excess fluid from the blood), heart failure, acquired absence of right leg below the knee, and muscle wasting and atrophy (muscle shrinking or wasting away due to lack of use or lack of nutrition or stimulation).A review of Resident 4's Minimum Data Set (MDS) (a standardized assessment used to understand health needs and to plan care) Section C indicated Resident 4 had a Brief Interview for Mental Status (BIMS: standardized cognitive screening that measures short-term memory and awareness) score of 15 indicating Resident 4 was cognitively intact.During an observation on 3/4/26 at 11:59 a.m., in Resident 4's room, Resident 4 was observed lying in bed. Resident 4 had multiple missing teeth. Remaining teeth appeared decayed and discolored. There was noticeable foul oral odor present. Resident 4 stated he was unable to perform ADLs independently. Resident 4 stated he was unable to hold a toothbrush due to contractures (permanent tightening or shortening of the muscles, tendons, ligaments, or skin) and that staff does not assist in oral care. Resident 4 stated he has asked for help with teeth brushing and no one helps. Resident 4 stated he last asked for help on 3/4/26 in the morning and that nobody helped. Resident 4 stated, staff had not brushed his teeth for over a year, with oral care only being performed sometimes when Resident 4's sister visited.A review of Resident 4's Care Plan revised 2/6/26, indicated Requires assistance with oral care and Will be assisted with current level of functioning in personal hygiene.During an interview on 3/4/26 at 3:00 p.m., with Licensed Nurse 7 (LN 7) at the nurses station, LN 7 stated, Resident 4 was a total assist for ADLs and has no orders for mouth care.During an interview on 3/5/26 at 7:50 a.m., with Certified Nursing Assistant 4 (CNA 4) in Resident 4's room, CNA 4 stated was unaware of refusals for teeth cleaning and oral care and stated Resident 4 had supplies at bedside. CNA 4 stated, There is no place to chart daily performance of oral care. CNA 4 stated, Resident 4 needs total assist with oral care.During an interview on 3/5/26 at 7:55 a.m., with Licensed Nurse 6 (LN 6) in the hallway, LN 6 stated she was unaware of any refusals of oral care and that oral hygiene was not being documented daily. LN 6 stated Resident 4 is totally dependent on assistance with ADLs.During an interview on 3/5/26 at 8:10 a.m., with Director of Rehab Services (DOR) in the rehabilitation gym, DOR stated that Resident 4 is on Restorative Nurses Aid (RNA) Therapy for passive Range of Motion (PROM) therapy due to upper extremity contractures and that Resident 4 is provided splinting and bracing for contracted extremities.During an interview on 3/5/26 at 1:15 p.m., with the Assistant Director of Nursing 1 (ADON 1), the ADON 1 stated, Resident 4 is dependent on assistance for ADLs. This was discussed and updated at Resident 4's Interdisciplinary Team (IDT) meetings.During an interview on 3/5/26 at 1:35 p.m., with Resident 4's family member in Resident 4's room, Resident 4's family member stated she sometimes brushes Resident 4's teeth when she visits and that they are in very poor condition, they do not brush his teeth. Resident 4's family member stated Resident 4 can't brush his teeth on his own.During an interview on 3/6/26 at 7:51 a.m., with CNA 4 in the hallway, CNA 4 stated that she observed tooth discoloration, discolored sputum, and plaque indicating lack of teeth cleaning for Resident 4's teeth.A review of Resident 4's MDS Section GG for Functional Abilities, indicated Resident 4 as dependent for oral care (Helper does (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	all of the effort, resident does none of the effort to complete the activity).A review of Resident 4's Rehab Screen dated 11/12/25, indicated, Change in Mobility Status [reviewed]. [Patient] presented with decreased mobility, decreased strength. Rehab Screen dated 2/27/26 indicated, No change in function since last assessment.A review of Resident 4's Joint Mobility Screen dated 2/27/26 indicated: Left shoulder (Active (moves own joints and limbs by themselves without help)/Passive (helper moves a person's arms or legs for them because they can't move those joints on their own) ROM): Severe impairment (.25% or less of full ROM), Left elbow (Active/Passive ROM): Severe impairment (.25% or less of full ROM) Left wrist (Active/Passive ROM): Severe impairment (.25% or less of full ROM) Left hand (Active/Passive ROM): Severe impairment (.25% or less of full ROM) Left elbow (Active/Passive ROM): Severe impairment (.25% or less of full ROM) Left wrist (Active/Passive ROM): Severe impairment (.25% or less of full ROM) Left hand (Active/Passive ROM): Severe impairment (.25% or less of full ROM) Right shoulder (Active ROM): Minimal impairment (.75% or less of full ROM), Right elbow (Active ROM): Severe impairment (.25% or less of full ROM), Right wrist (Active ROM): Severe impairment (.25% or less of full ROM), Right hand (Active ROM): Severe impairment (.25% or less of full ROM).A review of Resident 4's Personal Hygiene Log for oral care dated 3/1/26 to 3/5/26 indicated:Oral care was charted as performed three times on 3/1/26 with Resident 4 able to perform oral hygiene with set up assistance (Helper sets up or cleans up; resident completes activity) one time and as dependent on assistance two times.Oral care was charted as performed three times on 3/3/26 with Resident 4 able to perform oral hygiene with maximal assistance (Helper does more than half the effort. Helper holds limb and provides more than half the effort) one time and as dependent on assistance two times.A review of the facilities Policy and Procedure (P&P), dated 2001, revised 2018 indicated, If the resident refuses the treatment, [document] the reason(s) why and the intervention taken. and indicated reporting instructions to Notify the supervisor if the resident refuses the mouth care.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. Based on observation, interview and record review the facility failed to provide activities to one of 36 sampled residents (Resident 156) when the facility failed to provide activities meaningful to Resident 156 and according to the activities schedule.This failure had the potential to negatively affect Resident 156's mental health and wellbeing.During an interview on 3/4/26, at 8:42 a.m., with Resident 156, Resident 156 stated, she wishes she could get out of bed earlier so she can attend activities. Resident 156 stated, activitiy staff used to offer coffee at 10 am, but they offer that anymore. Resident 156 stated, look at the schedule posted on the wall and see if they offer those activities. Resident 156 further stated, When the state is here, everything is perfect. During a review of the Activity Schedule whiteboard dated March 2026 in Hallway 1, schedule indicated, Wednesday 3/4 10:00 Coffee Social. During a review of Resident 156's Brief Interview for Mental Status (BIMS: a screening tool used in long-term care to assess cognitive function, specifically orientation and short-term memory. Scores of 13-15 indicate intact cognition). BIMS score indicated, 15 indicating Resident 156 was cognitively intact.During an observation on 3/4/26, at 10:14 a.m., in dining room located in Hallway 1, no staff were observed in the dining room. No staff were observed going into resident's rooms, to ask if they wanted to join the scheduled activity in Hallway 1.During an interview on 3/4/26, at 10:17 a.m., with Recreation Assistant (RA) 1, RA 1 stated, The activity right now is coffee hour, I just have to get the cups. RA 1 stated, the activity is in the dining room. During an observation on 3/4/26, at 10:31 a.m., in the dining room, no staff were observed, and coffee hour activity had not started. Four residents were noted to be sitting alone in the dining room. During a review of the activity schedule posted in Hallway 1 dated 3/4/26, schedule indicated, 11 a.m, Puzzles.During an observation on 3/4/26, at 11:09 a.m to 11:30 a.m., in the dining room, RA 1 and RA 2 were noted to be in dining room with approximately 4-5 residents present. No puzzles were noted in the dining room. The television was turned on, RA 1 and RA 2 were noted to be speaking with each other and did not speak with Resident 156. During an interview on 3/4/26, at 11:15 a.m., with RA 1, RA 1 stated, we announce on the speakers to invite residents to the activities, that is how they are asked if they want to join. RA 1 stated, he does not go into the residents rooms to ask if they want to join activities.During an interview on 3/4/26, at 11:30 a.m., with Recreation Director (AD) AD stated, the activity staff will ask residents if they want to join the scheduled activity. AD stated, she expects the recreation staff to provide the activities to residents according to the schedule. During a review of Resident 156's care plan dated 10/25/25, care plan indicated, While in the facility, resident states that it is important that s/he has the opportunity to engage in daily routines that are meaningful relative to their preferences. Resident will have opportunities to make decisions/choices related to/for self-directed involvement in meaningful activities at least 5x per week.During a review of the facility's policy and procedure (P&P) titled, Activity Program, dated 2018, the P&P indicated, Activity programs are designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident.Activities offered are based on the comprehensive resident-centered assessment and preferences of each resident.

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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. Based on observation, interview, and record review, the facility failed to provide supervision for one of thirty-six sampled residents (Resident 88) to ensure Resident 88 wore a protective helmet when out of bed.This failure placed Resident 88 at serious risk for injury, including intracranial hemorrhage (bleeding inside the skull) from falls or accidents. A review of Resident 88's admission Record indicated Resident 88 was admitted to the facility in April 2024 with multiple diagnoses including cerebral infarction (blockage of a blood vessel in the brain causing cell death), hemiplegia (paralysis on one side of the body) and hemiparesis (weakness on one side of the body), and intracerebral hemorrhage (bleeding inside the brain). A review of Resident 88's Minimum Data Set (MDS-federally mandated assessment tool), Cognitive Patterns, dated 12/20/25, indicated Resident 88 had a Brief Interview for Mental Status (BIMS- tool to assess cognition) score of 3 out of 15 that indicated Resident 88 was severely cognitively impaired. Further review of Resident 88's MDS, Functional Abilities, dated 12/20/25, indicated Resident 88 required substantial assistance for bed mobility and transfers from bed to chair. A review of Resident 88's hospital Internal Medicine admission Adult History & Physical, dated 4/19/24, indicated .h/o [history of] ICH [Intracranial Hemorrhage] and CVA [Cerebrovascular Accident- disrupted blood flow to the brain causing brain cell death] . s/p [status post] decompressive hemicraniectomy [removal of large portion of the skull to relieve pressure on the brain] . A review of Resident 88's After Hospital Summary, dated 4/19/24 to 4/30/24, indicated .Activity .Continue to wear helmet when out of bed . A review of Resident 88's order dated 4/30/24, indicated Resident to be Out of bed with helmet every shift for craniectomy . A review of Resident 88's Change in Condition Evaluation, dated 8/1/25, indicated .Resident was sitting on the floor next to his bed, the bed was in the lowest position. Resident had stated he had fallen, resident has no c/o [complaints of] pain or discomfort. Vital signs were taken and normal results. Family notified. We will continue to monitor . A review of Resident 88's Change in Condition Evaluation dated 9/8/25, indicated .The CNA [Certified Nursing Assistant] went into the room and he was sitting on the floor next to his bed. Skin assessment was done, no c/o pain, no bleeding, no bruising noted, resident stated he did not hit his head, he was trying to transfer from his bed to his w/c [wheelchair] by himself, and he fell and landed on his bottom. Resident is back in his bed at lowest level, resting comfortably, call light within reach, reminded resident to press call light when he wants to get out of bed . A review of Resident 88's Medication Administration Records [MAR], for January 2026, February 2026, and March 2026, indicated Resident is to be Out of bed with helmet every shift for craniectomy-Start Date-04/30/2024 . The MARs indicated Behavior Observed, wearing helmet, to be charted for each shift. January 2026 MAR indicated 42 episodes of Resident 88 not wearing helmet during day and evening shift. February 2026 MAR indicated 46 episodes of Resident 88 not wearing helmet during day and evening shift. March 2026 MAR, 3/1/26 to 3/5/26, indicated 6 episodes of Resident 88 not wearing helmet during day and evening shift. A review of Resident 88's Care Plan, dated 9/23/25, indicated [Resident 88] is at risk for recurrent falls/ self-injury r/t [related to] impaired mobility/gait/balance, weakness, he desires his independence impulsive behavior does not wait or seek assistance with transfer .Interventions . Assist resident getting in and out of bed . Assist resident with ambulation . Care Plan does not indicate need to wear helmet when out of bed as an Intervention. During an observation on 3/3/26 at 12:01 p.m. in the dining room, Resident 88 was sitting at a table in his wheelchair and was not wearing his helmet. During a concurrent observation and interview on 3/3/26 at 3:38 p.m. with Resident 88, observed Resident 88 sitting at the edge of the bed with his wheelchair at the end of the bed and helmet hanging from the back of the wheelchair. Observed Resident 88 stand up and begin to turn to sit in wheelchair. Resident 88 appeared unsteady and appeared to have right-sided weakness. Resident 88 then turned and sat back down on the edge of the bed. When asked if he wears his helmet, Resident 88 stated, Occasionally. When asked if (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	anyone has told him to wear his helmet, he stated no one has told him to wear it. Resident 88 stated he has fallen a few times but does not remember if he was hurt. During an interview on 3/4/26 at 10:00 a.m. with Certified Nursing Assistant (CNA) 9, CNA 9 stated Resident 88 had a brain injury but is mostly independent, gets around by himself, and transfers to the wheelchair by himself with supervision. CNA 9 stated he reminds Resident 88 to wear his helmet, and he wears it most of the time when in the hallway but will take it off because he does not like to wear it. When asked if it was up to Resident 88 to put on the helmet, CNA 9 stated staff ask him to do it. CNA 9 stated there is an order for Resident 88 to wear the helmet when out of bed. During an interview on 3/4/26 at 10:06 a.m. with Licensed Nurse (LN) 9, LN 9 stated Resident 88 has an order to wear a helmet when he gets up. LN 9 stated Resident 88 will wear the helmet but will then take it off. LN 9 stated she or the CNA will ask him to replace it himself. Reviewed with LN 9 Resident 88's order to wear the helmet when out of bed. LN 9 stated the order only reflects Behavior Observed- Yes if Resident 88 is wearing the helmet or No if Resident 88 is not wearing the helmet. LN 9 acknowledged the order does not reflect whether staff placed the helmet or if the resident refused to wear the helmet. LN 9 stated if Resident 88 had a fall when not wearing the helmet could have a potential injury to the head. During a concurrent interview and record review on 3/5/26 at 9:03 a.m. with the Assistant Director of Nursing (ADON) 2, the ADON 2 stated Resident 88 has a history of a brain injury and is supposed to wear a helmet when he gets out of bed, but he takes it off. ADON 2 stated Resident 88 has helmet because he is at risk for seizures. ADON 2 stated Resident 88 needs assist when getting out of bed and whoever is assisting him should put on the helmet. ADON 2 acknowledged Resident 88's helmet order only indicated he needs to wear it when out of bed but does not indicate if it was applied or refused, just if it was observed on or off. The ADON 2 stated It was not an effective order. Reviewed Resident 88's February 2026 and March 2026 MARs. The ADON 2 acknowledged there were many multiple episodes of observations of Resident 88 not wearing the helmet. The ADON 2 stated, Do not know why it was charted No (indicating helmet was not observed on) during the day. The ADON 2 acknowledged Resident 88 had falls on 8/1/25 and 9/8/25. When asked what the potential harm is if Resident 88 falls without the helmet on, the ADON 2 stated the danger is an intracranial hemorrhage. During an interview on 3/5/26 at 10:41 a.m., with the Medical Director (MD), the MD stated she began seeing Resident 88 in July 2025. The MD stated Resident 88 had brain trauma and cerebellar (back of the brain) strokes which affected his balance. The MD stated Resident 88 is missing part of his skull and needs to wear a helmet when out of bed due to his imbalance. Nurses should be documenting if Resident 88 is wearing the helmet or not. The MD stated may have a serious injury if has a fall without the helmet on. A review of the facility's Policy and Procedure (P&P) titled Fall Management, effective 5/26/21, indicated .To reduce risk for fall and minimize the actual occurrence of falls. To address injury and provide care for a fall . Patients will be assessed for falls risk as part of the nursing assessment process. Those determined to be at risk will receive appropriate interventions to reduce risk and minimize injury . Communicate patient's fall risk status to caregivers .

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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. Based on observation, interview, and record review, the facility failed to ensure respiratory equipment was maintained in accordance with professional standards of practice for one of 36 sampled residents (Resident 193) when Resident 193's nasal cannula (NC; a medical device with two prongs that is connected to an oxygen source to deliver supplemental oxygen directly into the nostrils) was not labeled with the date it was first applied. This failure had the potential to result in unsanitary delivery of oxygen to Resident 193 and an increased risk of infection. A review of Resident 193's Facesheet, indicated he was admitted to the facility in 2025, with diagnoses that included, congestive heart failure (a condition where the heart muscle is too weak or stiff to pump blood efficiently causing blood to back up and fluids to accumulate in the lungs and body), pulmonary edema (excess fluid buildup in the lungs making it difficult to breathe), chronic obstructive pulmonary disease (a progressive long-term lung disease that makes it difficult to breath due to damaged airways). A review of Resident 193's Minimum Data Set (MDS; an assessment tool used to guide care), dated 3/4/26, indicated Brief Interview of Mental Status (BIMS) score was 10 out of 15 which indicated moderately impaired cognitive function. A review of Resident 193's Physician's Orders, dated 3/2/26 indicated, Oxygen tubing change weekly Sunday every night shift. A review of Resident 193's Physician's Orders, dated 3/2/26 indicated, Administer Oxygen at 2 liters per minute (LPM; a unit of measurement for oxygen administration flow rate) via NC as needed for shortness of breath. During a concurrent observation and interview on 3/3/26 at 9:05 a.m. in Resident 193's room, Resident 193 was observed sitting up in wheelchair wearing an unlabeled NC connected to a supplemental oxygen machine set at 2 LPM. Resident 193 stated the NC was never labeled. During an interview on 3/3/26 at 9:13 a.m. with Licensed Nurse (LN 1), LN 1 stated the expectation was the NC should be labeled with the date it was applied to the resident. LN 1 further stated the consequences if the NC was left unlabeled included staff could not determine when the equipment should be changed, and if the NC was clogged or dirty which had the potential to hinder oxygen delivery and an increased risk of infection. During an interview on 3/5/26 at 10:53 a.m. with Assistant Director of Nursing (ADON 1), ADON 1 stated her expectation was that the NC should be labeled with the date it was applied. ADON 1 further stated the consequences if left unlabeled included a risk of infection for Resident 193 and the NC could have kinked or clogged. During an interview on 3/5/26 at 2:17 p.m. with Administrator (ADM), ADM stated the facility did not have a specific policy on the NC being labeled upon application.

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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. Based on observation, interview, and record review, the facility failed to provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs) were maintained for one of 162 residents when prescription medications were stored in a medication cart without a resident specific prescription label with an increased risk of medication error or drug diversion. Inspection of the medication cart 2 in hall 7 with Licensed Nurse (LN) 11 on 3/4/26 at10:30 a.m. revealed the bottom drawer of the cart contained used prescription medications without resident specific pharmacy label. These medications included two blister packs of apremilast, medication used to help calm body's overactive immune system.During an interview on 3/4/26 10:35 a.m. with LN 11, LN 11 stated, the two blister packs did not have a resident specific pharmacy label.During an interview on 3/5/26 11:18 a.m. with the Assistant Director of Nursing (ADON) 1, ADON 1 stated, the prescription medications needed to be properly labeled within 24 hours after being received to prevent medication errors.A review of the facility policy and procedure (P&P) titled, Labeling of Medication Containers, revised 4/2019, indicated, All medications maintained in the facility are properly labeled in accordance with current state and federal guidelines and regulations. 1. Medication labels must be legible at all times. 2. Any medication packaging or containers that are inadequately or improperly labeled are returned to the issuing pharmacy. 3. Labels for individual resident medications include all necessary information, such as: a. The resident's name; b. The prescribing physician's name; c. The name, address, and telephone number of the issuing pharmacy; d. The name, strength, and quantity of the drug; e. The prescription number (if applicable); f. The date that the medication was dispensed; g. Appropriate accessory and cautionary statements; h. The expiration date when applicable; and i. Directions for use.