STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055481	A. Building B. Wing	02/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vienna Nursing and Rehabilitation Center	800 So. Ham Lane Lodi, CA 95242

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review the facility failed to ensure proper food storage and preparation, as well as maintaining kitchen equipment and food contact surfaces in accordance with professional standards for food safety for 133 residents who consumed facility-prepared meals when:1. Kitchen contained worn and improperly maintained food preparation equipment such as, three blenders were visibly discolored, five cooking sheet trays had dark brown residue buildup in the inside corners, and two cutting boards had multiple scratches on both sides; and2. A container of cheddar cheese dated 1/29/26 and a container of mozzarella cheese dated 2/4/26 were not properly labeled and were stored in the walk-in refrigerator without clear identification to ensure safe use within appropriate time frames. These failures had the potential to promote the growth of harmful microorganisms and increase the risk of foodborne illness for all residents receiving meals prepared in the facility.Findings:1.During the initial tour of the kitchen on 2/17/26 at 8:14 a.m., the following concerns were identified:a. Three blenders in the food preparation area were visibly discolored. During a concurrent observation and interview on 2/17/26 at 8:23 a.m., the Dietary Manager (DM) confirmed the finding and stated the blenders were old and in need of replacement; b. Five cooking sheet trays stored inside of the hot box had dark brown residue buildup in the inside corners. During a concurrent observation and interview on 2/17/26 at 8:29 a.m., the DM confirmed the finding and stated the trays were old and that repeated cooking over time had caused the buildup. The DM further stated that dietary staff were expected to thoroughly scrub trays to remove residue; andc. The food-contact surfaces of the two cutting boards stored on a rack in the food preparation area had significant scratches on both sides. During a concurrent observation and interview on 2/17/26 at 8:34 a.m., the DM confirmed the finding and stated cutting boards were old and would be replaced. During an interview on 2/17/26 at 8:57 a.m., a Dietary Assistant (DA) described the dishwashing process as removing food debris from dishes and cooking equipment, spraying items with water, placing them in the dishwasher to be washed and sanitized, and allowing them to air dry. The DA stated that if items were not completely clean, the process would be repeated. During an interview on 2/19/26 at 9:43 a.m., the DM stated that food preparation equipment, including blenders, cooking sheet trays, and cutting boards, were processed through the dishwashing system. The DM stated the blenders were visibly discolored due to hard water buildup and frequent use, despite repeated dishwashing. The DM further stated the blenders should be discarded because there was a possibility that hard water buildup could dislodge during food preparation and contaminate food. The DM stated her expectation was for dietary staff to thoroughly wash cooking sheet trays prior to placing them in clean storage areas. The DM stated that if food residue remained on cooking trays, it could come off during the cooking process and potentially cause residents to become sick from consuming food prepared on those trays. The DM also stated that cutting boards with significant scratches on both sides should be discarded. The DM explained that food particles could become lodged in the scratches, increasing the risk of bacterial growth and potentially causing residents to become sick if food prepared on those surfaces become contaminated. The DM further stated there was potential for hazardous food conditions by having such items in use in the kitchen and acknowledged the facility did not want that (continued on next page)

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

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	risk. During an interview on 2/19/26 at 10:16 a.m., the Registered Dietitian (RD) stated the blenders discolored with hard water deposits were clean and sanitized; however, she added it would be best practice to replace them. Regarding the cooking sheet trays with food residue buildup, the RD stated her expectation was that if trays could not be thoroughly cleaned and all residue removed, they should be replaced and no food residue buildup should be present. The RD further stated cutting boards with significant scratches that could capture debris should be periodically replaced. Review of the facility's policy and procedure (P&P) titled SANITATION, dated 2023, indicated, . Food & Nutrition Services Department shall have equipment of the type and in the amount necessary for the proper preparation, serving, and storing of food. PROCEDURE. 11. All utensils, counters, shelves, and equipment shall be kept clean, maintained in good repair and shall be free from breaks, corrosions, open seam, cracks, and chipped areas. 12. Plastic ware. that become unsightly, unsanitary, or hazardous because of chip, cracks, or loss of glaze shall be discarded. The review revealed that the facility's P&P was not followed.Review of the US Food and Drug Administration, Food Code 2022 section 4-601.11 on Equipment, Food-Contact Surfaces indicated, . (A) EQUIPMENT FOOD-CONTACT SURFACES and UTENSILS shall be clean to sight and touch. Pf (B) The FOOD-CONTACT SURFACES of cooking EQUIPMENT and pans shall be kept free of encrusted grease deposits and other soil accumulations. 2.During a concurrent observation and interview conducted during the initial kitchen tour on 2/17/26 at 8:44 a.m., in the walk-in refrigerator, a container of cheddar cheese dated 1/29/26 and a container of mozzarella cheese dated 2/4/26 were observed stored on a shelf without clear identification of the received date, open date, and use-by date (UBD). The DM confirmed the findings at the time of observation and stated the cheeses were considered good for one month; however, the labels did not clearly indicate the opened date or use-by date as required. During an interview on 2/19/26 at 9:43 a.m., the DM stated that when cheese containers were not properly labeled and lack clear identification of the opened date and UBD, staff would not know how long the cheeses were safe for use. The DM stated she expected improperly labeled items to be identified during shift changes; however, she acknowledged that items missing proper labels could be overlooked. The DM further stated that the cheeses could spoil without obvious visual signs and may not be detected by sight alone. The DM further added that if the items exceeded their recommended use period and were served, residents could become ill from consuming spoiled food. During an interview conducted on 2/19/26 at 10:16 a.m., the RD stated that once food items were removed from their original packaging, they should be labeled with the received date, opened date, and UBD in accordance with the facility's food storage guidelines. The RD stated that these dates were necessary so staff could determine the safe period for use. The RD further stated that she expected dietary staff to properly label all items with required dates such as received dates; however, this expectation was not met at the time of observation. Review of the facility's P&P titled LABELING AND DATING OF FOODS, dated 2023, indicated, . All food items in the storeroom, refrigerator, and freezer need to be labeled and dated. PROCEDURE. Newly opened food items will need to be closed and labeled with an open date and used by date that follows the various storage guidelines. Review of the US Food and Drug Administration, Food Code 2022 section 3-501.17 on Ready-to-Eat, Time/Temperature Control for Safety Food, Date Marking indicated that (B) Except as specified in (E) - (G) of this section, refrigerated, READY-TO-EAT TIME/TEMPERATURE CONTROL FOR SAFETY FOOD prepared and PACKAGED by a FOOD PROCESSING PLANT shall be clearly marked, at the time the original container is opened in a FOOD ESTABLISHMENT and if the FOOD is held for more than 24 hours, to indicate the date or day by which the FOOD shall be consumed on the PREMISES, sold, or discarded, based on the temperature and time combinations specified in (A) of this section and: (1) The day the original container is opened in the FOOD ESTABLISHMENT shall be counted as Day 1; and (2) The day or date marked by the FOOD ESTABLISHMENT may not exceed a manufacturer's use-by date if the manufacturer determined the use-by date based on FOOD safety .

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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. Based on observation, interview, and record review, the facility failed to practice appropriate infection prevention and control measures for a census of 136, when:1. Enhanced barrier precautions (EBP - an infection control intervention that requires staff to wear gowns and gloves during high contact care for residents with wounds, medical devices or known multidrug resistant germs) were not followed while draining Resident 6's foley catheter;2. Staff did not do hand hygiene while passing meal trays for Resident 158, Resident 152, Resident 115, and Resident 31, and;3. Oxygen tubing for Resident 148 and Resident 149 did not have protective storage bags. These failures in infection prevention and control measures had the potential to spread the infection to staff and other residents in the facility.Findings: 1. A review of Resident 6's medical record titled, admission RECORD, indicated Resident 6 was admitted to the facility in 2026 with diagnoses that included urinary tract infection (infection of the bladder) and retention of urine (condition when the bladder does not empty completely). A review of Resident 6's medical record titled, Order Summary Report, indicated the following orders: a.16 French Foley catheter [a rubber or plastic tube that drains urine from the bladder into a collection bag].b.Enhanced Barrier Precautions:.Wear gloves and gown for the following High Contact Resident Care Activities:.Device care or use (central line, urinary catheter.every shift. During an observation on 2/17/26, at 2:18 p.m., Certified Nurse Assistant (CNA) 5, CNA 5 was observed bringing in Resident 6 into his room while seated on his wheelchair. CNA 5 was then observed emptying Resident 6's foley catheter while wearing a mask and gloves. During an interview on 2/17/26, at 2:22 p.m., with CNA 5, CNA 5 stated Resident 6 had his foley catheter in place for a long time and she usually emptied the catheter twice during her shift. CNA 5 confirmed she was wearing a mask and gloves while emptying Resident 6's catheter. CNA 5 stated she only wore the gown when providing care for Resident 6's room mates. CNA 5 further stated Resident 6 was not on any precaution, so she only needed to wear the gloves and not the gown when providing care. During an interview on 2/17/26, at 2:35 p.m., with CNA 6, CNA 6 stated Resident 6 was known to have a catheter. CNA 6 further stated residents with a foley catheter would be on EBP and staff would need to wear gown, gloves and mask when providing care. CNA 6 verified Resident 6's room doorway had the EBP sign posted with the PPE (personal protective equipment – specialized gear such as masks, gloves and gown to act as a barrier against germs, blood and bodily fluids) supplies hanging on the door. During a concurrent interview and record review on 2/17/26, at 4:08 p.m., with Licensed Nurse (LN) 4, Resident 6's chart was reviewed. LN 4 confirmed Resident 6 was on EBP and has had a foley catheter ever since being admitted to this facility. LN 4 stated the CNA should be wearing PPE gown, gloves and mask when providing care like draining the resident's foley catheter. LN 4 further stated the importance of wearing PPE was to have provided protection for both the resident and the staff. LN 4 stated the risk of not wearing the PPE would be the potential for infections and contamination. During a concurrent interview and record review on 2/19/26, at 11:57 a.m., with the Infection Preventionist (IP), Resident 6's chart was reviewed. The IP verified Resident 6 was on EBP due to having a foley catheter in place. The IP stated it was important for the staff to have worn PPE when (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	providing care for a resident on EBP. The IP stated the staff were expected to wear PPE gown and gloves when performing high contact care with residents with a foley catheter. The IP further stated emptying the foley catheter was considered a high contact activity due to the potential for splashes. The IP stated the risk of staff not following the EBP in place would be the potential of cross contamination and spreading of infection to roommates and staff members. During an interview on 2/19/26, at 2:54 p.m., with the Director of Nursing (DON), the DON stated it was her expectation for the staff to have worn PPE gown, gloves and mask during high contact care activities. The DON further stated the importance of following EBP guidelines was to prevent the spread of infection. The DON stated the risk of not following the EBP was the potential for infections and possible transmission to other residents. A review of facility's undated policy titled, INFECTION CONTROL POLICIES AND PROCEDURES, indicated .The facility will adopt the CDC [Centers for Disease Control and Prevention – a federal government agency that regulates prevention and control of infectious diseases) recommendations and guidance on Enhanced Barrier Precaution: Enhanced Barrier Precautions (EBP) refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms [MDRO] that employs targeted gown and glove use during high contact care activities.Device care or use:.urinary catheter.EBP are used in conjunction with standard precautions and expand the use of PPE to donning of gown and gloves during high-contact resident care activities that provide opportunities for transfer of MDROs to staff hands and clothing.EBP are indicated for residents with any of the following:.Wounds and/or indwelling medical devices even if the resident is not known to be infected or colonized with a MDRO.Indwelling medical device examples include central lines, urinary catheters. A review of an online document published by the Centers for Disease Control (CDC) titled, Implementation of Personal Protective Equipment (PPE) Use in Nursing Homes to Prevent Spread of Multidrug-resistant Organisms (MDROs), updated 4/2/24, indicated .Enhanced Barrier Precautions.Expand the use of PPE and refer to the use of gown and gloves during high-contact resident care activities that provide opportunities for transfer of MDROs to staff hands and clothing.Nursing home residents with wounds and indwelling medical devices are at especially high risk of both acquisition of and colonization with MDROs. Examples of high-contact resident care activities requiring gown and glove use for Enhanced Barrier Precautions include:.Device care or use: central line, urinary catheter. https://www.cdc.gov/long-term-care-facilities/hcp/prevent-mdro/PPE.html 2a. During an observation on 2/17/26, at 12:18 PM, with Certified Nursing Assistant (CNA) 4, CNA 4 picked up the meal tray from the tray cart without doing hand hygiene and brought it inside the room of Resident 152 and Resident 158. CNA 4 was then observed helping Resident 152 in slicing the food but did not do hand hygiene before doing so. During an interview on 2/17/26, at 12:23 PM, with CNA 4, CNA 4 stated she should have done hand hygiene before and after picking up the meal tray and serving food to Resident 152. During an interview on 2/19/2026, at 10:14 AM, with the Infection Preventionist (IP), the IP stated that before opening the food cart, the staff needs to do hand hygiene and they need to do it again for the next meal tray when serving it for the residents. The IP further stated that the staff needs to do hand hygiene before and after coming out of the resident's room. The IP stated that the risk of not doing hand hygiene would be cross contamination and the spread of bacteria from one resident to (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	another and the food could be contaminated. The IP stated that every resident care and high activity care, the staff need to do hand hygiene, before and after going to each resident, regardless if they provided care or not, they still need to do hand hygiene to prevent cross contamination and spread of organism or bacteria. During an interview on 2/20/26, at 10:54 AM with the Director of Staff Development (DSD), the DSD stated that the CNAs need to do hand hygiene before and after each meal tray pass. During an interview on 2/20/26, at 11:01 AM, with the Director of Nursing (DON), the DON stated that she expected the nursing staff to do hand hygiene before and after passing the meal trays and in between residents. The DON further stated that if not doing it, there was a possibility of spreading infection, and it could be unsanitary for the residents. 2b. During a concurrent observation and interview on 2/17/26, at 12:01 p.m., in room (room #), Certified Nursing Assistant (CNA) 1 was observed assisting Resident 31 with setting up a lunch tray. After completing the tray setup for Resident 31, CNA 1 immediately proceeded to assist Resident 115 with setting up the lunch tray without performing hand hygiene between residents. CNA 1 then exited (room#) and approached the meal cart in the hallway. CNA 1 explained that Resident 31 and Resident 115 required assistance with meal tray setup only and did not require feeding assistance. CNA 1 acknowledged that she did not perform hand hygiene between assisting Resident 31 and Resident 115. CNA 1 further stated that hand hygiene should be performed between residents and acknowledged the potential risk for the spread of infection and bacterial contamination. Review of Resident 115's medical record titled admission RECORD, indicated Resident 115 was admitted to the facility originally in June 2025 with diagnosis including acute transverse myelitis in demyelinating disease of central nervous system (a rare neurological syndrome by acute spinal cord inflammation, causing damage to the myelin sheath [a protective, fatty coating that surrounds nerve fibers, acting like insulation on an electrical wire to enable rapid and efficient transmission of electrical impulses between nerve cells] and disrupting nerve signals. Patients with acute transverse myelitis associated with demyelinating disease are more prone to secondary infections), and neuromyelitis optica (a rare autoimmune inflammatory disease of the central nervous system that attacks the optic [eyesight, or vision] nerve causing eye pain and vision loss). During an interview on 2/19/26, at 4:50 p.m., the Infection Prevention (IP) nurse stated that nursing staff were expected to perform hand hygiene before opening tray carts, use alcohol-based hand rub in the resident's room before setting up the tray, assist the residents, and then perform hand hygiene again afterward. The IP nurse emphasized that performing hand hygiene between residents was a key component in preventing cross-contamination and reducing the spread of infection within the facility. During an interview on 2/20/26, at 9:12 a.m., the Director of Nursing (DON) stated that she expected nursing staff to follow best practices to prevent the transmission of infectious diseases. The DON stated nursing staff were expected to perform hand hygiene before removing a meal tray from the tray cart, knock on the resident's door, enter the room, set up the tray as needed, exit the room, and perform hand hygiene. The DON further stated nursing staff were expected to perform hand hygiene again before opening the tray cart to remove the next tray and should perform hand hygiene between each resident to prevent the spread of infectious disease to other residents residing in the facility. However, these expectations were not met, as staff failed to perform hand hygiene between Resident 31 and Resident115 during meal tray distribution. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility provided policy and procedure titled Assistance with Meals, revised in October 2009, indicated, . Policy Statement. Residents shall receive assistance with meals in a manner that meets the individual needs of each resident. Policy Interpretation and Implementation. 7. All employees who provide resident assistance with meals will be trained and shall demonstrate competency in the prevention of foodborne illness, including personal hygiene practices and safe food handling. A review of the facility's undated policy and procedure titled, INFECTION CONTROL POLICIES AND PROCEDURES, indicated, .Hand hygiene (HH) (e.g [for example]., hand washing and/or ABHR [Alcohol-based hand rub]): consistent with accepted standards of practice such as the use of ABHR instead of soap and water in all clinical situations except when hands are visibly soiled (e.g., blood, body fluids), or after caring for a resident with known or suspected Clostridium (C.) difficile or norovirus infection during an outbreak, or if infection rates of C. difficile infection (CDI) is high; in these circumstances, soap and water should be used; According to the CDC, strict adherence to glove use is the most effective means of preventing hand contamination with C. difficile spores as spores are not killed by ABHR and may be difficult to remove even with thorough hand washing. 3. Review of Resident 148's admission RECORD indicated, Resident 148 was admitted to the facility in 2/9/26 with diagnoses including encounter for palliative care (care focused on comfort and symptom relief rather than cure), malignant neoplasms of unspecified orbit (cancer affecting the eye socket), acute respiratory failure with hypoxia (sudden breathing failure with low oxygen) , encephalopathy (brain dysfunction causing confusion), unspecified atrial fibrillation (irregular heart rhythm), hypertensive heart disease with heart failure (long-term high blood pressure that has weakened the heart and caused heart failure), acute systolic heart failure (, anxiety disorder, chronic obstructive pulmonary disease (long term lung disease that makes breathing difficult), unspecified asthma (breathing condition causing airway narrowing), acute pulmonary edema (sudden fluid buildup in the lungs). Review of Resident 148's physicians order on 2/10/26 indicated that the physician ordered supplemental oxygen at two liters per minute (L/min-a measure of how much oxygen to help the resident breathe) continuously. Review of Resident 148' s Medication Administration Record (MAR) on 2/2026, the MAR indicated Resident 148 received continuous oxygen at two L/min every shift from 2/1/26 through 2/18/26. During concurrent observation and interview on 2/17/26 at 2:38 PM with Licensed Nurse (LN)2 in Resident 148's room, Resident 148 was in bed with nasal canula oxygen tubing (small tubing placed in the nose to deliver oxygen) in place and connected to an oxygen concentrator (a machine that supplies oxygen) at bedside. LN 2 stated there was no protective storage bag available at the bedside to store Resident 148's oxygen tubing when not in use. LN 2 further stated a protective storage bag should available for Resident 148 to store the tubing when not in use to prevent the spread of infection. Review of Resident 149's admission RECORD indicated, Resident 149 was admitted to the facility in 1/25/26 with diagnoses including acute on chronic heart failure (long-term heart failure that suddenly got worse), respiratory failure with unspecified with hypoxia (the lungs are not working well and oxygen levels are too low), pneumonia, history of falling, dependence on supplemental oxygen Review of Resident 149's physicians order on 1/26/26 indicated that the physician ordered oxygen at (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	two L/min via nasal cannula every shift for shortness of breath Review of Resident 149' s Medication Administration Record (MAR) on 2/2026, the MAR indicated Resident 149 received continuous oxygen at two L/min via nasal cannula every shift from 2/1/26 through 2/19/26. During concurrent observation and interview on 2/17/26 at 3:30 PM with LN 8 in Resident 149's room, Resident 149 was in bed with nasal canula oxygen tubing in place connected to an oxygen concentrator at the bedside. LN 8 stated there was no protective storage bag available at the bedside to store Resident 149's oxygen tubing when not in use. LN 8 further stated that if Resident 149 removed the nasal cannula and placed the tubing on any surfaces, this would increase the risk for contaminations and infection. During an interview on 2/19/16 at 4:50 PM with the Infection Preventionist (IP), the IP stated that when a resident used oxygen, a protective storage bag was expected to be available at resident's bedside to store oxygen tubing when not in use. The IP further stated that placing the nasal cannula oxygen tubing on shared surfaces increased the risk for infection due to cross-contamination. During an interview on 2/20/16 at 9:12 AM with Resident 149, Resident 149 stated that if she had to remove the nasal cannula oxygen tubing, she would place it on the overbed table. During an interview on 2/20/16 at 9:12 AM with the Director of Nursing (DON), the DON stated residents with physician orders for oxygen were required to have a protective storage bag available at the bedside to store oxygen tubing when not in use to prevent the spread of infection. Review of facility's policy and procedure (P&P), titled Oxygen Tubing/Nasal Cannula Change Policy revised on 11/2024, indicated .Avoid placing tubing/cannula in regular trash unless saturated with blood/body fluids requiring biohazard handling per facility policy.Store oxygen supplies in a clean, dry area protected from dust and moisture.

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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 ensure residents were treated with dignity and respect for two of 35 sampled residents (Resident 4 and Resident 152) when:Staff stood while assisting Resident 4 with meals and did not position themself at Resident 4's eye level.Resident 152's urinary catheter bag (a bag that collects urine from the bladder through a urinary catheter - a soft tube that drains urine from the bladder) was exposed and not placed in a dignity bag (a cover used to hold and hide the catheter bag to maintain privacy).These failures had the potential to negatively impact Resident 4 and Resident 152's psychosocial well-being (emotional and social health, including how a person feels and interacts with others).Findings: 1.Review of Resident 4's admission RECORD, indicated Resident 4 was admitted to the facility with diagnoses including cerebrovascular disease (a condition affecting blood flow to the brain), aphasia (difficulty in speaking or understanding words), dysphagia (difficulty swallowing), hemiplegia and hemiparesis (paralysis or weakness on one side of the body), depression, and pain. During a concurrent observation and interview on 2/17/26 at 12:04 PM with Licensed Nurse (LN) 1 in Resident 4's room, Certified Nurse Assistant (CNA) 1 was observed assisting Resident 4 with the lunch meal while standing at the side of the bed without maintaining eye-level interaction with Resident 4. LN 1 stated staff were expected to sit at eye level when assisting residents with meals to promote comfort and a respectful interaction.During an interview on 2/17/26 at 12:17 PM with CNA 1, CNA 1 confirmed she stood while assisting Resident 4 with lunch. CNA 1 stated that when staff assisted residents with their meals, staff were expected to sit to support proper positioning, comfort, and eye-level interaction. CNA 1 further stated that standing while assisting with meals was a dignity issue. Review of Resident 1's Care Plan, initiated on 9/23/24, in the section titled Focus, indicated .I [Resident 4] have Functional Abilities (Self Care and Mobility) Performance Deficit. In the section titled Goal, indicated, .I [Resident 4] will maintain comfort and dignity. In the section titled Interventions, indicated, .I am [Resident 4] Dependent on staff assistance to use suitable utensils to bring food and/or liquid to my [Resident 4's] mouth.During an interview on 2/20/26 at 9:25 AM with the Director of Nursing, the DON stated staff were expected to engage with residents during meal assistance by maintaining eye-level interaction and not standing over the resident. The DON further stated that standing over residents while assisting with meals created an intimidating environment and was a dignity and resident rights issue.Review of facility's policy and procedure (P&P), titled Assistance with Meals revised on 10/2009, the P&P indicated .Residents who cannot feed themselves will be fed with attention to safety, comfort and dignity, for example.Not standing over residents while assisting them with meals. 2. A review of Resident 153's admission RECORD, indicated Resident 153 was admitted to the facility with diagnoses of urinary tract infection (an infection caused by bacteria entering and growing in any part of the urinary system—the kidneys, bladder, ureters, or urethra), quadriplegia (a severe medical condition characterized by the partial or total loss of function in all four limbs and the torso), depression (a common, serious mood disorder characterized by a persistent, intense, and long-lasting feeling of sadness or a loss of interest in activities), general anxiety disorder (a mental health condition that causes fear, a constant feeling of being overwhelmed and excessive worry about everyday things) and bipolar disorder (a mental health condition that causes extreme mood swings). (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 153's Care Plan Report, dated 2/9/26, indicated, .Catheter: Diagnosis: Quadriplegia.Interventions.Position catheter bag and tubing below the level of the bladder and away from entrance room door. During a concurrent observation and interview on 2/17/26, at 12:23 PM, with Certified Nursing Assistant (CNA) 4, Resident 152's urinary bag was observed hanging on the side of the bed without a dignity bag. CNA 4 stated that Resident 152's urinary bag should have been covered with a dignity bag. During an interview on 2/17/26, at 12:28 PM, with CNA 3, CNA 3 stated they do not provide a dignity bag for the urinary catheter bag when it hangs on the bed, they only used a dignity bag when the resident was using the wheelchair outside the room. During an interview on 2/20/26, at 9:05 AM, with Resident 152, Resident 152 stated she prefers her urinary catheter bag covered and she would feel embarrassed if she went out of her room in a wheelchair and her catheter bag was exposed. Resident 152 stated she prefers having her catheter bag covered at all times including when she stays in bed. During an interview on 2/20/26, at 10:54 AM with the Director of Staff Development (DSD), the DSD stated that if the resident came from the hospital and the catheter bag did not have a cover, the nurse needed to cover it. The DSD further stated that when a resident used a wheelchair, the CNAs should ensure there was a privacy bag. The DSD stated it would be a dignity issue for the resident if the catheter bag was not covered. The DSD stated Resident 152's catheter bag should have been covered. During an interview on 2/20/26, at 11:01 AM, with the Director of Nursing (DON), the DON stated if the catheter bag was not covered, it would be a privacy and dignity issue. The DON further stated that she expected the nursing staff to cover the urinary catheter bag. A review of the facility's policy and procedure titled, Quality of Life - Dignity, revised October 2009, indicated, .Each resident shall be cared for in a manner that promotes and enhances quality of life, dignity, respect and individuality.Demeaning practices and standards of care that compromise dignity are prohibited. Staff shall promote dignity and assist residents as needed by: a. Helping the resident to keep urinary catheter bags covered. A review of the facility's undated policy and procedure titled, RESIDENT RIGHTS UNDER CALIFORNIA STATUTE, indicated, .Patients shall have the right:.To be treated with consideration, respect and full recognition of dignity and individuality, including privacy in treatment and in care of personal needs. A review of the facility's undated policy and procedure titled, RESIDENT RIGHTS UNDER FEDERAL REGULATIONS, indicated, .Facility shall protect and promote the rights of each Resident, including each of the following rights: 1. The Resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside Facility.

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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 accommodate the needs of two of 35 sampled residents (Resident 17 and Resident 147) when Resident 17 and Resident 147 had call lights (devices used to contact staff for assistance) that were not within their reach.This deficient practice placed Resident 17 and Resident 147 at increased risk for unmet care needs, delayed staff response, falls, and potential for accidents or injury.Findings:1.Review of Resident 17's admission RECORD, indicated Resident 17 was admitted to the facility with diagnoses including unspecified dementia (memory loss and trouble thinking), encephalopathy (a problem with the brain that affects thinking or alertness), anxiety disorder, unspecified falls, fracture of lumbosacral spine and pelvis (broken bones in the lower back and hip area).During a concurrent observation and interview on 2/17/26 at 2:25 PM, with Certified Nurse Assistant (CNA) 2 in Resident 17's room, Resident 17 was lying in his bed, and the call light was not within his reach. CNA 2 confirmed Resident 17's call light was placed on top of a plastic storage unit beside the bed near Resident 17's feet. CNA 2 stated Resident 17 could have fallen if Resident 17 attempted to reach the call light.During a concurrent interview and record review on 2/17/26 at 2:32 PM, with Licensed Nurse (LN) 2, Resident 17's Care Plan, initiated on 8/19/25, was reviewed. Resident 17's fall risk care plan indicated, Focus .I am [Resident 17] at Moderate risk for falls.Interventions.Be sure my [Resident 17] call light is within reach. LN 2 stated staff did not follow Resident 17's fall risk care plan, as Resident 17's call light was placed on top of a plastic storage unit near Resident 17's feet and was not within Resident 17's reach. LN 2 further stated a resident's call light should always be kept within the resident's reach to help prevent falls.2.Review of Resident 147's admission RECORD, indicated Resident 147 was admitted to the facility with diagnoses including hereditary factor VIII deficiency (a blood clotting disorder that increases bleeding risk), palliative care (care that focuses on comfort, relief of pain or symptoms), unspecified dementia, personal history of transient ischemic attack and cerebral infarction without residual deficits (a past mini stroke and stoke with no lasting effects), anxiety disorder, pain, polyneuropathy (nerve damage causing numbness, tingling, pain, or weakness).During a concurrent observation and interview on 2/17/26 at 11:22 AM, with LN 1 in Resident 147's room, Resident 147 was lying in bed, and the call light was not within Resident 147's reach. LN 1 stated Resident 147's call light was on the floor hanging from the right-side bed rail. LN 1 further stated Resident 147 was at risk for falls and unmet needs because the call light was not within Resident 147's reach.Review of Resident 147's Care Plan, initiated on 1/30/26, indicated, Focus .I am [Resident 147] at Moderate risk for falls.Interventions.Be sure my [Resident 17] call light is within reach.During an interview on 2/20/26 at 10:26 AM, with the Director of Nursing (DON), the DON stated staff were expected to keep residents' call lights within residents' reach. The DON further stated when call lights were not within residents' reach, residents could not request help, placing them at risk for unmet care needs and falls.Review of facility's policy and procedure (P&P), titled Answering the Call Lights revised on 10/2010, the P&P indicated, .When the resident is in bed or confined to a chair be sure call light is within easy reach of the resident.

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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 promote and facilitate resident choices and preferences for care in accordance with professional standards of practice for 1 of 35 sampled residents (Resident 86) when, Resident 86's hair was cut against his wishes.This failure had the potential to negatively impact Resident 86's dignity and well-being due to not being able to make decisions regarding his care.Findings: A review of Resident 86's medical record titled, admission RECORD, indicated Resident 86 was admitted to the facility in 2023 with diagnoses that included hemiplegia (a form of paralysis that affects one side of the body, usually due to a brain or spinal cord injury) and depression (a mood disorder that causes a persistent feeling of sadness and loss of interest in things and activities). A review of Resident 86's progress notes, dated 2/18/26, indicated .SSD was informed by resident that last week he had his hair cut by a CNA without his consent. SSD interviewed resident and he stated that last week sometime his CNA came in and cut his hair which he stated he did not consent to. Stated that he then went to the beauty shop and cut his hair again because the CNAs did a bad job.Res stated, 'I'm a hippie I like my hair long'.A review of Resident 86's Minimum Data Set (MDS - a federally mandated resident assessment tool) report Section C - Cognitive Patterns, dated 1/29/26, indicated Resident 86's BIMS (Brief Interview for Mental Status-an assessment tool used by facilities to screen and identify memory, orientation, and judgement status of the resident) score was 13 (Score of 13-15 - the person's thinking, memory, and orientation are considered cognitively intact or normal). A review of Resident 86's Minimum Data Set report Section GG - Functional Abilities, dated 1/29/26, under section GG0130. Self-care, indicated .I. Personal Hygiene: The ability to maintain personal hygiene, including combing hair, shaving, applying makeup, washing/drying face and hands. was scored 02 (02 Coding: Substantial/maximal assistance - Helper does MORE THAN HALF the effort, Helper lifts or holds trunk or limbs and provides more than half the effort). During an interview on 2/18/26 at 4:05 p.m. with Resident 86, Resident 86 stated the hair cut incident happened a couple of days ago during the morning time when the Certified Nursing Assistant (CNA) staff teased him that she wanted to cut his hair. Resident 86 further stated it happened while he was getting ready to get up from his bed to his wheelchair and the CNA was trying to fix his hair. Resident 86 stated the CNA held him down and took a big portion of his hair and cut it with scissors. Resident 86 further stated he did not ask the CNA to cut his hair, and the CNA did not ask for his permission. Resident 86 stated he was not scheduled to get his haircut and only the facility's beauty salon staff was able to do haircuts at this facility. Resident 86 further stated he's only had his hair cut once during his stay at this facility because he liked his hair long. Resident 86 stated after the CNA cut his hair, he got mad. Resident 86 stated it bothered him that the CNA cut his hair since she had not asked for permission. Resident 86 further stated he did not trust this CNA anymore, did not feel safe around her, did not want her assigned to him anymore after this incident. During an interview on 2/18/26 at 4:24 p.m. with CNA 11, CNA 11 stated CNA staff were not authorized to cut a resident's hair, and the facility had a beauty salon where the residents got scheduled for haircuts. CNA 11 further stated only the beauty salon staff could cut the resident's hair at this facility. CNA 11 stated if Resident 86 asked the CNA to cut the hair, the CNA staff should have told the resident an appointment needed to be scheduled with the salon. CNA 11 stated it was important to have respected Resident 86's wishes because he had the right to choose on what they wanted. During an interview on 2/18/26 at 4:30 p.m. with CNA 12, CNA 12 stated Resident 86 was alert and was able to have made his needs known. CNA 12 further stated if a resident requested for a haircut, the nurse or the staff should have made an appointment with the beauty salon staff. CNA 12 stated it was important to have respected Resident 86' wishes and to maintain his dignity and independence. CNA 12 further stated the facility staff could have gotten in trouble for cutting Resident 86's hair and that the facility management would have needed to be involved in the (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	matter.During an interview on 2/19/26 at 4:03 p.m. with CNA 13, CNA 13 stated Resident 86 would tell her, You pulled my hair, the gloves were getting stuck when she gave him showers or when his hair was combed. CNA 13 stated the incident happened after Resident 86 had his shower and while his hair was being groomed. CNA 13 further stated Resident 86 showed his scissors and then assumed he was okay and cut a little bit of hair. CNA 13 stated Resident 86 told her, Okay and he never stated, no, stop or don't do it. CNA 13 further stated CNA staff were not allowed to cut or trim hair because this facility had a beauty salon where the residents made appointments for a haircut. During an interview on 2/18/26 at 4:42 p.m. with Licensed Nurse (LN) 9, LN 9 stated the CNA staff were not allowed to cut residents' hair. LN 9 further stated if a resident wanted a haircut, the family would have been asked for permission, and the nurse should have been notified. LN 9 stated it was important to have honored Resident 86's wishes because residents have the right to do what they want. LN 9 further stated the risk of not honoring the resident's wishes would be feelings of sadness or neglect. During an interview on 2/19/26 at 11:24 a.m. with the Director of Staff Development (DSD), the DSD stated the Social Services Director (SSD) came to her and reported Resident 86's hair was cut by the CNA. The DSD further stated the CNA was interviewed and got her statement of what happened. The DSD stated Resident 86 was complaining of hair pulling during grooming because the hair was getting caught in the CNA's gloves. The DSD further stated the CNA told Resident 86 that his hair was too long, so it was getting caught and needed to be trimmed to not get caught. The DSD stated Resident 86 then said, okay and showed her scissors and the CNA started trimming his hair. The DSD further stated the CNA then told her she had to leave to take care of another resident. The DSD stated that the CNA told her Resident 86 said okay, but Resident 86 was saying otherwise. The DSD further stated Resident 86 was alert and was responsible for his own self. The DSD stated CNA staff were not allowed to cut the resident's hair because it was not part of their job scope and the facility had a beauty salon with two salon staff that provide haircuts. The DSD further stated the CNA should have reported the hair getting caught in the gloves to the LN or should have made the salon appointment herself. The DSD stated there was a lack of communication with this CNA involved. The DSD further stated the importance of respecting Resident 86's wishes was because the facility was his home and space. The DSD stated the risk to Resident 86 could have been the lack of socialization, personal hygiene might have stressed him out, lack of self-esteem and possible impact to his dignity. The DSD further stated Resident 86 might not let anyone touch his hair anymore because his rights were not respected. During an interview on 2/19/26 at 4:20 p.m. with the SSD, the SSD stated Resident 86 had a psychologist consult Tuesday (2/17/26) night and made comments about his hair and stated, The CNA cut it and it looked bad and the beauty shop had to fix it. The SSD further stated the psychologist called the SSD and reported Resident 86's comments so the SSD talked to him the next morning (2/18/26). The SSD stated Resident 86 was very alert, with no cognition (mental processes that take place in the brain which includes thinking, attention, memory and perception) issues and knew people's names. The SSD stated Resident 86 was clear on which CNA staff was involved and stated the CNA came in and forced to cut his hair. The SSD further stated she had asked Resident 86 if he told the CNA, No and he reported he did say no to the CNA at the time. The SSD stated she immediately reported the incident to the DSD, and the CNA was relieved from patient care. The SSD further stated the CNA confirmed she cut a section of Resident 86's hair because he was yelling because his hair got caught in her glove. The SSD stated the CNA did not communicate Resident 86's hair issue with any nurse, SDD or to the beauty salon. The SSD further stated Resident 86 preferred his long hair because he called himself a hippie and liked it long. The SSD stated the salon staff noticed Resident 86's hair and offered to take him to the salon to get his haircut after the incident. The SSD stated CNA staff could not cut resident's hair because of the facility's beauty salon in place. The SSD stated whatever happened to Resident 86 was not normal procedure and the CNA should have reported to the LN or to have gone to the beauty salon to set up an appointment. The SSD further stated if something urgent had to be done, the CNA should have called the LN. The SSD stated (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the importance of respecting residents' wishes was to preserve their dignity, since a lot of their choices were taken from them, so they have a right to make their own choices. The SSD stated the risk to Resident 86 was increased depression, withdrawal, loss of self-identity, alteration in his mood or state and power over his own body. During an interview on 2/26/26 at 1:38 p.m. with the Beauty Salon Staff (BS), the BS stated Resident 86 has had long hair and a long beard when he first came to the facility and then slowly got him to trim the beard because he was getting food caught in it. The BS stated she fixed Resident 86's hair on 2/10/26 at the facility's beauty salon. The BS further stated Resident 86 was on the bicycle during his physical therapy that day, when she first noticed his hair. The BS stated she was talking to Resident 86 when she noticed a piece on one side, about 1-2 inches had been cut and was told by the resident that somebody cut a tangle on his hair. The BS further stated she then offered to even out Resident 86's hair at the salon. The BS stated he did not get regular haircuts, did not come often to the salon often and probably saw him about 6 months ago to get his beard maintained. The BS further stated she was not aware if the CNA staff were allowed to cut resident's hair, but that was why there was a beauty salon at the facility.During an interview on 2/19/26 at 3:03 p.m. with the Director of Nursing (DON), the DON stated it was reported that one of the CNA staff forced Resident 86 to cut his hair. The DON further stated the CNA staff's gloves were getting caught in Resident 86's hair, so the CNA then asked Resident 86 if she could cut his hair which he agreed to. The DON stated Resident 86 stated he did not agree with cutting his hair. The DON further stated CNA staff were not allowed to cut the resident's hair, and the facility had a beauty salon that was open from Monday to Friday for the residents. The DON further stated if a resident wanted to get a haircut, the staff knew they would have needed to set an appointment with the beauty salon. The DON stated the CNA should have called for help to have Resident 86's hair assessed first and should have gone from there. The DON stated it was important to have respected Resident 86's wishes and to have monitored if he was unhappy or with any emotional distress.During an interview on 2/20/26 at 1:14 p.m., with the Administrator (ADM), the ADM stated cutting a resident's hair was not part of the CNA's job scope. The ADM further stated the facility had a beautician for the beauty salon in place, and the expectation was for the CNA staff to have referred Resident 86 to the beauty salon. The ADM stated the facility had completed their investigation and determined Resident 86's hair was tangled so the CNA cut his hair. A review of the facility's policy titled, Brushing and Combing Hair, revised 4/07, indicated .Purpose.The purpose of this procedure is to provide hair and scalp care.7. If the resident's hair is long and tangled, work the tangles out with a comb starting at the ends and working toward the scalp.Documentation.4. If and how the resident participated in the procedure or any changes in the resident's ability to participate in the procedure.5. Any problems or complaints made by the resident related to the procedure.A review of the facility's policy titled, RESIDENT RIGHTS, dated 9/1/10, and revised on 4/16, indicated .PURPOSE.To assure protection of rights for residents in the facility.POLICY.This facility supports residents rights.RESIDENT BILL OF RIGHTS.Section 72527. Skilled Nursing Facilities.(12) To be treated with consideration, respect and full recognition of dignity and individuality, including privacy in treatment and in care of personal needs.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure 1 of 35 sampled residents (Resident 6) rights related to treatment choices were known and protected when Resident 6's code status was not available on the electronic health record (EHR). This failure had the potential for Resident 6's wishes regarding emergency treatment to not be followed. Findings: A review of Resident 6's medical record titled, admission RECORD, indicated Resident 6 was admitted to the facility in 2026 with diagnoses that included congestive heart failure (a long term condition when the heart could not pump blood efficiently that causes blood to build up), hypertensive heart failure (an uncontrolled high blood pressure condition that forces the heart to work too hard causing the muscle to thicken, stiffen or weaken) and palliative care (specialized medical care that focuses on providing pain relief, symptoms and stress caused by serious illnesses). During a record review on [DATE] at 2:26 p.m., of Resident 6's electronic health record, Resident 6's list of orders did not indicate his code status order (determines what emergency actions staff would need to perform if a resident's heart or breathing stops) and a copy of the POLST (Physician Orders for Life-Sustaining Treatment - a legal document that turns care preferences into actionable medical orders to guide emergency care such as CPR [cardiopulmonary resuscitation - an emergency lifesaving procedure performed when the heart stops beating], intubation [a temporary life-saving procedure when a tube is placed through the mouth or nose into the windpipe to keep the airway open], and comfort measures) form was not found. During a concurrent interview and record review on [DATE] at 4:42 p.m. with Licensed Nurse (LN) 9, Resident 6's EHR was reviewed. LN 9 verified Resident 6's EHR did not have his code status listed under his name and did not have an MD order in place for his code status. LN 9 further reviewed Resident 6's chart and stated she was not able to verify the code status by looking at the EHR and needed to obtain the physical chart next. During a concurrent interview and record review on [DATE] at 5:02 p.m. with LN 9, Resident 6's physical chart was reviewed. LN 9 verified Resident 6's POLST form found in the physical chart indicated DNR (Do not resuscitate - informs health care providers not to perform CPR if the resident's heart stops beating or if their breathing stops) status. LN 9 further reviewed Resident 6's physical chart and stated Resident 6 had an order in place for hospice care (specialized care to manage symptoms while supporting quality of life rather than finding a cure). LN 9 stated it was important to have had Resident 6's code status on his EHR due to the potential of staff not knowing what to do in an emergency. A review of Resident 6's medical record titled, Physician Orders for Life-Sustaining Treatment (POLST), dated [DATE], indicated .A. CARDIOPULMONARY RESUSCITATION (CPR): If patient has no pulse and is not breathing.Do Not Attempt Resuscitation/DNR (Allow Natural Death) . section box was marked. During a concurrent interview and record review on [DATE] at 5:08 p.m. with LN 4, Resident 6's EHR was reviewed. LN 4 verified Resident 6's EHR did not have his code status listed and there was no copy of his POLST form uploaded either. LN 4 confirmed Resident 6 was a hospice patient. LN 4 stated it was important to have had Resident 6's code status on the EHR for the staff to have access to right away. LN 4 further stated if part-time staff were working and if Resident 6 had a sudden change in condition or emergency, it would be hard for the staff to figure what type of care was needed right away. LN 4 stated the staff could have started doing CPR on Resident 6 without realizing he was a hospice patient. During an interview on [DATE] at 2:51 p.m. with the Director of Nursing (DON), the DON stated it was her expectation for the resident's physical chart to have contained the resident's POLST form and a scanned copy to be uploaded in the resident's EHR. The DON stated the importance of having the resident's code status in the chart was to provide the right care and to honor the resident's wishes. The DON further stated if the code status was not in the resident's chart, the staff would have considered performing a full code (every possible measure that can be used to save (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	a resident's life will be used if the resident's heart stops beating or if they stop breathing) or urgent treatment while checking the resident's chart. A review of the facility's policy titled, Physician Order for Life Sustaining Treatment (POLST), dated 2/10, indicated .PURPOSE.To ensure each resident's treatment preferences and code status are: Clearly documented and available.POLICY.1. The facility will determine and document each resident's code status and treatment preferences upon admission and ensure they are readily accessible to staff.4. In an emergency, staff will follow: The most current valid medical orders (POLST, physician order for DNR, etc.) .If code status is unknown or not immediately available, staff will initiate emergency response, CPR/Full Treatment while urgently clarifying orders.D. Documentation Requirements.Code status clearly documented in the designated EHR location.POLST scanned/uploaded and filed in rapid-access location.

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Vienna Nursing and Rehabilitation Center	800 So. Ham Lane Lodi, CA 95242

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observation, interview, and record review, the facility failed to maintain a comfortable and homelike environment for six of 136 residents (Resident 6, Resident 12, Resident 54, Resident 67, Resident 105, Resident 126), when the hot water temperature in the bathroom of rooms A and B were found to be less than the required temperature range of 105 degrees Fahrenheit (F - unit of measure) to 120 F.This failure has the potential to negatively impact on the hygiene and comfort of the residents who used the bathroom in rooms A and B. Findings:A review of facility provided document titled, Daily Census, dated 2/17/26, indicated that room A had three residents occupying the room and room B had three residents occupying the room.A review of Resident 67's admission RECORD, indicated Resident 67 was admitted to the facility with multiple diagnoses including anemia (low red blood count [RBC] - RBCs carry oxygen throughout the body and a low RBC count can cause a person to feel cold) and resided in room B.A review of Resident 126's admission RECORD, indicated Resident 126 was admitted to the facility with multiple diagnoses including Parkinson's disease (affects the autonomic nervous system, causing poor temperature regulation, cold sensitivity, and severe coldness in limbs) and resided in room B.A review of Resident 6's admission RECORD, indicated Resident 6 was admitted to the facility with multiple diagnoses including anemia and resided in room B.During a concurrent observation and interview on 2/19/26 at 3:26 PM with the Maintenance Supervisor (MS), the MS measured the hot water temperature using a thermometer on the bathroom sink of room B and confirmed the hot water temperature was at 102.6 F. During a continued observation, the MS measured hot water temperature of room A's bathroom sink, and the measurement read 99.6 F. The MS stated that the residents' room hot water temperature should have been at least 105 F. The MS stated residents' room A and room B's hot water temperature were below the required range. During an interview on 2/19/26 at 3:36 PM with Resident 67 in room B, Resident 67 stated that the water was too cold to shower.During an interview on 2/20/26 at 10:04 AM with the Infection Preventionist (IP), the IP stated the hot water temperature range should have been between 105 F to 120 F in the resident's room. The IP stated that when the hot water temperature was not within the appropriate range, the elderly got cold easily, and the low hot water temperature might not have killed all the bacteria when the residents showered. The IP further stated that it could have affected the residents' hygiene if they had not wanted to shower because of the low hot water temperature.During an interview on 2/20/26 at 11:01 AM with the Director of Nursing (DON), the DON stated that her expectation was for each of the resident rooms to have had a hot water temperature within the acceptable range of 105 F to 120 F. The DON stated that if the minimum hot water temperature range was not reached, the residents would not have been able to tolerate the water temperature, which could have affected the residents' hygiene.A review of the facility's policy and procedure titled, Quality of Life - Homelike Environment, revised 10/09, indicated, .Residents are provided with a safe, clean, comfortable and homelike environment and encouraged to use their personal belongings to the extent possible.Staff shall provide person-centered care that emphasizes the resident's comfort, independence and personal needs and preferences. The facility staff and management shall maximize, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting. These characteristics include.Comfortable temperatures.A review of the facility's policy and procedure titled, Resident Room - Water Temp [temperature] Checks, dated 10/25/19, indicated, .Check Water Temperatures in Random Resident Rooms Monthly.Regulations require that all hot water used by resident is checked periodically. Temperatures should be between 105 degrees F and 120 degrees F.A resident room temp log shall be maintained by the Maintenance Department.

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. Based on observation, interview, and record review, the facility failed to ensure the use of physical restraint (equipment used to limit a resident's movement) was safe to use and medically necessary for one of 35 sampled residents (Resident 147) when Resident 147, who had the ability to walk with assistance, was placed in a Geri chair (a reclining chair used when a resident cannot safely sit in a regular chair or wheelchair and can prevent a resident from rising independently) without informed consent (resident or resident's representative was informed and agreed to its use), or a Geri chair care plan. This failure removed Resident 147's ability to move freely and placed Resident 147 at risk for physical decline and psychosocial harm (effects on feelings, comfort, and dignity) related to restraint use. Findings: Review of Resident 147's admission RECORD, indicated Resident 147 was admitted to the facility with diagnoses including hereditary factor VIII deficiency (a blood clotting disorder that increases bleeding risk), unspecified dementia (memory loss and trouble thinking), personal history of transient ischemic attack and cerebral infarction without residual deficits (reduced blood flow to the brain with no lasting effects), anxiety disorder, pain, polyneuropathy (nerve damage causing numbness, tingling, pain, or weakness).During a concurrent observation and interview on 2/17/26 at 11:10 AM with Certified Nurse Assistant (CNA) 1 in Resident 147's room, Resident 147 had a front wheel walker (FWW - a walking aid with wheels in front that helps a person walk safely and keep their balance) placed near the foot of Resident 147's bed. CNA 1 stated the FWW was used by Resident 147 for walking.During a concurrent observation and interview on 2/17/26 at 11:22 AM with Licensed Nurse (LN) 1 in Resident 147's room, Resident 147 attempted to get up from bed with the upper half of her body raised. LN 1 advised Resident 147 not to get up because Resident 147 could fall. During a concurrent observation and interview on 2/17/26 at 4:05 PM with LN 2 in Resident 147's room, Resident 147 was seated in a Geri chair and attempted to get up. LN 2 stated the Geri chair prevented Resident 147 from getting up.During a concurrent interview and record review on 2/17/25 at 4:08 PM with LN 2, Resident 147's PHYSCIAN ORDERS for Geri chair dated 2/16/26 was reviewed. The physician's order for Geri chair indicated Patient [Resident147] able to get up to Geri chair as tolerated. LN 2 stated the physician's order did not include a medical indication for the use of a Geri chair. LN 2 stated that without a documented medical indication, the use of a Geri chair could be a physical restraint. LN 2 stated the Geri chair limited Resident 147's mobility, including the ability to reposition. During the record review with LN 2, Resident 147's informed consents and care plans were also reviewed. LN 2 stated Resident 147 did not have a Geri chair informed consent or a Geri chair care plan. LN 2 further stated informed consent was required to explain the purpose and risks of the Geri chair and allow the resident's representative to make an informed decision, and a Geri chair care plan was required to outline safe use and appropriate interventions. LN 2 further stated Resident 147 was at risk for falling if Resident 147 attempted to get up from the Geri chair. During an interview on 2/20/26 at 9:28 AM with the Director of Nursing (DON), the DON stated staff were expected to assess whether a Geri chair functioned as a physical restraint and ensure a medical indication, informed consent, and a care plan were in place. The DON further stated that if a Geri chair restricted a resident's movement, it functioned as a restraint and placed the resident at risk for health decline, falls, and injury.Review of Resident 147's Documentation Survey Report v2 dated 2/2026, inn the section titled .Lying to Sitting on Side of Bed indicated, Resident 147 performed lying to sitting on the side of bed with supervision or touching assistance on 2/1/26 day shift, 2/3/26 day shift, 2/9/26 day shift, 2/13/26 day shift, and 2/18/26 days shift, and with set up assistance on 2/17/26 day shift. The section titled .Sit to Stand indicated, Resident 147 performed sit to stand on 2/17/26 day shift with supervision or touching assistance. The section titled .Walk 150 Feet indicated, Resident 147 walked 150 feet on 2/9/26 with set up assistance. Review of Resident 147's Care Plan, initiated on 2/11/26, in the section Focus, indicated I am [Resident 147] at risk for elopement [leaving the (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	facility without prior notification] and/or wandering. The section titled Goal indicated, I [Resident 147] will not leave facility unaccompanied or unsafely and will not wander into unsafe areas or invade others .privacy.Review of the facility's policy and procedure (P&P) titled CONSENT, INFORMED dated 5/208, the P&P indicated .Physical Restraint: Any physical or mechanical device.which has the effect of restricting the resident's freedom of movement.The resident or representative must give the consent to the physician or designee. Facility must document verification of the informed consent.Review of facility's P&P titled PHYSICAL RESTRAINTS dated 11/2008, the P&P indicated, .physician order for use of any restraint. The order must specify the presence of a medical symptom that requires the use a restraint, type of restraint, when used and for what period of time.verify informed consent obtained from resident and/or surrogate.Risks and benefit, alternatives and how the restraint will treat the medical condition.Acceptable forms of physical restraints include:.geri-chairs.enter the problem, goal and approaches in the Resident's Care Plan. The care plan shall identify the medical symptoms requiring restraint, goals, systematic and gradual approaches for minimizing or eliminating the behavior and restraint use.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure an environment free of accidents or hazards for one of 35 sampled residents (Resident 131) when Resident 131's smoking assessment was not completed quarterly by the required due date, no smoking care plan was initiated, and Resident 131 was allowed to smoke without supervision.This failure had the potential to place Resident 131 and other residents in the facility at risk for accidental burns and injuries.Findings:Review of Resident 131's admission RECORD, indicated Resident 131 was admitted to the facility with diagnoses including dysarthria following cerebral infarction (slurred or unclear speech after a clot/bleed in the brain), depression, type 2 diabetes mellitus (body has trouble controlling blood sugar), polyneuropathy (nerve damage causing numbness, tingling, pain, or weakness), pain, displaced comminuted fracture of shaft of right tibia (a broken lower leg bone that shattered into multiple pieces and moved out of place), anxiety disorder, other stimulant abuse (the continued use of stimulants despite harm to the person using them).During a concurrent observation and interview on 2/18/26 at 10:17 AM with Resident 131, Resident 131 was observed smoking in the designated smoking area at the end of the office building. Resident 131 stated she smoked without staff supervision. During a concurrent observation and interview on 2/18/26 at 10:20 AM with the Medical Records Director (MRD), the MRD stated that Resident 131 was smoking in the designated smoking area without supervision and this was a safety concern. During a concurrent interview and record review on 2/18/26 at 11:34 AM with Licensed Nurse (LN) 2, Resident 131's smoking assessment dated [DATE] was reviewed. The smoking assessment indicated that it was not completed until 2/18/26 (two months late). In the smoking assessment question, .Is the resident free of any sedating [to make sleepy] medications? . the response was marked No. The smoking assessment also indicated .If the resident does not have all questions answered Yes, but the IDT [interdisciplinary team- a group of professional staff at the facility] determines that this resident is safe to smoke.unsupervised, explain rational behind this decision. The area for the rational to be filled in was blank. LN 2 stated the quarterly smoking assessment was late and completed two months after the required due date (12/18/25). LN 2 stated the late assessment increased Resident 131's safety risk while smoking. LN 2 further stated the smoking assessment completed on 2/18/26 indicated Resident 131 was not free of sedating medications due to physician orders for insulin (for diabetes), hydrocodone (for pain), and sertraline (for depression), making it unsafe for Resident 131 to smoke without supervision. Review of Resident 131's care plan was also reviewed with LN2. LN 2 confirmed that there was no smoking care plan for Resident 131, which posed a safety risk because there were no interventions in place for safe smoking, and the designated smoking area was not easily visible to staff if Resident 131 needed assistance. Review of Resident 131's Medication Administration Record (MAR) dated 2/2026 indicated Resident 131 received insulin before each meal from 2/1/26 through 2/18/26. Resident 131 received hydrocodone one to four times daily from 2/5/26 through 2/19/26. Resident 131 received sertraline three tablets by mouth once daily from 2/1/26 through 2/18/26.During an interview on 2/20/26 at 9:28 AM with the Director of Nursing (DON), the DON stated residents who smoked were required to have a timely smoking assessment to determine if they could smoke safely and independently. The DON stated the late smoking assessment increased the resident's safety risk because smoking safety needs were not identified on time. The DON further stated residents taking sedating medications were not safe to smoke without supervision and that a smoking care plan was required to guide staff in providing safe smoking interventions. Review of Resident 131's Care Plan, initiated on 7/9/22, in the section titled Focus, indicated I [Resident 131] use antidepressant medication (Sertraline). In the section titled Interventions, indicated BLACK BOX WARNING [a serious warning about dangerous side effects] for (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	antidepressant.drowsiness.dizziness.Review of Resident 131's Care Plan, initiated on 6/24/22, in the section titled Focus, indicated I [Resident 131] have (acute/chronic pain). In the section titled Interventions, indicated .BLACK BOX WARNING: NORCO (hydrocodone).Life threatening respiratory depression.profound sedation, respiratory depression, coma, and death.Review of facility's policy and procedure (P&P) titled SMOKING, RESIDENTS, the P&P indicated, .residents who desire to smoke shall be addressed for safety prior to being allowed to smoke independently in the area designated for smoking.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. Based on observation, interview, and record review, the facility failed to assess pain and provide timely pain relief for one of 35 sampled residents (Resident 2) when Resident 2 reported moderate (medium level) pain, waited for 10 minutes for non-pharmacological interventions (comfort measures that do not involve medication), and was not reassessed for pain.This failure resulted in Resident 2 experiencing ongoing, uncontrolled pain, which affected Resident 2's comfort and emotional well-being (the ability to feel calm, comfortable, and free from distress). Findings:Review of Resident 2's admission RECORD, indicated Resident 2 was admitted to the facility with diagnoses including unspecified B-Cell lymphoma (type of blood cancer with swollen glands), depression, age-related osteoporosis (weak or brittle bones), and pain.Review of Resident 2's Pain Assessment - V1 dated 12/5/25 indicated Resident 2 had chronic (long lasting) pain relieved by repositioning and pain pills.Review of Resident 2's Care Plan, initiated on 12/8/25, in the section titled Focus, indicated .I [Resident 2] have (acute/chronic) pain r/t [related to] Cancer .Osteoporosis. In the section titled Interventions, indicated, .Evaluate effectiveness of pain interventions.Monitor/record/report to Nurse my [Resident 2] complaints of pain or request for pain treatment. In the section titled Focus, indicated .I [Resident 2] have Osteoporosis.In the section titled Interventions, indicated .Give analgesics (medications used to relieved pain) prn (given only when needed) for pain.Provide with pillows.to help maintain comfortable position During a concurrent observation and interview on 2/19/26 at 3:24 PM with Resident 2 in Resident 2's room, Resident 2 was seated in her wheelchair next to her bed. Resident 2 stated that her back and legs were hurting badly and requested to be transferred back to bed.During a concurrent observation and interview on 2/19/26 at 3:25 PM with Certified Nursing Assistant (CNA) 8 by the door of Resident 2's room, CNA 8 stated that Resident 2 had to wait to be transferred back to bed. CNA 8 remained in the hallway by Resident 2's door while Resident 2 moaned and yelled for help. At 3:35 PM (ten minutes later) CNA 9 together with CNA 8 went to Resident 2's room, and CNA 9 transferred Resident 2 back to bed using a standing transfer lift (a device used to transfer a resident safely).During an interview on 2/19/26 at 3:58 PM with CNA 9, CNA 9 stated he transferred Resident 2 back to bed and that Resident 2 complained of moderate pain during the transfer. CNA 9 stated Resident 2 was often in pain and that repositioning, including transferring Resident 2 back to bed, helped relieve Resident 2's pain. CNA 9 further stated pain interventions had to be provided without delay and that transferring residents could be provided by any CNA as part of routine care. During an interview on 2/19/26 at 4:17 PM with CNA 8, CNA 8 stated Resident 2 had moderate pain in her legs when she and CNA 9 entered Resident 2's room. CNA 8 stated Resident 2 waited from 3:25 PM to 3:35 PM to be repositioned, an approximately 10-minute wait. CNA 8 stated that when a resident was in pain, the CNA should ask about comfort needs, provide comfort measures such as adjusting pillows, and report the pain to the nurse. CNA 8 stated she did not ask about Resident 2's pain, did not provide comfort measures, and did not notify the nurse. CNA 8 further stated Resident 2 moaned and yelled while waiting to be transferred back to bed due to pain and that comfort measures should be provided as soon as possible. During an interview on 2/20/26 at 8:13 AM with Resident 2, Resident 2 stated that she had severe pain in her legs and had not taken any medication to help relieve the pain.During a current interview and record review on 2/20/26 at 8:35 AM with Licensed Nurse (LN) 6, Resident 2's Medication Administration Record (MAR) dated 2/2026 was reviewed. The MAR indicated the last pain medication administered to Resident 2 was acetaminophen (pain medication used to treat mild pain) 500 milligrams (mg - a unit measure), two tablets, on 2/18/26 at 12:00 AM. LN 6 stated Resident 2 had chronic pain and had not received any pain medication on 2/19/26 through the morning of 2/20/26. LN 6 stated staff should check residents for pain at the beginning of their shift and at least every two hours for residents with uncontrolled chronic pain. LN 6 stated she had not assessed Resident 2 for pain and should have assessed Resident 2 at the beginning of her shift at 6:30 AM. LN 6 further stated unmanaged pain (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	could cause a resident to become restless and increase the risk of a falls. Review of Resident 2's physician order indicated that on 2/14/26, the physician ordered 5mg oxycodone (pain medication) every six hours as needed for severe pain, tramadol (pain medication) 50mg every six hours as needed for moderate to severe pain, and acetaminophen 500mg two tablets every eight hours as needed for pain.During an interview on 2/20/26 at 10:08 AM with the Director of Nursing (DON), the DON stated CNAs were expected to check residents every two hours and ask them if they had pain. The DON stated that if residents reported pain, the CNA should provide non-pharmacological interventions such as repositioning or transferring without delay and report the resident's pain to the nurse. The DON stated nurses were expected to assess residents for pain right away and residents should not have to wait for pain relief. The DON further stated uncontrolled pain was a safety concern. Review of facility's policy and procedure (P&P) titled Pain Assessment and Management revised on 10/2010, the P&P indicated, .The pain management program is based on a facility-wide commitment to resident comfort.the process of alleviating the resident's pain to a level that is acceptable to the resident.Ask the resident if he/she is experiencing pain.Review the medication administration record to determine how often the individual requests and receives pain medication.Non-pharmacological interventions may be appropriate alone or in conjunction with medications.Pharmacological interventions.may be prescribed to manage pain.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. Based on observation, interview, and record review, the facility failed to assess the safe use of bed rails (side rails) for one of 35 sampled residents (Resident 80) when Resident 80 did not have a completed bed rail assessment to determine whether bed rails were needed and safe to use.This failure placed Resident 1 at risk of entrapment and serious injury.Findings:Review of Resident 80's admission RECORD, indicated Resident 80 was admitted to the facility in 10/2025 with diagnoses including Alzheimer's disease (a condition that causes memory loss and confusion), hyperosmolality and hypernatremia (high levels of salt or concentration in the blood that can cause dehydration and confusion), anxiety disorder, depression, metabolic encephalopathy (confusion caused by a medical condition), and anemia.Review of Resident 80's Minimum Data Set Assessment (MDS: an assessment tool) dated 2/5/26, in the section titled Section C-Cognitive Patterns, indicated Resident 80 had short-term and long-term memory problems, impaired recall ability and severely impaired cognitive skills for daily decision making. In the section titled Section GG - Functional Abilities indicated Resident 80 had limited range of motion, impairments in both upper and lower extremities on both sides of the body and was dependent (staff perform all the effort) for rolling left and right in bed, sitting to lying, lying to sitting, and transfers. Review of Resident 80's physician order dated 10/27/25 indicated May use bed handrail (side rails) to enable highest level of functional independence with bed mobility and/or transfer.During a concurrent observation and interview on 2/17/26 at 3:18 PM with Certified Nursing Assistant (CNA) 7 in Resident 80's room, Resident 80 was lying in bed with the left and right half side rails in the raised position. CNA 7 stated Resident 80 was totally dependent on staff for bed mobility and repositioning and could not follow instructions to hold or use the side rails. CNA 7 further stated Resident 80 did not need both side rails raised and that the use of side rails could increase the risk for injury including entrapment. During a concurrent interview and record review on 2/19/26 at 3:41 PM with Licensed Nurse (LN) 2, Resident 80's Bed Rail Assessment was reviewed with LN2. LN 2 stated there was no bed rail assessment completed for Resident 80 to determine whether side rails were safe to use or needed. LN 2 stated Resident 80 had severe cognitive impairment and could not follow instructions to hold or use the side rails. LN 2 further stated raised side rails for a resident with severe cognitive impairment increased the risk for injury and entrapment. During an interview on 2/20/26 at 9:36 AM with the Director of Nursing (DON), the DON stated that residents' bed rail assessments were required to be completed quarterly because residents' health conditions and abilities could change. The DON further stated that when a bed rail assessment was not completed, residents were at risk for safety concerns, including falls, strangulations, entrapment, and the use of bed rails could function as a physical restraint. Review of facility's policy and procedure (P&P), titled Bed Safety revised on 12/2007, indicated .If side rails are used, there shall be interdisciplinary assessment of the resident.Side rails may be used if assessment.has determined that they are needed to help manage a medical symptom or condition, or to help the resident reposition or move in bed and transfer.Review of undated facility's policy and procedure (P&P), titled SIDE RAILS, the P&P indicated .IDT will document initial assessment in the medical record.Quarterly re-evaluations may be done during Care Plan Conference and should include any adverse effects.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Based on observation, interview, and record review, the facility failed to ensure medication error rate was less than 5% (% or percentage is a fraction of a number out of 100) during medication administration. The facility had a total of three errors out of 28 opportunities which resulted in a facility wide medication error rate of 10.71%. Medication observations were conducted over multiple days, at varied times, in random locations throughout the facility. The three medication errors were identified in two residents (Resident 93 and Resident 83) out of eight residents observed for medication administration observation as follows:1. Resident 93 was given medication without a doctor's order.2. Resident 93's ordered medication was not given.3. Resident 83's medication that was ordered to be given with food was not given as ordered.These failures could contribute to unsafe medications use, medication error, and not following the doctor's orders.Findings:1. During a medication observation with Licensed Nurse (LN) 7, at station 2 hallway, on 2/18/26, at 8:44 AM, LN 7 prepared and poured five medications for Resident 93 into a cup. The medications included two tablets of acetaminophen (a widely used over-the-counter analgesic [pain reliever] and antipyretic [fever reducer]), two tablets of vitamin B12(a crucial water-soluble nutrient essential for nerve tissue health, brain function, and red blood cell formation), one tablet of risperidone (a medication used to treat schizophrenia, bipolar disorder, or irritability associated with autistic disorder), one tablet of sertraline (a prescription selective serotonin reuptake inhibitor [SSRI] used to treat depression, anxiety, PTSD, OCD, and panic disorder), and one tablet of divalproex sodium (prescription medication used to treat certain seizures [epilepsy], manic episodes associated with bipolar disorder, and to prevent migraine headaches) for a total of seven pills. LN 7 proceeded to give the seven pills to Resident 93.During a review of Resident 93's electronic medical record titled, Order Summary Report, (doctor's orders) dated 2/18/26, the record included nursing orders, dietary orders, and medication orders. The Order Summary Report did not show any doctor's order to give two tablets of vitamin B12.During an interview on 2/18/26 at 1:48 PM with LN 7, LN 7 confirmed that she gave two tablets of vitamin B12. LN 7 acknowledged that there were no doctor's orders to administer vitamin B12. LN 7 stated that it was important to follow the doctor's orders as written and that she needed to have a better eye for detail. LN 7 also stated that by giving an incorrect medication to a resident, it could potentially harm them.During an interview on 2/19/26 at 9:42 AM with the Director of Nursing (DON), the DON stated that it would be incorrect for the nurses to give medications without a doctor's order. The DON also stated that a resident could be allergic and would be at risk if they were to get incorrect medication.During an interview on 2/20/26 at 11:18 AM with the Pharmacist Consultant (PC), the PC stated that there should be an order listed before nurses could give medications. The PC also stated that potential issues could arise if medications were given without an order.2. During a review of Resident 93's electronic medical record titled, Order Summary Report, dated 2/18/26, the Order Summary Report indicated: Cholecalciferol ([vitamin D3] a fat-soluble vitamin essential for calcium absorption, bone health, and immune function) Tablet 1000 UNIT .Give 2 tablet by mouth one time a day for supplement .Order Date 5/21/24.During an interview on 2/18/26 at 1:48 PM with LN 7, LN 7 confirmed that she did not give the two tablets of Cholecalciferol 1000 UNIT as ordered by the doctor. LN 7 stated that by not giving Resident 93 the ordered medication, the medication would not be effective, and the staff would not know if the medication were helping the resident. LN 7 also stated that the doctor would think the medication was given, but it was not. LN 7 further stated she needed to pay more attention to detail to keep the residents safe during medication administration.During an interview on 2/19/26 at 9:42 AM with the DON, the DON stated that her expectation was for the staff nurses to give medications as they are ordered. The DON also stated that if a medication was ordered by the doctor, the nurses needed to ensure that medication was given.3. During a review of Resident 83's electronic medical record titled, Order Summary Report, dated 2/18/26, the Order Summary Report indicated: Carvedilol (a prescription beta-blocker used to (continued on next page)

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	055481	A. Building B. Wing	02/20/2026

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	treat high blood pressure, chronic heart failure, and improve survival after a heart attack by relaxing blood vessels and slowing the heart rate) Tablet 3.125 MG .Give 1 tablet by mouth two times a day for Hypertension Administer with food .Order Date 2/7/26.During a medication observation with Licensed Nurse (LN) 7, at station 2 hallway, on 2/18/26, at 8:53 AM, LN 7 prepared and poured twelve medications for Resident 83 into a cup. LN 7 also poured a powdered medication into a four-ounce cup of apple juice. LN 7 then proceeded to give Resident 83 the medications without any food.During an interview on 2/18/26 at 1:48 PM with LN 7, LN 7 confirmed that she did not give any food with Resident 83's medications during her medication administration.During an interview on 2/19/26 at 9:42 AM with the DON, the DON stated that her expectation was for the nurses to follow the doctor's orders when it stipulated that certain medications needed to be given with food. The DON also stated that residents could have an upset stomach or other discomfort if the prescribed medications were not given with food.During an interview on 2/20/26 at 11:18 AM with the PC, the PC stated that blood pressure medications needed to be given with food. The PC also stated that nurses needed to follow the doctor's orders to ensure accuracy.During a review of the facility's policy and procedure (P&P) titled, Medication Administration-General Guidelines, revised 1/1/23, the P&P indicated, .Medications are administered as prescribed in accordance with good nursing principles and practices and only by persons legally authorized to do so .FIVE RIGHTS - Right resident, right drug, right dose, right route and right time, are applied for each medication being administered. A triple check of these 5 Rights is recommended at three steps in the process of preparation of a medication for administration: (1) when the medication is selected, (2) when the dose is removed from the container, and finally (3) just after the dose is prepared and the medication put away .Medications are administered in accordance with written orders of the prescriber .

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. Based on observation, interview, and record review the facility failed to ensure safe medication storage and labeling practices in one out of two medication rooms and two out of three medication carts when:1. An expired bottle of ocular vitamins (specialized supplements containing high concentrations of nutrients designed to support vision and reduce the risk of age-related eye disease) was found in the Station 2 Medication Storage Room and an expired bottle of ocular vitamins was found in the Station 1 Medication Cart 3; and2. Two pill cutters (a device used to safely and accurately divide medication tablets, vitamins, and supplements) were found with white and grayish residue in two different medication carts (Medication Cart 5 and Medication Cart 3).These failed practices could contribute to unsafe medication use, medication error, and risk of contaminated products or supplies.Findings:1. During a concurrent interview and inspection of the facility's medication storage room at Station 2, on 2/17/26 at 8:41 AM, accompanied by Licensed Nurse (LN) 2, a bottle of ocular vitamins had an expiration date 11/25 and was stored in the active use area of the medication storage room. LN 2 confirmed that the bottle of ocular vitamins was expired. LN 2 stated that expired medications should not have been available to use. LN 2 also stated that the medications could accidentally be given to the residents, and it would not be a good outcome for them.During a concurrent interview and inspection of the facility's medication cart 3 at Station 1, on 2/17/26 at 2:16 PM, accompanied by LN 3, a bottle of ocular vitamins had an expiration date 11/25 and was stored in the medication cart. LN 3 confirmed that the bottle of ocular vitamins was expired. LN 3 stated that expired medications would not be as effective and would not give the residents the intended therapeutic effect. LN 3 also stated that expired medications would be less potent, and the residents could be harmed if they were to receive expired medications.During an interview on 2/17/26 at 3:57 PM with the Director of Nursing (DON), the DON stated expired medications should not have been available to use. The DON also stated that expired medications could potentially have negative side effects if given to the residents.During an interview on 2/20/26 at 11:18 AM with the Pharmacist Consultant (PC), the PC stated that all expired medications should have been removed from active use areas in the medication carts and the medication storage rooms.During a review of the facility's policy and procedure (P&P) titled, MEDICATION STORAGE IN THE FACILITY, revised 1/1/23, the P&P indicated, .Outdated, contaminated, or deteriorated medications and those in containers that are cracked, soiled, or without secure closures are immediately removed from inventory, disposed of according to procedures for medication disposal .All expired medications will be removed from the active supply and destroyed in the facility, regardless of amount remaining. The medication will be destroyed in the usual manner .2. During a concurrent interview and inspection of the facility's medication cart 5 at Station 2, on 2/17/26 at 1:52 PM, accompanied by LN 5, a pill cutter was observed to have whitish and grayish colored residue on it. LN 5 confirmed that the pill cutter was dirty and should have been cleaned. LN 5 stated that the residue from the pill cutter could interact with other medications and cause unwanted drug interactions. LN 5 also stated that residents with potential drug allergies could be at risk for potential issues as well.During a concurrent interview and inspection of the facility's medication cart 3 at Station 1, on 2/17/26 at 2:16 PM, accompanied by LN 3, a pill cutter was observed to have whitish and grayish colored residue on it. LN 3 confirmed that the pill cutter was dirty and should have been cleaned after each use. LN 3 stated that cross-contamination of other medications could occur with the residue being on the pill cutter and lead to possible allergic reactions for the residents.During an interview on 2/17/26 at 3:57 PM with the DON, the DON stated that her expectation was for the pill cutters to be cleaned after each use. The DON also stated that cross-contamination of other medications could occur with the residue being on the pill cutter and pose a risk to the residents.During an interview on 2/20/26 at 11:18 AM (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	with the PC, the PC stated that the pill cutters should have been cleaned in between uses.During a review of the facility's P&P titled, MEDICATION STORAGE IN THE FACILITY, revised 1/1/23, the P&P indicated, .Medication storage areas are kept clean .During a review of the facility's P&P titled, Medication Administration-General Guidelines, revised 1/1/23, the P&P indicated, .A tablet-splitter is used to ensure accuracy and to minimize contact with the tablet. The splitter blade and surface contacting tablet are cleaned before and after each use .

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F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly Based on interview and record review, the facility's Resident Care/Quality Assurance Committee (a mandatory, internal group within a nursing home or skilled nursing facility. Its purpose is to identify, monitor, and improve the quality of care and life for residents, as required by federal law for facilities receiving Medicare or Medicaid funding) failed to meet quarterly with all required members, when the Infection Preventionist (IP) did not attend the quarter 2 meeting on 4/24/25.This failure had the potential of leading to staff lacking knowledge and coordination of care for a census of 136, thereby resulting in risk for safety, spread of infection, and hospitalization.Findings: During a concurrent interview and record review on 2/20/26, at 11:50 AM, with the Director of Nursing (DON), the Quality Assurance and Performance Improvement (QAPI- a data-driven, proactive approach mandated by the Centers for Medicare & Medicaid Services [CMS] for healthcare facilities to continuously monitor, analyze, and improve the quality of care and services) 2025 binder was reviewed. The DON confirmed that the IP did not attend the QAPI quarter 2 meeting that was scheduled on 4/24/25. The DON stated that her expectation was for the IP to attend every quarterly QAPI meeting. The DON also stated that the IP plays an important role in identifying potential infection related issues and educating the staff members. During an interview on 2/20/26 at 12:01 PM with the IP, the IP stated that she was sick and was on leave for a while in the year 2025. The IP confirmed that she was not able to attend the QAPI quarter 2 meeting that was scheduled on 4/24/25. The IP also stated that she did not have a replacement to cover for her at that time. The IP further stated that it was important for the IP to have a say in the quarterly QAPI meetings so trends and organisms could be identified and reviewed. The IP elaborated that it was important to educate the staff and follow up on recommendations from the other departments to work together effectively as a team. The IP expressed that the ball was dropped during the QAPI quarter 2 meeting where the IP information and data could not be addressed. During an interview on 2/20/26 at 1:32 PM with the Administrator (ADM), the ADM confirmed that the IP did not attend the QAPI quarter 2 meeting that was scheduled on 4/24/25. The ADM stated it was a struggle to find an IP nurse during the months the IP was not available.

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F 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, four rooms (rooms 24, 33, 43 and 68) in the facility did not meet the required 80 square feet per resident.This failure placed the residents in rooms 24, 33, 43 and 68 at potential risk to impede their care and highest possible level of functioning due to smaller than required square footage.Findings: During an interview on 2/19/26, at 11:30 AM, in room [ROOM NUMBER], with Resident 53, Resident 147, Resident 4 and Resident 11, Resident 53 stated that the room was okay. Resident 53 further stated that he had a good space and did not have a problem with it. Resident 147 and Resident 4 both stated that the room space was good. Resident 11 stated that the room was providing enough space for him. During an interview on 2/20/26, at 8:55 AM, in room [ROOM NUMBER], with Resident 158, Resident 158 stated that she felt that she had enough space. Resident 158 stated that she felt comfortable with the space and that the space was good. Resident 158 further stated that she felt she had enough privacy. Resident 158 uses walker and wheelchair. Resident 158 stated that she had no concerns with the room size and she likes her room.During an interview on 2/20/26, at 9:05 AM, in room [ROOM NUMBER], with Resident 152, Resident 152 stated that she felt the space was too narrow. Resident 152 stated that the room space was not enough for her with the care that she needed. Resident 152 further stated that she felt she needed more space. During an interview on 2/20/26, at 9:09 AM, with housekeeping (HK) 1, HK 1 stated there were 4 beds in room [ROOM NUMBER]. HK 1 stated that she cleaned room [ROOM NUMBER] and felt that the space was good. HK 1 stated she had no issues or problems when cleaning the room. HK 1 stated she thought she had enough room to move around and clean. During an interview on 2/20/26, at 9:13 AM, with Certified Nursing Assistant (CNA) 5, CNA 5 stated that in room [ROOM NUMBER] there were three residents and they have enough space to move around. CNA 5 stated that when there were four residents, the room space feels crowded, and they need to move stuff around and shift things around. CNA 5 stated it was important to have enough room for all residents because there was a possible fall risk if it was too crowded. CNA 5 stated she thought it would affect the resident's comfort when it was too crowded. During a concurrent observation and interview on 2/20/26, at 10:17 AM, with the Maintenance Supervisor (MS), MS measured room [ROOM NUMBER] and has measurement of 13 ft by 23 ft. MS was observed measuring room [ROOM NUMBER], with measurement of 13 ft by 23ft. MS stated that rooms 24, 33, 43 and 68 has 4 beds. MS stated that room [ROOM NUMBER] was occupied with 4 residents right now. MS stated room [ROOM NUMBER] has 4 beds but 1 bed has not been occupied and it always has 3 residents for this room. During an interview on 2/20/26, at 10:37 AM, with CNA 10, CNA 10 stated she had no issue with the room space in room [ROOM NUMBER]. CNA 10 stated she had adequate space and it did not restrict the care provided. CNA 10 further stated that the room allowed easy maneuverability and could accommodate an emergency stretcher if needed.Room Occupancy Required Sq. Ft/Actual Actual Sq. Ft/Resident 24 4 Residents 320/296 7433 4 Residents 320/286 7143 4 Residents 320/310 77.568 4 Residents 320/293 73.3Based on the findings during the Recertification survey, the Department recommends continuation of the room size waiver for rooms 24, 33, 43 and 68.