STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055649	A. Building B. Wing	03/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Tulare Healthcare & Wellness Center, LP	680 East Merritt Avenue Tulare, CA 93274

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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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observation, interview, and record review, the facility failed to:1. Ensure four of 45 sampled residents (Resident 38, Resident 86, Resident 76, and Resident 29) were provided palatable (pleasant to taste) meals at a safe temperature. This failure had the potential for to cause foodborne illness (illness caused by the ingestion of contaminated food or beverages) and unintended weight loss.2. Ensure 45 of 45 sampled residents were served foods prepared in a method which maintained nutritive value of food, when vegetables were not prepared as close as possible to serving time. This failure had the potential to decrease the nutritional value of the food, cause nutritional decline, and negatively affect the resident's health.Findings: 1. During an interview on 3/9/26 at 10:07 a.m. with Resident 38, Resident 38 stated the facility food was not good. Resident 38 stated she ate meals in her room and the food was usually cold and did not taste good. During an interview on 3/9/26 at 10:21 a.m. with Resident 86, Resident 86 stated she does not like the facility food. Resident 86 stated the food had no taste and was usually cold. During an interview on 3/9/26 at 10:47 a.m. with Resident 76, Resident 76 stated the facility meals were not good. Resident 76 stated the food was cold and had no taste. During an interview on 3/9/26 at 11:04 a.m. with Resident 29, Resident 29 stated food served by the facility was cold and had no taste. During a concurrent observation and interview on 3/10/26 at 1:25 p.m. with Regional Registered Dietitian (RRD), the last lunch meal tray was served, and food temperatures were taken. RRD stated the following food temperatures:a. Meatball temperature was 115 degrees Fahrenheit (F). b. Pasta temperature was 103 F. c. Spinach temperature was 113 F. d. Milk was 52 F. RRD stated the holding temperature for hot foods was 140 F and was 41 F for cold foods. During an interview on 3/10/26 at 1:27 p.m. with RRD, RRD stated there were no specific temperature requirements for foods being served in resident rooms and was based on palatability. RRD stated it was expected that food served to residents was palatable. During a review of the facility's policy and procedure (P&P) titled, Food Temperatures, dated 11/14/25, the P&P indicated, 4. Acceptable Serving Temperatures a. Food should be served promptly to maintain safe and palatable temperatures b. Hot foods are held at 140F or higher on the steam table, cold foods are held at 41F or below at point of service. 2. During a concurrent observation and interview on 3/9/26 at 9:24 a.m. with Dietary Supervisor (DS) in the facility kitchen, two pans containing vegetables were heating on the stove burners. DS stated one pan contained diced carrots, the other pan contained vegetable soup and both were being prepared for lunch (at 12:00 p.m.) and would be held in the oven until served. DS stated the vegetables should be prepared as close to serving time as possible to conserve the nutritional value of the vegetables. During a review of the facility's P&P titled, Vegetable Cookery, dated 7/1/14, the P&P indicated, Dietary department employees ensure that food is prepared in a manner that preserves quality, maximizes nutrient retention. II. Vegetables will be prepared as close to time of service as possible to maintain highest quality.

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

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

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F 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure 45 of 45 sampled residents were served food prepared according to professional standards for food service safety and sanitary kitchen conditions when: 1. Dry food item was not stored in an airtight sealed container. 2. Three boxes of produce were not labeled with received dates. 3. Clean cooking utensils were not covered to prevent contamination. 4. Temperature of vegetable was not taken before serving to resident plate. 5. Dirty food serving pan was not sanitized before re-use. These failures had the potential to cause foodborne illnesses (illness caused by the ingestion of contaminated food or beverages) for residents.Findings: 1. During a concurrent observation and interview on 3/9/26 at 9:33 a.m. with Dietary Supervisor (DS) in Dry Storage room, one opened package of spaghetti pasta was on the shelf inside of a plastic bag that was not sealed. DS stated the open pasta should be stored in an airtight container. During a review of the facility's policy and procedure (P&P) titled, Food Storage and Handling, dated 6/4/24, the P&P indicated, 13. Dry Storage Area. g. Place opened products in storage containers with tight fitting lids. 2. During a concurrent observation and interview on 3/9/26 at 9:36 a.m. with DS in Storage room [ROOM NUMBER], one box of oranges, one box of potatoes, and one box of apples were not labeled with the date received. DS stated each box should be labeled with the received date. During a review of the facility's P&P titled, Food Storage and Handling, dated 6/4/24, the P&P indicated, 6. Fresh Fruits Storage. e. Label and date all food items. 9. Fresh Vegetable Storage. f. Label and date all food items. 3. During a concurrent observation and interview on 3/9/26 at 9:42 a.m. with DS in Storage room [ROOM NUMBER], two uncovered tubs containing miscellaneous cooking utensils were on a wire rack. DS stated the utensils were clean, used for meal preparation, and should have been covered to help keep clean. On 3/12/26 at 11:47 a.m., a facility P&P for storage of cooking utensils and dishware was requested from Administrator. The P&P was not provided. 4. During a concurrent observation and interview on 3/9/26 at 12:12 p.m. with Regional Registered Dietitian (RRD) in the kitchen, a pan of green beans was removed from tabletop steamer. The temperature of the pan of green beans was not checked before being placed resident's plate. RRD stated the temperature of the green beans should have been taken before being plated. During a review of the facility's P&P titled, Food Temperatures, dated 11/14/25, the P&P indicated, a. Record the reading on Food Temperature Log at the beginning of the tray line making sure to take the temperature of each pan of product before serving. 5. During an observation on 3/10/26 at 11:26 a.m. dietary staff was washing dirty dishes in a three compartment sink next to food being prepped for lunch. A pan was rinsed utilizing a spray nozzle, then soap was dispensed into the pan, followed by the pan being washed by hand with a sponge. The pan was not placed into a sanitizer solution and was not allowed to air dry before re-use. The wet pan was taken to the stove and used to warm tomato soup that was served with lunch. During an interview on 3/11/26 at 10:10 a.m. with DS and RRD, DS stated dietary staff should be using the three-sink process for washing dishes. DS stated sink 1 (right side) with water and detergent solution. DS stated the temperature of the water needed to be between 110-120 degrees Fahrenheit (F). DS stated sink 2 (middle) was filled with water for rinsing and the water temperature needed to be between 110-120 F. DS stated sink 3 (left side) needed to be filled with the sanitizer solution and the water temperature needed to be between 60-80 F. RRD stated dishes washed using the three sinks needed to be placed into the sanitizer solution for one minute then placed on the rack to air dry before use. During a review of the facility's P&P titled, Pot and Pan Cleaning and Sanitizing, dated 12/22/25, the P&P indicated, VI. Sanitize the pots and pans in the third compartment by immersing them in the sanitizer water solution for a minimum of 60 seconds or per manufacturer recommendations. Remove items from the sanitizer solution. VII. Invert the pots and pans and place them on a drying rack or counter. Allow the items to air dry.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 ensure three of 45 sampled residents (Resident 38, Resident 86, and Resident 53) were provided a homelike environment that ensured comfortable sound levels and reduced chronic noise. This failure had the potential to cause stress, decreased rest, and other health concerns. for Resident 38, Resident 86, and Resident 53.Findings: During an observation on 3/9/26 at 10:07 a.m. in Resident 38's room, alarm sounds and overhead paging announcements were heard coming from the hallway. During an observation on 3/9/26 at 10:21 a.m. in Resident 86's room, alarm sounds were heard coming from the hallway. During an observation on 3/9/26 at 10:47 a.m. in Resident 76's room, alarm sounds and overhead paging announcement were heard coming from the hallway. During an observation on 3/9/26 at 10:59 a.m. in Resident 9's room, alarm sounds were heard coming from the hallway. During an observation on 3/10/26 at 10:05 a.m. in hall 200, multiple staff and residents were entering and exiting through door (leading to outside garden area) which activated a door alarm sound each time. During an observation on 3/11/26 at 8:52 a.m. at the entrance to hallway 300, staff exited through door (by kitchen, leading to area by maintenance building), alarm sounded. During an observation on 3/11/26 at 8:54 a.m. at the entrance to hallway 300, staff entered through door (by kitchen, leading to area by maintenance building), which activated a door alarm sound each time. During an observation on 3/11/26 at 8:54 a.m. at the entrance to hallway 300, staff exited through door (by kitchen, leading to area by maintenance building), which activated a door alarm sound each time. During an interview on 3/11/26 at 8:59 a.m. in Resident 38's room, Resident 38 stated she prefers the door to her room remained closed due to all the noises in the hallway. Resident 38 stated she was able to hear alarms sounding, doors slamming, and overhead paging announcements frequently which prevents her from getting rest. Resident 38 stated she likes her room to be quiet. During an observation on 3/11/26 at 9:01 a.m. at the entrance to hallway 300, staff entered through door (by kitchen, leading to area by maintenance building), which activated a door alarm sound. During an observation on 3/11/26 at 9:02 a.m. at the entrance to hallway 300, staff exited through door (by kitchen, leading to area by maintenance building), which activated a door alarm sound. During an observation on 3/11/26 at 9:03 a.m. at the entrance to hallway 300, staff entered through door (by kitchen, leading to area by maintenance building), door alarm sounded twice. During an observation on 3/11/26 at 9:04 a.m. at the entrance to hallway 300, staff entered through door (by kitchen, leading to area by maintenance building), the door alarm sounded. During an observation on 3/11/26 at 9:14 a.m. at the entrance to hallway 300, staff exited through door (by kitchen, leading to area by maintenance building), the door alarm sounded. During an observation on 3/11/26 at 9:17 a.m. at the entrance to hallway 300, door (by kitchen, leading to area by maintenance building) the door alarm sounded. During an observation on 3/11/26 at 9:18 a.m. at the entrance to hallway 300, staff entered through door (by kitchen, leading to area by maintenance building), the door alarm sounded. During an observation on 3/11/26 at 9:19 a.m. at the entrance to hallway 300, staff exited through door (by kitchen, leading to area by maintenance building), the door alarm sounded. During an observation on 3/11/26 at 9:21 a.m. at the entrance to hallway 300, staff entered through door (by kitchen, leading to area by maintenance building), the door alarm sounded. During a concurrent observation and interview on 3/11/26 at 9:22 a.m. in hallway 300, the call light panel was alarming. LVN 7 stated the call light system alarms in hallway 300 for all rooms throughout the facility. LVN 7 stated the call light system also alarmed on hallways 100 and 200 for all rooms throughout the facility. During a concurrent observation and interview on 3/11/26 at 9:26 a.m. with Resident 38, in Resident 38's room, door alarms sounded, call lights alarmed, and overhead paging announcement were heard coming from the hallway. Resident 38 stated the facility changed the call light system recently and she could now hear the call light alarms constantly. Resident 38 stated the overhead paging announcements were too loud and were also being used at (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	night while she was sleeping. During an interview on 3/11/26 at 9:34 a.m. with Resident 86, Resident 86 stated it was loud sometimes in her room. Resident 86 stated she preferred the door to her room was kept closed because the alarms and overhead announcements are so loud and occur frequently making it hard to rest. During an observation on 3/11/26 at 9:56 a.m. in hallway 300, the call light panel was alarming. The alarm panel had a red light above numbers 102 and 105 and alarm was sounding. During a concurrent observation and interview on 3/11/26 at 3:21 p.m. with Resident 53, in Resident 53's room, alarm beeping could be heard coming from hallway. Resident 53 stated the beeping sound bothered her when she was trying to rest. During an interview on 3/12/26 at 9:19 a.m. with Administrator, Administrator stated the alarms on doors were to alert facility staff when a person was exiting or entering the facility. Administrator stated he understood the constant alarming would be a concern for residents' comfort due to the noise levels. Administrator stated there was no reason why hallway 300 would hear call lights for rooms in the 100 and 200 hallways. Administrator stated there was no reason staff had to use the overhead paging system when they could use the phone system instead. Administrator stated the facility needed to make a homelike environment for the residents and understood the noise level was a concern. During a review of the facility's policy and procedure (P&P) titled, Resident Rooms and Environment, dated 1/1/12, the P&P indicated, I. Facility Staff aim to create a personalized, homelike atmosphere, paying close attention to the following. G. Comfortable noise levels. II. Facility staff work to minimize, to the extent possible, the characteristics of the Facility that reflect a depersonalized, institutional setting, including: A. Overhead paging.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interview, and record review, the facility failed to follow its policy and procedure (P&P) titled, Person-Centered Care Planning, for three of 24 residents (Resident 64, Resident 5 and Resident 10). This failure had the potential to result in Resident 64, Resident 5 and Resident 10's care needs not being met.Findings:1. During an observation on 3/9/26 at 9:39 am, Resident 64 was in her room seated in a wheelchair. Resident 64 had a foley catheter bag with yellow urine inside the foley catheter bag that was attached to the railing on the left side of the resident's bed.During a review of Resident 64's Order Summary Report (OSR), dated 3/2/26, OSR indicated, Resident 64 had an Indwelling (fixed in the body)/SP [status post] Catheter (a flexible tube inserted through a narrow opening into a body cavity, particularly the bladder for removing fluid) 18(FR# [French - catheter size]) with [NAME] 10ml via gravity drainage for urinary retention (the inability to fully or partially empty the bladder, causing urine to build up)During a concurrent record review and interview on 3/12/26 2:20 pm with Director of Nursing (DON), DON reviewed Resident 64's medical record for a foley catheter care plan which addressed the residents' specific goal, objectives, and interventions. DON stated, I don't see care plan for foley catheter for Resident 64, it should have been done when the foley catheter was initiated. 2. During an observation on 3/9/26 at 2:32 pm, Resident 5 was in his room in bed. Resident 5 had a foley catheter bag with yellow urine inside the foley catheter bag that was attached to the railing on the right side of the bed.During a review of Resident 5's OSR, dated 1/22/26, OSR indicated, Resident 5 had an Indwelling /SP Catheter 16FR# with 10 cc (unit of measurement) [NAME] via gravity drainage. Unspecified Hydronephrosis (is a condition of the urinary tract where one or both kidneys swell, urine doesn't fully empty from the bladder)During a concurrent record review and interview on 3/12/26 2:32 pm with DON, DON reviewed Resident 5's medical record for a foley catheter care plan which addressed the residents' specific goal, objectives, and interventions. DON was unable to provide evidence of a current care plan for Resident 5' foley catheter in the medical record.3. During an observation on 3/9/26 at 2:32 pm, Resident 10 was in his room in bed. Resident 10 had a foley catheter bag with yellow urine inside the foley catheter bag.During a review of Resident 10's OSR, dated 1/22/26, OSR indicated, Resident 10 had an Indwelling /SP Catheter (16) with [NAME] via gravity drainage.During a concurrent record review and interview on 3/12/26 2:34 pm with DON, DON reviewed Resident 10's medical record for a foley catheter care plan which addressed the residents' specific goal, objectives, and interventions. DON stated she was unable to find a care plan that addressed Resident 10's foley catheter.During a review of the facility's policy and procedures (P&P) titled, Person - Centered Care Planning, dated 2022, the P&P indicated, a. Person-centered care plan means that the facility focuses on the resident as the center of control and supports each resident in making his or her own choices. Person-centered care includes making an effort to understand what is important to each resident with regard to daily routines and preferred activities and having an understanding of the resident's life before coming to reside the nursing facility . a. The baseline care plan must include the minimum healthcare information necessary to properly care for each resident immediately upon their admission. It should address resident-specific health and safety concerns to prevent decline or injury, and would identify deeds for supervision, behavioral interventions, and assistance with activities of daily living, as necessary. c. The baseline care plan must reflect the resident's stated goals and objectives and include interventions that address his or her needs.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident?s preferences and goals. Based on observation, interview, and record review, the facility failed to ensure one of four sampled residents (Resident 98) physician order for oxygen therapy was followed. This failure had the potential to result in oxygen toxicity (a condition where breathing too much oxygen starts to harm the body's cells instead of helping them) for Resident 98.Findings: During a review of Resident 98's Order Summary Report (OSR), dated 3/7/26, the OSR indicated, Oxygen 2 Lpm [liters per minute] Via [by] Nasal Cannula [NC, lightweight tube that has two small prongs that sit inside the nose to deliver oxygen] Continuously every shift. During a concurrent observation and interview on 3/9/26 at 10:27 a.m. with Registered Nurse (RN) 1 in Resident 98's room, Resident 98 was in bed wearing a NC. Resident 98's oxygen concentrator (medical device that provides oxygen) was set to 3 Lpm. RN 1 stated Resident 98 was receiving 3 Lpm of oxygen. RN 1 stated she was unsure of Resident 98's oxygen orders. During an interview on 3/9/26 at 10:31 a.m. with RN 1, RN 1 stated Resident 98 should have only been receiving oxygen at 2 Lpm. During a review of the facility's policy and procedure (P&P) titled, Oxygen Therapy, dated 10/21/25, the P&P indicated, Administer oxygen and obtain oxygen saturation levels as ordered by the provider.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observation, interview, and record review, the facility failed to maintain an environment free of accident hazards for 45 of 45 sampled residents when a pack of cigarettes and a lighter were found unsupervised on a table, outside, near the 300 hallway exit door. This failure had the potential to result in the burn injuries, fire or death.Findings:During a concurrent observation and interview on 3/11/26 at 10:22 a.m. with Administrator, outside, near the 300 hallway's exit door, there was a pack of cigarettes and a lighter sitting unsupervised on a table. Administrator stated there were 16 cigarettes in the pack and the lighter was working. Administrator stated that anyone could have picked up the lighter and started a fire.During a review of the facility's policy and procedure (P&P) titled Smoking Residents, dated 8/18/23, the P&P indicated, The IDT will develop an individualized plan of care for safe storage, use of smoking materials, assistance and/or required supervision, for residents who smoke.During a review of the facility's P&P titled, Resident Rooms and Environment, dated 1/1/12, the P&P indicated, The facility provides residents with a safe, clean, comfortable, and homelike environment.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. Based on interview and record review, the facility failed to ensure three of three sampled Licensed Vocational Nurses (LVN 2, LVN 1, and LVN 3) completed a wound vacuum (a device that removes fluid, reduces swelling and increases blood flow to wound and stimulates tissue growth) care and dressing change competency. This failure had the potential to result in severe complications including infection, bleeding, skin damage, pain, and tissue damage to the wound.Findings: During a review of Resident 7's Brief Interview for Mental Status [BIMS - an assessment of cognition (how well a person thinks, remembers, and learns]. A score of 0 - 7 suggests severe cognitive impairment, 8 - 12 suggests moderate cognitive impairment and 13 - 15 suggests cognition is intact], dated 1/6/26, the BIMS indicated Resident 7's BIMS score was 14. During a review of Resident 7's Order Summary Report (OSR), dated 1/16/26, the OSR indicated, Wound Vac.STAGE 4 PRESSURE ULCER [a full thickness wound that has gone through all layers of skin and fat, reaching deep enough to expose muscle and bone] TO SACRAL REGION [triangular area at the base of the spine, in between the hips].every Tue [Tuesday], Thur [Thursday], Sat [Saturday]. During an interview on 3/9/26 at 3:30 p.m. with Resident 7, Resident 7 stated her wound vac was changed every two to three days. Resident 7 stated she felt like the nursing staff, who changed the wound vac, did not have the skills/training to do it. During a concurrent interview and record review on 3/11/26 at 1:53 p.m. with Director of Staff Development (DSD), Resident 7's Treatment Administration Record (TAR), dated March 2026, the TAR indicated, Resident 7 had her wound vac changed on 3/3/26, 3/5/26 and 3/7/26. DSD stated Resident 7's wound vac dressing was changed on 3/5/26 by LVN 1, on 3/5/26 by LVN 2 and by LVN 3 on 3/7/26. During an interview on 3/11/26 at 2:18 p.m. with Director of Nursing (DON), DON stated nursing staff should have competencies in their file prior to performing a wound vac dressing change. During a concurrent interview and record review on 3/11/26 at 2:19 p.m. with DSD, LVN 2's Employee Competency File (ECF), (undated) was reviewed. DSD stated LVN 2 did not have a competency evaluation for a wound vac dressing change in her ECF. DSD stated LVN 2 should have had training with a return demonstration prior to performing a wound vac dressing change. During a concurrent interview and record review on 3/11/26 at 2:23 p.m. with DSD, LVN 1's ECF, (undated) was reviewed. DSD stated LVN 1 did not have a competency evaluation for a wound vac dressing change in her ECF. DSD stated LVN 1 should have had a competency evaluation prior to performing a wound vac dressing change. During a concurrent interview and record review on 3/11/26 at 3:09 p.m. with DSD, LVN 3's ECF, (undated) was reviewed. DSD stated LVN 3 did not have a competency evaluation for a wound vac dressing change in her ECF. DSD stated LVN 3 should have had a competency evaluation prior to performing a wound vac dressing change. During an interview on 3/11/26 at 3:54 p.m. with Resident 7, Resident 7 stated the DON had never been in her room to change her wound vac dressing. During a review of the facility's policy and procedure (P&P) titled, Staff Competency Validation, dated 6/4/24, the P&P indicated, Competency validation is completed to evaluate an individual's performance.meet standards set by regulatory agencies, address problematic issues, and enhance performance reviews. Competency evaluation is a determination based on an individual's satisfactory performance of each specific element of his/her job description, and the specific requirements for the area in which he or she is employed.PURPOSE.To protect the health, safety, and well-being of residents. During a review of the Manufacturer's Guidelines (MG) titled, XLR8+ Negative Pressure Wound Therapy [NPWT, wound vac] System, dated 10/6/21, the MG indicated, As a condition of use, the XLR8+ NPWT System should only be used by qualified and authorized personnel. The user must have the necessary knowledge of the specific medical application for which Negative Pressure Wound Therapy Treatment is being used.Use this manual as a personal reference and also in the training of personnel.

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. Based on interview and record review, the facility failed to ensure one of five sampled residents (Resident 8) had an informed consent for psychotropic (medication to treat mental disorders) medication prior to administration. This failure resulted in Resident 8 receiving psychotropic medication without his consent and without knowing the risks and benefits of the medication.Findings:During a review of Resident 8's Order Details (OD), dated 7/26/25, the OD indicated, Resident 8 was prescribed Risperdal (to treat mental disorders) 0.5 mg (milligram) by mouth daily to begin 7/27/25.During a review of Resident 8's OD, dated 8/22/25, the OD indicated, Resident 8's Risperdal was increased to 0.5 mg twice a day.During a concurrent interview and record review on 3/11/26 at 9:26 a.m. with Medical Record (MR). MR was unable to provide a Risperdal consent form completed for Resident 8's Risperdal 0.5 mg by mouth daily started on 8/27/26 or when the Risperdal was increased to 0.5 mg twice a day on 8/22/25.During a review of the facility's P&P titled, Informed Consent, dated 1/30/2026, the P&P indicated, C. If the resident lacks capacity to provide informed consent, the surrogate decision-maker will provide informed consent.E. It is the Healthcare Practitioner's (physician, Nurse Practitioner, Physician Assistant) responsibility to obtain informed consent. II. Verification of Informed Consent. A. The licensed nurse will confirm that the Healthcare Practitioner obtained informed consent and will document the verification in the Resident's medical record, before administering the first dose or first increased dose of psychoactive medication, applying physical restraints or medical devices.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a discharge notice was sent to Ombudsman (an advocate for residents of nursing homes, board and care centers and assisted living facilities) for one of two sampled residents (Resident 85). This failure had the potential to result in Resident 85 not having an advocate who could inform them of their admission, transfer, and discharge rights.Findings:During a review of Resident 85's Electronic Health Record (EHR), [undated], the EHR indicated Resident 85 was transferred to the hospital on [DATE] and came back to the facility on 1/3/26.During an interview on 3/11/26 at 2:36 p.m. with Social Service Director (SSD), SSD stated there is no Ombudsman notification for Resident 85. SSD stated nurses should be notifying the Ombudsman when residents are transferred to the hospital.During an interview on 3/12/26 at 9:30 a.m. with Registered Nurse (RN) 2, RN 2 stated nurses do not notify Ombudsman for any discharges to the hospital or home.During an interview on 3/12/26 at 9:39 a.m. with Director of Nursing (DON). DON stated the expectation was for SSD to notify Ombudsman each time a resident was transferred or discharged to the hospital.During a review of the facility's policy and procedure titled, Notice of Transfer/Discharge, dated 10/2017, the P&P indicated, III. Before the transfer or discharge occurs, the facility must notify the resident and, if known, the responsible party, and Ombudsman of the transfer and reasons for the transfer, and document in the resident's clinical record.

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F 0729 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Verify that a nurse aide has been trained; and if they haven't worked as a nurse aide for 2 years, receive retraining. Based on interview and records review, the facility failed to ensure one of five sampled staff (Certified Nursing Assistant [CNA] 2) had a completed initial competency evaluation completed upon hire. This failure had the potential to result in CNA 2 providing care that did not meet the resident's needs.Findings:During a concurrent interview and record review on 3/12/26 at 10:15 a.m. with Director Staff Development (DSD), CNA 2's personnel file (PF), undated, was reviewed. The PF indicated CNA 2 was hired on 4/23/25 and there was no initial competency evaluation document. DSD stated CNA 2's initial competency evaluation was not completed.During a review of the facility's Staff Competency Validation (SCV), dated 3/28/24, SCV indicated, Policy: Competency validation is completed to evaluate an individual's performance, evaluate group performance, meet standards set by regulatory agencies, address problematic issues, and enhance performance review.During a review of the facility's policy and procedures (P&P) titled, Performance Review, dated May 23, 2019, the P&P indicated, Procedure, V. Completing a Formal Evaluation: A. Approximately two weeks prior to the evaluation, the employee will be given a copy of their job description, a performance evaluation form, and the competency skills assessment specific to their position. C. The employee will complete the self-assessment portion of the Competency Skills Assessment.

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observe each nurse aide's job performance and give regular training. Based on interview and records review, the facility failed to ensure one of five staff (Certified Nursing Assistant [CNA] 1) completed an annual performance review. This failure had the potential to result in CNA 1 providing care that did not meet the residents' needs. Findings:During a concurrent interview and record review on 3/12/26 at 10:15 a.m. with Director of Staff Development (DSD), CNA 1's personnel file (PF) undated, was reviewed. The PF indicated CNA 1's most recent performance evaluation was completed on 8/30/24. DSD stated CNA 1 did not have an annual performance in August 2025. DSD stated CNA 1 should have had an annual performance evaluation completed.During a review of the facility's policy and procedures (P&P) titled, Performance Review, dated 5/23/19, the P&P indicated, Procedure II. Formal Evaluations for Full-Time and Part-Time employees are to be conducted at a minimum of, annually.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. Based on interview and record review, the facility failed to ensure the Monthly Medication Regimen Review (MRR evaluation of medications by a pharmacist to identify, prevent or resolve medication related problems) recommendations was acted upon for one of five sample residents (Resident 85). This failure had the potential to result in adverse health outcomes for Resident 85. Findings:During a review of Resident 85's Order Summary Report (OSR), dated 1/10/26, the OSR indicated Resident 85 was prescribed Lasix (a medication used to treat fluid retention) 20 milligram (mg) one time a day for seven days (1/10/26 to 1/17/26).During a concurrent interview and record review on 3/11/26 at 2 p.m. with Medical Records (MR), Resident 85's MRR, dated 1/17/26, was reviewed. The MRR indicated, consider continuing Lasix 20 mg po [by mouth] daily. MR stated Resident 85's MRR medication recommendation by the pharmacist was not implemented. MR stated Resident 85's Lasix was discontinued on 1/17/26 and was not continued.During an interview on 3/11/26 at 2:56 p.m. with Director of Nursing (DON), DON stated the expectation was to implement pharmacy recommendations documented on the MRR within 24 hours. DON stated Resident 85's January 2026 MRR pharmacy recommendation for the continuation of Lasix was not implemented. DON stated there was no documentation that Resident 85's doctor was notified of the MRR pharmacist recommendations.During a review of the facility's policy and procedure (P&P) titled Consultant Pharmacist Reports, dated 10/2024, the P&P indicated, iii Routine Findings .Nursing: Items will be initially reviewed and addressed within 14 days and a final action taken in not more than 30 days or the date of next monthly pharmacist MRR.

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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: 1. Ensure medications were properly labeled in two of four sampled medication carts (Med Cart 1 and Med Cart 2). This failure had the potential to result in residents receiving the wrong medication, the wrong dose, or another resident's medication. 2. Ensure medications were stored in a safe and secure manner when;a. One of four sampled medication carts (Med cart 2) was left unlocked;b. One of 24 sampled residents (Resident 44) medications were left unattended on Resident 44's bedside table. These failures had the potential to result in accidental ingestion by residents, drug diversion/theft, medication being misplaced and/or tampered with, and data breech of resident health information.Findings: 1. During a concurrent observation and interview on 3/10/26 at 10:20 a.m. with Licensed Vocational Nurse (LVN) 5 near the A and B wing nurses' station, Med Cart 1 contained one opened bottle of Geri Care (brand name) artificial tears eye drops (used to provide hydration and lubrication for dry, irritated eyes) that had a ripped label containing only a residents last name on the outer packaging. LVN 5 stated, There should have been a label. During a concurrent observation and interview on 3/10/26 at 10:25 a.m. with LVN 5 near the A and B wing nurses' station, Med Cart 1 contained one opened bottle of Geri-Care artificial tears eye drops that did not contain a label. The outer packaging had a residents' first name and room number. LVN 5 stated, the vial of artificial tears should have been labeled properly. During a concurrent observation and interview on 3/10/26 at 10:26 a.m. with LVN 5 near the A and B wing nurses' station, Med Cart 1 contained one albuterol inhaler (device that delivers medication to the lungs to treat or prevent breathing difficulties) that had a ripped label containing a partial name and partial directions for use. LVN 5 stated, there should have been a label. During a concurrent observation and interview on 3/10/26 at 10:43 a.m. with LVN 4 near the A and B wing nurses' station, Med Cart 2 contained one opened and unlabeled bottle of Refresh (brand name) eye drops (used to provide hydration and lubrication for dry, irritated eyes). LVN 4 stated there should have been a resident label. During a review of the facility's policy and procedure (P&P) titled, Medication Ordering and Receiving From Pharmacy, dated October 2024, the P&P indicated, Medication Labels.Labels are permanently affixed to the outside of the prescription container.If a label does not fit directly onto the product, e.g., eye drops, the label may be affixed to an outside container or carton.Each prescription label includes.Resident's name.Medication name.Strength of medication.Prescriber's name.Date dispensed.Quantity of medication dispensed.Expiration date. 2a. Based on observation and interview on 3/10/26 at 10:14 a.m. with LVN 5 near the A and B wing nurses' station, Med Cart 2 was unlocked and unattended. LVN 5 stated Med Cart 2 should not have been unlocked. LVN 5 stated medication carts should be locked at all times when not actively pulling medications. During a review of the facility's P&P titled, Medication Storage, dated 10/2024, the P&P indicated, Medications and biologicals are stored safely, securely, and properly.The medication supply is accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	authorized to administer medications.Medication rooms, carts and medications supplies are locked or attended by persons with authorized access. 2.b During a concurrent observation and interview on 3/9/26 at 9:42 a.m. with LVN 6, in Resident 44's room, a bottle of Systane ultra-high (medication used for dry eyes) eye drops and a medication cup containing 5 ml (milliliter) of white liquid medication was on Resident 44's bedside table. LVN 6 stated the white medication in the cup was megace (a medication used for appetite loss). LVN 6 stated he handed Resident 44 the morning dose of megace but did not watch Resident 44 take medication. LVN 6 stated when medications are administered to residents, nurses should watch residents swallowing their medication. During a concurrent interview and record review on 3/11/26 at 1:55 p.m. with Medical Records (MR), Resident 44's Electronic Health Record (EHR), [undated] was reviewed. MR stated Resident 44 had no physician order to keep medication at bedside and no self-administer order. MR stated there was no self-administer assessment for Resident 44. During a review of the facility's policy and procedure (P&P) titled, Medication Storage, dated 10/2024, the P&P indicated, Beside medication storage is permitted for residents who are able to self-administer medications, upon the written order of the prescriber and when it is deemed appropriate in the judgment of the facility's interdisciplinary resident assessment team. A. A written order for the bedside storage of medication is present in the resident's medical record.c) The manner of storage prevents access by other residents. Lockable drawers or cabinets are required.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview, and record review, the facility failed to implement infection prevention practices when:1. One of two clean laundry bins had dirt-like debris at the bottom.2. One of one unmarked laundry bin containing clean pillows was stored in the dirty laundry area.3. Two of five sampled staff members (Medical Doctor [MD] 1, Nurse Practitioner [NP] 1) did not apply appropriate Personal Protective equipment (PPE, gowns, gloves, face masks, face shields or other equipment designed to protect the wearer from injury or the spread of infection or illness) prior to providing care to a resident on enhanced barrier precautions (EBP, an infection control practice that utilizes the use of gown and gloves during high contact care activities to stop the spread of multi-drug resistant organisms [MDRO]). 4. One of two sampled Licensed Vocational Nurse (LVN 3) did not disinfect glucometers between resident use.These failures had the potential to result in the spread of disease causing organisms and infections of residents, staff, and visitors. Findings: 1. During a concurrent observation and interview on 3/9/26 at 9:41 a.m. with Maintenance Supervisor (MS), in the laundry room, there were two laundry bins in front of two dryers designated as clean. One clean laundry bin had dirt-like debris at the bottom with pieces of material present. MS stated laundry aides should have cleaned and removed the trash from the bin. During a review of the facility's policy and procedure (P&P) titled, Laundry, dated 12/2007, the P&P indicated, E. Maintenance of Laundry Room Equipment: . 6. Clean laundry barrels, hampers, and carts regularly. During a review of the facility's P&P titled, Laundry – Supply and Storage, dated 1/1/12, the P&P indicated, Procedure: . F. All laundry hampers are cleaned daily. iii. Plastic hampers and covers are to be washed with disinfectant solution and dried. 2. During a concurrent observation and interview on 3/9/26 at 10:35 a.m. with Laundry Aide (LA), in the laundry room, there was one unmarked laundry bin stored in the dirty laundry area containing clean pillows. LA stated the extra clean pillows were stored in the dirty laundry area due to not having enough storage space. During a review of the facility's P&P titled, Laundry, dated 12/2007, the P&P indicated, D. Linen Supply and Storage: . 3. Ensure soiled and clean linens are never stored in the same room. During a review of the facility P&P titled, Laundry – Supply and Storage, dated 1/1/12, the P&P indicated, Policy I. Laundry areas should have at a minimum: A. Separate room for the storage of clean linen and soiled linen. 3. During an observation on 3/12/26 at 10:16 a.m. in Resident 7's room, Resident 7 had a sign on the wall above the bed indicating EBP. Resident 7 was laying in her bed undressed from the waist down, NP 1 was standing on the right side of Resident 7's bed, holding Resident 7 with both hands to help Resident 7 position onto her right side. MD 1 was standing on the left side of Resident 7's bed and proceeded to provide wound treatment to Resident 7's sacral (area at the bottom of the spine) wound. MD 1 and NP 1 were not wearing gowns. During an interview on 3/12/26 at 10:45 a.m. with MD 1 and NP 1, MD 1 stated Resident 7 was on EBP. MD 1 and NP 1 both stated they should have been wearing gowns during Resident 7's wound treatment. MD 1 stated he forgot. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's P&P titled, Enhanced Barrier Precautions, dated 10/15/24, the P&P indicated, Enhanced Barrier Precautions will be used for novel or targeted multi-drug-resistant organisms (MDROs) in the facility. No physician order is necessary for Enhanced Barrier Precautions.2. For residents for whom EBP are indicated, EBP is employed when performing the following high-contact resident care activities.h. Wound care: any skin opening requiring a dressing.Enhanced Barrier Precautions.Required PPE.Gloves and gown prior to the high contact care activity.(Face protection may also be needed if performing activity with risk of splash or spray). 4. During an observation on 3/11/26 at 11:25 a.m. in Resident 106's room, LVN 3 used glucometer (small portable electronic device used to measure the amount of glucose [sugar] in a person's blood) 1 to check Resident 106's blood glucose level. During an observation on 3/11/26 at 11:28 a.m. outside of resident 106's room, LVN 3 removed a Sani-Wipe (hospital-grade disinfectant wipes used to kill disease causing organisms) from its container, folded the Sani-Wipe around glucometer 1 and placed it on top of the medication cart. LVN 3 did not use a wiping motion to disinfect glucometer 1 prior to placing it on the medication cart. During an observation on 3/11/26 at 11:32 a.m. in Resident 105's room, LVN 3 used glucometer 2 to check Resident 105's blood glucose level. During an observation on 3/11/26 at 11:37 a.m. outside of Resident 105's room, LVN 3 removed a Sani-Wipe from its container, folded the Sani-Wipe around glucometer 2 and placed it on top of the medication cart. LVN 3 did not use a wiping motion to disinfect glucometer 2 prior to placing it on the medication cart. During a concurrent observation and interview on 3/11/26 at 11:43 a.m. outside of Resident 105's room, LVN 3 picked up glucometer 1 from the medication cart, removed the Sani-Wipe and started walking towards a resident room to check the glucose level. LVN 3 stated the process to clean a glucometer was to wipe it with a Sani-Wipe, cover the glucometer with a Sani-Wipe and let it sit for two minutes before using it again on another resident. LVN 3 stated she did not wipe down glucometer 1 or glucometer 2 after use and only wrapped them in Sani-Wipes. LVN 3 stated she should have wiped the glucometers prior to placing them on the medication cart. During a review of the facility's P&P titled, Cleaning & Disinfection of Resident Care Equipment, dated 1/1/12, the P&P indicated, Reusable resident care equipment is decontaminated and/or sterilized between residents according to manufacturers' instructions. During a review of the Manufacturers' Guidelines (MG) titled, Asure Platinum Blood Glucose Meter, dated 2026, the MG indicated, The meter should be cleaned and disinfected after use on each patient.CLEANING. Wear appropriate protective gear such as disposable gloves.Open the cap of the disinfectant container and pull out 1 towelette and close the cap. Wipe surface of the meter to clean blood and other body fluids. Carefully wipe around the test strip port by inverting the meter so that the test strip port is facing down. This prevents disinfectant liquid from entering the meter. If blood is visibly present on the meter, it should be cleaned prior to each disinfection step. DISINFECTING.Pull out 1 new towelette and wipe the entire surface of the meter horizontally and vertically to remove bloodborne pathogens. Carefully wipe around the test strip port by inverting the meter so that the test strip port is facing down.Treated surface must remain wet for recommended contact time. DO NOT WRAP THE METER IN A WIPE.

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep all essential equipment working safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure one of one sampled resident's (Resident 9) feeding pump (used to deliver feeding and nutrition through a gastrostomy tube [G-tube inserted through the abdominal wall into the stomach) was secured to a pole to prevent pump from falling. This failure had the potential to cause injury to Residents, staff, and visitors and cause injury to Resident 9's G-tube if feeding pump falls. Findings: During an observation on 3/9/26 at 10:59 a.m. in Resident 9's room, a feeding pump was sitting on the overbed table next to Resident 9's bed. During a concurrent observation and interview on 3/11/26 at 1:57 p.m. with Licensed Vocational Nurse (LVN) 7, in Resident 9's room, a feeding pump was sitting on over bed table next to Resident 9's bed. LVN 7 stated she did not know why the feeding pump was on the overbed table and not attached to the pole. LVN 7 stated the pump could fall and should have been secured to the pole. During a review of the operating manual for the Kangaroo [NAME] Enteral Feed and Flush Pump with Pole Clamp (IFU - Instructions for Use), (undated), the IFU indicated, 35. This device is designed for use on a conventional IV [intravenous- within the vein] pole.

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. Based on observation, interview, and record review, the facility failed to ensure a safe, functional, sanitary, and comfortable environment when:1. Two of two laundry dryer filters were not free of thick lint buildup. This failure had the potential to increase the risk of a fire affecting residents' safety. 2. One of one shower room ceiling had cracked ceiling plaster. This failure had the potential to increase the risk mold and contaminants which can contribute to respiratory illness in residents.3. One of two housekeeping carts containing chemicals was missing the locking top. This failure had the potential to result in an increased risk of residents' exposure to accidental ingestion, poisoning, skin and or eye irritation, and burns from housekeeping chemicals. 4. Two of two resident restrooms had cracked flooring. This failure had the potential to increase the risk of lacerations (cuts) and severe bruising to residents. Findings: 1. During a concurrent observation and interview on 3/9/26 at 9:38 a.m. with the Maintenance Supervisor (MS), in the laundry room, there were two dryers not in use. There was thick lint buildup in each dryer's filter. MS stated the laundry aide must not have cleaned the dryer filters. During a review of the facility's policy and procedure (P&P) titled, Laundry, dated 12/2007, the P&P indicated, E. Maintenance of Laundry Room Equipment: . 5. Clean dryer lint compartment and screens.During a review of the facility's P&P titled, Laundry - Supply and Storage, dated 1/1/12, the P&P indicated, Procedure. E. After each use of the washing machine or dryer, and at least daily: . ii. Clean lint filters.2. During a concurrent observation and interview on 3/9/26 at 11:14 a.m. with MS, in the shower room, the ceiling plaster around the ceiling light was cracked and bubbling. MS stated the ceiling plaster was cracked and needed repair. During a review of the facility's P&P titled, Residents Rooms and Environment, dated 1/1/12, the P&P indicated, Procedure. I. Facility Staff aim to create a personalized, homelike atmosphere, paying close attention to the following: A. Cleanliness and Order.During a review of the facility's P&P titled, Maintenance Service, Operational Manual, dated 1/1/12, the P&P indicated, Procedure. II. Functions of the Maintenance Department may include but are not limited to:. B. Maintaining the Building in good repair and free from hazards.3. During a concurrent observation and interview on 3/10/26 at 12:24 p.m. with Housekeeper (HSK) 1, in the 300-wing hallway, one of two housekeeping carts was missing the locking top which exposed housekeeping chemicals which were accessible to residents and staff. HSK 1 stated that the top broke three days ago. During an interview on 3/10/26 at 12:32 p.m. with MS, MS stated he was notified about the broken housekeeping cart two or three weeks ago.During a review of the facility's P&P titled, General Housekeeping Duties, dated 11/8/06, the P&P indicated, 1. General Duties of housekeeping staff are as follows: j. Clean and keep in order all housekeeping equipment, supply areas, and closets. K. Be especially considerate of residents. Watch your equipment and chemicals, so as not to endanger anyone. J. Safety, Housekeeping staff safety procedures and responsibilities are as follows: 1. Know the correct and safe procedure and follow it closely when using any cleaning product, device, or appliance. 5. Check all cleaning machines and appliances daily to make sure they are.operating correctly, free form defects.Report any defects to your supervisor immediately. 4. During a concurrent observation and interview on 3/12/26 at 8:39 a.m. with HSK 2, in Resident 102's bathroom, there were cracks in the flooring around the toilet. HSK 2 stated the linoleum behind the toilet appeared to be cracked and pulling away from the wall. During a concurrent observation and interview on 3/12/26 at 8:50 a.m. with MS, in Resident 99's bathroom, there were cracks in the flooring around the toilet. MS stated there were cracks in the flooring.During a review of the facility's P&P titled, Residents Rooms and Environment, dated 1/1/12, the P&P indicated, Procedure. I. Facility Staff aim to create a personalized, homelike atmosphere, paying close attention to the following: A. Cleanliness and Order.During a review of the facility's P&P titled, Maintenance Service, Operational Manual, dated 1/1/12, the P&P indicated, Procedure. II. Functions of the Maintenance Department may include but are not limited to:. B. Maintaining the Building in good repair and free from hazards.