STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055739	A. Building B. Wing	02/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Salinas Valley Post Acute	637 East Romie Lane Salinas, CA 93901

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to implement infection control and prevention practices when:1. Staff did not wear appropriate personal protective equipment (PPE, clothing and equipment that is worn or used to provide protection against hazardous substances and/or environments, e.g., gloves, mask, gown) when caring for a resident on enhanced-barrier precautions (an infection control practice used to reduce transmission of multidrug-resistant organisms); 2. Licensed Vocational Nurse (LVN) M used the same paper tissue to wipe excess liquid from both eyes during the administration of eye medications for Resident 74; 3. Staff did not perform hand hygiene between contaminated (exposed to body fluids or potentially infectious material) and clean tasks during wound treatment;4. Unlabeled resident's care items;5.Unlabeled oxygen (O2, colorless, odorless, and tasteless gas essential for life) nasal cannula (NC, a flexible plastic tube used to deliver O2 directly into the nostrils) and uncovered nebulizer treatment face mask ((a plastic covering device that fits over the nose and mouth to deliver liquid medication directly into lungs [a pair of spongy body organ, primary function to keep body cells with supply of O2]) when not in use for Resident 72;6.Failed to do hand hygiene between residents in dining room while setting lunch meal;7.Unconvered suction yankauer (a rigid medical device, with a large opening used to clear fluids/secretions from mouth and throat via suctioning [a medical procedure that uses a vacuum device to remove fluids/secretions when resident not able get rid of on his/her own]) when not in use for Resident 105;8. The facility's Water Management Plan (measures to prevent the growth of Legionella [bacteria that can cause Legionnaires' disease, a serious type of pneumonia or lung infection] or other opportunistic waterborne pathogens in the facility's water system) was not updated.9. There was no documentation of surveillance monitoring or audits that indicated staff were compliant with hand hygiene, donning PPE, and other infection control practices.These failures had the potential to result in transmission and spread of infection to all residents in the facility. 1.During a medication administration observation on 2/10/26 starting at 8:33 a.m., Registered Nurse Q (RN Q) observed administering insulin (medication to treat high sugar levels in blood) to Resident 37, Resident 37's entrance door posted a sign EBP (enhanced barrier precautions, a infection control intervention designed to reduce the spread of infections) RN Q pulled Resident 37's shirt and held Resident 37 right lower abdomen to give the insulin without using gloves, then she stopped and went back to the cart to get the gloves. During a follow up interview on 2/10/26 at 9:08 a.m., with RN Q, she confirmed she was not wearing gloves when she held resident abdomen, RN Q stated she forgot to wear gloves, and she went back to cart get gloves. During an interview on 2/12/26 at 3:14 p.m., with the Infection Preventionist (IP) she stated she expected the nurse to wear PPE (personal protective equipment, specialized clothing, equipment such as masks, gowns and gloves to protect residents and staff from spread of infections) when administering insulin or when touching residents on EBP, she further stated any contact with the (continued on next page)

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	resident they have to wear PPE not just gloves. A review of the facility's policy and procedures titled Enhanced Barrier Precautions, undated, indicated, 7. EBPs employ targeted gown and glove use in addition to standard precautions during high contact resident care activities when contact precautions do not otherwise apply. a. Gloves and gown are applied prior to performing the high contact resident care activity (as opposed to before entering the room).) 8. Examples of high-contact resident care activities requiring the use of gown and gloves for EBPs include: h. prolonged, high-contact with items in the resident's room, with resident's equipment, or with resident's clothing or skin (e.g., in the shower room, therapy gym, or during restorative care); 2.During a medication administration observation on 2/11/26 starting at 4:15 p.m., Licensed Vocational Nurse P (LVN P), LVN P was observed preparing 2 medications for Resident 74. Included in the medications was Brimonidine 0.1% eye solution (eye medications to treat high eye pressure in the eye [glaucoma]). On 2/11/26 at 4:18 p.m., LVN P observed instilling 1 drop of the brimonidine 0.1% eye solution into each of the residents' eyes, then using same tissue to wipe Resident 74's both eyes. During an interview on 2/11/26 at 4:28p.m., LVN P confirmed she used one tissue to wipe the resident's both eyes after each eye drop administration. LVN P further stated she uses one tissue, but different corner in each resident eyes. During an interview on 2/12/26 at 3:16 p.m., with the Infection Preventionist (IP) she stated, when administering eye drops, the staff needs to use a different tissue in each eye or use a different corner of tissue. A review of the facility's policy and procedures titled Instillation of Eye Drops, undated, indicated, Gently dry the eyelid with cotton ball if dripping occurs. (Note: Use only one cotton ball per wipe). 3.During a wound treatment observation on 2/12/26 at 11:30 a.m., Treatment Nurse C (TN C) provided care to Resident 92 for sacral (lower back area) and right groin (between abdomin fold and thigh area) wounds. At the start of treatment, TN C performed hand hygiene and donned (put on) gown and gloves. TN C repositioned Resident 92, handled the Foley Catheter (FC, flexible, indwelling tube inserted through the urethra into the bladder to continuously drain urine into a collection bag) drainage bag, and removed Resident 92's old sacral wound dressing. The old dressing appeared soiled. TN C removed her gloves and donned a new pair of gloves without performing hand hygiene, then continued the wound treatment without performing hand hygiene between contaminated and clean tasks. On multiple occasions during the treatment, TN C did not perform hand hygiene, including after touching the soiled dressing and after glove removal. TN C performed hand hygiene only after completing the wound treatment and removing the gown and gloves. During a concurrent interview on 2/12/26, TN C acknowledged the old dressings were contaminated. TN C stated she performed hand hygiene at the beginning and at the end of the treatment and stated additional hand hygiene was not required between tasks. During an interview on 2/12/26 at 2:30 p.m., IP was informed of the observation. The IP stated staff should perform hand hygiene when moving from dirty to clean tasks during wound care. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the facility's undated policy titled Handwashing/Hand Hygiene, indicated .Hand hygiene is indicated: after touching resident's environment, before moving from work on a soiled body site to a clean body site on the same resident, and immediately after glove removal . 4.During initial room rounds on 2/9/2026 at 11:12 a.m., observed five unlabeled gray color plastic wash basins (small container, used to provide personal care for individual resident) as a stack, left on top of paper towel holder in a bathroom for room [ROOM NUMBER]. During an interview with certified nursing assistant F (CNA F) on 2/9/2026 at 11:14 a.m., CNA F confirmed above observation for unlabeled wash basins and they all were used. CNA F also confirmed this bathroom been shared by multiple residents. CNA F stated resident's personal care items should be labeled with resident's name before started using for residents. CNA also stated without resident's name label, potential for using wash basin for unassigned resident and risk of infection when bathroom been shared between more than one resident. During initial room rounds on 2/9/2026 at 11:40 a.m., observed one unlabeled plastic gray color wash basin on top of paper towel holder in a bathroom for room [ROOM NUMBER]. During an interview with CNA J on 2/9/2026 at 11:29 a.m., CNA J confirmed above observation of unlabeled wash basin and it was used. CNA J also confirmed this bathroom been shared between two rooms and more than 4 residents. CNA J stated without resident's name, risk of spreading infection if it was used for unassigned resident. During initial room rounds on 2/9/2026 at 11:47 a.m., observed six unlabeled gray color plastic wash basins stacked, left on floor next to toilet commode, one more, left on floor next to sink and one more left on paper towel holder in a bathroom for room [ROOM NUMBER]. During an interview with CNA J on 2/9/2026 at 11:52 a.m., CNA J confirmed above observation in bathroom for room [ROOM NUMBER]. CNA J confirmed this bathroom also shared between 2 room and more than 4 residents. CNA J stated all these 8 wash basins were used for residents. CNA J stated nursing staff should have labeled with resident's name before started using and should not have had left on floor in bathroom for infection control practices. CNA J also stated risk of using unassigned resident if not labeled with resident's name when this bathroom been sharing between multiple residents. During an interview with license vocational nurse L (LVN L) on 2/13/2026 at 9:09 a.m., LVN L stated nursing staff should have had labeled wash basins with resident's name to prevent used for unassigned resident and followed infection control practice. During an interview with facility's infection preventionist (IP) on 2/13/2026 at 9:24 a.m., IP stated resident's personal care items should be labeled with resident's name. IP also stated nursing staff should have labeled wash basins with resident's name before started using for individual resident for infection control. 5.During an initial observation on 2/9/2026 at 11:03 a.m., observed Resident 72 was using O2 via room air concentrator (RAC, a medical device that draws in room air, filters and provides purified O2) with a NC and this NC was not labeled with date when it was changed. Also observed nebulizer face mask left uncovered in a top drawer of night stand next to Resident 72's bed when not in use. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview with Resident 72 on 2/9/2026 at 11:03 a.m., Resident 72 communicated through hand gestures and written communication indicated, using O2 on and off at times for shortness of breath (SOB, difficulty breathing). Resident 72 also communicated saying that nursing staff left nebulizer mask without cover in night stand yesterday after Resident 72 completed the nebulizer treatment. Review of Resident 72's face sheet (FS, a document that gives information at a quick [NAME]) indicated Resident 72 was admitted to facility on 12/9/2020. Review of Resident 72's diagnoses included chronic respiratory failure (a progressive condition where lungs cannot adequately enough gas exchange, often requiring O2 therapy to breath). Review of Resident 72's minimum data set assessment (MDS, assessment tool) for brief interview for mental status (BIMS) dated 2/3/2026 indicated, his BIMS score of 13/15, cognitively intact. Review of Resident 72's order summary report indicated oxygen therapy 2L (liters, concentration of O2 to deliver), titratable to maintain O2 at or above 93% as needed., dated 2/8/2026. Review of Resident 72's order summary report also indicated ipratropium-albuterol (a combination medication used to treat breathing problems) solution (liquid medication) 0.5-2.5 MG/3ML (MG, milligram, a unit of mass equal to one thousandth of gram/ML, milliliter, a unit of volume, equal to one thousandth of a liter) every 4 hours as needed for SOB, dated 2/6/2026. During an interview with LVN L on 2/13/2026 at 9:09 a.m., LVN confirmed unlabeled NC and uncovered nebulizer face mask for Resident 72. LVN L stated NC tubing should be changed every week and labeled with date when changed for infection control. LVN L also stated nebulizer face mask should be stored in a plastic bag when not in use. During an interview with IP on 2/13/2026 at 9:24 a.m., IP stated nursing staff should have labeled NC tubing when changed every week for residents. IP also stated nursing staff should have stored nebulizer face mask in a plastic bag when not in use for Resident 72 to follow infection control practice. 6.During lunch meal observation in facility's dining room on 2/9/2026 at 12:19 p.m., observed CNA K took lunch meal tray from meal cart (movable cart stores and carries multiple resident's meal trays at a time), which came from facility's kitchen, CNA K went to a resident's table, set the tray for a resident. CNA K went to lunch cart, took another resident's meal tray, went to Resident's table, set the lunch meal, and went back to lunch cart, repeated same for two more residents, no hand hygiene between each resident while providing the meal trays. Observed same as above with assistant director of nursing (ADON) and CNA H when they served mealsto multiple residents, no hand hygiene between each resident. All three staff members washed hands at the end of serving meals to all residents. During an interview with CNA K on 2/9/2026 at 12:22 p.m., CNA K confirmed she did not wash hands after serving meal tray to a resident before started taking another resident's meal tray from food cart. CNA K stated should have washed hands between each resident for infection control. During an interview with ADON on 2/9/2026 at 1:14 p.m., ADON stated she did not wash hands between residents when serving meal trays. ADON stated should have wash hands between tasks for (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	infection control practices. During an interview with CNA H on 2/9/2026 at 2:26 p.m., CNA H confirmed he did not wash hands after serving a resident before starting with another resident's tray. CNA H stated should have wash hands between each resident to follow infection control practice. During an interview with IP on 2/13/2026 at 9:24 a.m., IP stated nursing staff should have provided hand hygiene between residents and tasks while serving the meals in the dining room. 7. During room rounds on 2/10/2026 at 9:23 a.m., noted uncovered long blue color plastic suction yankauer catheter left between bed rail and bed frame when not in use in Resident 105's room. Review of Resident 105's FS indicated Resident 105 was admitted to facility on 9/10/2023. Review of Resident 105's order summary report indicated an order for, ok for bedside suction machine for oral suctioning, dated 2/1/2026. During an interview with LVN L on 2/13/2026 at 9:09 a.m., LVN L confirmed suction yankauer left on bed rail and uncovered for Resident 105. LVN L stated yankauer should be stored in a plastic bag when not in use for infection control purposes. During an interview with IP on 2/13/2026 at 9:24 a.m., IP stated suction yankauer should not be left uncovered when not in use. Nursing staff should have stored in a plastic bag for infection control. Review of facility's policy and procedure (P&P) titled, Handwashing/Hand Hygiene, undated, the P&P indicated, Hand hygiene is indicated: after touching a resident; after touching the resident's environment; Review of facility's P&P titled, Cleaning and Disinfecting Non-Critical Resident-Care Items, revised June 2011, the P&P indicated, Single resident use items are for single resident use only. [NAME] with the resident's name and/or room number and discard upon transfer or discharge. The facility did not provide a policy and procedure for label nasal cannula, storage of nebulizer face mask, and suction yankauer catheter when not in use. 8. Review of the facility's Water Management Plan, dated 6/9/2025 indicated, This Water Management Plan expires on 10/15/25. It also indicated the plan will describe the water systems and flow diagrams within the building and develop water-system schematics. The Water Flow Diagram page was blank. The plan also indicated the facility had a decorative fountain and included a picture of the water fountain. During an interview and concurrent record review on 2/13/26 at 10:39 a.m., the Maintenance Director (MD) confirmed the facility's water management plan needed to be updated. The MD stated the facility needed to develop water flow diagram for the water system. The MD also confirmed the facility no longer had a water fountain. Review of the US Centers for Disease Control and Prevention's (CDC, a federal agency with the primary mission of protecting public health and safety through control and prevention of disease) Toolkit, Developing a Water Management Program to Reduce Legionella (a type of bacteria [living (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	cells that can cuase infections] found in natural freshwater) Growth & Spread in Buildings: A Practical Guide to Implementing Industry Standards, dated 9/30/25 indicated, All healthcare facilities should have a Legionella water management program. The toolkit indicated the key elements of a Water Management Plan include to describe the building water systems using text and flow diagrams, identify areas where Legionella could grow and spread, and decide where control measures should be applied and how to monitor them. 9. During an interview on 2/12/26 at 12:32 p.m., the IP stated she had no documentation that indicated that she checked whether staff is following infection control practices. During an interview on 2/13/26 at 1:35 p.m., the director of nursing (DON) stated there is no surveillance log for when the IP monitors staff for appropriate hand hygiene, donning of PPE, and other infection control practices. Review of the facility's Job Description, Infection Control Nurse, dated 2/2024 indicated essential duties include to monitor infection control practices and procedures to ensure that all personnel are implementing our standard operating procedures for tasks involving exposure to blood/body fluids and monitor medications passes and treatments to ensure that appropriate handwashing/hand hygiene techniques are being followed in the handling and administering of drugs, medications, and treatments. Review of the facility's undated policy, Monitoring Compliance with Infection Control, indicated the following: Routine monitoring and surveillance of the workplace are conducted to determine compliance with infection prevention and control policies and practices . Compliance surveillance includes the use of standardized assessment and observation tools . The infection preventionist and or the IPC [Infection Prevention and Control] committee provides reports to the QAPI [Quality Assurance and Performance Improvement] committee that reflect: a. staff adherence to infection prevention processes (hand hygiene, use of personal protective equipment, etc.) .

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide assessments and services which meet professional standards of quality for 11 of 21 sampled residents (Residents 92, 52, 83, 1, 72, 73, 7, 8, 91, 47, and 9) when the following were observed: 1.Inaccurate bed rail (metal or rigid plastic and adjustable safety bars attached to the sides of the bed) and entrapment risk observation/assessments for Resident 72, 52, 1, and 83; 2.Inaccurate bed rail and entrapment risk observation/assessments for Resident 73, 7, 8, 91, 47, and 9; 3.Treatment nurse C (TN C) applied zinc oxide (topical skin barrier) to wound without a physician's order for Resident 92.These failures had the potential to compromise the health and safety of above sampled residents. Findings: 1.During room rounds on 2/9/2026 at 11:03 a.m., observed Resident 72 was in bed with two partial bed rails or side rails (BR, SR, metal or hard plastic adjustable devices attached to the sides of a bed frame for safety or to assist with positioning and support while in bed) up at head of the bed for Resident 72's bed. Review of Resident 72's face sheet (FS, a document that gives information about resident at a quick glance) indicated, Resident 72 was admitted to facility on 12/9/2020. Review of Resident 72 's bed rail and entrapment risk observation/assessment dated [DATE] indicated No for bed rail use. During room rounds on 2/9/2026 at 11:36 a.m., observed Resident 52 was in bed and two partial bed rails up at head of the bed for Resident 52's bed. Review of Resident 52's FS indicated, Resident 52 was admitted to facility on 8/23/2025. Review of Resident 52 's bed rail and entrapment risk observation/assessment dated [DATE] indicated No for bed rail use. During room rounds on 2/9/2026 at 1:56 p.m., observed Resident 1 was in bed and two partial bed rails up at head of the bed for Resident 1's bed. Review of Resident 1's FS indicated, Resident 1 was admitted to facility on 1/19/2026. Review of Resident 1 's bed rail and entrapment risk observation/assessment dated [DATE] indicated No for bed rail use. During room rounds on 2/10/2026 at 9:11 a.m., observed Resident 83 was in bed with two partial bed rails up at head of the bed for Resident 83's bed. Review of Resident 83's FS indicated, Resident 83 was admitted to facility on 9/21/2023. Review of Resident 83 's bed rail and entrapment risk observation/assessment dated [DATE] indicated No for bed rail use. During an interview with certified nursing assistant H (CNA H) on 2/12/2026 at 12:49 p.m., CNA H confirmed bed rails up both sides, at the head of the bed for Resident 1, 52, and 83 while residents (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	were in bed. CNA H stated bed rails have been in use since residents were admitted to facility. CNA H also stated these three residents were able to use bed rails for positioning as needed. During an interview with CNA G on 2/12/2026 at 1:25 p.m., CNA G confirmed bed rails were up both sides at the head of the bed for Resident 72 while resident was in bed. CNA H stated bed rails been in use since resident was admitted to facility. CNA H also stated Resident 72 was able to use bed rails for positioning as needed. During a concurrent record review and interview with director of nursing (DON) on 2/13/2026 at 11:15 a.m., DON reviewed bed rail and entrapment risk observation/assessments for Resident 72, 52, 1, and 83. DON confirmed nursing staff documented No for bed rail use for above residents, answer should be yes. DON stated these three residents were using bed rails since admission to facility. DON also stated nursing staff should have observed and documented bed rail assessment accurately for Residents 72, 52, 1 and 83. 2. During a review of Resident 73's clinical record it indicated Resident 73 was admitted to the facility on [DATE] with diagnoses including cardiomegaly (an enlarged heart) and major depressive disorder (a persistently low or depressed mood and a loss of interest in activities that you used to enjoy), recurrent, unspecified. A review of Resident 73's physician's orders indicated an order for side rail 1/4 x2 up in bed as enabler to assist with mobility - non restraint, dated 3/14/23. A review of Resident 73's assessment titled, Bed Rail and Entrapment Risk Observation/Assessment dated 11/19/25 indicated, A. section I Bed Rails Use 1. Are Bed Rails Currently in use? documented, No. A review of Resident 73's assessment titled, Bed Rail and Entrapment Risk Observation/Assessment, Type Quarterly, dated 2/5/26 indicated, A. section I Bed Rails Use 1. Are Bed Rails Currently in use? documented, No. During an observation on 2/9/26 at 10:52 a.m., inside Resident 73's room, Resident 73's bed was observed with two side rails up. During an interview on 2/12/26 at 11:22 a.m., with Registered Nurse I (RN I), RN I confirmed Resident 73 has side rails in use. RN I further stated Resident 73 has been using the side rails for a while. During a concurrent interview and record review on 2/12/26 at 1:24 p.m., with the Director of Nursing (DON), the DON reviewed Resident 73's Bed Rail and Entrapment Risk Observation/Assessment, dated 11/19/25 and dated 2/5/26. The DON confirmed use of bed rails documented, No for above both assessments. DON stated nursing staff should have documented yes for both assessments. During a review of Resident 7's clinical record it indicated Resident 7 was admitted to the facility on [DATE] with diagnoses including anxiety disorder and contracture, unspecified joint. A review of Resident 7's assessment titled, Bed Rail and Entrapment Risk Observation/Assessment, dated 9/12/25 indicated, A. section I Bed Rails Use 1. Are Bed Rails Currently in use? documented, No. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 7's assessment titled, Bed Rail and Entrapment Risk Observation/Assessment, Type Quarterly, dated 12/1/25 indicated, A. section I Bed Rails Use 1. Are Bed Rails Currently in use? documented, No. During an observation on 2/9/26 at 10:56 a.m., inside Resident 7's room, Resident 7's bed was observed with two side rails up. During an interview on 2/12/26 at 11:21 a.m., with Registered Nurse I (RN I), RN I confirmed Resident 7 has side rails in use. RN I further stated Resident 7 has been using the side rails for a while. During a concurrent interview and record review on 2/12/26 at 1:26 p.m., with the Director of Nursing (DON), the DON reviewed Resident 7's Bed Rail and Entrapment Risk Observation/Assessment, dated 9/12/25 other and 12/1/25 quarterly. The DON confirmed use of bed rails documented, No for above both assessments. DON stated nursing staff should have documented yes for both assessments. During a review of Resident 8's clinical record it indicated Resident 8 was admitted to the facility on [DATE] with diagnoses including other seizure anxiety disorder, unspecified. A review of Resident 8's physician's orders indicated an order for side rail 1/4 x2 up in bed as enabler to assist with mobility - non restraint, dated 7/30/25. A review of Resident 8's assessment titled, Bed Rail and Entrapment Risk Observation/Assessment, Type Quarterly, dated 9/18/25 indicated, A. section I Bed Rails Use 1. Are Bed Rails Currently in use? documented, No. A review of Resident 8's assessment titled, Bed Rail and Entrapment Risk Observation/assessment dated [DATE] indicated, A. section I Bed Rails Use 1. Are Bed Rails Currently in use? documented, No. During an observation on 2/09/26 at12:08 p.m., inside Resident 8's room, Resident 8's bed was observed with two side rails up. During an interview on 2/12/26 at 11:21 a.m., with Registered Nurse I (RN I), RN I confirmed Resident 8 has side rails in use, RN I further stated Resident 8 has been using the side rails for a while. During a concurrent interview and record review on 2/12/26 at 1:28 p.m., with the Director of Nursing (DON), the DON reviewed Resident 8's Bed Rail and Entrapment Risk Observation/Assessment, dated 9/18/25 and 2/5/26. The DON confirmed section I 1. Are Bed Rails Currently in use? documented, No for above both assessments. DON stated nursing staff should have documented yes for both assessments. During a review of Resident 91's clinical record it indicated Resident 91 was admitted to the facility on [DATE] with diagnoses including major depressive disorder, recurrent, unspecified and type 2 diabetes mellitus diabetes mellitus (a condition which affects the way the body processes blood sugar) without complications. A review of Resident 91's physician's orders indicated an order for side rail 1/4 x2 up in bed as enabler to assist with mobility - non restraint, dated 7/29/25. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 91's assessment titled, Bed Rail and Entrapment Risk Observation/Assessment, Type Annual, dated 10/31/25 indicated, A. section I Bed Rails Use 1. Are Bed Rails Currently in use? documented, No. A review of Resident 91's assessment titled, Bed Rail and Entrapment Risk Observation/Assessment, Type Quarterly, dated 1/19/26 indicated, A. section I Bed Rails Use 1. Are Bed Rails Currently in use? documented, No. During an observation on 2/09/26 at12:05 p.m., inside Resident 91's room, Resident 91's bed was observed with two side rails up. During an interview on 2/12/26 at 11:22 a.m., with Registered Nurse I (RN I), RN I confirmed Resident 91 has side rails in use. RN I further stated Resident 91 has been using the side rails for a while. During a concurrent interview and record review on 2/12/26 at 1:30 p.m., with the Director of Nursing (DON), the DON reviewed Resident 8's Bed Rail and Entrapment Risk Observation/Assessment, dated 10/31/25 annual and 1/19/26 quarterly. The DON confirmed use of bed rails documented No for above both assessments. DON stated nursing staff should have documented yes for both assessments. During a review of Resident 47's clinical record it indicated Resident 47 was admitted to the facility on [DATE] with diagnoses including bipolar disorder, unspecified and thrombocytopenia (low blood platelet count. Platelets, also called thrombocytes, are colorless blood cells that help blood clot), unspecified. A review of Resident 47's physician's orders indicated an order for side rail 1/4 x2 up in bed as enabler to assist with mobility - non restraint, dated 1/29/25. A review of Resident 47's assessment titled, Bed Rail and Entrapment Risk Observation/Assessment, Type Quarterly, dated 10/31/25 indicated, A. section I Bed Rails Use 1. Are Bed Rails Currently in use? documented, No. A review of Resident 47's assessment titled, Bed Rail and Entrapment Risk Observation/Assessment, Type Annual, dated 1/16/26 indicated, A. section I Bed Rails Use 1. Are Bed Rails Currently in use? documented, No. During an observation on 2/9/26 at 12:03 p.m., inside Resident 47's room, Resident 47's bed was observed with two side rails up. During a concurrent observation and interview on 2/12/26 at 11:20 a.m., with Registered Nurse I (RN I), RN I confirmed Resident 47 has side rails and has been using for a while. During a concurrent interview and record review on 2/12/26 at 1:22 p.m., with the Director of Nursing (DON), the DON reviewed Resident 47's quarterly Bed Rail and Entrapment Risk Observation/Assessment, dated 10/31/25 and annual assessment, dated1/16/26. The DON confirmed use of bed rails documented, No for above both assessments. DON stated nursing staff should have documented yes for both assessments. During a review of Resident 9's clinical record it indicated Resident 9 was admitted to the facility on [DATE] with diagnoses including depression (loss of pleasure or interest in activities for long periods (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	of time),unspecified and anxiety disorder (a group of mental health conditions that cause fear, dread and other symptoms that are out of proportion to the situation),unspecified. A review of Resident 9's physician's orders indicated an order for side rail 1/4 x2 up in bed as enabler to assist with mobility - non restraint, dated 7/29/25. A review of Resident 9's assessment titled, Bed Rail and Entrapment Risk Observation/Assessment, Type Quarterly, dated 10/17/25 indicated, A. section I Bed Rails Use 1. Are Bed Rails Currently in use? documented, No. A review of Resident 9's assessment titled, Bed Rail and Entrapment Risk Observation/Assessment, Type Annual, dated 1/5/26 indicated, A. section I Bed Rails Use 1. Are Bed Rails Currently in use? documented, No. During an observation on 2/9/26 at 12:22 p.m., inside Resident 9's room, Resident 9's bed was observed with two side rails up. During a concurrent observation and interview on 2/12/26 at 11:17 a.m., with Registered Nurse I (RN I), RN I confirmed Resident 9 has side rails, RN I further stated Resident 9 has been using the side rails for a while. During a concurrent interview and record review on 2/12/26 at 1:16 p.m., with the Director of Nursing (DON), the DON reviewed Resident 9's Bed Rail and Entrapment Risk Observation/Assessment, dated 10/17/25 quarterly and 1/5/26 annual. The DON confirmed use of bed rails documented No for both assessments. the DON stated no for initial assessment and for quarterly assessment, DON believes it should be Yes, the DON further stated resident is already using the side rails. 3.Review of Resident 92's active physician's order for the right genital (private area) region, dated 2/12/26, indicated the wound treatment included cleansing with normal saline, patting dry, applying 1/4 Dakins (solution used to clean and treat wounds) or Vashe (solution used to clean and treat wounds) wet-to-dry (type of treatment to remove dead tissue to promote wound healing) dressing, packing Nugauze strip gauze (cotton gauze used to packing the deep wound) into the opening near the medial groin, covering with gauze or abdominal pad, and securing with tape every day shift. The physician's order did not include zinc oxide (used to treat and prevent skin irritations). During a wound treatment observation on 2/12/26 at 11:30 a.m., TN C applied zinc oxide to the peri-wound (skin surrounding a wound) area of Resident 92's right groin wound. During a concurrent interview on 2/12/26, TN C confirmed there was no physician's order for zinc oxide prior to applying it. Review of Resident 92's Skin/Wound progress note dated 2/12/26 at 13:20 indicated maceration (skin appears white, pale and wrinkled due to prolonged exposure to excessive moisture) was noted to the peri-wound area of the right groin wound, zinc oxide had been applied, the physician was notified, and a telephone order for zinc oxide was obtained after the treatment had been completed. During a follow-up interview on 2/13/26 at 2:00 p.m., the Director of Nursing (DON) confirmed zinc oxide was not included in the facility's standing orders and stated a physician order is required before zinc oxide can be applied to Resident 92's wound or peri-wound area. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of facility's policy and procedure (P&P) titled, Medication and Treatment Orders, revision date 7/2016, the P&P indicated, Medications shall be administered only upon the written order of a person duly licensed and authorized to prescribe such medications . Review of facility's P&P titled, Pressure Ulcers/Skin Breakdown, the P&P indicated, The physician will order pertinent wound treatments, including .application of topical agents. Review of facility's P&P titled, Bed Safety and Bed Rails, revision date August 2022, the P&P indicated, The use of bed rails or side [NAME] (including temporarily raising the side rails for episodic use during care) is prohibited unless the criteria for use of bed rails have been met,

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to ensure dietary staff covered facial hair while working over exposed food in the kitchen. This deficient practice placed 95 residents at risk for receiving contaminated food in the facility. Findings: During an observation of the meal tray line on 2/11/26 at approximately 11:35 a.m., the dietary aide N (DA N) and dietary cook M (DC M) were observed with visible facial hair and were not wearing beard restraints while working over exposed food in kitchen. Dietary staff were plating and checking meal trays while standing over exposed food items during tray line service. During an interview on 2/11/26 at 2:30 p.m., DA N stated that during tray line he was only checking the food and not handling it. During an interview on 2/11/26 at 2:40 p.m., DC M stated that his beard was long and that he needed to wear a beard restraint. During an interview on 2/11/26 at 2:45 p.m., the Registered Dietitian (RD) stated that when working in direct food preparation or plating food, staff should wear hair and beard nets. During an interview on 2/13/26 at 10:15 a.m., the DM stated that during tray line both DA N and DC M should wear beard nets to cover facial hair because exposed food was present. Review of the facility policy titled Food Preparation and Service, revised 11/22, indicated, Food and nutrition services staff wear hair restraints (hairnet, hat, beard restraint, etc.) so that hair does not contact food.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on interview, and record review, the facility failed to ensure free from loss of personal property for one (Resident 6) of three sampled residents. This failure had the potential to affect the health and emotional well-being of sampled Resident 6.Findings:During room rounds for Resident 6 on 2/10/2026 at 8:38 a.m., Resident 6 informed facility lost his clothes and shoes and he informed facility staff. Resident 6 also stated no staff responded back to him for his missing items.Review of Resident 6's face sheet (FS, a document that gives a resident's information at a quick glance) indicated Resident 6 was admitted to facility on 12/26/2025.Review of document for Resident 6's inventory of personal effects (record of personal belongings, clothing and valuables brought into the facility) undated, indicated several items including clothes, shoes and slippers. Review of facility's list of grievance and theft/ lost logs for December 2025, January 2026 and February 2026 indicated no documented evidence of lost personal clothes and shoes for Resident 6.During an interview with certified nursing assistant E (CNA E) on 2/10/2026 at 1:06 p.m., CNA E stated Resident 6 informed he lost clothes and shoes while in facility last week. During an interview with social service assistant (SSA) on 2/11/2026 at 11:30 a.m., SSA confirmed there were no grievance or report of theft, and lost process initiated for missing clothes and shoes for Resident 6. SSD stated not aware of Resident 6 lost clothes and shoes in facility.During on interview with director of nursing (DON) on 2/12/2026 a 4:22 p.m., DON searched for clothes and shoes in Resident 6's personal belongings in facility and confirmed one grey pant, one gray shirt and one gray slippers missing from documented Resident 6's inventory of personal effects. DON stated facility should not have lost clothes and slippers for Resident 6. DON also stated facility will reimburse or replace missing 3 items for Resident 6.Review of Facility's policy and procedure (P&P) titled, Investigation Incidents of Theft and /or Misappropriation of Resident property, revised April 2017, the P&P indicated, Resident have the right to be free from theft and/or misappropriation of personal property. When an incident of theft and/or misappropriation of resident property is reported, the Administrator will appoint a staff member to investigate the incident.

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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. Based on interview and record review, the facility failed to ensure one out of four residents (Resident 9) is free from unnecessary psychotropic (drugs that affects brain activities associated with mental processes and behavior) medication when: Resident 9's Seroquel (an antipsychotic medication that helps treat several kinds of mental health conditions) ordered as needed with no stop date. This failure had the potential for increased risks associated with use of psychotropic medication that could negatively affect the resident's physical, mental, and psychosocial well-being.During a review of Resident 9's clinical record indicated Resident 9 was admitted to the facility with diagnoses including depression (loss of pleasure or interest in activities for long periods of time),unspecified and anxiety disorder (a group of mental health conditions that cause fear, dread and other symptoms that are out of proportion to the situation),unspecified.During a review of Resident 9's physician's order indicated an order for Seroquel Oral Tablet 25 MG (milligram, unit of measure) Give 1 tablet by mouth every 6 hours as needed for Paranoid Schizophrenia (a chronic mental health condition [now clinically classified under the broader diagnosis of schizophrenia] characterized primarily by intense delusions and auditory hallucinations. Individuals often experience extreme fear, mistrust, and false beliefs that others are plotting against them) Breakthrough agitation, dated 11/27/25. During a concurrent interview and record review on 2/12/26 at 1:00 p.m., with director of nursing (DON), DON reviewed Resident 9's physician's order and confirmed there was no stop date for Seroquel, and it was ordered more than 14 days. The DON stated it should be discontinued. During a review of the facility's policy and procedure (P&P) titled, Psychotropic Medication Use, revised date February 2025, the P&P indicated, .PRN medication 3. PRN order for psychotropic medications are limited to 14 days. a. For psychotropic medications that are not antipsychotic: If the prescriber or the attending physician believes it is appropriate to extend the PRN order beyond 14 days, they will document the rationale for extending the use and include the duration for the PRN order. b. For psychotropic medications the ARE antipsychotics: PRN orders cannot be renewed unless the attending physicians or prescriber evaluates the resident and documents the appropriateness of the medications. Monitoring and Adverse Consequences.4. In addition, residents are monitored for adverse consequences associated with psychotropic medication.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure to code minimum data set (MDS, resident assessment tool) assessment accurately to reflect status of the residents for three of six sampled residents (Resident 6, 49, and 1) when; 1.Resident 6's dental status was coded inaccurately;2. Resident 6's weight loss status was coded inaccurately;3.Resident 49's dental status was coded inaccurately;4.Resident 1's orders for insulin (medication used to treat and regulate blood sugar) was coded inaccurately. These failures can lead to inappropriate care and interventions for sampled residents.Findings: 1.Review of Resident 6's face sheet (FS, a document that gives a resident's information at a quick glance) indicated Resident 6 was admitted to facility on 12/26/2025.Review of Resident 6's admission and readmission evaluation dated 12/26/2025 indicated Resident 6 had his own and broken teeth.Review of Resident 6's readmission evaluation dated 1/9/2026 indicated broken natural teeth.Review of Resident 6's MDS assessment dated [DATE], section L for oral and dental status not indicated, no natural teeth or tooth fragments.During an interview with licensed vocational nurse A (LVN A) on 2/11/2026 at 11:06 a.m., LVN A confirmed several missing upper and lower teeth for Resident 6.During concurrent record review of Resident 6's above admission, readmission evaluations, and MDS assessments and interview with minimum data set coordinator (MDSC) on 2/11/2026 at 12:14 p.m., MDSC confirmed Resident 6's admission and readmission evaluation for several missing teeth. MDSC also confirmed MDS assessment was not coded accurately for missing teeth for Resident 6. MDSC stated MDS staff should have coded dental status accurately to reflect missing teeth for Resident 6.2.Review of Resident 6's MDS assessment dated [DATE] section K for weight loss indicated, Yes, on physician-prescribed weight-loss regimen.Review of Resident 6's clinical documentation indicated there was no documented evidence for physician prescribed weight loss regimen for Resident 6.During an interview with MDSC on 2/11/2026 at 12:14 p.m., MDSC confirmed above MDS assessment for section K for weight loss documented physician prescribed weight loss regimen. MDSC stated no documented evidence for MD approved weight loss regimen and MDS assessment for weight loss coded inaccurately. MDSC also stated section K for weight loss should have coded accurately.During a telephone interview with Resident 6's primary care physician (PCP) on 2/12/2026 at 1:43 p.m., PCP confirmed he did not approve planned weight loss regimen for Resident 6. PCP also stated Resident 6 was treated for fluid retention last month, not for weight loss. PCP further stated will not recommend or approve prescribed weight loss regimen based on current medical condition for Resident 6.3. Review of Resident 49's FS indicated Resident 49 was admitted to facility on 1/11/2025.Review of Resident 49's nursing admission evaluation dated 1/11/2025 indicated, Resident does not have teeth or dentures (removable or fixed device to replace missing teeth).Review of Resident 49's MDS assessment dated [DATE], section L for dental status not indicated No natural teeth or tooth fragment(s) (edentulous) (no natural teeth).During a concurrent record review of Resident 49's above nursing admission evaluation, MDS assessment and interview with MDSC on 2/11/2026 at 12:07 p.m., MDSC confirmed Resident 49 edentulous and MDS assessment coded inaccurately for dental assessment. MDSC stated it should be coded accurately to reflect no natural teeth for Resident 49. 4. Review of Resident 1's FS indicated Resident 1 was admitted to facility on 1/19/2026. Review of Resident 1's diagnoses included diabetes type 2 (DM 2, a chronic disorder when body becomes resistant to insulin, causes high blood sugar levels).Review of Resident 1's order summary indicated insulin glargine (long acting insulin to treat diabetes type 2) 100 units (concentration of insulin) /ML (milliliter, a metric unit of volume equal to one thousandth of a liter) 6 units inject subcutaneous (SQ, inject under the skin, using thin needle to deliver medication) one time a day for DM 2, dated 1/19/2026. Humalog SQ 100 unit/ML, SQ inject SQ per sliding scale (a customized scheduled insulin regimen that adjusts does based on blood sugar levels) before meals and bedtime for DM 2, dated (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1/19/2026.Review of Resident 1's electronic medication administration record (EMAR, a digital healthcare document to track and manage the administration of medications) for January/2026 and February/2026 indicated Resident 1 received glargine insulin 6 units everyday at 9:00 a.m., and Humalog insulin per sliding scale everyday before meals and at bed time for January/2026 and February/2026.Review of Resident 1's MDS assessment dated [DATE], section N for medications hypoglycemic (medications used to treat high blood sugar) (including insulin) documented No.During an interview with MDSC on 2/12/2026 at 1:03 p.m., MDSC confirmed above MDS assessment for medications for insulin. MDSC stated MDS assessment dated [DATE] coded wrong, it should have coded Yes for hypoglycemic including insulin for Resident 1. MDSC also stated MDS staff should have coded to reflect Resident 1's insulin as ordered and received.Review of facility's policy and procedure (P&P) titled, Resident Assessments, undated, P&P indicated, Information in the MDS assessments will consistently reflect information in the progress notes, plan of care, and resident observation/interviews.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities Based on interview and record review, the facility failed to ensure an accurate Preadmission Screening and Resident Review (PASARR, a screening for mental illness and treatment to ensure the facility coordinates with the appropriate State-designated authority to ensure that individuals with a mental disorder, intellectual disability or a related condition receives care and services in the most integrated setting appropriate to their needs) screening form for one of eight sampled residents (Resident 84). This failure had the potential to result in the resident not receiving specialized care and services appropriate to the condition. Findings: Review of Resident 84's clinical record indicated diagnoses that included Paranoid Schizophrenia (a severe mental illness characterized by persistent false beliefs and hallucinations that affect thinking, perception, and behavior) and psychosis (loss of contact with reality, often involving hallucinations or false beliefs). Review of the PASARR Level 1 screening form dated 2015, indicated incomplete information. During concurrent interview and record review on 2/13/26 at 12:00 p.m. the Minimum Data Set Coordinator (MDSC) confirmed the PASARR level 1 screening in the record was incomplete and that no Level II evaluation had been obtained. The MDSC stated she would complete a new PASARR Level 1 screening for Resident 84. Review of the facility's policy titled admission Criteria revised 3/2019, indicated All new admissions and readmissions are screened for mental disorders (MD), intellectual disabilities (ID) or related disorders (RD) per the Medicaid Pre-admission Screening and Resident Review process .If the Level 1 screen indicates that the individual may meet the criteria for MD, ID, or RD, he or she is referred to the state PASARR representative for the Level II (evaluation and determination) screening process .

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to develop and implement person centered comprehensive care plans that included target symptoms, measurable objectives, and interventions for four out of 21 sampled residents (Resident 47, Resident 6, Resident 49, and Resident 72) when: 1.Resident 47, the facility did not develop care plan for bipolar disorder (mental disorder characterized by periods of elevated mood and depression, often with poor decision-making);2.Resident 49, facility did not develop care plan for missing/broken teeth; and3.Resident 6, facility did not develop care plan for edentulous (no natural teeth);4.Resident 72, facility did not develop care plan for use of oxygen therapy. These failures had the potential for above sampled residents not meeting their highest practicable physical, mental, and psychosocial plan of care needs. Findings: 1. During a review of Resident 47's clinical record, it indicated Resident 47 was admitted to the facility on [DATE] with diagnosis which includes bipolar disorder (a chronic mental health condition with intense mood changes between high energy episodes and low energy depressive episodes) and thrombocytopenia (low blood platelet count.Platelets, also called thrombocytes, are colorless blood cells that help blood clot). A review of Resident 47's physician's orders indicated an order for Valproate sodium (anticonvulsant medication used to treat epilepsy [all seizure types], prevent migraines, and stabilize mood in bipolar disorder) oral solution 250 mg (milligrams unit of measure) /5ml (milliliter, unit of volume) give 5ml by mouth every morning and at bedtime for bipolar disorder, dated 1/8/26. A review of Resident 47's clinical record indicated there were no comprehensive care plans developed for the resident's bipolar disorder. During a concurrent interview and record review on 2/12/26 at 1:07 p.m., with Director of Nursing (DON), DON reviewed Resident 47's clinical record and confirmed Resident 47 taking Valproate sodium for bipolar disorder. DON stated Resident 47 should have a care plan the diagnosis of bipolar disorder. The DON reviewed Resident 47's care plans and confirmed there was no care plan developed for bipolar disorder, the DON further stated we don't have a care plan for bipolar disorder for Resident 47. 2. Review of Resident 49's face sheet (FS, a document that gives a resident's information at a quick glance) indicated Resident 49 was admitted to facility on 1/11/2025. Review of Resident 49's nursing admission evaluation dated 1/11/2025 indicated, Resident does not have teeth or dentures (removable or fixed device to replace missing teeth). Review of Resident 49's care plans indicated there was no documented evidence for care plan for missing own teeth. During an interview with MDSC on 2/11/2026 at 12:07 p.m., MDSC confirmed there was no care plan for edentulous (no teeth) for Resident 49. MDSC stated Resident 49 should have a care plan for no teeth and nursing staff should have documented and implemented care plan for Resident 49 for missing all teeth. (continued on next page)

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	055739	A. Building B. Wing	02/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Salinas Valley Post Acute	637 East Romie Lane Salinas, CA 93901

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with facility's director of nursing (DON) on 12/13/2026 at 10:48 a.m., DON stated nursing staff should have initiated care plan for edentulous for Resident 49. 3. Review of Resident 6's FS indicated Resident 6 was admitted to facility on 12/26/2025. Review of Resident 6's admission and readmission evaluation dated 12/26/2025 indicated Resident 6 had own and broken teeth. Review of Resident 6's readmission evaluation dated 1/9/2026 indicated broken natural teeth. Review of Resident 6's care plans indicated there was no documented evidence of care plan for broken natural teeth. During an interview with MDSC on 12/11/2026 at 12:14 p.m., MDSC confirmed there was no care plan for broken and missing teeth for Resident 6. MDSC stated Resident 6 should have a care plan for broken teeth and nursing staff should have documented care plan for broken teeth for Resident 6. During an interview with DON on 12/13/2026 at 11:03 a.m., DON stated nursing staff should have initiated a care plan for broken teeth for Resident 6. 4. During an initial observation on 2/9/2026 at 11:03 a.m., noted Resident 72 was using O2 (Oxygen) via room air concentrator (RAC, a medical device that draws in room air, filters and provides purified O2). During an interview with Resident 72 on 2/9/2026 at 11:03 a.m., Resident 72 communicated through hand gestures and written communication indicated using O2 on and off at times for shortness of breath (difficulty breathing). Review of Resident 72's FS indicated Resident 72 was admitted to facility on 12/9/2020. Review of Resident 72's diagnoses included chronic respiratory failure {a progressive condition where lungs [a pair of spongy body organ, primary function to keep body cells with supply of oxygen (O2, colorless, odorless, and tasteless gas essential for life) cannot adequately provide enough gas exchange, often requiring O2 therapy to breath}. Review of Resident 72's MDS assessment for brief interview for mental status (BIMS - an assessment to test a person's cognition level, [a score of 0 to 7 indicates severe cognitive impairment, 8-12 moderate impairment, 13-15 patient is cognitively intact] dated 2/3/2026 indicated, his BIMS score of 13/15, cognitively intact. Review of Resident 72's order summary report indicated oxygen therapy 2L (liters, concentration of O2 to deliver), titratable to maintain oxygen at or above 93% as needed., dated 2/8/2026. Review of Resident 72's care plans indicated there was no documented evidence of care plan for oxygen therapy. During an interview with MDSC on 2/11/2026 at 12:14 p.m., MDSC confirmed there was no care plan for O2 therapy for Resident 72. MDSC also confirmed Resident 72 using O2 as needed. MDSC stated this resident should have a care plan for O2 therapy when receiving O2. MDSC also stated nursing (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	staff should have documented care plan for O2 therapy for Resident 72. During an interview with DON on 2/12/2026 at 4:31 p.m., DON stated nursing staff should have initiated and implemented care plan for oxygen for Resident 72. Review of facility's policy and procedure (P&P) titled, Care Plans, Comprehensive Person-Centered, revision date March 2022, the P&P indicated, the interdisciplinary team (IDT, a collaborative group of healthcare professionals from different disciplines who work together toward person-centered plan of care and needs), in conjunction with the resident and his/her family or legal representative (a person authorized to make medical decisions on behalf of resident when he/she become incapacitated), develops and implements comprehensive, person-centered care plan for each resident. The comprehensive, person-centered care plan is developed within seven (7) days of the completion of the required MDS (minimum data set, assessment tool) assessment (Admission, Annual or Significant Change in Status), and no more than 21 days after admission.

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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 and record review, the facility failed to ensure to updated and revised comprehensive person-centered care plans for 3 of 21 sample residents (Resident 9, 25 and 88) when;1. Care plans was not revised or updated after the fall for Resident 9;2. Care plan was not revised or updated after the fall for Resident 25;3.Care plan for smoking not revised or updated for non-compliance with smoking for Resident 88.This failure had the potential to result in not meeting sampled Residents 9, 25 and 88's plan of care needs.Findings: 1.During a review of Resident 9's clinical record indicated Resident 9 was admitted to the facility with diagnoses including depression (loss of pleasure or interest in activities for long periods of time) and anxiety disorder (a group of mental health conditions that cause fear, dread and other symptoms that are out of proportion to the situation). Review of Resident 9's care plan Falls: indicated Resident is at risk for falls with or without injury related to history of falls the care plan included interventions, e.g. Obtain physical therapy (PT, a healthcare profession that treats residents with medical conditions or injuries that limit their ability to move around) and occupational therapy (OT, a healthcare profession that helps, develops, and maintain the skills for daily living) consult, keep bed in low position, the interventions was not updated after 7/10/25. Review of Resident 9's IDT notes indicated Resident 9 had multiple falls, including falls on 10/18/25, 10/19/25, 11/21/25, 1/30/26, and 2/10/26. Resident 9's IDT (interdisciplinary team, a group of healthcare professionals from different disciplines work together towards resident's person-centered goals) note dated 10/20/25 indicated interventions, persist in employing redirection techniques. re-orientation, and supportive care measures while maintaining ongoing follow up appointments. Medications and care interventions will be regularly reviewed and adjusted as needed. with immediate notification to the MD (medical doctor) for any new or concerning changes. After thorough review of the contributing factors and circumstances surrounding the falls. Resident 9's IDT Note dated 11/21/25 indicated interventions included, non pharmacological approaches such as music therapy, positive reinforcement, dim lighting. social service visits, redirection, and encouraging use of a communication board. Preventative measures include low bed positioning, pain management, neuro checks (a rapid and focused assessments to evaluate mental, sensation and coordination status of the resident after fall and other medical condition change). and frequent safety checks. Nursing staff will report any new signs or symptoms to the MD. Resident 9's IDT Note dated 2/2/26 indicated, interventions assess resident, neuro checks, notify provider, notify RP, remind resident to use call light, call light within reach. Resident 9's IDT Note dated 2/12/26 indicated, interventions assess resident, nuero checks, Notify provider, notify RP, encourage resident to use call light, keep call light with in reach. There was no documentation that indicated new fall interventions were implemented after falls on 10/18/25, 10/19,25, 11/11/25, 2/2/25, and 2/12/25. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 2/13/26 at 12:38 p.m., with the Director (DON), the DON stated every time the resident had a fall, they do IDT meeting and updated the care plan, if the care plan is ineffective updated the care plan with new intervention. The DON reviewed Resident 9's fall risk care plan and confirmed the fall risk care plan was last updated on 7/10/25, the DON confirmed Resident 9 has multiple history of falls. The DON was asked if the care plan needs to update, the DON stated absolutely. During a follow up interview and record review on 2/13/26 at 2:55 p.m., with DON, DON reviewed Resident 9's IDT notes and fall risk care plan, DON confirmed the fall risk care plan was last updated on 7/10/25, and IDT recommendation dated 11/21/25 are not in the care plan. 2.Review of Resident 25's clinical record indicated she was admitted to the facility with diagnoses including metabolic encephalopathy (brain disorder caused by a chemical imbalance in the blood which can result in confusion and memory issues) and diabetes (a disorder characterized by difficulty in blood sugar control and poor wound healing). Review of Resident 25's fall care plan, dated 8/20/25 indicated she was at risk for injury. The care plan included interventions, e.g. Obtain PT and OT, consult, keep bed in low position, initiated 8/20/25. There were no revisions to the care plan after 8/20/25. Review of Resident 25's IDT notes indicated the resident had multiple falls, including falls on 9/11/25, 9/17/25, and 12/11/25. -Resident 25's IDT Note, dated 9/15/25 indicated interventions were pain management, notify MD of any changes or conditions, neurological checks and 72 hour charting (documentation). Resident 25's IDT Note, dated 9/18/25 indicated interventions were pain management, neurological checks, and 72 hour charting. -Resident 25's IDT Note dated 12/15/25 indicated interventions were PT and OT evaluations, neuro checks, and notifying MD. There was no documentation that indicated new fall interventions were implemented after falls on 9/11/25, 9/17/25, and 12/11/25. During an interview on 2/13/26 at 12:21 p.m., the Director of Nursing (DON) confirmed new interventions were not in Resident 25's care plan for fall. He confirmed fall interventions were repeated after Resident 25's fall. The DON stated Resident 25's fall care plan should have been updated with new interventions. 3.During observation of smoking at designated smoking area, located back of the facility on 2/10/2026 at 10:50 a.m., noted Resident 88 had a lighter in his pant pocket. Resident 88 used lighter from his pant pocket to light his cigarette, placed lighter back in his pant pocket while activity staff supervised him. Resident 88 left smoking area to inside facility with a lighter in his pant pocket. Review of Resident 88's face sheet (FS, a document that gives a resident's information at a quick glance) indicated Resident 88 was admitted to facility on 1/28/2026. Review of Resident 88's smoking observation/assessment dated [DATE] indicated Resident 88 was a smoker, staff should light the cigarette for smokers. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 88's care plan for smoking dated 1/29/2026 indicated, The resident's smoking supplies are kept by the activity staff during the day and kept in the west wing med room at night. Further review of this care plan indicated there was no documented evidence of revised and updated with Resident's non-compliance with smoking materials. During an interview with activity assistant C (AA C) on 2/10/2026 at 10:55 a.m., AA C confirmed Resident 88 had cigarette lighter with him. AA C stated Resident 88 keeps lighter with him, refusing to give to staff to store since he came to facility. During interview with activity director (AD) on 2/12/2026 at 8:43 a.m., AD confirmed Resident 88 was non-compliance with smoking materials, keeping cigarette lighter with him, refusing to give to staff to store. AD also confirmed care plan for smoking not revised and updated with his non-compliance with storage of lighter. During an interview with Director of nursing (DON) on 2/12/2026 at 9:19 a.m., DON confirmed care plan for smoking not updated with non-compliance with cigarette lighter for Resident 88. DON stated care plan for smoking should have been revised and updated when Resident 88 was non-compliant with cigarette lighter. Review of facility's policy and procedure (P&P) titled, Family Notification Letter-Smoking Safety Policy Update, undated, the P&P indicated, All smoking materials (cigarettes, lighters, vapes, etc.) are secured by the facility and released only during approved smoking times. Review of facility's P&P titled, Care Plans, Comprehensive Person-Centered, revision date March 2022, the P&P indicated, Assessments of residents are ongoing and care plan are revised as information about the residents and the resident's condition change. The interdisciplinary team (IDT, a group of healthcare professionals work together to ensure all aspect of resident's health and care been addressed) reviews and update the care plan: a. When there has been a significant change in the resident's condition; b. When the desired outcome is not met; .

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure to follow policy and procedure for electrical and smoking safety for two of six sampled residents (Resident 52 and 88) and in room one out of eleven sampled room (room [ROOM NUMBER]) when;1.Observed long cell phone charging cord on floor while charging in room [ROOM NUMBER].Observed ungraded (not certified for safe use in healthcare setting) power strip (an electrical device to be powered from a single plug in electric socket with many electrical devices to charge at same time) in Resident 52's bed;3.Observed cigarette lighter with Resident 88.Above failures had the potential for accidental hazard for fire for above sampled residents, risk for tripping and fall with or without injury for residents and staff in room [ROOM NUMBER].Findings:1.During an initial room rounds in room [ROOM NUMBER] on 2/9/2026 at 11:10 a.m., observed long cell phone cord one end plugged in electric socket on the wall opposite to bed A and B, on the floor between both beds. This cord went all way to bed B's tray table next to bed and connected to cell phone.During an interview with certified nursing assistant F (CNA F) on 2/9/2026 at 11:14 a.m., CNA F confirmed above observation. CNA F stated cell phone cord should be off the floor for safety reasons. CNA F adjusted the cell phone cord from floor and between both resident's beds before she left the room.During an interview with facility's Maintenance Director (MD) on 2/12/2026 at 10:46 a.m., MD stated cell phone long cord should be off the floor to prevent tipping hazard and potential injury for whoever goes in to room [ROOM NUMBER].2.During an initial room rounds and interview with Resident 52 on 2/9/2026 at 1:36 p.m., noted ungraded power strip plugged in wall socket, 6 different electronic equipment charging in progress, left next to pillow at head of the bed on Resident 52s bed. During interview, Resident 52 stated power strip was his own, started using to charge all his electronic equipment since came to facility, not aware of safety concerns to use. Resident 52 also stated facility staff were aware of this.Review of Resident 52's face sheet (FS: a document that gives resident's information at a quick glance) indicated Resident was admitted to facility on 8/23/2025.Review of Resident 52's minimum data set assessment (MDS, resident assessment tool) dated 12/1/2025, section C for brief interview for mental status (BIMS) score of 12/15, moderately impaired cognition.During an interview with MD on 2/12/2026 at 10:46 a.m., MD confirmed Resident 52 was using non-hospital grade power strip to charge his electronic equipment and keeping power strip on bed withing reach for him. MD stated he replaced with hospital grade power strip on 2/9/2026 for Resident 52. MD also stated facility should have used hospital grade power strip and should not kept on resident's bed for safety and to prevent fire hazard.3.During smoking observation at designated smoking area, located back of the facility on 2/10/2026 at 10:50 a.m., noted Resident 88 had a lighter in his pant pocket. Resident 88 used lighter from his pant pocket to lighten his cigarette, placed lighter back in his pant pocket while activity staff supervised him. Resident 88 left smoking area to inside facility with a lighter in his pant pocket.Review of Resident 88's face sheet (FS, a document that gives a resident's information at a quick glance) indicated Resident 88 was admitted to facility on 1/28/2026.Review of Resident 88's smoking observation/assessment dated [DATE] indicated Resident 88 was a smoker, staff should light the cigarette for smokers.Review of Resident 88's care plan for smoking dated 1/29/2026 indicated, The resident's smoking supplies are kept by the activity staff during the day and kept in the west wing med room at night.During an interview with activity assistant C (AA C) on 2/10/2026 at 10:55 a.m., AA C confirmed Resident 88 had a cigarette lighter with him. AA C stated Resident 88 keeps lighter with him, refusing to give to staff for storage, since he came to facility.During interview with activity director (AD) on 2/12/2026 at 8:43 a.m., AD confirmed Resident 88 was non-compliance with smoking materials, keeping cigarette lighter with him, refusing to give to staff to store. AD stated smoking materials including lighters should be with activity staff all the times for safety and Resident 88 (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	should not have had a lighter with him.Review of facility's policy and procedure tilted, Electrical Safety For Residents, undated, the P&P indicated, Inspect electrical outlets, extension cords, power strips, and electrical devices as part of routine fire safety and maintenance inspections. Secure extension cords and do not place overhead, under carpets, or where they can cause trips, falls or overheat. Connect extension cords to only one device.Review of facility's P&P titled, Family Notification Letter-Smoking Safety Policy Update, undated, the P&P indicated, All smoking materials (cigarettes, lighters, vapes, etc.) are secured by the facility and released only during approved smoking times.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, and record review, the facility failed to ensure proper medication storage and labeling of medications for one of two medication carts (a mobile, secured, and organized cart to store, transport and administer medications to residents) (Medication Cart AA), when expired bottle of brimonidine eyedrop (used primarily as eye drops to lower high pressure in the eye caused by open-angle glaucoma [group of eye diseases that can cause vision loss and blindness]) or ocular hypertension (high pressure inside your eye) and latanoprost eyedrop (used to treat glaucoma) medications were not removed from medication cart's active stock. These failures had the potential for residents to receive medications with reduced efficacy. During an inspection of Medication Cart AA on 2/9/26 at 10:23 a.m., with Registered Nurse I (RN I), RN I confirmed the following findings: a. A bottle of Brimonidine eyedrop had an open date of 1/7/26. Upon reviewing with RN I, he confirmed it expired on 2/6/26. b. A bottle of latanoprost eyedrop had an open date of 12/27/25. Upon reviewing with RN I, he confirmed it expired on 2/7/26. During an interview on 2/12/26 at 1:15 p.m., with the Director of Nursing, The DON stated any expired medications in the cart should be taken and disposed. During a review of the facility's P&P titled Medication Labeling and Storage, indicated, .5. Multi-dose vials that have been opened or accessed (e.g., needle punctured) are dated and discarded within 28 days unless the manufacturer specifies a shorter or longer date for the open vial. During a review of the facility's P&P titled Administering Oral Medications, indicated, .Steps in the Procedure.7. Check the expiration date on the medication. Return any expired medication to the pharmacy.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to offer the influenza (flu, respiratory infection) vaccine timely for one of five sampled residents (Resident 4). This failure had the potential to negatively affect the resident's health and well-being.Review of Resident 4's clinical record indicated she was admitted to the facility on [DATE] with diagnoses including diabetes (DM, a disorder characterized by difficulty in blood sugar control and poor wound healing) and hypertension (high blood pressure). Review of Resident 4's Immunization Audit Report indicated there was no documentation that the resident received or was offered the flu vaccine in 2025. During an interview on 2/12/26 at 12:32 p.m., the infection preventionist (IP) confirmed Resident 4 was admitted to the facility in March 2025. The IP stated Resident 4 was offered and recieved the flu vaccine on 2/11/26. The IP stated she was not sure why yesterday was the only time Resident 4 was offered the flu vaccine. Review of the facility's policy, Influenza Vaccine, dated 3/2022 indicated, Between October 1st and March 31st each year, the influenza vaccine shall be offered to residents and employees .