STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055689	A. Building B. Wing	03/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St. Catherine Healthcare	245 E Wilshire Avenue Fullerton, CA 92832

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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 0606 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Not hire anyone with a finding of abuse, neglect, exploitation, or theft. Based on interview, facility document review, and facility P&P review, the facility failed to ensure the safety of the residents when one of two volunteer staff (the Activity Volunteer) with a prior history of conviction was recruited to work with the residents. * The Activity Volunteer was a current sex offender registrant who was volunteering in the facility. This failure had the potential to put the residents at risk of harm or negative outcomes.Findings: Review of the facility's P&P titled Abuse: Prevention and Prohibition Against revised December 2023 showed the following:- The P&P applies to all facility staff including but not limited to employees, consultants, volunteers, students, and other caregivers who provide care and services to residents on behalf of the facility; and- All employees, temporary staff, prospective consultants, contractors, volunteers, caregivers, and students will be properly screened prior to working at the Facility. Review of the Activity Volunteer's facility volunteer application dated 8/2/24, showed a hand written response of yes to the section asking if the applicant had been convicted of a criminal offense by any court. The volunteer application showed the Activity Volunteer disclosed he was currently a sex offender registrant. The volunteer application further showed the facility initiated a background check, which came back with no criminal findings. On 3/11/26 at 1625 hours, an interview and concurrent facility document review was conducted with the Administrator. The Administrator stated all the employees and volunteers have background checks conducted. The Administrator stated he was not aware Activity Volunteer wrote their sex offender status on the application. On 3/12/26 at 0932 hours, a telephone interview was conducted with the Activity Volunteer. The Activity Volunteer stated he had been on the sex offender registry since before the early 2000's. On 3/12/26 at 1105 hours, an interview was conducted with the HR. The HR stated she did not see the Activity Volunteer's application showing he was a registered sex offender. The HR stated she ran a background check done on him and the results did not show any criminal history. The HR stated she missed where he wrote he was a registered offender on the application. The HR stated had she seen it, she would have contacted him to get more information. The HR stated she first reached out to the Activity Volunteer about his application's sex offender response yesterday (3/11/26), and he refused to give her any information other than it went back 20 years.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, medical record review, facility document review and facility P&P review, the facility failed to implement their antibiotic stewardship program to show timely physician notification for two final sampled residents (Residents 17 and 49) and three nonsampled residents (Residents 16, 47, and 93) who received antibiotics for infections that did not meet McGeer's criteria. * The facility failed to ensure Resident 47's symptoms met the criteria for a UTI, notify the physician the infection did not meet the criteria, and reassess the need for continued antibiotic therapy. * Resident 16's physician was notified the UTI infection did not meet the criteria, however there was no indication as to when the physician was notified. Additionally, the form was completed by the IP who was out of the facility at the time and returned in March 2026. * Resident 17's physician was notified the UTI infection did not meet the criteria, however there was no indication as to when the physician was notified. * Resident 49's physician was notified the UTI infection did not meet the criteria, however there was no indication as to when the physician was notified. * Resident 93's physician was notified the UTI infection did not meet the criteria, however there was no indication as to when the physician was notified. These failures had the potential for the residents' being on unnecessary antibiotic therapy potentially resulting in MDRO's. Findings: Review of the facility's P&P titled Antibiotic Stewardship revised January 2022 showed the Antibiotic Stewardship Program will promote appropriate use of antibiotics while reducing possible adverse events associated with antibiotics use with the potential to limit antibiotic resistance. The World Health Organization has reported that antibiotic resistance is one of the major threats to human health, especially because some bacteria have developed resistance to all known classes of antibiotics. Diseases caused by these bacteria are increasing in long-term care facilities and contributing to higher rates of morbidity and mortality. 1. Medical record review for Resident 47 was initiated on 3/13/26. Resident 47 was admitted to the facility on [DATE]. Review of Resident 47's UTI Surveillance Data Collection Form for symptoms that started on 1/4/26, showed the data met criteria for a true infection. However, review of Resident 47's medical record failed to show the resident's symptoms met criteria for a UTI. Review of Resident 47's MAR for January 2026 showed the resident received ciprofloxacin (an antibiotic) 500 mg medication from 1/7/26 through 1/17/26. Review of Resident 47's medical record and the Surveillance Data records failed to show the resident's physician was notified the infection did not meet criteria, and to reassess the need for continued antibiotic therapy. On 3/13/26 at 1305 hours, an interview, medical record review, and concurrent facility document review for Resident 47 was conducted with the IP and DSD. The DSD stated she assisted the IP with IP duties. The IP and DSD verified Resident 47's Surveillance Data Collection Form incorrectly showed the UTI met criteria, and therefore the physician was not followed-up with to re-assess the need for continued antibiotic therapy. 2. Medical record review for Resident 16 was initiated on 3/13/26. Resident 16 was admitted to the facility on [DATE]. Review of Resident 16's UTI Surveillance Data Collection Form for UTIs for symptoms that started on 2/19/26, showed the infection did not meet McGeer's criteria for infection. The form showed the physician was notified the infection did not meet criteria and instructed to continue the antibiotics, however the form failed to show when the physician was notified. In addition, the form was completed by the IP, who was out of the facility at the time, and returned in March 2026. Review of Resident 16's MAR for February 2026 showed the resident received cephalexin (an antibiotic) 500 mg medication from 2/20/26 to 2/24/26. On 3/13/26 at 1305 hours, an interview, medical record review for Resident 16 and concurrent facility document review was conducted with the IP. The IP stated she completed the Surveillance Data Collection Form after returning to the facility on 3/1/26, which was after the resident completed the antibiotic therapy, and verified the physician was not notified timely regarding the resident's infection did not meet criteria. 3. Medical record review for Resident 17 was initiated on 3/11/26. Resident 17 was admitted to the facility on [DATE]. Review of (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident 17's Surveillance Data Collection Form for UTIs showed the resident's symptoms started on 1/18/26, showed the infection did not meet McGeer's criteria for infection. The form showed the physician was notified the infection did not meet criteria and instructed to continue the antibiotics, however the form failed to show when the physician was notified. Review of Resident 17's MAR for January 2026 showed the resident received ciprofloxacin 500 mg medication from 1/22/26 through 1/29/26. On 3/13/26 at 1305 hours, an interview, medical record review, and concurrent facility document review for Resident 17 was conducted with the IP and DSD. The DSD stated she assisted the IP with IP duties. The IP and DSD verified Resident 17's Surveillance Data Collection Form failed to show when the physician was notified the infection failed to meet criteria, and re-assessed the need for continued antibiotic therapy. 4. Medical record review for Resident 49 was initiated on 3/11/26. Resident 49 was initially admitted to the facility on [DATE]. Review of Resident 49's Surveillance Data Collection Form for Other Infections for symptoms which started on 1/30/26, showed the infection did not meet McGeer's criteria for infection. The form showed the physician was notified the infection did not meet criteria and instructed to continue the antibiotics, however the form failed to show when the physician was notified. Review of Resident 49's MAR for February 2026, showed the resident had an order dated 1/30/26, for amoxicillin-potassium clavulanate (an antibiotic) 875-125 mg. The antibiotic was administered through 2/5/26. On 3/13/26 at 1305 hours, an interview, medical record review for Resident 49 and concurrent facility document review was conducted with the IP and the DSD. The DSD stated she assisted the IP with IP duties. The IP and the DSD verified Resident 49's Surveillance Data Collection Form failed to show when the physician was notified the infection failed to meet criteria, and reassessed the need for continued antibiotic therapy. 5. Medical record review for Resident 93 was initiated on 3/13/26. Resident 93 was re-admitted to the facility on [DATE]. Review of Resident 93's UTI Surveillance Data Collection Form initiated for symptoms which started on 2/2/26, showed the infection did not meet McGeer's criteria for infection. The form showed the physician was notified the infection did not meet criteria and instructed to continue the antibiotics, however the form failed to show when the physician was notified. Review of Resident 93's MAR for February 2026 showed the resident received cephalexin 500 mg medication from 2/4/26 to 2/11/26. On 3/13/26 at 1305 hours, an interview, medical record review, and concurrent facility document review for Resident 49 was conducted with the IP and DSD. The DSD stated she assisted the IP with IP duties. The IP and DSD verified Resident 93's Surveillance Data Collection Form failed to show when the physician was notified the infection failed to meet criteria, and reassessed the need for continued antibiotic therapy.

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review and facility P&P review, the facility failed to ensure one of 19 final sampled residents (Resident 6) and one nonsampled resident (Resident 41) were assessed to self-administer medications. * Resident 6's bedside table was observed with a bottle of Mylanta (antacid and anti-gas medication) on top of bedside table. There was no physician's order for the Mylanta medication and no self-administration assessment for Resident 6. * Resident 41's bedside table was observed with a Biofreeze Cool the Pain (topical analgesic) medication on top of bedside table. There was no physician's order for the Biofreeze Cool the Pain and no self-administration assessment for Resident 41. These failures had the potential for the residents to administer the medications inaccurately and negatively impact the residents' well-being.Findings: Review of the facility's P&P titled Self Administration of Medications dated February 2021 showed it is the policy of this facility to respect the wishes of alert, competent residents to self-administer prescribed as allowable under state regulations. The Procedure section showed if a resident desires to participate in self-administration, the interdisciplinary team will assess and periodically re-evaluate the resident based on change in the resident's status. 1. On 3/11/26 at 0956 hours, during the initial tour of the facility, an observation and concurrent interview was conducted with Resident 6 in Resident 6's room. Resident 6's bedside table was observed with a bottle of Mylanta medication on top of the bedside table. Resident 6 stated he forgot who brought the medication for him. Resident 6 stated he took the medication about a week ago or maybe more. Medical record review for Resident 6 was initiated on 3/11/26. Resident 6 was admitted to the facility on [DATE]. Review of Resident 6's MDS assessment dated [DATE], showed the resident was cognitively intact. Review of Resident 6's Order Summary Report for March 2026 failed to show there was a physician's order for the Mylanta medication and for self-administration of medications. On 3/11/26 at 1018 hours, an observation and concurrent interview was conducted with LVN 1. LVN 1 verified there was a bottle of Mylanta medication on top of Resident 6's bedside table. LVN 1 stated the Mylanta medication should not be on Resident 6's bedside and every medication would need a physician's order. LVN 1 stated Resident 6 had no consent for self-administration. On 3/13/26 at 0933 hours, an interview and concurrent medical record review for Resident 6 was conducted with RN 2. RN 2 verified there was no physician's order for the Mylanta medication and no documented evidence an assessment of self-administration of the medication was conducted for Resident 6. RN 2 stated the licensed nurse should have explained to Resident 6 the medication he had needed to have a physician's order. 2. During the initial tour of the facility on 3/11/26 at 1039 hours, an observation and concurrent interview was conducted with Resident 41 in Resident 41's room. Resident 41's bedside table was observed with a Biofreeze Cool the Pain medication. Resident 41 stated he brought Biofreeze Cool the Pain medication when he came to the facility. Resident 41 further stated he applies the Biofreeze Cool the Pain medication on his hand when it hurts. Resident 41 stated he only used Biofreeze Cool the Pain medication when the pain was really bad. Medical record review for Resident 41 was initiated on 3/11/26. Resident 41 was admitted to the facility on [DATE]. Review of Resident 41's MDS assessment dated [DATE], showed the resident was cognitively intact. Review of Resident 41's Order Summary Report for March 2026 failed to show there was a physician's order for the Biofreeze Cool the Pain medication and for self-administration of medications. On 3/11/26 at 1048 hours, an observation and concurrent interview was conducted with LVN 1. LVN 1 verified the Biofreeze Cool the Pain medication was on top of right bedside table. LVN 1 acknowledged the Biofreeze Cool the Pain medication was open and not sealed. LVN 1 stated Resident 41's belongings should have been searched better. LVN 1 stated the staff should make sure there was nothing at the bedside that could harm Resident 41 and the Biofreeze Cool the Pain medication should have been accounted for. On 3/13/26 at 0918 hours, an interview and concurrent medical record review for Resident 41 was (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	conducted with RN 2. RN 2 verified Resident 41 did not have a physician's order and self-administration assessment for the Biofreeze Cool the Pain medication. RN 2 stated usually the licensed nurse would ask the resident if they wanted to use a medication that was not on their medication list. RN 2 further stated the licensed nurse would let the physician know and ask if the resident could use the medication. RN 2 stated if the resident wanted to self-administer the medication, the licensed nurse would notify the physician again. RN 2 stated if the resident was capable of self-administration of the medication, the licensed nurse would do the self-administration assessment. On 3/17/26 at 1036 hours, the Administrator and DON were informed and acknowledged the above findings.

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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, medical record review, and facility P&P review, the facility failed to ensure the Advance Directive and POLST were complete for one of 19 final sampled residents (Resident 32). * Resident 32's Advanced Directive did not show who the resident selected as his health care agent. In addition, the facility failed to ensure the POLST completed with Family Member 1 matched the resident's wishes for life sustaining treatment as detailed in Resident 32's Advanced Directive. This failure had the potential for the resident's end of life wishes not being followed.Findings: Review of the facility's P&P titled Advance Directives revised [DATE] showed the following:- Should the resident indicate that he or she has issued Advance Directives about his/her care and treatment, the facility will require that a copy of such directives be included in the medical record;- The facility will notify the attending physician of Advance Directives so that appropriate orders can be documented in the resident's medical records and plan of care; and- Inquiries concerning Advance Directives should be referred to social services, and/or to the director of nursing services. Medical record review for Resident 32 was initiated on [DATE]. Resident 32 was admitted to the facility on [DATE], and transferred to another facility on [DATE]. Review of Resident 32's Advanced Directive Durable Power of Attorney for Health Care and Living Will dated [DATE], showed the following specific scenarios and the residents request if life-sustaining treatment (CPR, a breathing machine, kidney dialysis, feeding tubes/artificial nutrition and hydration) should be provided:- If the resident is unconscious, in a coma, or a vegetative state and there is little or no chance of recovery: the resident selected no, he would not want life-sustaining treatments; - If the resident is in need of a breathing machine and will be in bed for the rest of his life: the resident selected no, he would not want life-sustaining treatment;- The Advance Directive also showed the resident selected he wanted his preferences, as expressed in this Living Will, to be followed strictly, even if the person making the decisions for him thinks it isn't in the resident's best interests; and- The Advance Directive was missing page number two, and failed to show who the resident selected as his healthcare agent. The form was labeled acute care hospital form 10-0137 [DATE] in the lower left corner. Review of the acute care hospital's form 10-0137 [DATE] template showed page two was where the option to select a health care agent, and an alternate health care agent. Review of Resident 32's POLST dated [DATE], signed by Family Member 1 showed the resident had an Advance Directive dated 2024 and the legally recognized decision maker was Family Member 1. The POLST showed to attempt resuscitation/CPR, full treatment with the primary goal of prolonging life, and long term artificial nutrition including feeding tubes. The back side of the POLST's directions for health care provider showed: A POLST does not replace the Advanced Directive. When available, review the Advance Directive and POLST form to ensure consistency, and update form appropriately to resolve any conflicts. Review of Resident 32's H&P examination dated [DATE], showed the resident had no capacity to understand and make decisions. Review of Resident 32's Social Services Assessment/Evaluation - V 3 dated [DATE], showed a copy of the acute care hospital's Healthcare Directive was in the resident's medical record, and the POLST was completed with Family Member 1. Review of Resident 32's Social Services note dated [DATE], showed the resident's acute care hospital's Advance Healthcare Directive contradicts with the POLST, and the SSD discussed it with Family Member 1, who wants to continue with the current POLST. On [DATE] at 1611 hours, an interview and concurrent medical record review for Resident 32 was conducted with the SSD. The SSD stated Family Member 1 was Resident 32's health care agent. The SSD stated she noticed the resident's POLST and Advance Directive did not match and discussed it with Family Member 1 on [DATE]. The SSD verified the resident's Advance Directive failed to show Family Member 1 was listed as the health care agent. The SSD stated she would reach out to the acute care hospital and see if they have a copy of the resident's Advance (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Directive. On [DATE] at 0936 hours, the facility provided a copy of a prior, now void, Advance Directive that was on file at the acute care hospital. The Advanced Healthcare Directive was dated [DATE], and listed Family Member 2 as the designated healthcare agent and Family Member 1 as the alternate.

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and medical record review, the facility failed to ensure two of seven final sampled residents (Residents 7 and 8) reviewed for unnecessary medications were free from unnecessary psychotropic drugs. * The facility failed to document the nonpharmacological interventions to be attempted when Resident 7 had an episodes of angry outbursts. * The facility failed to ensure the episodes of anxiety were monitored for Resident 8. In addition, the facility failed to provide interventions to address Resident 8's behavior when the resident exhibited agitation and angry outbursts. These failures had the potential for adverse effects from the psychotropic medications and the potential for not providing the correct data to the prescriber to adjust the dosage of the psychotropic medications.Findings: 1. Medical record review for Resident 7 was initiated on 3/11/26. Resident 7 was admitted to the facility on [DATE]. Review of Resident 7's H&P examination dated 1/24/26, showed Resident 7 had no capacity to understand and make decisions. Review of Resident 7's Order Summary Report showed the following physician's orders: - dated 6/16/25, to monitor and document number of psychotic behaviors as evidence by angry outburst every shift; and -dated 2/17/26, to administer quetiapine (anti-psychotic medication) 25 mg by mouth, at bedtime for schizoaffective disorder manifested by angry outburst. Review of Resident 7's care plan for potential behavior problem related to angry outbursts dated 6/16/25, showed interventions including document behaviors and resident response to interventions. Review of Resident 7's MAR for September to December 2025 showed to monitor and document the number of psychotic behaviors as evidenced by angry outburst. The MAR from September 2025 to December 2025 showed the following: - dated 9/23 at night shift - one episode; - dated 10/21 at evening shift – two episodes; - dated 12/20 at day shift – one episode; and - dated 12/28 at night shift – one episode. Further review of Resident 7's MAR failed to show documented evidence of nonpharmacological interventions when Resident 7 had episodes of angry outbursts. On 3/12/26 at 1446 hours, an interview and medical record review for Resident 7 was conducted with the MDS Coordinator. The MDS Coordinator verified the above findings. The MDS Coordinator stated there was no documentation related on which nonpharmacological interventions would be attempted if the resident had an episode of angry outburst. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/17/26 at 0909 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings. 2. Medical record review for Resident 8 was initiated on 3/12/26. Resident 8 was admitted to the facility on [DATE]. Review of Resident 8's Order Summary Report showed the following physician's orders: - dated 2/19/26, to monitor for episodes of anxiety as evidenced by agitation and angry outbursts every shift; - dated 2/19/26, to administer Ativan (antianxiety medication) 1 mg one tablet by mouth every eight hours as needed for anxiety with manifested behavior of agitation and angry outbursts for 14 days (2/19 to 3/5/26); and -dated 3/5/26, to administer Ativan 1 mg one tablet by mouth every eight hours as needed for anxiety with manifested behavior of agitation and angry outbursts for 30 days (3/5 to 4/4/26). a. Review of Resident 8's MAR for March 2026 showed Resident 8 received Ativan 1 mg on the following dates and times: - dated 3/1 at 0300 hours; - dated 3/11 at 0721 hours; - dated 3/12 at 0636 hours; and - dated 3/15 at 1208 hours. Review of Resident 8's medical record failed to show the episodes of anxiety were monitored and documented when the Ativan medication was given on the above listed dates. b. Review of Resident 8's care plan for Ativan for anxiety dated 1/13/26, showed interventions including to give antianxiety medication ordered by physician, monitor/record occurrence of target behavior symptoms, and nonpharmacological interventions (back rub, redirection, speak to/approach in a calm manner, reposition, offer snacks or fluid/milk, assess for pain, provide a quiet environment, encourage to express feelings, take to activities, and provide reassurance). Review of Resident 8's MAR for March 2026 showed Resident 8 was monitored and documented with episodes of anxiety as evidenced by agitation and angry outbursts on the following dates and shifts: - dated 3/2 at night shift – one episode; - dated 3/4 at evening shift – one episode; - dated 3/4 at night shift – one episode; - dated 3/6 at day shift – one episode; (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- dated 3/7 at day shift – one episode; - dated 3/7 at night shift – one episode; - dated 3/8 at day shift – one episode; and - dated 3/10 at day shift – one episode; Review of Resident 8's medical record failed to show the manifested behaviors were addressed by either providing nonpharmacological interventions or administering the Ativan medication as prescribed. On 3/16/26 at 1344 hours, an interview and concurrent medical record review for Resident 8 was conducted with RN 1. RN 1 verified the above findings. RN 1 stated the manifested behaviors should be accurately documented to determine if the resident was getting better or worse and it would also assist in determining whether the medication should be continued or not. RN 1 further stated the manifested behavior should be addressed by providing nonpharmacological interventions and if not effective, administer the prescribed medication for anxiety. On 3/16/26 at 1455 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings for Resident 8.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, medical record review and facility P&P review, the facility failed to ensure the comprehensive plan of care was revised to reflect the resident's current care needs and interventions for one of 19 final sampled residents (Resident 5). * The facility failed to revise Resident 5's care plan to address the interventions for the left arm AV fistula. This failure posed the risk of not providing the resident with individualized and person-centered care.Findings: Review of the facility's P&P titled Care plan and care plan update revised 3/2020 showed it is the policy of this facility to ensure each resident receives quality of care and services to attain and maintain the highest practicable physical mental and psychosocial well being in accordance with the interdisciplinary comprehensive assessment and plan of care. Care plan will be initiated based on identified problems and medical change of condition. On 3/11/26 at 0808 hours, during the initial tour of the facility, Resident 5 was observed with the upper right chest perma-catheter. Resident 5 stated that she goes to dialysis and use the perma-catheter for dialysis. Resident 5 further stated she has a new left upper arm fistula. Medical record review for Resident 5 was initiated on 3/11/26. Resident 5 was admitted to the facility on [DATE]. Review of Resident 5's Care Plan Report showed a care plan problem dated 10/29/24, addressing needs for dialysis related to renal failure. Review of Resident 5's H&P examination dated 10/10/25, showed the resident could make needs known and make medical decisions. Review of Resident 5's Arteriovenous Access Creation/Surgery Discharge Instructions dated 2/10/26, showed left arm AV fistula creation with a discharge instruction to not lift anything or strain your access arm. Review of Resident 5's care plans failed to show the care plan interventions for dialysis related to renal failure was updated to include addressing precautions to be taken on the new left arm AV fistula. On 3/16/26 at 1017 hours, an interview and concurrent medical record review for Resident 5 was conducted with RN 1. RN 1 verified there were no interventions developed to address the left arm AV fistula and verified the findings. On 3/17/26 at 0902 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings. Cross reference to F842

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. Based on observation, interview, facility document review, and facility P&P review, the facility failed to ensure two licensed nurses reviewed for competency had specific competencies and standard of practice skill sets needed to provide safe and efficient nursing care. * The facility failed to ensure LVN 3 was able to demonstrate competency in the calibration of a glucometer accucheck machine (a device used to measure the concentration of glucose in the blood). * The facility failed to ensure RN 2 was able to competently administer the correct intravenous medication dosage to Resident 101. These failures had the potential to put the residents at risks for the care not provided in a safe and competent manner.Findings: Review of the facility's document titled Registered Nurse Supervisor Job Description dated 12/17/21, showed the RN must be knowledgeable of nursing and medical practices and procedures, as well as laws, regulation and guidelines that pertain to long-term care. Review of the facility's document titled Licensed Vocational Nurse/Licensed Practical Nurse Job Description dated 12/17/21, showed the LVN must be knowledgeable of the nursing and medical practices and procedures, as well as laws, regulation and guidelines that pertain to long-term care. Review of the blood glucose meter manufacturer's information sheet titled Quality Assurance/ Quality Control Reference Manual (undated) showed the following:- under Quality Control Test section showed to perform a control test to ensure the meter is working properly:a. Insert a test strip;b. Select mode: Press the arrow buttons to enter control solution mode (indicated by a bottle icon);c. Apply solution: Shake the Assure Dose Control Solution, discard the first drop, and apply the second drop to the cap;d. Check range: Compare the result to the range printed on the test strip vial.- under the Troubleshooting and Tips section showed to use Assure Dose Control Solution (blue cap = normal, green cap = high). Make sure the test strips and control solutions are not past expiration date. The date is shown in the bottle. Discard control solution 90 days after the bottle is opened. Results that fall outside the range may be caused by the test strip bottle was opened for more than three months. 1. On 3/11/26 at 1606 hours, an observation of the glucometer quality control, review of the glucometer quality control record, and concurrent interview was conducted with LVN 3. When LVN 3 was asked to calibrate the glucometer, LVN 3 stated she did not know how to calibrate the glucometer. LVN 3 stated she was oriented by another charge nurse during her orientation period. When asked if she was taught how to calibrate the glucometer, LVN 3 stated she could not recall. On 3/13/26 at 1504 hours, an interview and concurrent employee file review for LVN 3 was conducted with the DON. Review of LVN 3's Medication Pass Guidelines (undated) showed under Insulins/Diabetic Management/Glucometer: a. Vials are dated when opened; b. Insulin suspensions are gently rolled in palms; and c. The clear rapid or short-acting insulin is drawn up first when insulins are mixed, LVN 3 had checks in #1 column for a, b, and c. The file showed LVN 3 was observed on 11/20/25 by the DON. However, the section did not show if the glucometer calibration was reviewed/observed for LVN 3. The DON stated the checked in column #1 meant yes showing LVN 3 passed the observations. The DON stated she was responsible for checking off the skills competency for licensed nurses. The DON stated she provided training and performed the glucometer calibration skills check to LVN 3 upon hire. The DON stated the competency skills check including calibration of the glucometer was done upon hire, annually, and as needed. The DON was informed and acknowledged the above findings. 2. Review of the facility's P&P titled Policy and Procedure of IV (undated) showed because of the complexity involved in the administration of infusion therapy, it is essential that responsibility not only be assigned and taught, but that accountability of each person involved in the delivery and maintenance of infusion therapy be stressed. The practicing nurse is ultimately responsible to be knowledgeable regarding the specific drug and therapy to effectively implement these policies and procedures in individual clinical applications. On 3/12/26 at 0908 hours, a medication administration observation for Resident 101 was conducted with RN 2. RN 2 stated she (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	would be administering ertapenem (antibiotic) IV 500 mg to Resident 101. RN 2 stated Resident 101 received the antibiotic once daily since 3/7/26. The ertapenem medication vial showed one gram/10 ml. The pharmacy label attached showed ertapenem one gram/10 ml sterile water, then transfuse 5 ml (500 mg) into 50 ml NS piggyback, and infuse one IVPB over 30 minutes one time a day. RN 2 was observed diluting the one vial of ertapenem with 10 ml of NS, aspirated the whole amount in the vial which totaled to 10 ml, and mixed it in the 50 ml of NS piggyback. RN 2 was observed hanging the 50 ml of NS piggyback with the ertapenem medication. RN 2 connected the IV tubing to Resident 101's peripheral IV catheter in the right arm. RN 2 stated she would run the whole bag of NS IVPB for 30 minutes and would come back after that to recheck Resident 101 when asked if she would administer the whole bag of NS with the ertapenem medication. RN 2 was instructed by the surveyor not to administer the IV medication she prepared. RN 2 was informed by the surveyor the dosage she prepared was incorrect according to the physician's order. RN 2 acknowledged the above findings and stated she should have removed the other five ml of the ertapenem medication after she diluted the one vial with the 10 ml of NS. On 3/13/26 at 1504 hours, an interview and concurrent employee file review for RN 2 was conducted with the DON. Review of RN 2's Skills Checklist-LN-IV Therapy (undated) showed under IV Skills for Order Check: a. Order compared to label, and b. Label has date, time and initiated when hung was signed by the DON on 5/27/25. The DON stated she was responsible for checking off the skills competency for licensed nurses. The DON stated the competency skills check including IV Skills for RNs was done upon hire, annually, and as needed. The DON was informed and acknowledged the above findings. Cross reference to F755.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure the correct dosage of the medication was administered as per physician's order for one of 19 final sampled residents (Resident 101) observed for medication administration. * RN 2 failed to ensure the correct dosage of Resident 101's IV ertapenem (antibiotic) medication was administered per physician's order. This failure posed the risk for negative health outcomes for Resident 101.Findings: Review of the facility's P&P titled Medication Administration revised 8/2021 showed the medications must be administered in accordance with the written orders of the attending physician. According to DailyMed, the most common clinically adverse effects of the ertapenem sodium medication overdosage were nausea, diarrhea, and transient dizziness. Review of the manufacturer's information titled Ertapenem (brand name Invanz), the Dosage and Frequency section showed for renal impairment: for patients with creatinine clearance, the dose should be reduced to 500 mg daily. On 3/12/26 at 0908 hours, a medication administration observation for Resident 101 was conducted with RN 2. RN 2 stated she would be administering the ertapenem IV 500 mg to Resident 101. RN 2 stated Resident 101 received the antibiotic once daily since 3/7/26. The ertapenem medication vial showed one gram/10 ml. The pharmacy label attached showed ertapenem one gram/10 ml sterile water, then transfuse 5 ml (500 mg) into 50 ml NS piggyback, and infuse one IVPB over 30 minutes one time a day. RN 2 was observed diluting the one vial of ertapenem with 10 ml of NS, aspirated the whole amount in the vial which totaled to 10 ml, and mixed it in the 50 ml of NS piggyback. RN 2 was observed hanging the 50 ml of NS piggyback with the ertapenem. RN 2 connected the IV tubing to Resident 101's peripheral IV catheter in the right arm. RN 2 stated she would run the whole bag of NS IVPB for 30 minutes and would come back after that to recheck Resident 101 when asked if she would administer the whole bag of NS with the ertapenem medication. RN 2 was instructed by the surveyor not to administer the IV medication she prepared. RN 2 was informed by the surveyor the dosage she prepared was incorrect according to the physician's order. RN 2 acknowledged the above findings and stated she should have removed the other five ml of the ertapenem medication after she diluted the one vial with the 10 ml of NS. Medical record review for Resident 101 was initiated on 3/12/26. Resident 101 was readmitted to the facility on [DATE], with diagnoses including Stage 1 CKD. Review of Resident 101's Basic Metabolic Panel result dated 3/3/26, showed the BUN was 44 mg/dL (normal range between 7-20 mg/dL) and the Creatinine was 1.8 mg/dL (normal range 0.7-1.3 mg/dL). Review of Resident 101's Order Summary Report showed a physician's order dated 3/7/26, to administer ertapenem sodium injection solution reconstituted 500 mg IV one time a day for lower UTI, ESBL of the urine until 3/17/26. On 3/12/26 at 1640 hours, an interview and concurrent medical record review for Resident 101 was conducted with the Pharmacy Consultant via telephone call. The Pharmacy Consultant stated the common general adverse reactions to the ertapenem medication overdosing were nausea, diarrhea and headache. The Pharmacy Consultant stated the ertapenem medication should be administered carefully to the residents with chronic kidney disease, especially if the BUN and Creatinine were not stable. The Pharmacy Consultant was informed regarding the findings for Resident 101 during the medication administration. The Pharmacy Consultant stated nurses should pay attention, read carefully the label of the medication, and administer the correct dosage per physician's order. The Pharmacy Consultant stated Resident 101's renal function at this time was stable based on the laboratory results. On 3/13/26 at 1504 hours, an interview and concurrent medical record review for Resident 101 was conducted with the DON. The DON stated the expectations for the nurses during medication administration were for them to check the orders and make sure the correct dosage was given to the resident per physician's order. The DON was informed and acknowledged the above findings for Resident 101. Cross reference to F726, example #2.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and medical record review, the facility failed to provide the necessary pharmacy services to ensure proper labeling of the medications for three nonsampled residents (Residents 41, 52, and 69). * The facility failed to ensure the medications for Residents 41, 52, and 69 were properly labeled with open date. This failure had the potential for the residents to have received expired medications and risk of undermining the efficacy of the stored medications.Findings: On 3/11/26 at 1606 hours, an observation of Medication Cart A and concurrent interview was conducted with LVN 3. The following was observed in Medication Cart A:- The geri-tussin (medication for cough) 100 mg/5 ml liquid bottle for Resident 41 was not labeled with an open date;- The gabapentin (medication for seizure) 250 mg/5 ml liquid bottle for Resident 52 was not labeled with an open date; and- The megestrol acetate (medication for appetite loss and severe weight loss) 40 mg/ml liquid bottle for Resident 69 was not labeled with open date. LVN 3 verified the findings and stated the medications should be labeled with open dates. a. Medical record review for Resident 41 was initiated on 3/11/26. Resident 41 was admitted to the facility on [DATE]. Review of Resident 41's Order Summary Report showed a physician's order dated 3/7/26, to administer geri-tussin oral liquid 100 mg/5 ml by mouth every six hours as needed for cough. b. Medical record review for Resident 52 was initiated on 3/11/26. Resident 52 was admitted to the facility on [DATE]. Review of Resident 52's Order Summary Report showed a physician's order dated 2/24/26, to administer gabapentin oral solution 250 mg/5 ml by mouth every eight hours for neuropathic pain (chronic pain characterized by burning, shooting, or pins and needles sensation). c. Medical record review for Resident 69 was initiated on 3/11/26. Resident 69 was admitted to the facility on [DATE]. Review of Resident 69's Order Summary Report showed a physician's order dated 8/4/24, to administer megestrol acetate suspension 400 mg/10 ml by mouth one time a day for appetite stimulant. On 3/13/26 at 1504 hours, an interview and concurrent medical record review for Residents 41, 52 and 69 was conducted with the DON. The DON stated for the house stock medications, the facility goes by the manufacturer's expiration date and there was no need to label with open date. The DON stated for the medications prescribed specifically to the residents, it should be labeled with open dates because there were certain medications which were only good for certain days and it could also indicate if the medications were being administered properly or correctly regarding the ordered frequency and amount. The DON was informed and acknowledged the above findings.

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Dispose of garbage and refuse properly. Based on observation, interview, and facility P&P review, the facility failed to ensure the facility's garbages and refuse was properly disposed for one of three garbage dumpsters. * One blue garbage dumpster was not fully closed. This failure had the potential to cause unsafe sanitary conditions and potential to harbor pests and rodents.Findings: According to the USDA Food Code 2022, Section 5-501.113 Covering Receptacles: Receptacles and waste handling units for refuse, recyclables, and returnable shall be kept covered. (B) With tight-fitting or doors if kept outside the food establishment. Review of the facility's P&P titled Miscellaneous Areas dated 2023 showed the garbage and trashcans must be inspected daily that no debris is on the ground or surrounding area, and that the lids are closed. On 3/13/26 at 0652 hours, an observation was conducted of the facility's outside dumpsters located on the side of the facility. The lid of one of the three blue garbage dumpsters was observed open and not fully closed. On 3/13/26 at 0730 hours, an observation of the facility's outside dumpsters and concurrent interview was conducted with the DSS. The DSS verified the lid of a blue garbage dumpster was partially propped open with bags of trash. On 3/17/26 at 1047 hours, the Administrator, DON, DSS, and RD were informed and acknowledged the above findings.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure the medical record were complete and accurately documented for four of 19 final sampled residents (Residents 5, 32, 42, and 107). * The facility failed to ensure Resident 5's BP access site was accurately documented in the medical record. * Resident 32's Advanced Directive was missing a page and failed to show who he selected as his healthcare agent. * The facility failed to ensure the Narcotic and Hypnotic Record form was properly documented for Resident 42. * Resident 107's POLST showed the resident did not have an Advanced Healthcare Directive, however the resident did have one at her home. These failures have the potential for the residents' care needs not being met as their medical information was inaccurate and incomplete.Findings: 1. Review of the facility's P&P titled Care of Residents on Renal Dialysis, Hemodialysis Access Site, Care Plan Diet/Fluid Restriction revised 6/2009 showed it is the policy of this facility to provide standards of care of the residents on renal dialysis and the care of the vascular access site for hemodialysis. Blood pressures or venous punctures will not be performed on the extremity where AV fistula and AV graft sites are located. On 3/11/26 at 0808 hours, during the initial tour of the facility, Resident 5 was observed with upper right chest perma-catheter. Resident 5 stated that she goes to the dialysis and uses the perma-catheter for dialysis, Resident 5 further stated she has a new left upper arm fistula. Medical record review for Resident 5 was initiated on 3/11/26. Resident 5 was admitted to the facility on [DATE]. Review of Resident 5's H&P examination dated 10/10/25, showed the resident could make needs known and make medical decisions. Review of Resident 5's care plan for dialysis related to renal failure dated 10/29/24, showed interventions including to not draw blood or take blood pressure in the left arm. Review of Resident 5 Arteriovenous Access Creation/Surgery Discharge Instructions dated 2/10/26, showed the resident had a left arm AV fistula creation. Review of Resident 5's documentation of BP for March 2026 showed the following: - On 3/1/26 at 0732 hours, a BP reading of 148/59 mmHg on the left arm; - On 3/1/26 at 1410 hours, a BP reading of 132/72 mmHg on the left arm; - On 3/3/26 at 0732 hours, a BP reading of 126/68 mmHg on the left arm; - On 3/3/26 at 1151 hours, a BP reading of 145/66 mmHg on the left arm; - On 3/3/26 at 1817 hours, a BP reading of 156/65 mmHg on the left arm; - On 3/3/26 at 2118 hours, a BP reading of 139/59 mmHg on the left arm; (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- On 3/4/26 at 0739 hours, a BP reading of 143/57 mmHg on the left arm; - On 3/4/26 at 1145 hours, a BP reading of 144/58 mmHg on the left arm; - On 3/4/26 at 2157 hours, a BP reading of 142/69 mmHg on the left arm; - On 3/5/26 at 1214 hours, a BP reading of 156/66 mmHg on the left arm; - On 3/7/26 at 0759 hours, a BP reading of 128/61 mmHg on the left arm; - On 3/7/26 at 1155 hours, a BP reading of 141/65 mmHg on the left arm; - On 3/8/26 at 0811 hours, a BP reading of 124/60 mmHg on the left arm; - On 3/8/26 at 1310 hours, a BP reading of 125/68 mmHg on the left arm; - On 3/8/26 at 1727 hours, a BP reading of 125/60 mmHg on the left arm; - On 3/9/26 at 1149 hours, a BP reading of 148/65 mmHg on the left arm; - On 3/9/26 at 2000 hours, a BP reading of 124/68 mmHg on the left arm; - On 3/9/26 at 2152 hours, a BP reading of 132/66 mmHg on the left arm; - On 3/10/26 at 0739 hours, a BP reading of 118/60 mmHg on the left arm; - On 3/10/26 at 2104 hours, a BP reading of 138/60 mmHg on the left arm; - On 3/11/26 at 0052 hours, a BP reading of 114/55 mmHg on the left arm; - On 3/11/26 at 0645 hours, a BP reading of 120/60 mmHg on the left arm; - On 3/11/26 at 0806 hours, a BP reading of 118/68 mmHg on the left arm; - On 3/12/26 at 0543 hours, a BP reading of 111/61 mmHg on the left arm; - On 3/12/26 at 1214 hours, a BP reading of 122/61 mmHg on the left arm; - On 3/13/26 at 2203 hours, a BP reading of 142/68 mmHg on the left arm; - On 3/14/26 at 0813 hours, a BP reading of 105/58 mmHg on the left arm; - On 3/14/26 at 1226 hours, a BP reading of 125/61 mmHg on the left arm; - On 3/15/26 at 0801 hours, a BP reading of 137/57 mmHg on the left arm; - On 3/15/26 at 1143 hours, a BP reading of 134/65 mmHg on the left arm; - On 3/15/26 at 1438 hours, a BP reading of 130/62 mmHg on the left arm; and (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- On 3/16/26 at 0809 hours, a BP reading of 145/63 mmHg on the left arm; On 3/16/26 at 1009 hours, an interview was conducted with Resident 5. Resident 5 stated she never allowed the licensed nurses to take her BP on the left upper arm. On 3/16/26 at 1017 hours, an interview and concurrent medical record review for Resident 5 was conducted with RN 1. RN 1 verified blood pressures were not taken on Resident 5's left arm and the documentation for the BP readings for March 2026 were inaccurate. On 3/17/26 at 0902 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings. 2. Medical record review for Resident 42 was initiated on 3/11/26. Resident 42 was admitted to the facility on [DATE]. Review of Resident 42's Order Summary Report showed a physician's order dated 2/27/26, to administer oxycodone-acetaminophen (pain reliever) 10-325 mg one tablet by mouth every four hours as needed for moderate to severe pain (4-10, on the pain scale of 0 to 10 with 0 = no pain and 10 = worst). Review of Resident 42's MAR for March 2026 showed Resident 42 received the oxycodone-acetaminophen 10-325 mg medication on 3/10/26 at 1246 hours. On 3/11/26 at 1606 hours, a review of the facility's document titled Narcotic and Hypnotic Record and concurrent interview was conducted with LVN 3. Review of Resident 42's Narcotic and Hypnotic Record for the oxycodone-acetaminophen 10-325 mg showed the medication was given with an initial. However, the time the medication was given was left blank. LVN 3 verified the findings. On 3/13/26 at 1504 hours, an interview and concurrent medical record review for Resident 42 was conducted with the DON. The DON stated the nurses should document accurately and correctly. The DON was notified and acknowledged the above finding for Resident 42. 3. Review of the facility's P&P titled Documentation revised May 2021 showed the resident's medical record is a concise and accurate account of treatment and care. Review of the facility's P&P titled Advance Directives revised May 2021 showed the following:- prior to, or upon admission, the care plan team will ask residents, and/or their family members, about the existence of any Advance Directives; and- should the resident indicate that he or she has issued Advance Directives about his/her care and treatment, the facility will require that a copy of such directives be included in the medical record. a. Medical record review for Resident 32 was initiated on 3/11/26. Resident 32 was admitted to the facility on [DATE]. Review of Resident 32's H&P examination dated 2/21/26, showed the resident had no capacity to understand and make decisions. Review of Resident 32's POLST dated 2/19/26, signed by Family Member 1 showed the resident had an Advance Directive dated 2024 and the legally recognized decision maker was Family Member 1. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 32's Advanced Directive Durable Power of Attorney for Health Care and Living Will dated 9/24/24, was missing page two and failed to show who the resident selected as his healthcare agent. On 3/12/26 at 1611 hour, an interview and concurrent medical record review for Resident 32 was conducted with the SSD. The SSD verified Resident 32's Advanced Directive was incomplete and did not show who the resident had selected as his healthcare agent. b. Medical record review of Resident 107 was initiated on 3/11/26. Resident 107 was admitted to the facility on [DATE]. Review of Resident 107's POLST dated 3/9/26, showed the resident did not have an Advance Directive. On 3/12/26 at 1013 hours, an interview was conducted with Resident 107. Resident 107 stated she had an Advance Directive, but it was at home on her desk. Resident 107 stated no one at the facility asked her about an Advance Directive. On 3/12/26 at 1608 hours, an interview and concurrent medical record review for Resident 107 was conducted with the SSD. The SSD stated she saw Resident 107 earlier today and the resident informed her she had an Advance Directive, but was unable to retrieve it, but would see if her family could try and retrieve it from her home. The SSD stated Resident 107's POLST should reflect the resident had an Advance Directive not currently available for review. The SSD reviewed Resident 107's POLST and verified it incorrectly showed the resident did not have one.

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	055689	A. Building B. Wing	03/17/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St. Catherine Healthcare	245 E Wilshire Avenue Fullerton, CA 92832

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. Based on interview and facility document review, the facility failed to implement the facility's QAPI plan and the past Recertification Survey POC for F554 and F761. * The facility failed to show audits and/or monitoring tools were completed per the facility's POC for F554 and F761. This failure had the potential for ongoing non-compliance and complete data being reviewed by the QAPI committee. Findings: During the survey process, the survey team identified repeat deficient practices from the facility's prior recertification survey conducted from 9/23/24 to 9/26/24, for F554 and F671. Review of the facility's 2024 Recertification Survey POC accepted by the department on 11/27/24, included the following:- for F554, the POC showed the Medical Records will perform chart reviews upon admission and check for any new orders. The DON or designee will report findings to the QA&A Committee monthly for six months. - for F761, the RN Supervisor/Designee will randomly check medication carts weekly for eight weeks, and then monthly to ensure proper medication storage. The DON or designee will report findings to the QA&A Committee monthly for six months. On 3/17/26 at 1317 hours, a review of the facility's QAPI binder and supporting documents was reviewed with the Administrator. The Administrator was unable to provide records to show Medical Records staff performed chart reviews of new admissions for new orders, and the RN Supervisor or designee performed medication cart checks weekly for eight weeks, and then monthly per the 2024 Recertification Survey's POC. The Administrator stated the audits were part of their routine process and therefore did not have records to show the above were completed.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, facility document review, and facility P&P review, the facility failed to ensure the infection control practices were followed. * The facility records showed Resident 47 had a UTI, when the resident's symptoms did not meet criteria for a true infection. * The facility failed to ensure the Medication Cart A's fourth small drawer was free of medication spillage. In addition, the iron liquid bottle was observed with sticky spillage. * LVN 4 failed to perform hand hygiene and change gloves after touching Resident 87's surroundings, before checking the GT and administering the medications. These failures posed the risk for transmission of disease-causing microorganisms and infections to the residents, staff, and visitors.Findings: 1. Review of the facility's P&P titled Infection Prevention and Control Program revised October 2022 showed the facility will use McGeer's Criteria as a surveillance tool used to recognize the occurrent of infections, record the infection count and frequency. The facility will maintain a record of incidence per infection and actions taken. The IP will complete infection surveillance and report monthly to the Administrator and DON, and quarterly to the QAPI Committee. Medical record review for Resident 47 was initiated on 3/13/26. Resident 47 was admitted to the facility on [DATE]. Review of the facility's Infection Prevention and Control Surveillance Log for January 2026 showed Resident 47 started antibiotics for a HAI UTI. Review of Resident 47's Surveillance Data Collection Form for UTIs showed the resident's symptoms started on 1/4/26. The form showed the resident's symptoms including an increase in urinary urgency and frequency met criteria for a true infection. Review of Resident 47's medical record failed to show the resident had urinary urgency or frequency, and failed to show the resident met criteria for a UTI. On 3/13/26 at 1305 hours, an interview, medical record review for Resident 47 and concurrent facility document review was conducted with the IP and DSD. The IP and DSD verified Resident 47's Surveillance Data Collection Form showed the resident's UTI met criteria for a HAI infection. However, the IP and DSD verified review of Resident 47's medical record failed to show the resident's symptoms met the criteria, and was incorrectly reported to the QAPI Committee as a HAI UTI. 2. Review of the facility's P&P titled Medication Access and Storage revised 2/2019 showed medication storage areas are kept clean, well lit, and free of clutter. On 3/11/26 at 1606 hours, an observation of Medication Cart A and concurrent interview was conducted with LVN 3. Medication Cart A's fourth small drawer was observed with multiple medication spillage. Medication Cart A was observed with nine big bottles of liquid medications. LVN 3 stated the liquid medications were house stock and used for the residents in the facility. In addition, one big bottle of iron supplement liquid medication was observed with sticky spillage all over it. LVN 3 verified the findings and stated the medication carts should be maintained clean and free of any spillage. 3. Review of the facility's P&P titled Hand Washing revised 5/2021 showed it is the policy of the (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	facility to cleanse hands to prevent transmission of possible infectious material and to provide clean, healthy environment for residents and staff. Review of the facility's P&P titled IPCP Standard and Transmission-Based Precautions revised 10/2022 showed under the Procedure section, the standard precautions are infection prevention practices that apply to the care of all residents, regardless of suspected or confirmed infection or colonization status. Standard precautions include: proper selection and use of PPE, hand hygiene, safe injection practices, respiratory hygiene and cough etiquette, environmental cleaning and disinfection, and reprocessing of reusable medical equipment. On 3/12/26 at 0945 hours, a medication administration observation for Resident 87 was conducted with LVN 4. LVN 4 was observed performing hand hygiene and donned new gloves. LVN 4 stopped the tube feeding pump, repositioned Resident 87, and raised the resident's bed. LVN 4 proceeded with checking the GT for residual & administered the medications to Resident 87 without performing hand hygiene and changing with new gloves. On 3/12/26 at 1000 hours, an interview was conducted with LVN 4. LVN 4 acknowledged she did not perform hand hygiene and changed with new gloves after she touched Resident 87's surroundings. LVN 4 stated she should have done hand hygiene and donned new gloves for infection prevention. On 3/13/26 at 1451 hours, an interview was conducted with the IP. The IP was informed of the findings regarding the Medication Cart A and LVN 4 during medication administration for Resident 87. The IP stated she checked the medication carts weekly. The IP stated the facility should maintain the cleanliness of the medication carts or storage and the medication bottles used for the residents should be free of any leakage or spillage to prevent contamination. The IP stated the nurses were expected to perform hand hygiene and change with new gloves after touching the equipment or the surrounding in the resident's room before performing any task for the medical device attach to the resident and administering medications to prevent cross contamination. The IP acknowledged the above findings, On 3/17/26 at 1400 hours, an interview was conducted with the DON and Administrator. The DON and Administrator were informed and acknowledged the above findings.

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F 0583 Level of Harm - Potential for minimal harm Residents Affected - Some	Keep residents' personal and medical records private and confidential. Based on observation, interview, and facility document review, the facility failed to protect the residents' identifiable information.* The facility's survey results binder for public viewing included three confidential resident rosters. This failure resulted in confidential residents' information being accessible to the public.Findings: On 3/17/26 at 1019 hours, the Survey Inspection Results binder was observed on top of the Nursing Station 1 countertop and was posted for public view. Review of the Survey Inspection Results binder (undated) showed three Confidential Resident Rosters (a list which identified the names of the residents by their identifiers given for surveys to protect the residents' identities) for the following surveys:- a Concurrent Relicensing and Recertification Survey roster dated 9/24/24 - 9/26/24, with six residents identifiers and their names;- an Abbreviated Survey dated 7/9/25, with two resident identifiers and their names; and - an Abbreviated Survey dated 2/5/26, with three resident identifiers and their names. The rosters were identified as being confidential and had Confidential printed diagonally across the page in a large grey font. On 3/17/26 at 1055 hours, an interview and concurrent facility document review was conducted with the Administrator. The Administrator verified the three confidential resident rosters should not have been in the survey binder for public view.

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F 0695 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, medical record review, and facility P&P review, the facility failed to provide the necessary respiratory care and services for one of 19 final sampled residents (Resident 49). * The facility failed to ensure Resident 49's nasal cannula tubing was dated and labeled as per the facility's P&P. In addition, the facility failed to ensure the nasal cannula tubing was stored in a set-up bag when not in use for Resident 49. This failure had the potential for the residents not to receive the appropriate care and may negatively impact the resident's medical conditions.Findings: Review of the facility's P&P titled Use of Oxygen revised 5/2021 showed it is the policy of this facility to promote resident safety in administering oxygen. The oxygen cannula or mask will be changed at least every seven (7) days, as well as the disposable humidifier. The tubing, masks, humidifiers, and other disposables used for oxygen administration will be dated in an identifiable fashion. Labeled and dated bags should be provided for cannulas and masks to be placed in when not in use. On 3/11/26 at 0819 hours and 1027 hours, during the initial tour of the facility, Resident 49's nasal cannula tubing was observed unlabeled and undated. In addition, the nasal cannula tubing was placed on top of the resident bed and not stored in a set up bag. Resident 49 stated she removed the nasal cannula when she eats and there was no set up bag to put the nasal cannula when she removed the nasal cannula. Medical record review for Resident 49 was initiated on 3/11/26. Resident 49 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 49's H&P examination dated 2/21/26, showed Resident 49 had the capacity to understand and make decisions. Review of Resident 49's Order Summary Report showed a physician's order dated 3/10/26, to administer oxygen at two LPM via nasal cannula as needed for angina (a type of chest pain caused by reduced blood flow to the heart). Review of Resident 49's Care Plan Report dated 3/10/26, showed a care plan focus addressing the resident has as needed oxygen therapy related to history of respiratory failure, hypoxia and angina. The interventions included administering the oxygen via nasal cannula at two LPM as needed. On 3/11/26 at 1029 hours, an observation of Resident 49 and concurrent interview was conducted with LVN 2. LVN 2 verified the oxygen nasal cannula tubing was not labeled with the date when it was changed and was not stored in a set up bag. LVN 2 stated the nasal cannula should have been labeled with the date and should have been stored in a bag to keep it clean, sanitary and for infection control purposes. On 3/17/26 at 0902 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings.