STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055449	A. Building B. Wing	06/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Covina Rehabilitation Center	261 W. Badillo Street Covina, CA 91723

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the accuracy and completeness of an informed consent (voluntary agreement to accept treatment and/or procedures after receiving education regarding the risks, benefits, and alternatives offered) for the use of psychotropic medications (any drug that affects brain activities associated with mental processes and behavior) for two of two sampled residents (Residents 8 and 74) by failing to:a. Ensure Resident 8's informed consent for the use of Ativan (medication to treat anxiety [feeling of worry, fear or nervousness]) was dated when the informed consent was obtained.b. Ensure Resident 74's informed consent for the use of Seroquel (medication to treat mental health condition) indicated the name of the person giving the consent. These failures had the potential for Residents 8 and 74 to not receive adequate information to make educated decisions on the use of psychotropic medications.Findings: a. During a review of Resident 8's Face Sheet (FS), the FS indicated the facility initially admitted Resident 8 on 5/26/2023 and readmitted on [DATE] with diagnoses including schizoaffective disorder (a mental illness that is characterized by disturbances in thought), anxiety disorder and major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest).During a review of Resident 8's Minimum Data Set (MDS, a resident assessment tool) dated 4/30/2026, the MDS indicated Resident 8 had intact cognition (ability to understand and process information). The MDS indicated Resident 8 required partial/moderate assistance (helper did less than half the effort) with eating, upper body dressing and personal hygiene. The MDS indicated Resident 8 was dependent (helper did all the effort) with oral hygiene, toileting, shower and lower body dressing. During a review of Resident 8's Order Summary Report (OSR) dated 5/21/2026, the OSR indicated Resident 8 had an order for Ativan 0.5 milligrams (mg - unit of measurement) tablet via (by way of) gastrostomy tube (GT, a medical device inserted through the abdomen directly into the stomach) every eight (8) hours as needed for anxiety manifested by excessive worrying about health concerns. During a review of Resident 8's undated Psychotherapeutic Drug Informed Consent Form (IC), the IC indicated a telephonic consent (verbal or documented agreement obtained over a phone call) for Ativan was obtained from Resident 8's representative. The telephonic IC did not indicate when the telephonic consent was obtained. During a concurrent interview and record review on 6/17/2026 at 11:28 am with Registered Nurse Supervisor 1 (RN 1), Resident 8's OSR dated 5/21/2026 and the undated IC were reviewed. RN 1 stated Resident 8 had an order for Ativan. RN 1 stated Resident 8's IC was obtained telephonically. RN 1 stated Resident 8's IC was not dated when the IC was obtained. RN 1 stated Resident 8's IC should have complete information and should have a date to determine when the IC was taken/obtained. RN 1 stated an IC with incomplete information was not valid. b. During a review of Resident 74's FS, the FS indicated the facility admitted Resident 74 on 9/10/2022 and readmitted on [DATE] with diagnoses including dementia (a progressive state of decline in mental abilities), schizophrenia (a mental illness characterized by disturbances in thought), and schizoaffective disorder. During a review of Resident 74's MDS dated [DATE], the MDS indicated Resident 74 had severely impaired cognition. The MDS indicated Resident 74 was independent with eating. The MDS indicated Resident 74 required substantial/maximal assistance (helper did more than (continued on next page)

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

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	half the effort) with oral hygiene, toileting, shower, upper/lower body dressing and personal hygiene. During a review of Resident 74's OSR dated 5/13/2026, the OSR indicated Resident 74 had an order for Seroquel 25 mg tablet by mouth at bedtime for schizoaffective disorder. During a concurrent interview and record review on 6/17/2026 at 12:28 pm with Licensed Vocational Nurse 1 (LVN 1), Resident 74's OSR dated 5/13/2026 and IC were reviewed. LVN 1 stated Resident 74 had an order for Seroquel. LVN 1 stated Resident 74's IC did not indicate whether the IC was obtained by phone or in-person (physically present in the same location). LVN 1 stated the IC did not indicate the name of the person giving the consent for the use of Seroquel on Resident 74. LVN 1 stated the IC should be accurate and complete for the safety of the residents. During an interview on 6/18/2026 at 11:08 am with the Director of Nursing (DON), the DON stated all IC should have the name of the person giving the consent and all IC should be dated when the IC was obtained to ensure the risks and benefits of the medications or procedures were explained and understood by the resident or responsible party. During a review of the facility's Policy and Procedures (P&P) titled, Informed Consent, revised December 2024, the P&P indicated the purpose of the P&P was To ensure that residents and/or their representatives are fully informed of the benefits, risks, frequency/duration, and alternatives before initiating the administration of psychotherapeutic drugs or physical restraints. A licensed nurse will verify the informed consent information and sign it to confirm its accuracy and completeness.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide care and services to prevent skin breakdown, promote wound healing and skin maintenance for two of four sampled residents (Residents 7 and 45) by failing to:a. Ensure staff trimmed the fingernails and provided a pressure-relieving barrier between the fingers, contracted thumb, and palm of the right hand for Resident 7 who was assessed as high risk for pressure ulcer (a localized injury to the skin and/or underlying tissue usually over a bony prominence as a result of pressure, or pressure in combination with shear) development. This deficient practice resulted in Resident 7 developing skin indentations (depression or dent on the skins surface) and discoloration in the palm of Resident 7's hand and placed Resident 7 at risk for development of right-hand pressure ulcers. b. Ensure Resident 45's Low Air Loss (LAL, a specialized medical support surface designed to prevent and treat skin ulcers by combining alternating pressure with a steady low-volume airflow) was set on alternating pressure (a system of interconnected air cells that inflate and deflate in cycles to continuously shift support and relieve pressure over bony prominence) and not on static pressure mode.This deficient practice had the potential to result in worsening of wounds or development of new skin breakdown for Resident 45. Findings: a.During a review of Resident 7's Face Sheet (FS), the FS indicated Resident 7 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including myelin oligodendrocyte glycoprotein antibody disease (rare disease where the body's immune system attacks the protective nerve coverings in the brain and spinal cord), chronic respiratory failure (long term condition that occurs when the lungs cannot get enough oxygen into the blood or eliminate carbon dioxide from the body), and muscle spasms (involuntary contractions of the muscles). During a review of Resident 7's untitled Care Plan (CP) initiated on 7/12/2024, the CP indicated Resident 7 was at risk for pressure injury and skin breakdown. The CP indicated a goal to minimize the risk of skin breakdown and pressure sores daily with interventions to provide pressure relieving devices as needed. During a review of Resident 7's Minimum Data Set (MDS, a resident assessment tool) dated 5/11/2026, the MDS indicated Resident 7 had severely impaired cognitive skills (mental processes involved in gaining knowledge and comprehension) for daily decision making. The MDS indicated Resident 7 had functional limitations in ROM (limited ability to move a joint that interferes with daily functioning, including activities of daily living, or places the resident at risk of injury) of both arms and both legs. The MDS indicated Resident 7 was dependent (helper does all the effort) on staff with hygiene, bathing, dressing, rolling to both sides, and bed to chair transfers and was at risk for pressure ulcer development. During a review of Resident 7's Braden Scale (BS - pressure ulcer risk assessment tool) dated 5/11/2026, the BS indicated Resident 7 was at very high risk for pressure ulcer development due to very limited sensory perception (unresponsive to painful stimuli due to diminished level of consciousness or sedation or limited ability to feel pain over most of the body), occasionally moist skin, very limited mobility(inability to move), bedfast activity (confined to the bed), and concerns for friction (force that resists or slows down movement when two surfaces rub against each other) and shearing (tissue damage that occurs when skin stays in one place while the underlying bone or tissues shift causing tissues to stretch, tear or slide in opposite directions). (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation and interview on 6/17/2026 at 8:58 am with Restorative Nursing Aide 1 (RNA 1) and Registered Nurse 2 (RN 2) during an RNA session in Resident 7's room, Resident 7 was lying in bed with the right arm straight and hyperextended (the extension of a body part beyond its normal limits) at the elbow, wrist bent downwards, and the hand in a fist. Resident 7 did not have a splint or towel roll (rolled up hand towel) in the right hand. RNA 1 assisted with passive range of motion (PROM, movement at a given joint with full assistance from another person) exercises to Resident 7's right arm and was unable to bend the elbow, straighten the wrist, or straighten the thumb which was bent inwards and positioned across the palm of the hand. RNA 1 stated Resident 7 resisted with range of motion (ROM, full movement potential of a joint) exercises to the right arm and RNA 1 could not straighten or pull Resident 7's thumb away from the palm of the hand. RNA 1 opened the fingers of Resident 7's right hand. A pink indentation of the skin was observed in the middle crease on the right side of Resident 7's palm of the right hand, located beneath the ring finger and fifth digit (pinky finger). The fingernails of all of Resident 7's fingers were long with jagged edges. RNA 1 stated Resident 7's fingernails were long and were digging into Resident 7's palm because staff did not place a towel roll in Resident 7's palm when the right-hand splint was removed. RNA 1 stated staff should always place a towel roll in Resident 7's hand when the hand was not in a splint, because Resident 7 consistently held Resident 7's right hand in a fist and cannot control its movement. RNA 1 stated Resident 7 did not have a towel roll or splint in the right hand upon arrival to Resident 7's room for RNA but should have to prevent problems like this. RN 2 entered Resident 7's room and examined Resident 7's right hand. RN 2 confirmed Resident 7 had a pink indentation of the skin in the middle crease on the right side of Resident 7's palm of the right hand, located beneath the ring finger and the fifth digit. RN 2 confirmed the fingernails of all of Resident 7's fingers were long with jagged edges and should have been trimmed but were not. RN 2 stated Resident 7's indentation and skin discoloration of the palm appeared to be caused by Resident 7's long fingernails digging into the palm of the right hand and a lack of a barrier in between the fingers and the palm of the hand. RN 2 stated Resident 7 was at high risk for developing skin breakdown and pressure ulcers due to need for total care, inability to control right-hand movements, constant positioning of the right hand in a fist, long fingernails, and hand contractures (shortening and hardening of muscles, tendons, or other tissue, often leading to deformity and rigidity of joints).RN 2 stated staff were required to regularly trim Resident 7's fingernails and place a barrier, such as a towel roll or a right-hand splint, between Resident 7's fingers and the palm of Resident 7's right hand to prevent pressure ulcers, open wounds, and infections. During an interview on 6/17/2026 at 11:14 am with Certified Nursing Assistant 2 (CNA 2), CNA 2 stated CNAs (in general) were instructed to always place a towel roll in Resident 7's right hand whenever Resident 7 was not wearing a right-hand splint because Resident 7's right hand was always positioned in a fist and the fingers dug into the palm of Resident 7's hand. During an interview on 6/18/2026 at 2:03 pm with the Director of Nursing (DON), the DON stated prolonged areas of pressure, lack of repositioning, and immobility put residents at risk for skin breakdown (tissue damage caused by friction, shear, moisture, or pressure) and pressure ulcers. The DON stated if a resident positioned their hand in a fist and had hand contractures, staff needed to trim the resident's fingernails weekly and always place a barrier, such as a splint or towel roll in the hand, to prevent skin breakdown, pressure ulcers, punctures in the skin, skin discoloration and infection. During a review of the facility's Policy and Procedure (P&P) titled, Prevention of Pressure Injuries, revised 3/2023, the P&P indicated staff were to review the resident's care plan and identify the risk factors as well as the interventions designed to reduce or eliminate those considered modifiable. The P&P indicated staff were to inspect the skin daily when performing or assisting with personal care or (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	activities of daily living (ADLs) which included the inspection of pressure points and repositioning the resident as indicated on the care plan. The P&P indicated staff were to review and select medical devices with consideration to the ability to minimize tissue damage, including size, shape, its application and ability to secure the device, monitor regularly for comfort and signs of pressure-related injury, and to consult with current clinical practice guidelines for prevention measures associated with specific devices. During a review of the facility's P&P titled, Fingernails/Toenails, Care of, revised 3/2023, the P&P indicated trimmed and smooth nails prevent the resident from accidentally scratching and injuring his or her skin. b. During a review of Resident 45's FS, the FS indicated Resident 45 was admitted to the facility on [DATE] with diagnoses including peripheral vascular disease (PVD, a slow progressive narrowing of the blood flow to the arms and legs), osteoporosis (weak and brittle bones) and osteoarthritis (a progressive disorder of the joints, caused by a gradual loss of cartilage). During a review of Resident 45's untitled Care Plan (CP) dated 3/17/2025, the CP indicated Resident 45 had a LAL mattress for wound and skin management. The CP interventions included for the LAL mattress to be set according to the resident's weight, comfort, and manufacture setting and to monitor the air pressure setting and functionality of the mattress. During a review of Resident 45's Order Summary Report (OSR) dated 7/25/2025, the OSR indicated Resident 45 had an order for LAL mattress for wound care and management. During a review of Resident 45's MDS dated [DATE], the MDS indicated Resident 45 had severely impaired cognition. The MDS indicated Resident 45 was dependent (helper did all the effort) with eating, oral hygiene, toileting, shower, upper/lower body dressing and personal hygiene. During a concurrent observation inside Resident 45's room and interview on 6/16/2026 at 9:45 am with Licensed Vocational Nurse 2 (LVN 2), Resident 45 was in bed, sleeping on a LAL mattress, set at 73 and in static pressure mode. LVN 2 stated Resident 45's weight was 73 pounds (lbs.) During an interview on 6/18/2026 at 10:33 am with Treatment Nurse 2 (TN 2), TN 2 stated LAL mattress should be on alternating pressure when the resident was sleeping to relieve pressure on bony prominence. TN 2 stated static pressure mode was firmer and used during turning or repositioning and transfer of the resident. During an interview on 6/18/2026 at 11:16 am with the Director of Nursing (DON), the DON stated LAL mattress should be on alternating pressure to distribute pressure equally for skin maintenance, wound healing and prevent wound decline. During a review of the facility's undated LAL Mattress Operation Manual (OM), the OM indicated, A firm surface will make it easier for the patient to transfer or reposition. Make use of the static mode function for this feature. During a review of the facility's Policy and Procedure (P&P) titled, Support Surface Guidelines, revised on September 2013, the P&P indicated, Redistributing support surfaces are to promote comfort for all bed- or chairbound residents, prevent skin breakdown, promote circulation and provide (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	pressure relief or reduction. Any individual at risk for developing pressure ulcers should be placed on a redistribution support surface, such as foam, gel, static air, alternating air, or air-loss or gel when lying in bed.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure three of seven sampled residents (Residents 7, 9, and 12) received appropriate services to prevent a decline or maintain joint (where two bones meet) range of motion (ROM, full movement potential in a joint) and mobility (ability to move) by failing to: 1. For Resident 7, provide Occupational Therapy (OT, profession that provides services to increase and/or maintain a person's capability to participate in everyday life activities) evaluation and treatment to assess proper fit and wear time for Resident 7's right-hand splint (rigid material or apparatus used to support and immobilize a broken bone or impaired joint) after Resident 7's custom right hand splint was lost. 2a. For Resident 9, provide a Restorative Nursing Aide program (RNA, nursing aide program that help residents to maintain their function and joint mobility) as ordered for active assistive range of motion (AAROM, movement at a given joint with a person's own effort and assistance from an external force or another person) to both arms and both legs, five times a week, from 5/1/2026 to 6/17/2026. 2b. For Resident 9, objectively (unbiased, based on facts) measure ROM impairments of both of Resident 9's hands during the OT evaluation, dated 1/16/2026. 3. For Resident 12, provide passive ROM (PROM, movement at a given joint with full assistance from another person) exercises to both of Resident 12's wrists and ankles during the RNA session on 6/18/2026, in accordance with physician's orders. These deficient practices had the potential to cause injury, pain, and pressure injuries (localized damage to the skin and/or underlying tissue usually over a bony prominence) due to ill-fitting and prolonged wear time of Resident 7's right-hand splint to Resident 7 and an overall decline in ROM, mobility, and activities of daily living (ADLs, basic activities such as eating, dressing, and toileting) for Residents 9 and 12.Findings:1. During a review of Resident 7's Face Sheet (FS-admission record), the FS indicated Resident 7 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including, but not limited to myelin oligodendrocyte glycoprotein antibody disease (rare disease where the body's immune system accidentally attacks the protective nerve coverings in the brain and spinal cord), chronic (long term) respiratory failure (a condition that occurs when the lungs cannot get enough oxygen into the blood or eliminate carbon dioxide from the body), and muscle spasms (involuntary contractions of the muscles).During a review of Resident 7's Minimum Data Set (MDS, a resident assessment tool), dated 5/11/2026, the MDS indicated Resident 7 had severely impaired cognitive skills (mental processes involved in gaining knowledge and comprehension, includes thinking, knowing, remembering, judging, problem-solving) for daily decision making. The MDS indicated Resident 7 had functional limitations in ROM (limited ability to move a joint that interferes with daily functioning, including activities of daily living, or places the resident at risk of injury) of both arms and both legs. The MDS indicated Resident 7 required dependent assistance (helper does all the effort) with hygiene, bathing, dressing, rolling to both sides, and bed to chair transfers.During a review of Resident 7's Order Summary Report (OSR), the OSR indicated a physician's order, dated 4/10/2026, for RNA to don (apply) and doff (remove) resting hand splints (RHS, splint secured from the hand to the forearm to position the hand in a functional position with the thumb positioned away from the palm and the knuckles of the hand slightly bent) to both of Resident 7's hands, for four to six hours, seven times a week.During a concurrent observation and interview on 6/17/2026 at 8:58 am with Restorative Nursing Assistant (RNA) 1 in Resident 7's room, Resident 7's RNA session was observed. Resident 7 was lying in bed with the right arm straight and hyperextended (the extension of a body part beyond its normal limits) at the elbow, wrist bent downwards, and the hand in a fist. Resident 7's left arm was bent at the elbow and wrist, and the hand was positioned in a fist. RNA 1 assisted with PROM exercises to Resident 7's left shoulder, elbow, wrist, and hand and applied a splint to Resident 7's left hand. RNA 1 assisted with PROM exercises to Resident 7's right arm and was unable to bend the elbow, straighten (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the wrist, or straighten the thumb which was bent inwards and positioned across the palm of the hand. RNA 1 stated Resident 7 resisted with ROM exercises to the right arm and RNA 1 could not straighten or pull Resident 7's thumb away from the palm of the right hand. RNA 1 placed a resting hand splint on Resident 7's right hand with the thumb tucked in across the palm and secured the splint to the hand with a strap over the knuckles of the hand and in the webspace between the thumb and pointer finger. During a concurrent observation and interview on 6/17/2026 at 9:31 am with Occupational Therapist 1 (OT 1), OT 1 observed Resident 7 wearing the resting hand splint RNA 1 applied to Resident 7's right hand during the RNA session. OT 1 stated Resident 7's right-hand splint did not fit properly because Resident 7's right thumb was positioned underneath the hand and across the palm instead of away from the palm. OT 1 stated it was important that RNA positioned Resident 7's thumb away from the palm of the hand because it placed the thumb in a functional position and prevented the thumb from digging into the palm of the hand which could cause pressure injuries. OT 1 stated OT previously evaluated and recommended a custom hand splint for Resident 7's right hand which was different than the current splint because it held the thumb away from the palm of the hand. OT 1 stated Resident 7's custom right-hand splint was lost about a month ago and had no idea where the splint was. OT 1 stated OT 1 was unsure where RNA 1 got the current resting hand splint from but stated RNA 1 and RNAs (in general) should not be applying the splint without a licensed OT first assessing and determining the appropriate type of splint and wear time for the splint because it could cause skin breakdown (tissue damage caused by friction, shear, moisture, or pressure) and injury. During a concurrent interview and record review on 6/17/2026 at 9:57 am with the Director of Rehabilitation (DOR) and OT 1, Resident 7's medical record was reviewed. The DOR stated the purpose of splints was to improve or maintain a resident's ROM and prevent contractures (loss of motion of a joint associated with stiffness and joint deformity). The DOR stated a licensed OT or Physical Therapist (PT, profession aimed in restoration, maintenance, and promotion of optimal physical function) must assess a resident's need for splints and determine the splint wear tolerance and schedule by periodically assessing the splint for safety, comfort or need for modification. The DOR stated after the therapist assessed a resident for the correct type of splint and established the wear tolerance, the therapist transitioned the splinting plan of care to nursing and the RNA program. The DOR and OT 1 confirmed the custom right hand- splint was lost approximately one month ago and stated RNA replaced Resident 7's right-hand custom splint with one of the resting hand splints Resident 7 either arrived to the facility with or family brought into the facility without an OT assessment. The DOR stated Resident 7 did not receive any OT evaluation or treatment after Resident 7's custom right hand splint was lost and prior to continuing with the RNA program to apply a right-hand splint for four to six hours. The DOR stated a licensed OT should have assessed Resident 7 for a right-hand splint to determine the appropriate type of splint and establish a safe wear time schedule for a new splint when the custom right hand splint was lost but did not. The DOR stated if RNAs (in general) applied splints to residents without an OT or PT assessment, it could result in injury, deformity (condition where a part of the body does not have its normal or expected shape), and skin breakdown. During a review of the facility's Policy and Procedure (P&P) titled, Splinting, dated 5/4/2023, the P&P indicated once the patient has been screened for the appropriateness of splinting, the charge nurse or therapist will contact the physician and secure an evaluation order and treatment sessions for splint application, monitoring of wear schedule, splint modifications as needed and instruction of the nursing staff. The P&P indicated the therapist will order the splint, apply the splint, make the necessary fitting adjustments, proceed with a two-hour trial wearing period to check for pressure points and to assess the patient's tolerance to the splint, increase the angle of the splint and the wear time throughout the course of treatment, and in-service the nursing staff on the proper application, precautions, and wearing schedule once the therapist determines the splints has reached the maximum benefit to the resident. 2a. During a review of Resident 9's FS, the FS indicated Resident 9 was admitted to the facility on [DATE] with diagnoses including but not limited to (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Guillain-Barre Syndrome (condition where the immune system mistakenly attacks the body's own nerves), quadriplegia (weakness or paralysis to all four extremities), and acute (sudden) respiratory failure.During a review of Resident 9's MDS, dated [DATE], the MDS indicated Resident 9 was cognitively intact. The MDS indicated Resident 9 had functional limitations in ROM of both arms. The MDS indicated Resident 9 required dependent assistance with eating, hygiene, bathing, dressing, and bed to chair transfers.During a review of Resident 9's Order Summary Report (OSR), the OSR indicated a physician's order, dated 4/24/2026, for RNA to provide active assistive ROM exercises to both of Resident 9's arms and legs, five times a week.During a review of Resident 9's RNA Medication Administration Record (RNA MAR, daily record of RNA services provided for each month) for May 2026 and June 2026, the RNA MAR indicated for the RNA to provide AAROM exercises to both of Resident 9's arms and legs, five times a week. The squares on the RNA MAR flowsheet were blank on the following days: 5/4/2026, 5/13/2026, 5/23/2026, 5/29/2026, 6/5/2026, 6/6/2026, 6/10/2026, 6/13/2026, and 6/15/2026.During an observation and interview on 6/18/2026 at 10:09 am with Resident 9 in Resident 9's room, Resident 9 was observed sitting upright in bed with the head of the bed elevated. Resident 9 bent the fingers of both hands minimally at the knuckle joints and could not make fists with both hands. Resident 9 stated Resident 9 was unable to move the left shoulder and partially bent and straightened the left elbow and wrist. Resident 9 stated Resident 9's legs felt very stiff and minimally moved both hips, knees, and ankles. Resident 9 stated staff did not come enough to assist with ROM exercises and needed more therapy or staff to help move Resident 9's arms and legs because they felt very stiff. During a concurrent interview and record review on 6/18/2026 at 12:05 pm with the Assistant Director of Nursing (ADON), Resident 9's RNA physician's orders, dated 4/24/2026, and RNA MAR records for May 2026 and June 2026 were reviewed. The ADON stated the RNA program helps residents in the facility maintain and regain their mobility and strength to prevent contractures and functional decline. The ADON confirmed Residents 9 had physician orders for RNA to provide AAROM to both of Resident 9's arms and legs, five times a week, for the months of May 2026 and June 2026. The ADON stated a blank square on the RNA MAR indicated the resident was not seen for RNA treatment that day. The ADON confirmed that Resident 9 did not receive RNA services as ordered for four days in May 2026 and for five days in June 2026. The DSD stated it was important for RNA to provide services as ordered because missed treatments could place residents at risk for contracture development and functional decline.During an interview on 6/18/2026 at 2:03 pm with the Director of Nursing (DON), the DON stated the purpose of the RNA program was to maintain a resident's current level of function after discharge from skilled therapy services (services that require specialized training and experience of a licensed therapist or therapy assistant) and to prevent contractures and any functional declines. The DON stated that missed RNA treatments could potentially cause a resident to experience a decline in overall function, mobility, and ADLs.2b. During a review of Resident 9's Occupational Therapy Evaluation and Plan of Treatment (OT Eval), dated 1/16/2026, the OT Eval indicated Resident 9's ROM of both hands, thumbs, index fingers (pointer fingers), middle fingers, ring fingers, and little fingers were impaired.During a concurrent interview and record review on 6/18/2026 at 11:06 am with the DOR, Resident 9's OT Eval, dated 1/16/2026 was reviewed. The DOR stated the facility monitored for changes in joint ROM by staff report and Joint Mobility Assessments (JMA, a brief assessment of a resident's ROM in both arms and both legs) conducted by the Rehab upon admission, re-admission, annually, and upon a change of condition. The DOR stated PTs and OTs used goniometers (instrument used for the precise measurement of angles) to measure joint mobility to objectively determine a resident's baseline ROM and detect changes in joint ROM. The DOR stated Resident 9's ROM of all the fingers of both hands should have been measured with a goniometer since they were impaired but were not. The DOR stated that OT did not establish Resident 9's baseline ROM for both hands. The DOR stated if staff did not objectively measure ROM impairments on the OT and PT evaluations, staff could not effectively monitor or detect changes in a resident's ROM to prevent decline and contractures. During an interview on 6/18/2026 at (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2:03 pm with the DON, the DON stated the facility monitored for changes in ROM by staff report, weekly RNA meetings, and JMAs done annually by Rehab. The DON stated it was important for staff to objectively measure ROM during ROM evaluations to ensure the facility had an accurate assessment of a resident's joints since it affected their ability to effectively monitor changes and provide the appropriate services to address any declines.3. During a review of Resident 12's FS, the FS indicated Resident 12 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including, but not limited to acute respiratory failure, non-traumatic intracranial hemorrhage (spontaneous bleeding inside the skull that occurs without any injury, fall, or surgery), and osteoarthritis (a progressive disorder of the joints, caused by a gradual loss of cartilage). During a review of Resident 12's MDS, dated [DATE], the MDS indicated Resident 12 had severely impaired cognitive skills for daily decision making. The MDS indicated Resident 12 had functional limitations in ROM of both arms and both legs. The MDS indicated Resident 12 required dependent assistance with hygiene, bathing, dressing, and rolling to both sides.During a review of Resident 12's Order Summary Report (OSR), the OSR indicated a physician's order, dated 3/11/2026, for RNA to provide PROM exercises to both of Resident 12's arms and legs, seven times a week. The OSR indicated a physician's order, dated 4/23/2026, for RNA to apply hand splints, knee extension splints, and ankle foot orthoses (AFO, an orthotic device designed to correct or address problems with the ankle and foot) to both sides of the body for four to six hours a day, seven days a week. During an observation on 6/18/2026 at 10:25 am in Resident 12's room, Resident 12's RNA session was observed. Resident 12 was lying in bed with both legs bent at the hips and knees and rotated to the right side of the body with both feet pointing downwards. RNA assisted with PROM to both of Resident 12's shoulders, elbows, and fingers on both hands and applied splints to both hands. RNA 1 did not provide PROM exercises to either of Resident 12's wrists. RNA 1 provided PROM exercises to both of Resident 12's hips and knees and applied splints to both knees and feet. RNA 1 did not provide PROM to either of Resident 12's ankles. During a concurrent interview and record review on 6/18/2026 at 10:54 am with RNA 1, Resident 12's RNA orders, dated 3/11/2026 and 4/23/2026, were reviewed. RNA 1 stated the RNA order, dated 3/11/2026, indicated for RNA to provide PROM to both arms and both legs which meant that RNA 1 must assist with PROM exercises to Resident 12's entire arm-including the shoulder, elbow, wrist, and hand-and the entire leg-including the hips, knees, and ankles. RNA 1 confirmed RNA 1 did not assist with PROM exercises to both of Resident 12's wrists because RNA 1 forgot. RNA 1 confirmed RNA 1 did not provide PROM to both of Resident 12's ankles because they felt too stiff. RNA 1 stated ROM exercises should be done to all joints included in the splints before splint application because it helped loosen the joints. RNA 1 stated RNA 1 should have assisted with PROM exercises as ordered to both wrists and both ankles and before applying splints to both of Resident 12's hands and feet but did not. RNA 1 stated Resident 12 could have a decline in ROM if RNA exercises were not provided as ordered.During an interview on 6/18/2026 at 11:06 am with the DOR, the DOR stated the purpose of the RNA program was to maintain a resident's current level of function after discharge from skilled therapy services and to prevent contractures and any functional declines. The DOR stated Rehab determined the types of exercises RNAs were to perform when creating an RNA program. The DOR stated if an RNA order was written for RNA to provide ROM exercises to both arms, it was expected for the RNA to provide ROM to the entire arm, which included the shoulders, elbows, wrists, and hands. The DOR stated if an RNA order was written for RNA to provide ROM exercises to both legs, it was expected for the RNA to provide ROM to the entire leg, which included the hips, knees, and ankles. The DOR stated it was important for the RNA to provide ROM exercises to all joints prior to splint application to prepare the joints for splinting and to ensure the splint was fitting properly. The DOR stated if the RNA did not provide RNA services as ordered, it could potentially result in a decline in ROM and ADLs.During an interview on 6/18/2026 at 2:03 pm with the DON, the DON stated it was important for RNA to provide exercises as ordered to ensure the residents in the facility maintained their level of function and to prevent potential declines in mobility, (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	ADLs, and contracture development.During a review of the facility's P&P titled Resident Mobility and ROM, revised July 2017, the P&P indicated resident would not experience an avoidable reduction in ROM and residents with limited ROM would receive treatment and services to increase and/or prevent a further decrease in ROM. The P&P indicated the care plan would include specific interventions, exercises, and therapies to maintain, prevent avoidable decline in, and/or improve mobility and ROM. The P&P indicated the care plan would include the type, frequency, and duration of interventions as well as measurable goals and objectives. During a review of the facility's P&P, titled Restorative Nursing Services, revised July 2017, the P&P indicated the residents would receive restorative nursing care as needed to help promote optimal safety and independence

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have a policy regarding use and storage of foods brought to residents by family and other visitors. Based on observation, interview, and record review, the facility failed to ensure safe food storage practices in one of two residents' refrigerators (Refrigerator 1), by failing to:a. Discard a plate containing three (3) meat tacos with no expiration date.b. Discard a container with pizza that had no expiration date.c. Discard a container of watermelon dated 6/11/26.d. Discard a cup containing mango slices with no expiration date. These deficient practices had the potential to result in food-borne illnesses (illness caused by ingesting contaminated food or beverages) for the residents.During an observation and interview with the Dietary Supervisor (DS) on 6/16/26 at 8:44 AM, the DS stated the residents' refrigerator was located inside the activity room on the 2nd floor. The DS stated the nurses collected the food brought in for the residents by family members and placed it inside the residents' refrigerator. The DS stated there was no resident food brought in by the family members that was kept in the kitchen area. The DS stated inside the residents' refrigerator, there were a plate containing three meat tacos with no expiration date, a container with pizza that had no expiration date, a container of watermelon dated 6/11/26, and a cup containing mango slices with no expiration date. The DS stated the food should be labeled including the resident's name, room number and expiration date or date the food that were placed inside the refrigerator. The DS stated expired or non-labeled foods should be discarded. The DS stated nursing staff were responsible for checking and cleaning the residents' refrigerator. During an interview with the Assistant Director of Nursing (ADON) on 6/17/26 9:39 AM, the ADON stated the residents' refrigerator should be cleaned daily by housekeeping staff. The ADON also stated that the License Nurses would check the refrigerator's temperature and the food items that were placed inside of the refrigerator for expiration date. The ADON stated that if a food item had an open date, the expiration date for that food item would be 3 days after the open date. The ADON stated that food items needed to be removed from the residents' refrigerator within 72 hours of the open date and there should not be any expired food inside the residents' refrigerator. The ADON stated that if a resident ate expired food, it would make the resident get sick from food born illness and even cause hospitalization of the residents. During an interview with the Director of Nursing (DON) on 6/18/26 at 12:07 PM, the DON stated there was another residents' refrigerator located on the 3rd floor. The DON stated there was a sign posted outside of the residents' refrigerator indicating for staff to name and label the food stored inside of the residents' refrigerator. The DON stated all food items that were placed inside the residents' refrigerator needed to be labeled with a received date. The DON stated expired food should not be stored inside the residents' refrigerator to prevent getting the residents sick when they eat expired food. During a record review of the facilities undated Policies and Procedures (P&P) titled, Food From Outside Sources, the P&P indicated, Food brought to the facility by visitors and family members is permitted. The P&P indicated facility staff will assist residents with food brought in to ensure safe and sanitary storage of outside food. All outside food will be properly covered, dated, and labeled. The nursing staff will discard perishable foods on or before the use by date. Leftover food or unused portions of packaged foods should be discarded. No food will be stored beyond 72 hours from received date. Food items that are expired or beyond the best buy date are discarded.

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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 implement and follow infection prevention procedures to prevent the transmission of infectious organisms for two of five sampled residents (Residents 76 and 82) by failing to: a. Ensure Registered Nurse 1 (RN 1) wore required personal protective equipment (PPE, equipment that protects people from injury or illness) while providing care to Resident 76 who was placed on Enhanced Barrier Precaution (EBP, precautions that involve using a glove and gown during high-contact resident care activity for residents colonized or infected with multidrug-resistant organisms [MDRO, bacteria that is resistant to many types of antibiotics] and those at a higher risk of developing MDRO, such as residents with wounds or indwelling medical devices). b. Ensure Resident 82 had a urinal holder to hang the used urinal. These deficient practices had the potential to transmit infectious microorganisms and increase the risk of infection for Residents 76 and 82. Findings: a. During a review of Resident 76's admission Record (AR), the AR indicated the facility admitted Resident 76 on 5/21/2024 and readmitted on [DATE] with diagnoses including encounter for attention to gastrostomy (creation of an artificial external opening into the stomach for nutritional support), dysphagia (difficulty in swallowing) and muscle weakness. During a review of Resident 76's untitled care plan (CP) revised on 7/13/2025, the CP indicated Resident 76 was on EBP and high risk for infection due to the presence of feeding tube. The CP indicated for nursing staff to post signage for EBP and provide EBP gloves, gown and mask. During a review of Resident 76's Order Summary Report (OSR) dated 5/31/2026, the OSR indicated continuous GT feeding for Resident 76 of Jevity 1.5 (formula) at 40 milliliters (ml, unit of measurement) per hour (hr.) for 20 hours via pump; Turn on at 2 pm and turn off 10 am or until the dose was met. During an observation on 6/16/2026 at 9:18 am inside Resident 76's room together with Registered Nurse 1 (RN 1), Resident 76 was lying in bed with ongoing GT feeding running at 40 ml/hr. During an observation on 6/16/2026 at 9:23 am inside Resident 76's room, together with Registered Nurse 1 (RN 1), RN 1 did not wear a protective gown while assessing Resident 76's GT site. RN 1's clothes touched Resident 76's bed and beddings while RN1 was assessing Resident 76's GT site. During an interview on 6/16/2026 at 9:25 am, RN 1 stated RN1 did not wear a protective gown while doing GT site assessment on Resident 76. RN 1 stated protective gown and gloves needed to be worn while assessing Resident 76 to prevent infection and cross contamination (the process by which bacteria or other microorganisms are unintentionally transferred from one substance or object to another, with harmful effect). During an interview on 6/17/2026 at 11:52 am with the facility's Director of Nursing (DON), the DON stated, staff needed to wear gown, gloves and mask while assessing residents on EBP to prevent spread of infection from staff to residents. During a review of the facility's policy and procedure (P&P) titled, Enhanced Barrier Precautions, (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	dated 6/5/2024, the P&P indicated, EBPs' are utilized to prevent the spread of multi-drug-resistant organisms (MDROs) to residents. Enhanced barrier precautions are used as an infection prevention and control intervention to reduce the spread of multi-drug-resistant organisms (MDROs) to residents. Examples of high-contact resident care activities requiring the use of gown and gloves for EBPs include device care or use (central line, urinary catheter and feeding tube). b. During a review of Resident 82's Face Sheet (FS), the FS indicated Resident 82 was admitted to the facility on [DATE] with diagnosis including dementia (a decline in mental ability severe enough to interfere with daily life), benign prostatic hyperplasia without lower urinary tract symptoms (prostate gland has enlarged but not experiencing urinary side effects like a weak stream, urgency, or frequent nighttime urination), and cardiomegaly (enlargement of the heart). During a review of Resident 82's History and Physical (H&P) dated 8/20/25, the H&P indicated Resident 82 did not have the capacity to understand and make medical decisions. During a review of Resident 82's Minimum Data Set (MDS, a standardized assessment and care planning tool), dated 5/22/26, the MDS indicated Resident 82 was dependent (helper does all of the effort) for toileting hygiene. Resident 82 required substantial/maximum assistance (helper does more than half the effort) for putting on and taking off footwear. The MDS indicated Resident 82 required partial/moderate assistance (helper does less than half the effort) for personal and oral hygiene and eating. During an observation inside Resident 82's room on 6/16/2026 at 9:44 AM, Resident 82 was lying in bed attempting to place a urinal containing yellow liquid (urine) on Resident 82's bed rail. Resident 82 did not have a urinal holder hanging from the bed rail to place the used urinal. During an interview with the Assistant Director of Nursing (ADON) on 6/17/2026 at 8:45 AM, the ADON stated facility provided urinals and urinal holders were provided to the residents. The ADON stated the urinal holder should be placed hanging on the bedrail within the residents' reach so the residents could hang the urinal after they use it. The ADON stated that the urinal holder was provided to the residents to prevent the urine from spilling on the residents or the residents' bed. The ADON stated that placing a dirty or used urinal on the bedrail instead of inside the urinal holder was an infection control issue. During a concurrent observation inside Resident 82's room on 6/17/26 at 9:00 AM, Resident 82's bedrail had a urinal containing yellow liquid (urine). Some of the yellow liquid was dripping on the outside of the urinal landing on Resident 82's bed rail. During a review of the facility's undated P&P titled, Infection Control, the P&P indicated, This facility has established and will maintain an infection control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to follow its Antibiotic stewardship program (a coordinated healthcare initiative designed to promote the most appropriate, safe, and effective use of antibiotics [medication that kills or stops bacteria [microscopic single-celled organisms, some can cause illness] from reproducing]) by failing to prescribe antibiotics appropriately for three (3) of five (5) sampled residents (Residents 2, 15, and 77). These deficient practices had the potential to result in unresolved infections (the invasion and growth of germs in the body) and physical declines due to the inappropriate use of antibiotics for Residents 2, 15, and 77. Findings: a. During a review of Resident 2's Face Sheet (FS, admission record), the FS indicated the facility admitted Resident 2 on 10/3/2025 and readmitted the resident on 5/30/2026 with diagnoses that included Extended Spectrum Beta Lactamase (ESBL -a group of enzymes [specialized biological molecule] produced by certain bacteria that make them resistant to antibiotics) resistance and urinary tract infection (UTI - an infection in the bladder/urinary tract). During a review of Resident 2's Minimum Data Set (MDS - a resident assessment tool) dated 6/3/2026, the MDS indicated Resident 2 had severely impaired cognitive (the ability to think and process information) skills for daily decision making. The MDS indicated Resident 2 was dependent on activities of daily living. During a review of Resident 2's Order Summary Report (OSR), dated active as of 5/30/2026, the OSR indicated a physician order for Meropenem (a powerful antibiotic) one (1) gram (g, metric unit of mass) intravenously (IV - administering medication or fluids through a needle or catheter directly into the bloodstream) every eight (8) hours for UTI until 6/6/2026. During a review of Resident 2's Medication Administration Records (MAR), dated May and June 2026, the MARs indicated Resident 2 was administered Meropenem from 5/31/2026 to 6/6/2026. During a concurrent interview and record review on 6/18/2026 at 9:28 AM with the Assistant Director of Nursing (ADON), Resident 2's Surveillance Data Collection Form (SDCF) UTI with Indwelling [urinary] Catheter [a flexible tube that is inserted into the urinary bladder and remains in place for continuous drainage of urine]) was reviewed. The SDCF was completed and signed on 6/17/2026. The SDCF indicated meropenem IV 1 g antibiotic treatment was started on 5/30/2026 for Resident 2. The SDCF indicated for residents (in general) with indwelling catheters, both criteria 1 and criteria 2 must be present. The SDCF indicated Criteria 1 was checked and Criteria 2 (urinary catheter specimen culture with a least 10 colony forming unit [cfu] / milliliter [ml] of any organism) was left blank (unchecked). The SDCF indicated Resident 2 was hospitalized and readmitted on [DATE] with an order for meropenem for treatment of a UTI. The SDCF indicated there was no urine culture (a test that checks for bacteria in the urine) results were available from the hospital. During an interview on 6/18/2026 at 9:30 AM, the ADON stated the admitting nurse or the IPN should coordinate with the hospital immediately (upon readmission or on the next day after readmission) to obtain the resident's urine culture results. The ADON stated the urine culture and sensitivity results were used to determine whether the prescribed antibiotics were appropriate for the bacteria causing the UTI. The ADON stated the ADON completed and signed the SDCF on 6/17/2026 after Resident 2 had already completed the antibiotic (meropenem). The ADON stated the SDCFs review should have been completed 24 hours post order date (5/30/2026). During a review of Resident 2's Progress Notes (PN), dated 5/30/2026 to 6/7/2026, the PN did not have documented evidence that the PN reflected communication with the general acute care hospital (GACH) regarding a follow-up on Resident 2's urine culture results. b. During a review of Resident 15's FS, the FS indicated the facility admitted Resident 15 on 2/28/2026, with diagnoses that included UTI and ESBL resistance. During a review of Resident 15's MDS dated [DATE], the MDS indicated Resident 15 had intact cognitive skills for daily decision making. Resident 15 required maximal assistance (helper lifts or holds trunk or limbs and provides more than half the effort) for toileting hygiene, rolling left and right, sit to lying and lying to sitting on side of the bed. During a review of (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident 15's OSR dated 5/1/2026 to 5/31/2026, the OSR indicated an order for Ciprofloxacin (antibiotics) 500 mg, 1 tablet by mouth two times a day for UTI symptoms for seven (7) days, with an order date of 5/7/2026. During a review of Resident 15's MAR, the MAR indicated Resident 15 received Ciprofloxacin (antibiotics) 500 mg, 1 tablet two times a day from 5/7/2026 to 5/14/2026. During a review of Resident 15's urine culture results dated 5/6/2026, the result indicated the culture was not processed and the culture did not meet the National Healthcare Safety Network (NHSN, the most widely used system for tracking healthcareˆassociated infections [HAIs], allowing healthcare facilities, states, and the Centers for Disease Control and Prevention to collect and analyze data to identify problem areas, measure prevention efforts, and ultimately work toward eliminating HAIs) UTI criteria. During a concurrent interview with the ADON and review of Resident 15's SDCF for UTI without an Indwelling Catheter on 6/18/2026 at 10:55 AM, the ADON stated Resident 15 had an antibiotic order for Ciprofloxacin tablet 500 milligrams (mg, units of measurement). The SDCF indicated both Criteria 1 and Criteria 2 must be present. Criteria 1 was checked while Criteria 2 was blank. The SDCF indicated culture does not meet criteria for UTI surveillance due to mixed flora growth. ADON stated that the ADON completed and signed the SDCF on 6/17/2026, after Resident 15 had already completed the antibiotics. During a review of Resident 15's PN, the PN did not have documented evidence that reflected communication with the physician regarding the results of the urine culture. During an interview on 6/18/2026 at 10:55 AM, ADON stated Resident 15's SDCF should have been completed prior to administration of antibiotics. The ADON stated the antibiotics review was not timely. c. During a review of Resident 77's FS, the FS indicated the facility admitted Resident 77 on 5/19/2025, with diagnoses that included dementia (a progressive state of decline in mental abilities) and carrier (the bacteria lives on or in their body) or suspected carrier of methicillin resistant staphylococcus aureus (MRSA, a bacteria that is resistant to certain antibiotics). During a review of Resident 77's MDS, dated [DATE], the MDS indicated Resident 77's cognitive skills for daily decision making were severely impaired. The MDS indicated Resident 77 had impairment on both upper extremities (shoulder, elbow, wrist and hand). During a review of Resident 77's Physician Orders dated 4/1/2026- 4/30/2026, the Physician's Order indicated to collect urine for urinalysis (UA - a test that checks the urine for blood cells, proteins, and other substances) and culture and sensitivity (urine C&S - a test to identify and quantify the microorganisms present in a urine sample and determine their sensitivity to certain antibiotics). During a concurrent review of Resident 77's laboratory results dated [DATE], the Laboratory Results indicated a result for urinalysis but did not have results for urinary culture. During a review of Resident 77's Physician's Order dated 4/20/2026, the Physician's Order indicated to give Macrobid 100 mg 1 capsule by mouth two times a day for UTI for 7 days. During a review of Resident 77's SDCF for UTI without an indwelling catheter, the SDC indicated Macrobid (type of antibiotic) 100 mg as the antibiotic treatment to start on 4/20/2026. The SDCF indicated Criteria 1 and Criteria 2 (microbiologic sub criteria) must be present. The SDCF indicated Criteria 1 was checked while Criteria 2 was left blank. The SDCF was completed and signed on 5/12/2026. During a review of Resident 77's PN, dated 4/19/2026 to 4/30/2026, the PN did not have documented evidence reflecting any communication to the physician regarding absence of urine culture. During a review of Resident 77's MAR, dated 4/1/2026 to 4/30/2026, the MAR indicated Macrobid was administered on 4/20/2026 to 4/27/2026. During an interview on 6/18/2026 at 10:36 AM, the ADON stated that the ADON could not find Resident 77's urine C&S report or a notification to the physician that there was no urine C&S. ADON also stated the SDCF was completed and signed by the IPN on 5/12/2026, which was after Resident 77 completed the antibiotics. During a review of the facility's Policy and Procedure (P&P) titled, Antibiotic Stewardship - Review and Surveillance of Antibiotic Use and Outcomes, dated December 2016. The P&P indicated all clinical infections treated with antibiotics will undergo review by the infection preventionist, or designee. The IP or designee will review antibiotic utilization as part of the antibiotic stewardship program and identify specific situations that are not consistent with the appropriate use of antibiotics. Therapy may require further (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	review and possible changes if: The organism is not susceptible to antibiotics chosen; The organism is susceptible to narrower spectrum antibiotics Therapy was ordered for prolonged surgical prophylaxis; or Therapy was started awaiting culture, but culture results and clinical findings do not indicate continued need for antibiotics. At the conclusion of the review, the provider will be notified of the review findings.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. Based on observation, interview, and record review, the facility failed to ensure call light was within reach and appropriate to the resident's physical ability for one of three sampled residents (Resident 7).This failure had the potential for Resident 7 not to receive necessary care or receive delayed services to meet Resident 7's needs.During a review of Resident 7's Face Sheet (FS), the FS indicated the facility admitted Resident 7 on 3/12/2026 with diagnoses including chronic respiratory failure (CRF, a long-term condition where the lungs could not adequately pull oxygen into the blood or remove carbon dioxide from the body), gastrostomy (a surgical opening fitted with a device to allow feeding to be administered directly to the stomach common for people with swallowing problems), tracheostomy (a surgical opening through the neck into the windpipe), and dystonia (a neurological movement disorder that causes involuntary, sustained or intermittent muscle contractions). During a review of Resident 7's Minimum Data Set (MDS, a resident assessment tool), dated 5/11/2026, the MDS indicated Resident 7 had severely impaired cognition (ability to understand and process information). The MDS indicated Resident 7 was dependent (helper did all the effort, resident did none of the effort to complete the activity) with oral hygiene, toileting, shower, upper/lower body dressing and personal hygiene. During a concurrent observation inside Resident 7's room and interview on 6/16/2026 at 10:43 am with Treatment Nurse 1 (TN 1), Resident 7 was in bed with two splints (rigid or flexible device used to support, protect, or immobilize a part of the body) applied on bilateral (both) hands. Resident 7 had a pad sensor call light (flat call light activated by gross movement) on the upper right side of the bed. TN 1 stated Resident 7 could move Resident 7's left arm compared to Resident 7's right arm. TN 1 stated the pad sensor call light should be placed next to the resident's functional arm so Resident 7 would be able to call for help when needed. During an interview on 6/18/2026 at 11:07 am with the Director of Nursing (DON), the DON stated the push button or sensor pad call light should be placed next to Resident 7's functional extremity so Resident 7 would be able to reach and use the sensor pad call light to call for assistance and alert the staff to address the resident's needs. During a review of the facility's Policy and Procedures (P&P) titled, Call System, Resident, dated March 2023, the P&P indicated, Each resident is provided with a means to call staff directly for assistance from his/her bed, from toileting/bathing facilities and from the floor. If the resident has a disability that prevents him/her from making the use of the call system, an alternative means of communication that is usable for the resident is provided and documented in the care plan.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure one of one sampled resident's (Resident 3) fluid intake was monitored as ordered and in accordance with facility's policy and procedure (P&P) titled Care of Resident Receiving Renal Dialysis. This failure had the potential for complications related to electrolyte (minerals in the body) imbalance for Resident 3.Findings: During a review of Resident 3's admission Record (AR), the AR indicated the facility initially admitted Resident 3 on 2/23/2025 and readmitted on [DATE] with diagnoses that included chronic kidney disease (CKD, a progressive condition where the kidneys gradually lose their ability to filter waste and excess fluid from the blood) and retention of urine. During a review of Resident 3's untitled Care Plan (CP) dated 3/27/2026, the CP indicated Resident 3 had acute kidney failure. The care plan interventions indicated for nursing staff to encourage and maintain adequate hydration according to provider (physician) orders while avoiding excess fluid. During a review of Resident 3's Order Summary Report (OSR) dated 5/11/2026, the OSR indicated Resident 3 had an order for fluid restriction (FR, limits the amount of fluids a person consumes each day) of 1,200 cubic centimeters/day (cc/day, measure of volume per day) , allotted for dietary to provide 240 cc for breakfast, 360 cc for lunch, 360 cc for dinner, and for nursing to provide 100 cc for 7 am to 3 pm shift, 100 cc for 3 pm to 11 pm shift and 40 cc for 11 pm to 7 am shift. During a review of Resident 3's Minimum Data Set (MDS - a federally mandated resident assessment tool) dated 5/27/2026, the MDS indicated Resident 3 had severely impaired cognition (mental action or process of acquiring knowledge and understanding) for daily decision making. The MDS indicated Resident 3 was dependent (helper does all of the effort) from staff with eating, oral hygiene, toileting hygiene, shower, upper/lower body dressing, putting on/off footwear and personal hygiene. During an observation on 6/16/2026 at 9:55 am inside Resident 3's room, Resident 3 was asleep lying in bed. During a concurrent interview and record review of Resident 3's medical record (PointClickCare - PCC, a cloud-based software) on 6/16/2026 at 2:51 pm with Licensed Vocational Nurse 3 (LVN 3), LVN 3 stated Resident 3 was on fluid restriction of 1,200 ml/day. LVN 3 stated LVN 3 did not monitor Resident 3's fluid intake since 5/11/2026. LVN 3 stated there was no clinical documentation that Resident 3's fluid intake was documented or monitored. LVN 3 stated Resident 3's fluid intake should have been monitored daily by licensed nurses to prevent water retention because Resident 3 was on hemodialysis (procedure to remove wastes or toxins from the blood and adjust fluid and electrolyte imbalances). During a concurrent interview and record review of Resident 3's PCC on 6/17/2026 at 11:48 am with the facility's Director of Nursing (DON), the DON stated Resident 3 was on fluid restriction of 1,200 cc/day. The DON stated Resident 3's fluid intake needed to be documented in the Medication Administration Record (MAR) every shift by licensed nurses. The DON stated there was no other clinical documentation that Resident 3's fluid intake was documented and monitored by licensed nurses since 5/11/2026. The DON stated Resident 3's fluid intake needed to be monitored to determine if Resident 3 reached the restricted amount of 1,200 ml/day as ordered by the physician to prevent fluid overload, respiratory distress, shortness of breath (SOB) and edema (swelling caused by fluid retention). During a review of the facility's undated P&P titled, Care of Resident Receiving Renal Dialysis, the P&P indicated fluid restrictions will be followed per physician's order for specific fluid allowed in 24 hours. Intake and output were measured and recorded each shift if ordered.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. Based on observation, interview, and record review, the facility staff failed to elevate the resident's head of the bed (HOB) while receiving feeding (formula) through the gastrostomy tube (GT - a tube inserted through the abdomen that delivers nutrition directly to the stomach) in accordance with the resident's care plan and physician's order for one of five sampled residents (Resident 76). This deficient practice had the potential to result in aspiration (inhalation of foreign materials) and pneumonia (a lung infection) for Resident 76. Findings: During a review of Resident 76's admission Record (AR), the AR indicated the facility admitted Resident 76 on 7/11/2025 with diagnoses including encounter for attention to gastrostomy (creation of an artificial external opening into the stomach for nutritional support), dysphagia (difficulty in swallowing) and muscle weakness. During a review of Resident 76's Order Summary Report (OSR) dated 7/11/2025, the OSR indicated for staff to elevate Resident 76's head of bed (HOB) at 30 to 45 degrees at all times during GT feeding every shift for aspiration precaution. During a review of Resident 76's untitled Care Plan (CP) revised 2/27/2026, the CP indicated Resident 76 was at risk for aspiration and dehydration, related to dysphagia. The care plan interventions indicated for nursing staff to elevate Resident 76's head of bed and assess for shortness of breath, fever, congestion and other symptoms of aspiration and notify as indicated. During a review of Resident 76's Minimum Data Set (MDS - a federally mandated resident assessment tool) dated 5/26/2026, the MDS indicated Resident 76 had severely impaired cognition (ability to understand) for daily decision making. The MDS indicated Resident 76 was dependent (helper did all the effort) on staff for oral hygiene, toileting, shower, upper/lower body dressing, putting on/taking off footwear, and personal hygiene. During a review of Resident 76's OSR dated 5/31/2026, the OSR indicated Resident 76 had an order for continuous GT feeding of Jevity 1.5 (formula) at 40 milliliter (ml, unit of measurement) per hour (hr.) for 20 hours via pump; Turn on at 2 pm, turn off 10 am or until the dose was met. During an observation on 6/16/2026 at 9:18 am inside Resident 76's room together with Registered Nurse 1 (RN 1), Resident 76 was lying flat in bed, in supine position and receiving GT feeding formula running at 40 ml/hr. During a concurrent observation and interview on 6/16/2026 at 9:21 am, together with RN 1, Resident 76 was awake, lying in bed, in supine position and with ongoing GT feeding formula. RN 1 stated, Resident 76's HOB should have been elevated at 35 to 45 degrees while receiving GT feeding to prevent aspiration. During an interview on 6/17/2026, at 11:52 pm, with the Director of Nursing (DON), the DON stated Resident 76 should not be flat in bed while on GT feeding. The DON stated Resident 76's HOB needed to be elevated at 35 to 45 degrees while receiving GT feeding to prevent aspiration. During a review of the facility's policy and procedure (P&P) titled, Enteral Feedings - Safety Precaution, revised 11/2028, the P&P indicated, Elevate the head of the bed (HOB) at least 30 degrees during tube feeding and at least l hour after feeding. If elevating the HOB is medically contraindicated, use the reverse Trendelenburg (lies flat on back, but the entire bed or table is tilted so their head is higher than the feet) position.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility staff failed to ensure one of three sampled residents (Resident 47) received two liters of oxygen per minute continuously through nasal cannula according to the physician's order. This deficient practice had the potential to result in respiratory complications for Resident 47 associated with oxygen therapy. Findings: During a review of Resident 47's admission Record (AR), the AR indicated the facility admitted Resident 47 on 4/12/2024 and readmitted on [DATE] with diagnoses that included acute and chronic respiratory failure (a condition in which not enough oxygen passes from the lungs into the blood) with hypoxia (deprived of adequate oxygen supply) and hypercapnia (high levels of carbon dioxide [waste product that the body gets rid of] in the blood) and dependence on supplemental oxygen. During a review of Resident 47's untitled Care Plan (CP) dated 5/5/2026, the CP indicated Resident 47 was receiving oxygen therapy due to respiratory failure. The CP interventions indicated for nursing staff to check the rate of oxygen flow every shift and provide oxygen as ordered. During a review of Resident 47's Minimum Data Set (MDS - a federally mandated resident assessment tool) dated 5/14/2026, the MDS indicated Resident 47 had moderately impaired cognition (mental action or process of acquiring knowledge and understanding) for daily decision making. The MDS indicated Resident 47 required maximum assistance (helper does more than half the effort) from staff for toileting hygiene and lower body dressing. The MDS indicated Resident 47 required moderate assistance (helper does less than half the effort) from staff for oral hygiene. During a review of Resident 47's Order Summary Report (OSR) dated 5/22/2026, the OSR indicated for licensed staff to administer oxygen at two (2) liters per minute (L/min) via nasal cannula to Resident 47, every shift. During a concurrent observation and interview on 6/16/2026 at 9:42 am with Registered Nurse 1 (RN 1) inside Resident 47's room, Resident 47 was asleep, lying in bed with ongoing oxygen at 3.5 L/min via nasal cannula. During an interview with the Assistant Director of Nursing (ADON) on 6/17/2026 at 11:54 am and concurrent record review of Resident 47's medical records (PointClickCare - PCC, a cloud-based software), the ADON stated Resident 47 had an order of continuous 2 LPM of oxygen via nasal cannula. The ADON stated Resident 47 should be on continuous oxygen at 2 LPM via nasal cannula at all times as ordered by the physician to prevent respiratory distress. During an interview on 6/17/2026 at 11:58 am with the Director of Nursing (DON), the DON stated Resident 47 should have been on oxygen at 2 L/min via nasal cannula as ordered to prevent respiratory distress and complications. During a review of the facility's P&P titled, Oxygen Administration, revised 10/2010, the P&P indicated Verify that there is a physician's order for this procedure. Review the physician's orders or facility protocol for oxygen administration.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. Based on observation, interview, and record review, the facility failed to ensure Restorative Nursing Assistant 1 (RNA 1) (RNA, a Certified Nursing Assistant who is trained to assist residents with restorative care such as exercises, walking, and restorative equipment) was competent in providing RNA services to one of seven sampled residents (Resident 7) for splinting (applying and/or removing splint(s) [device used to immobilize a body part]) when RNA 1 did not apply Resident 7's custom right-hand splint as ordered by the physician. This deficient practice had the potential to cause Resident 7 and other residents receiving RNA services in the facility to experience pain, injury, and skin breakdown (tissue damage caused by friction, shear, moisture, or pressure). During a review of Resident 7's Face Sheet (FS, document that contains a patient's personal and contact information, diagnoses, and medical history), the FS indicated the facility initially admitted Resident 7 to the facility on 7/11/2024 and readmitted Resident 7 on 3/12/2026 with diagnoses which included myelin oligodendrocyte glycoprotein antibody disease (rare disease where the body's immune system accidentally attacks the protective nerve coverings in the brain and spinal cord), chronic respiratory failure (long term condition that occurs when the lungs cannot get enough oxygen into the blood or eliminate carbon dioxide from the body), and muscle spasms (involuntary contractions of the muscles).During a review of Resident 7's Minimum Data Set (MDS, a resident assessment tool), dated 5/11/2026, the MDS indicated Resident 7 had severely impaired cognitive skills (mental processes involved in gaining knowledge and comprehension, includes thinking, knowing, remembering, judging, problem-solving) for daily decision making. The MDS indicated Resident 7 had functional limitations in ROM (limited ability to move a joint that interferes with daily functioning, including activities of daily living, or places the resident at risk of injury) of both arms and both legs. The MDS indicated Resident 7 required dependent assistance (helper does all the effort) from staff with hygiene, bathing, dressing, rolling to both sides, and bed to chair transfers. During a review of Resident 7's Order Summary Report (OSR), the OSR indicated a physician's order, dated 4/10/2026, for RNA to don (apply) and doff (remove) resting hand splints (RHS, splint secured from the hand to the forearm to position the hand in a functional position with the thumb positioned away from the palm and the knuckles of the hand slightly bent) to Resident 7's both hands, for four to six hours, seven times a week.During a concurrent observation and interview on 6/16/2026 at 8:58 am with RNA 1 in Resident 7's room, Resident 7's RNA session was observed. Resident 7 was lying in bed with the right arm straight and hyperextended (the extension of a body part beyond its normal limits) at the elbow, wrist bent downwards, and the hand in a fist. Resident 7's left arm was bent at the elbow and wrist, and the hand was positioned in a fist. RNA 1 assisted with Passive Range of Motion (PROM, moving a joint by external force such as a therapist, caregiver, or device, without muscle effort from the resident) exercises to Resident 7's left shoulder, elbow, wrist, and hand and applied a splint to Resident 7's left hand. RNA 1 assisted with PROM exercises to Resident 7's right arm and was unable to bend the elbow, straighten the wrist, or straighten the thumb which was bent inwards and positioned across the palm of the hand. RNA 1 stated Resident 7 resisted with PROM exercises to the right arm and RNA 1 could not straighten or pull Resident 7's thumb away from the palm of the hand. RNA 1 placed a resting hand splint on Resident 7's hand with the thumb tucked in across the palm and secured the splint to the hand with a strap over the knuckles of the hand and in the webspace between the thumb and pointer finger. RNA 1 stated Resident 7 used to have a different splint for the right hand, but it was lost about a month ago. RNA 1 stated RNA found the current right-hand splint at the bedside and applied the splint to Resident 7's right hand because the RNA order indicated to apply splints to Resident 7's both hands. RNA 1 stated the previous right-hand splint, which was lost, fit Resident 7's right hand much better because it separated the fingers of the hand and brought the thumb away from the palm of the hand. During a concurrent observation and interview on 6/17/2026 at 9:31 am with (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Occupational Therapist 1 (OT 1) (OT- a healthcare professional who helps individuals improve their ability to perform everyday activities), OT 1 observed Resident 7 wearing the resting hand splint RNA 1 applied to Resident 7's right hand during the RNA session. OT 1 stated Resident 7's right-hand splint did not fit properly because Resident 7's right thumb was positioned underneath the hand and across the palm instead of away from the palm. OT 1 stated it was important that RNA positioned Resident 7's thumb away from the palm of the hand because it placed the thumb in a functional position and prevented the thumb from digging into the palm of the hand which could cause pressure injuries. OT 1 stated OT previously evaluated and recommended a custom hand splint for Resident 7's right hand which was appropriate and different than the current splint because it held the thumb away from the palm of the hand. OT 1 stated Resident 7's custom right-hand splint was lost about a month ago and had no idea where the splint was. OT 1 stated OT 1 was unsure where RNA 1 got the current resting hand splint from. OT 1 stated RNA should not be applying a splint on a resident without a licensed OT first assessing and determining the appropriate type of splint and wear time (amount of time the resident will have the splint on) for the splint because it could cause skin breakdown (tissue damage caused by friction, shear, moisture, or pressure) and injury. During a concurrent interview and record review on 6/17/2026 at 9:57 am with the Director of Rehabilitation (DOR) and OT 1, the DOR stated the purpose of splints was to improve or maintain a resident's ROM and prevent contractures (loss of motion of a joint associated with stiffness and joint deformity). The DOR stated a licensed OT or Physical Therapist (PT, profession aimed in restoration, maintenance, and promotion of optimal physical function) must assess a resident's need for splints and determine the splint wear tolerance and schedule by periodically assessing the splint for safety, comfort or need for modification. The DOR stated that after the therapist assessed a resident for the correct type of splint and established the wear tolerance, the therapist transitioned the splinting plan of care to nursing and the RNA program. OT 1 stated OT evaluated Resident 7 and recommended and issued a custom right-hand splint to ensure Resident 7's right thumb was supported and did not dig into the palm of the hand. The DOR and OT 1 confirmed Resident 7's custom right hand-splint was lost approximately one month ago and stated RNA replaced Resident 7's right-hand custom splint with one of the resting hand splints Resident 7 either arrived in the facility with or family brought into the facility, without an OT assessment. The DOR stated RNA should not have applied any other splint other than the custom right-hand splint which was issued to Resident 7 without OT first evaluating Resident 7 to determine if the splint was appropriate and establishing a safe wear time because RNAs were not qualified to do so. The DOR stated if RNAs applied splints to residents without an OT or PT assessment, it could result in injury, deformity (condition where a part of the body does not have its normal or expected shape), and skin breakdown (tissue damage caused by friction, shear, moisture, or pressure) leading to pressure injuries. During an interview on 6/18/2026 at 2:03 pm with the Director of Nursing (DON), the DON stated the Rehabilitation Department (Rehab) was responsible for splint assessments, determining the correct type of splint to issue, and establishing the splint wear time for all residents in the facility. The DON stated Rehab must formally assess a resident for splints prior to issuing splints to the residents and transitioning the splints to the RNA program. The DON stated the RNA treatment plan was determined by the licensed therapists and implemented by the RNAs as prescribed on the RNA order. The DON stated RNA must follow the RNA orders as written and were not qualified to modify the RNA program. The DON stated if a resident's recommended and prescribed splint was lost; the RNA must notify Rehab who in turn would reassess the resident for the appropriate type of splint and wear time. The DON stated RNAs lack the required training and expertise to apply splints to residents without a formal Rehab assessment. The DON stated if RNAs applied splints without following orders or without proper assessment, it could result in resident injury, ineffective treatment, pain, and decline in the resident's ROM and function. During a review of the facility's Policy and Procedure (P&P) titled, Competency Assessments, dated May 2023, the P&P indicated each employee must demonstrate competency requirement related to skills, technique, and (continued on next page)

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For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	training necessary to providing nursing and related care and services for all residents in accordance with resident care plans.During a review of the facility's undated Policy and Procedure (P&P) titled, Splinting, the P&P indicated once the patient has been screened for the appropriateness of splinting, the charge nurse or therapist will contact the physician and secure an evaluation order and treatment sessions for splint application, monitoring of wear schedule, splint modifications as needed and instruction of the nursing staff. The P&P indicated the therapist will order the splint, apply the splint, make the necessary fitting adjustments, proceed with a two-hour trial wearing period to check for pressure points and to assess the patient's tolerance to the splint, increase the angle of the splint and the wear time throughout the course of treatment, and in-service the nursing staff on the proper application, precautions, and wearing schedule once the therapist determines the splints has reached the maximum benefit to the resident.