| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 055755 | A. Building<br>B. Wing | 04/30/2026 |

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| Sharon Care Center | 8167 West Third St.<br>Los Angeles, CA 90048 |

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| F 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>Based on interview and record review the facility failed to provide care and services to prevent a fall (unintentionally coming to rest on a lower-level surface) for one of three sampled residents (Resident 11) reviewed for accidents by failing to: -Ensure Certified Nursing Assistant 7 (CNA 7) provided a two-person physical assistance (help from two person) and use of a Hoyer Lift (a medical device designed to safely transfer residents with limited mobility between beds, chairs, and wheelchairs) to transfer Resident 11 from Resident 11's bed to the wheelchair on 4/20/2026 at 6:50 AM as indicated in Resident 11's care plan. As a result, on 4/20/2026 at 6:50 AM, Resident 11 sustained a fall, experience severe knee pain (disabling; unable to perform daily living activities), and inability to bear weight (unable to stand or walk). Resident 11 was transferred to the emergency room (ER) of General Acute Care Hospital 1 (GACH 1) via emergency services. At GACH 1, Resident 11 was found to have a mildly displaced comminuted extra-articular fracture of the right distal femoral meta diaphysis (an injury where the right lower thigh bone is broken into multiple pieces); and a displaced comminuted peri implant fracture involving the distal left femur (an injury where the lower thigh bone is broken into multiple pieces near an existing orthopedic implant). Resident 11 underwent surgery on her right leg on 4/23/2026 and was scheduled to have another surgery on her left leg on 4/30/2026. Cross Reference F656 Findings: During a review of Resident 11's admission Record, the admission Record indicated the facility admitted the resident on 8/17/2024 with diagnoses that included type 2 diabetes (DM, a disorder characterized by difficulty in blood sugar control and poor wound healing), End Stage Renal Disease (ESRD, irreversible kidney damage), and dependence on renal (kidney) dialysis (a treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidney(s) have failed). During a review of Resident 11's Minimum Data Set (MDS, a resident assessment tool) dated 2/20/2026, the MDS indicated Resident 11 was cognitively intact (had the ability to think, understand, and reason). The MDS indicated Resident 11 normally used a wheelchair. The MDS indicated Resident 11 required partial/moderate assistance (helper does less than half the effort. Helper lifts, holds, or supports the trunk or limbs, but provides less than half the effort) with sit to stand mobility, chair/bed-to-chair transfer, toilet transfer, and tube/shower transfer. During a review of Resident 11's Nursing Documentation Evaluation dated 2/22/2026 at 6:57 PM, the Nursing Documentation Evaluation indicated Resident 11 had fall risk factors (any attribute, characteristic, or exposure that increases the likelihood of developing a disease, injury, or negative outcome) that included impaired balance (a condition in which an individual feels unsteady), predisposed disease or injury (a pre-existing medication condition, physical, or genetic trait that increases an individual's susceptibility to develop a different disease or injury), and required assistance for toileting. During a review of Resident 11's Care Plan Report dated 4/19/2026, the Care Plan Report indicated Resident 11 had an Activities of Daily Living (ADLs, the basic self-care tasks such as bathing, dressing, eating, and mobility that individuals perform daily to maintain independence and hygiene) self-care performance deficit related to impaired mobility (a condition that limits a person's ability to move freely or perform activities), generalized weakness (reduced muscle strength throughout the entire body), polyneuropathy (a condition in which multiple peripheral nerves in the body become damaged<br>(continued on next page) |



| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| F 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | and causing numbness, tingling, and pain), and the use of the wheelchair. The Care Plan Report indicated the goal for Resident11 was to maintain Resident 11's current level of mobility. The Care Plan Report indicated Resident 11 required total assistance with transfers, two staff participation, the use of the Hoyer lift machine, and a yellow color medium size sling (a supportive fabric device used with resident lifts to safely transfer residents between beds, chairs, and the floor). During a review of Resident 11's SBAR (Situation, Background, Assessment, Recommendation - a communication tool used by healthcare workers when there is a change of condition among the residents) Communication Form dated 4/20/2026, the SBAR Communication Form indicated Resident 11 had a fall. The SBAR Communication Form indicated that while the CNA (unidentified) was getting Resident 11 up to go to dialysis Resident 11 slipped from the bed to the floor and landed on her (Resident 11) knees. The SBAR Communication Form indicated Resident 11 was observed lying on the floor by the charge nurse (unidentified) when the charge nurse was informed that Resident 11 had a fall. The SBAR Communication Form indicated Resident 11 had right and left knee pain that Resident 1 rated a level five (rated on a scale of 1-10 with 10 being the worst). The SBAR Communication Form indicated Resident 11 did not show any obvious signs of injury. The SBAR Communication Form indicated Resident 11 stated her (Resident 11) knees hurt from the fall. The SBAR Communication Form indicated Resident 11 was safely put back on the wheelchair assisted by three people using a bed sheet. The SBAR Communication Form indicated Resident 11 was given Tylenol (acetaminophen, a medication used to reduce pain). The SBAR Communication Form indicated Resident 11 was taken to the lobby to wait for transportation to dialysis. The SBAR Communication Form indicated Resident 11 left the facility in stable condition. The SBAR Communication Form indicated Resident 11's Nurse Practitioner (NP, unidentified) was notified on 4/20/2026 at 7:30 AM of Resident 11's fall. The SBAR Communication form indicated Resident 11's NP ordered to monitor Resident 11 and to inform the NP if an x-ray (an imaging test that uses electromagnetic radiation to create pictures of bones and tissues) was needed when Resident 11 returned from dialysis. During a review of Resident 11's Order Summary Report, the Order Summary Report indicated the resident had a physician order dated 4/20/2026 to transfer Resident 11 to GACH 1's ER for further evaluation related to knee pain. During a review of Resident 11's GACH 1 bilateral knee x-ray report dated 4/20/2026 at 5:41 PM, the bilateral knee x-ray report indicated Resident 11 had a mildly displaced comminuted extra-articular fracture of the right distal femoral meta diaphysis. The bilateral knee x-ray report indicated Resident 11 had a displaced comminuted peri implant fracture involving the distal left femur. During a review of Resident 11's Hospitalist History and Physical from GACH 1 dated 4/21/2026, the Hospitalist History and Physical indicated Resident 11 presented to GACH 1 on 4/20/2026 for a fall. The Hospitalist History and Physical indicated Resident 11 had a mechanical fall (a fall caused by an external, physical force. such as tripping, slipping, or stumbling rather than an internal medical issue like fainting or dizziness) while trying to get back into the wheelchair and landed on her (Resident 11) knees. The Hospitalist History and Physical indicated Resident 11 had severe pain, was unable to bear weight, and was found to have bilateral distal femur fractures. During a review of Resident 1's Orthopedic Arthroplasty (a physician who focuses on replacing, repairing, or reconstructing damaged joints) Progress Note from GACH 1 dated 4/22/2026 at 6:08 AM, the Orthopedic Arthroplasty Progress Note indicated Resident 11 sustained bilateral distal femur fractures after an accident at the resident's care facility. The Orthopedic Arthroplasty Progress Note indicated Resident 11 was informed that it was best to address treatment for Resident 11's legs one leg at a time given Resident 11's comorbidities (the presence of more than one disease or disorder) and the risks of anesthesia (is the use of medications to block pain during medical procedures or surgery) and surgery. The Orthopedic Arthroplasty Progress Note indicated the intended plan was for Resident 11 to have an Open Reduction and Internal Fixation (ORIF, a surgical procedure to repair severe bone fractures) of the right femur first. The Orthopedic Arthroplasty Progress Note indicated surgery was planned for Resident 11's right femur on 4/23/2026. During a telephone interview on 4/28/2026 at 10:29 AM with Resident 11, Resident 11<br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | stated she (Resident 11) was at the GACH (unidentified). Resident 11 stated that on 4/20/2026 at almost 7 AM, CNA 7 was assisting her (Resident 11) to get to the wheelchair so the resident could go to dialysis. Resident 11 stated CNA 7 stood behind the wheelchair and grabbed the resident by her (Resident 11) sweatpants and waist. Resident 11 stated she (Resident 11) fell to the floor and landed on both knees. Resident 11 stated CNA 7 and her roommate (unidentified) were the only people in the room when she (Resident 11) fell. Resident 11 stated only CNA 7 was helping her Resident 11 during the resident's transfer. Resident 11 stated Registered Nurse 3 (RN 3) came to the room after Resident 11 had fallen. Resident 11 stated CNA 7 and RN 3 helped her (Resident 11) back to the wheelchair after the fall. Resident 11 stated she (Resident 11) was having a lot of pain. Resident 11 stated her pain level was 20, out of 10. Resident 11 stated she (Resident 11) was then taken to dialysis. Resident 11 stated she (Resident 11) was not doing good at the dialysis facility because she (Resident 11) was in a lot of pain. Resident 11 stated she (Resident 11) asked to go to the GACH (unidentified) when she (Resident 11) was at the dialysis facility. Resident 11 stated both of her (Resident 11) legs were broken. Resident 11 stated she (Resident 11) had surgery on her right leg on 4/23/2026 and was scheduled to have another surgery on her left leg on 4/30/2026. Resident 11 stated I'm so frustrated, and I am in a lot of pain. During a telephone interview on 4/29/2026 at 8:45 AM with CNA 7, CNA 7 stated that on 4/20/2026 at 6:50 AM she (CNA 7) was transferring Resident 11 from the bed to the wheelchair to get Resident 11was ready to go to dialysis. CNA 7 stated there were no other staff present in Resident 11's room at the time the CNA was assisting Resident 11 to the wheelchair. CNA 7 stated she (CNA7) was trying to get the wheelchair into position by Resident 11's bed, when Resident 11 started scooting to the edge of the bed trying to get to the wheelchair. CNA 7 stated Resident 11 started to slide to the floor. CNA 7 stated she (CNA 7) tried to grab Resident 11 under the resident's arms, but Resident 11 landed on her (Resident 11) knees. CNA 7 stated she (CNA 7) assisted Resident 11 to lay on her (Resident 11) back and called RN 3 to Resident 11's room. CNA 7 stated that Resident 11 said her (Resident 11) knees were hurting, but CNA 7 could not remember the resident's pain level. During an interview on 4/29/2026 at 9:29 AM with the Director of Nursing (DON), the DON stated RN 3 was on vacation. On 4/29/2026 at 9:29 AM an attempt to contact RN 3 by telephone was made, but RN 3 could not be reached for an interview. During a telephone interview on 4/29/2026 at 10:36 AM with Dialysis Registered Nurse 1 (DRN 1), DRN 1 stated she (DRN 1) worked at Dialysis Facility 1 (DF 1). DRN 1 stated Resident 11 received dialysis at DF 1. DRN1 stated she (DRN 1) was one of the nurses who assisted Resident 11 on 4/20/2026. DRN 1 stated Resident 11 informed DRN 1 that she (Resident 11) had fallen when she (Resident 11) was being assisted by a staff member (unidentified) at the facility during a transfer. DRN 1 stated Resident 11 informed DRN 1 that the person (unidentified) who was transferring the resident at the SNF was holding the resident from behind, when Resident 11 slipped and fell on her (Resident 11) knees. DRN 1 stated Resident 11 had a pain level of 10 out of 10 while at DF 1. DRN 1 stated that after dialysis Resident 11 stated she (Resident 11) would not be able to get back into the wheelchair, because it was too painful for Resident 11. DRN 1 stated Resident 11 wanted to go to the ER. During an interview on 4/29/2026 at 10:42 AM with Dialysis LVN 1 (DLVN 1), DLVN 1 stated that on 4/20/2026 (unidentified time), he (DLVN 1) called DRN 1 to assess Resident 11 at DF 1. DLVN 1 stated that Resident 11 had informed him (DLVN 1) that she (Resident 11) had slid and landed on both her (Resident 11) knees when a staff (unidentified) assisted Resident 11 during a transfer at the SNF. DLVN 1 stated Resident 11 had a 10 out of 10 pain level to both of her (Resident 11) knees. DLVN 1 stated that when Resident 11 finished dialysis, Resident 11 requested a gurney (stretcher) transportation to the GACH (unidentified). DLVN 1 stated Resident 11 could not bend her (Resident 11) knees because it was too painful. DLVN 1 stated the DF1 called 911 (emergency services phone number) and Resident 11 was transferred to the GACH (unidentified). On 4/29/2026 at 1:43 PM a second attempt to contact RN 3 by telephone was made. RN 3 could not be reached for interview. During a concurrent interview and record review on 4/29/2026 at 3:33 PM with the Director of Nursing (DON), Resident 11's Care Plan Report dated<br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | 4/19/2026 was reviewed. The DON stated a care plan was a guide that had interventions for the nurses (in general) and the staff (in general) to follow the care plan to provide good care for the residents (in general). The DON stated the care plan was resident centered and based on resident needs. The DON stated Resident 11 had a care plan for an ADL self-care performance deficit related to impaired mobility, generalized weakness, polyneuropathy, and use of the wheelchair. The DON stated Resident 11's ADL self-care performance deficit care plan had an intervention for transfers. The DON stated Resident 11's ADL self-care performance deficit care plan indicated Resident 11 required total assistance with transfers, two staff participation, use of the Hoyer lift machine, and a medium yellow color sling size. The DON stated staff (in general) were expected to follow Resident 11's care plan when transferring the resident. The DON stated that if Resident 11's care plan indicated the resident required total assistance with transfers, two staff participation and use of the Hoyer lift machine it was the expectation that the resident be transferred with two staff members. The DON stated Resident 11's care plan was not followed. The DON stated Resident 11 was being transferred to the wheelchair from the bed by one staff member, CNA 7, on the morning of 4/20/2026. The DON stated it was important that Resident 11's care plan be followed for safety and prevention of injury. The DON stated Resident 11's fall on 4/20/2026 could have been prevented if two staff members transferred Resident 11 from the bed to the wheelchair on 4/20/2026. During an interview on 4/30/2026 at 11:31 AM with Restorative Nursing Assistant 2 (RNA 2), RNA 2 stated she (RNA 2) was familiar with Resident 11. RNA 2 stated she (RNA 2) was often called to help transfer the resident to and from the wheelchair to the bed, especially after dialysis. RNA 2 stated she (RNA2) had just assisted Resident 11 with a transfer the week before. RNA 2 stated Resident 11 required a gait belt (a strap with a metal or plastic buckle, used by caregivers to safely assist individuals with mobility issues during walking or transfers) and assistance from two staff members with transfers. During a concurrent interview and record review on 4/30/2026 at 12:33 PM with the Director of Staff Development (DSD), Resident 11's Care Plan Report dated 4/19/2026 was reviewed. The DSD stated Resident 11's Care Plan Report indicated Resident 11 needed two-person assistance with a Hoyer lift for transfers. The DSD stated that based on Resident 11's care plan, the CNAs (in general) were expected to have two-persons with a Hoyer lift when assisting Resident 11 with transfers. The DSD stated Resident 11's care plan needed to be followed. The DSD stated the care plan was a guide that indicated what the staff (in general) needed to do for Resident 11. The DSD stated interventions on the care plan were to be followed for the safety of the residents (in general). The DSD stated injury to a resident (in general) could happen if interventions on the care plan were not followed. The DSD stated if Resident 11's care plan was followed and two staff were present and used a Hoyer lift during Resident 11's transfer, the resident's fall on 4/20/2026 could have been prevented. During a review of the facility's Policy and Procedure (P&P) titled Fall Management dated 12/18/2025, the P&P indicated Patients will be assessed for falls risk as part of the nursing assessment process. Those determined to be at risk will receive appropriate interventions to reduce risk and minimize injury .Identify patient's fall risk by reviewing the Nursing Documentation. Communicate patient's fall risk status to caregivers. Develop individualized plan of care. Review and revise care plan as indicated. |

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| F 0605<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to attempt a gradual dosage reduction (GDR - a periodic attempt to reduce a dose of a medication in an attempt to mitigate potential side effects) or document a clinical rationale for contraindication (why the attempt would be clinically inappropriate) for risperidone (a medication used to treat mental illness) since 9/15/2022 in one of five sampled residents(Resident 4) reviewed unnecessary medications. The deficient practice of failing to attempt a GDR or document why an attempt would be contraindicated for Resident 4's risperidone increased the risk that Resident 4 could have experienced adverse effects (a harmful unintended result) related to psychotropic medication (medications that affect brain activities associated with mental processes and behavior) therapy, such as drowsiness, dizziness, constipation, movement disorders, or increased risk of fall, possibly leading to impairment or decline in his mental or physical condition or functional or psychosocial status.Findings:During a review of Resident 4's admission Record (a record containing diagnostic and demographic resident information), the admission Record indicated the facility admitted Resident 4 on 3/2/2021 and readmitted the resident on 8/26/2024 with diagnoses including schizoaffective disorder bipolar type (a mental illness characterized by seeing and/or hearing things that are not there, believing things that are untrue, and extreme mood swings). During a review of Resident 4's physician orders for risperidone, dated between 9/15/2022 and 4/29/2026, indicated Resident 4 was initially prescribed risperidone on 9/15/2022 to be given one milligram (mg - a unit of measure for mass) by mouth at bedtime. The physician orders for risperidone indicated the dose was increased on 1/26/2023 to two milligrams by mouth every evening and then increased again on 7/12/2024 to two milligrams by mouth every 12 hours. During a review of Resident 4's History and Physical (H&P - a record of a physician's comprehensive medical assessment and plan) dated 9/16/2025, the H&P indicated Resident 4 had a mildly impaired cognitive status (noticeable decline in memory or thinking skills). During a review of Resident 4's current Order Summary Report (a report of all currently active physician's orders), dated 4/29/2026, indicated he was currently taking risperidone 2 mg by mouth every 12 hours for schizoaffective disorder. During a review of Resident 4's clinical record indicated there were no attempts to use a lower dose of risperidone to manage symptoms of schizoaffective disorder since the medication was initially prescribed on 9/15/2022. During a review of Resident 4's Minimum Data Set (MDS - a resident assessment tool) Section N (medications), dated 2/20/2026, indicated Resident 4 had been receiving an antipsychotic medication (a class of medications used to treat mental illness which includes risperidone) continuously, a GDR had not been attempted for it, and there was no date in the clinical record on which the physician had documented that a GDR attempt on risperidone would be clinically contraindicated. During a review of the pharmacist's recommendation dated 3/30/2026, indicated the pharmacist recommended that the physician attempt a GDR for Resident 4's risperidone. The pharmacist's recommendation indicated the physician declined to perform the GDR citing failures from previous attempts which resulted in violent behaviors. During an interview on 4/29/2026 at 11:57 AM with the Director of Nursing (DON), the DON stated Resident 4 had been taking risperidone continuously since September 2022. The DON stated the dose was increased in January of 2023 and then again in July of 2024. The DON stated there was no record of any dosage decrease having been attempted since the risperidone was initially prescribed. The DON stated the MDS assessment dated [DATE] indicated there had been no attempt at a GDR on risperidone and no date when it was documented as contraindicated. The DON stated she (DON) could not explain why the physician's response to the pharmacist's recommendation references previously failed GDR attempts on risperidone when there was no evidence of it having been attempted in the clinical record. The DON stated the GDR must be attempted at least every year for residents (in general) on antipsychotics. The DON stated failing to attempt the GDR increased<br>(continued on next page) |

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| F 0605<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Resident 4's risk of adverse effects of antipsychotics such as drowsiness, dizziness, risk of falls, and movement disorders which could cause medical complications and a decrease in his quality of life. During an interview on 4/29/2026 at 1:03 PM with the psychiatrist (MD 1), MD 1 stated she (MD 1) had attempted a GDR on Resident 4's lithium (a medication used to treat mental illness) in the past but not on the risperidone. MD 1 stated she (MD 1) mistakenly responded to Resident 4's pharmacist recommendation from March 2026 to do a GDR on his risperidone that previous attempts have been failed as she (MD 1) confused the previous attempts with the lithium. MD 1 stated she (MD 1) understood that the clinical rationale to decline a GDR as contraindicated cannot be previous failures when no actual attempts had been made to do a GDR on that specific medication. During a review of the facility's policy titled Psychotropic Medication Use, dated June 2021, indicated .Within the first year in which a resident is admitted on a psychotropic medication or after the prescribing practitioner had initiated a psychotropic medication, the facility must attempt a GDR in two separate quarters (with at least one month between the attempts), unless clinically contraindicated. After the first year, a GDR must be attempted annually, unless clinically contraindicated. Physician/Prescriber should document the clinical rationale for why any additional attempted dose reduction at that time would be likely to impair the resident's function or increase distressed behavior. |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to develop and implement a comprehensive person-centered care plan (a plan of care that summarizes a resident's health conditions, specific care needs, and current treatments) to meet the needs of five of 18 sampled residents (Resident 2, Resident 9, Resident 11, Resident 40, and Resident 88) by failing to ensure to: 1.Implement Resident 2's care plan for at risk for skin breakdown. 2.Develop a care plan for Resident 9's language communication preference. 3.Implement Resident 11's care plan for Activities of Daily Living (ADLs, the basic self-care tasks such as bathing, dressing, eating, and mobility that individuals perform daily to maintain independence and hygiene) self-care performance deficit (when a resident cannot independently perform daily activities due to physical or mental health limitations). 4.Develop a care plan for Resident 40's flu (a respiratory virus) vaccine (medications used to prevent diseases usually given by injection or by mouth) refusal. -Develop a care plan for Resident 40's arteriovenous (AV) fistula/shunt (a surgically created connection linking an artery [a type of blood vessel that carries oxygen-rich blood the entire body] directly to a vein [a type of blood vessel that collected oxygen-poor blood and returns it to the heart] to facilitate blood flow for HD) in the right upper arm. 5. Develop a care plan for Resident 88's refusal of the pneumonia (PNA-an infection/inflammation in the lungs) vaccines. These failures had the potential for Resident 2, Resident 9, Resident 11, Resident 40, and Resident 88 to receive inadequate care causing resident injury and harm.Findings:<br><br>1.During a review of Resident 2's admission Record, the admission Record indicated the facility originally admitted Resident 2 on 7/16/2025 and re-admitted the resident on 9/17/2025 with diagnoses including gastrostomy (GT- a flexible tube surgically inserted through the abdomen into the stomach for feeding, fluid, and medication administration), malnutrition (lack of sufficient nutrients in the body), and generalized muscle weakness (weakening, shrinking, and loss of muscle).<br><br>During a review of Resident 2's History and Physical (H&P) dated 9/3/2025, the H&P indicated Resident 2 did not have the capacity to understand and make decisions.<br><br>During a review of Resident 2's Minimum Data Set (MDS - a resident assessment tool), dated 3/20/2026, the MDS indicated Resident 2 had impaired cognition (mental action or process of acquiring knowledge and understanding) for daily decision-making and maximal assistance (helper does more than half the effort) to dependent (helper does all the effort) from staff for ADLs. The MDS indicated Resident 2 was at risk of developing pressure ulcers/injuries (PI, injuries to the skin and underlying tissue resulting from prolonged pressure on the skin) with treatment for pressure reducing devices for bed.<br><br>During a review of Resident 2's Braden Scale (pressure ulcer risk predictor tool) for predicting pressure ulcer risk (BSPPUR) dated 4/14/2026, the BSPPUR indicated Resident 2 was at risk for pressure ulcer development.<br><br>During a review of Resident 2's Care Plan Report revised on 4/14/2026, Care Plan Report indicated Resident 2 was at risk for skin breakdown, related to advanced age (greater than 75 years), decreased activity, frail fragile skin, impaired cognition and limited mobility with intervention to provide lower extremity protectors-prevalon boots (type of heel protector to help reduce the risk of bedsores by keeping the heel floated, relieving pressure) and off load/float heels while in bed.<br>(continued on next page) |

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During a concurrent observation and interview on 4/27/2026 at 9:38 AM, with Certified Nursing Assistant 9 (CNA 9) and Resident 2, inside Resident 2's room, Resident 2 was observed in bed with both heels touching the bed mattress, and without the prevalon boots. CNA 9 stated that both heels were supposed to be elevated, not touching the bed mattress. CNA 9 also stated Resident 2 was supposed to have prevalon boots.<br><br>During a concurrent observation and interview on 4/28/2026 at 10:20 AM with Licensed Vocational Nurse 3 (LVN 3), inside Resident 2's room, Resident 2 was observed in bed with both heels touching the bed mattress and without prevalon boots. LVN 3 stated that since Resident 2 was on a low air loss mattress (LAL-a mattress designed to prevent and treat pressure wounds), Resident 2 did not need any offloading/floating of the heels and as well as the prevalon heels.<br><br>During an interview on 4/30/2026 at 11:51 AM, with the Director of Nursing (DON), the DON stated that Resident 2 was at risk for skin breakdown and nursing staff should be following the care plan specifically for Resident 2. The DON stated and validated that Resident 2's bilateral heels should still be offloaded when in a LAL mattress and Resident 2 should be provided with prevalon boots per care plan. The DON also stated importance of implementing care plans to be able to provide proper care to Resident 2.<br><br>2. During a review of Resident 9's admission Record, the admission Record indicated the facility admitted Resident 9 on 3/21/2026 with diagnoses including atherosclerotic heart disease (build-up of fats, cholesterol, and other substances in and on the artery walls), metabolic encephalopathy (a disease in which the functioning of the brain is affected by some agent or condition-such as viral infection or toxins in the blood) and dementia (a chronic or persistent disorder of mental processes caused by brain disease).<br><br>During a review of Resident 9's MDS, dated [DATE], the MDS indicated Resident 9 had impaired cognition for daily decision-making and maximal assistance from staff for ADLs.<br><br>During a review of Resident 9's H&P dated 4/27/2025, the H&P indicated Resident 9 did not have the capacity to understand and make decisions.<br><br>During an interview with Resident 9 and Activities Assistant (AS) on 4/27/2026 at 11:02 AM during initial tour, Resident 9 was speaking a different language, unable to speak English when asked if she (Resident 9) could communicate in English. The AS stated that Resident 9 mainly spoke a different language and facility staff used communication board to communicate with her (Resident 9).<br><br>During a concurrent interview and record review on 4/30/2026 at 11:31 AM with the DON, Resident 9's Care Plan Report was reviewed. The Care Plan Report indicated Resident 9 did not have a care plan in regards with Resident 9's communication needs related to language barrier. The DON stated that Resident 9 was at risk for impaired verbal communication related to language barrier since Resident 9 spoke mainly spoke a different language, and facility communicated via communication board written in Resident 9's language. The DON stated it was important to have an individualized and comprehensive care plan for Resident 9's communication needs.<br><br>3. During a review of Resident 11's admission Record, the admission Record indicated the facility admitted the resident on 8/17/2024 with diagnoses that included type 2 diabetes (DM, a disorder characterized by difficulty in blood sugar control and poor wound healing), End Stage Renal Disease (ESRD, irreversible kidney damage), and dependence on renal (kidney) dialysis (a treatment to<br>(continued on next page) |

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| | 055755 | A. Building<br>B. Wing | 04/30/2026 |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | cleanse the blood of wastes and extra fluids artificially through a machine when the kidney(s) have failed).<br><br>During a review of Resident 11's MDS dated [DATE], the MDS indicated Resident 11 was cognitively intact (had the ability to think, understand, and reason). The MDS indicated Resident 11 normally used a wheelchair. The MDS indicated Resident 11 required partial/moderate assistance (helper does less than half the effort. Helper lifts, holds, or supports the trunk or limbs, but provides less than half the effort) with sit to stand mobility, chair/bed-to-chair transfer, toilet transfer, and tube/shower transfer.<br><br>During a review of Resident 11's Nursing Documentation Evaluation dated 2/22/2026 at 6:57 PM, the Nursing Documentation Evaluation indicated Resident 11 had fall risk factors (any attribute, characteristic, or exposure that increases the likelihood of developing a disease, injury, or negative outcome) that included impaired balance (a condition in which an individual feels unsteady), predisposed disease or injury (a pre-existing medication condition, physical, or genetic trait that increases an individual's susceptibility to develop a different disease or injury), and required assistance for toileting.<br><br>During a review of Resident 11's Care Plan Report dated 4/19/2026, the Care Plan Report indicated Resident 11 had an ADLs self-care performance deficit related to impaired mobility (a condition that limits a person's ability to move freely or perform activities), generalized weakness (reduced muscle strength throughout the entire body), polyneuropathy (a condition in which multiple peripheral nerves in the body become damaged and causing numbness, tingling, and pain), and the use of the wheelchair. The Care Plan Report indicated the goal for Resident11 was to maintain Resident 11's current level of mobility. The Care Plan Report indicated Resident 11 required total assistance with transfers, two staff participation, the use of the Hoyer lift machine, and a yellow color medium size sling (a supportive fabric device used with resident lifts to safely transfer residents between beds, chairs, and the floor).<br><br>During a review of Resident 11's SBAR (Situation, Background, Assessment, Recommendation – a communication tool used by healthcare workers when there is a change of condition among the residents) Communication Form dated 4/20/2026, the SBAR Communication Form indicated Resident 11 had a fall. The SBAR Communication Form indicated that while the CNA (unidentified) was getting Resident 11 up to go to dialysis Resident 11 slipped from the bed to the floor and landed on her (Resident 11) knees. The SBAR Communication Form indicated Resident 11 was observed lying on the floor by the charge nurse (unidentified) when the charge nurse was informed that Resident 11 had a fall. The SBAR Communication Form indicated Resident 11 had right and left knee pain that Resident 1 rated a level five (rated on a scale of 1-10 with 10 being the worst). The SBAR Communication Form indicated Resident 11 did not show any obvious signs of injury. The SBAR Communication Form indicated Resident 11 stated her (Resident 11) knees hurt from the fall. The SBAR Communication Form indicated Resident 11 was safely put back on the wheelchair assisted by three people using a bed sheet. The SBAR Communication Form indicated Resident 11 was given Tylenol (acetaminophen, a medication used to reduce pain). The SBAR Communication Form indicated Resident 11 was taken to the lobby to wait for transportation to dialysis. The SBAR Communication Form indicated Resident 11 left the facility in stable condition. The SBAR Communication Form indicated Resident 11's Nurse Practitioner (NP, unidentified) was notified on 4/20/2026 at 7:30 AM of Resident 11's fall. The SBAR Communication form indicated Resident 11's NP ordered to monitor Resident 11 and to inform the NP if an x-ray (an imaging test that uses electromagnetic radiation to create pictures of bones and tissues) was needed when Resident 11 returned from dialysis.<br>(continued on next page) |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During a review of Resident 11's Order Summary Report, the Order Summary Report indicated the resident had a physician order dated 4/20/2026 to transfer Resident 11 to General Acute Care Hospital (GACH 1's) emergency room (ER) for further evaluation related to knee pain.<br><br>During a review of Resident 11's GACH 1 bilateral (both) knee x-ray report dated 4/20/2026 at 5:41 PM, the bilateral knee x-ray report indicated Resident 11 had a mildly displaced comminuted extra-articular fracture of the right distal femoral meta diaphysis (an injury where the right lower thigh bone is broken into multiple pieces). The bilateral knee x-ray report indicated Resident 11 had a displaced comminuted peri implant fracture involving the distal left femur (an injury where the lower thigh bone is broken into multiple pieces near an existing orthopedic implant).<br><br>During a review of Resident 11's Hospitalist History and Physical from GACH 1 dated 4/21/2026, the Hospitalist History and Physical indicated Resident 11 presented to GACH 1 on 4/20/2026 for a fall. The Hospitalist History and Physical indicated Resident 11 had a mechanical fall (a fall caused by an external, physical force. such as tripping, slipping, or stumbling rather than an internal medical issue like fainting or dizziness) while trying to get back into the wheelchair and landed on her (Resident 11) knees. The Hospitalist History and Physical indicated Resident 11 had severe pain, was unable to bear weight, and was found to have bilateral distal femur fractures.<br><br>During a review of Resident 1's Orthopedic Arthroplasty (a physician who focuses on replacing, repairing, or reconstructing damaged joints) Progress Note from GACH 1 dated 4/22/2026 at 6:08 AM, the Orthopedic Arthroplasty Progress Note indicated Resident 11 sustained bilateral distal femur fractures after an accident at the resident's care facility. The Orthopedic Arthroplasty Progress Note indicated Resident 11 was informed that it was best to address treatment for Resident 11's legs one leg at a time given Resident 11's comorbidities (the presence of more than one disease or disorder) and the risks of anesthesia (is the use of medications to block pain during medical procedures or surgery) and surgery. The Orthopedic Arthroplasty Progress Note indicated the intended plan was for Resident 11 to have an Open Reduction and Internal Fixation (ORIF, a surgical procedure to repair severe bone fractures) of the right femur first. The Orthopedic Arthroplasty Progress Note indicated surgery was planned for Resident 11's right femur on 4/23/2026.<br><br>During a telephone interview on 4/28/2026 at 10:29 AM with Resident 11, Resident 11 stated she (Resident 11) was at the GACH (unidentified). Resident 11 stated that on 4/20/2026 at almost 7 AM, CNA 7 was assisting her (Resident 11) to get to the wheelchair so the resident could go to dialysis. Resident 11 stated CNA 7 stood behind the wheelchair and grabbed the resident by her (Resident 11) sweatpants and waist. Resident 11 stated she (Resident 11) fell to the floor and landed on both knees. Resident 11 stated CNA 7 and her roommate (unidentified) were the only people in the room when she (Resident 11) fell. Resident 11 stated only CNA 7 was helping her Resident 11 during the resident's transfer. Resident 11 stated Registered Nurse 3 (RN 3) came to the room after Resident 11 had fallen. Resident 11 stated CNA 7 and RN 3 helped her (Resident 11) back to the wheelchair after the fall. Resident 11 stated she (Resident 11) was having a lot of pain. Resident 11 stated her pain level was 20, out of 10. Resident 11 stated she (Resident 11) was then taken to dialysis. Resident 11 stated she (Resident 11) was not doing good at the dialysis facility because she (Resident 11) was in a lot of pain. Resident 11 stated she (Resident 11) asked to go to the GACH (unidentified) when she (Resident 11) was at the dialysis facility. Resident 11 stated both of her (Resident 11) legs were broken. Resident 11 stated she (Resident 11) had surgery on her right leg on 4/23/2026 and was scheduled to have another surgery on her left leg on 4/30/2026. Resident 11 stated I'm so frustrated, and I am in a lot of pain.<br>(continued on next page) |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During a telephone interview on 4/29/2026 at 8:45 AM with CNA 7, CNA 7 stated that on 4/20/2026 at 6:50 AM she (CNA 7) was transferring Resident 11 from the bed to the wheelchair to get Resident 11was ready to go to dialysis. CNA 7 stated there were no other staff present in Resident 11's room at the time the CNA was assisting Resident 11 to the wheelchair. CNA 7 stated she (CNA7) was trying to get the wheelchair into position by Resident 11's bed, when Resident 11 started scooting to the edge of the bed trying to get to the wheelchair. CNA 7 stated Resident 11 started to slide to the floor. CNA 7 stated she (CNA 7) tried to grab Resident 11 under the resident's arms, but Resident 11 landed on her (Resident 11) knees. CNA 7 stated she (CNA 7) assisted Resident 11 to lay on her (Resident 11) back and called RN 3 to Resident 11's room. CNA 7 stated that Resident 11 said her (Resident 11) knees were hurting, but CNA 7 could not remember the resident's pain level.<br><br>During an interview on 4/29/2026 at 9:29 AM with the Director of Nursing (DON), the DON stated RN 3 was on vacation.<br><br>On 4/29/2026 at 9:29 AM an attempt to contact RN 3 by telephone was made, but RN 3 could not be reached for an interview.<br><br>During a telephone interview on 4/29/2026 at 10:36 AM with Dialysis Registered Nurse 1 (DRN 1), DRN 1 stated she (DRN 1) worked at Dialysis Facility 1 (DF 1). DRN 1 stated Resident 11 received dialysis at DF 1. DRN1 stated she (DRN 1) was one of the nurses who assisted Resident 11 on 4/20/2026. DRN 1 stated Resident 11 informed DRN 1 that she (Resident 11) had fallen when she (Resident 11) was being assisted by a staff member (unidentified) at the facility during a transfer. DRN 1 stated Resident 11 informed DRN 1 that the person (unidentified) who was transferring the resident at the SNF was holding the resident from behind, when Resident 11 slipped and fell on her (Resident 11) knees. DRN 1 stated Resident 11 had a pain level of 10 out of 10 while at DF 1. DRN 1 stated that after dialysis Resident 11 stated she (Resident 11) would not be able to get back into the wheelchair, because it was too painful for Resident 11. DRN 1 stated Resident 11 wanted to go to the ER.<br><br>During an interview on 4/29/2026 at 10:42 AM with Dialysis LVN 1 (DLVN 1), DLVN 1 stated that on 4/20/2026 (unidentified time), he (DLVN 1) called DRN 1 to assess Resident 11 at DF 1. DLVN 1 stated that Resident 11 had informed him (DLVN 1) that she (Resident 11) had slid and landed on both her (Resident 11) knees when a staff (unidentified) assisted Resident 11 during a transfer at the SNF. DLVN 1 stated Resident 11 had a 10 out of 10 pain level to both of her (Resident 11) knees. DLVN 1 stated that when Resident 11 finished dialysis, Resident 11 requested a gurney (stretcher) transportation to the GACH (unidentified). DLVN 1 stated Resident 11 could not bend her (Resident 11) knees because it was too painful. DLVN 1 stated the DF1 called 911 (emergency services phone number) and Resident 11 was transferred to the GACH (unidentified).<br><br>On 4/29/2026 at 1:43 PM a second attempt to contact RN 3 by telephone was made. RN 3 could not be reached for interview.<br><br>During a concurrent interview and record review on 4/29/2026 at 3:33 PM with the DON, Resident 11's Care Plan Report dated 4/19/2026 was reviewed. The DON stated a care plan was a guide that had interventions for the nurses (in general) and the staff (in general) to follow the care plan to provide good care for the residents (in general). The DON stated the care plan was resident centered and based on resident needs. The DON stated Resident 11 had a care plan for an ADL self-care performance deficit related to impaired mobility, generalized weakness, polyneuropathy, and use of the wheelchair. The DON stated Resident 11's ADL self-care performance deficit care plan had an<br>(continued on next page) |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | intervention for transfers. The DON stated Resident 11's ADL self-care performance deficit care plan indicated Resident 11 required total assistance with transfers, two staff participation, use of the Hoyer lift machine, and a medium yellow color sling size. The DON stated staff (in general) were expected to follow Resident 11's care plan when transferring the resident. The DON stated that if Resident 11's care plan indicated the resident required total assistance with transfers, two staff participation and use of the Hoyer lift machine it was the expectation that the resident be transferred with two staff members. The DON stated Resident 11's care plan was not followed. The DON stated Resident 11 was being transferred to the wheelchair from the bed by one staff member, CNA 7, on the morning of 4/20/2026. The DON stated it was important that Resident 11's care plan be followed for safety and prevention of injury. The DON stated Resident 11's fall on 4/20/2026 could have been prevented if two staff members transferred Resident 11 from the bed to the wheelchair on 4/20/2026.<br><br>During an interview on 4/30/2026 at 11:31 AM with Restorative Nursing Assistant 2 (RNA 2), RNA 2 stated she (RNA 2) was familiar with Resident 11. RNA 2 stated she (RNA 2) was often called to help transfer the resident to and from the wheelchair to the bed, especially after dialysis. RNA 2 stated she (RNA2) had just assisted Resident 11 with a transfer the week before. RNA 2 stated Resident 11 required a gait belt (a strap with a metal or plastic buckle, used by caregivers to safely assist individuals with mobility issues during walking or transfers) and assistance from two staff members with transfers.<br><br>During a concurrent interview and record review on 4/30/2026 at 12:33 PM with the Director of Staff Development (DSD), Resident 11's Care Plan Report dated 4/19/2026 was reviewed. The DSD stated Resident 11's Care Plan Report indicated Resident 11 needed two-person assistance with a Hoyer lift for transfers. The DSD stated that based on Resident 11's care plan, the CNAs (in general) were expected to have two-persons with a Hoyer lift when assisting Resident 11 with transfers. The DSD stated Resident 11's care plan needed to be followed. The DSD stated the care plan was a guide that indicated what the staff (in general) needed to do for Resident 11. The DSD stated interventions on the care plan were to be followed for the safety of the residents (in general). The DSD stated injury to a resident (in general) could happen if interventions on the care plan were not followed. The DSD stated if Resident 11's care plan was followed and two staff were present and used a Hoyer lift during Resident 11's transfer, the resident's fall on 4/20/2026 could have been prevented.<br><br>4. During a review of Resident 40's admission Record, the admission Record indicated the facility originally admitted Resident 40 on 7/12/2023 and was readmitted on [DATE] with diagnoses including end stage renal disease (ESRD-a medical condition in which a person's kidney [organ in the body that filters waste and excess fluid from the blood] stop functioning on a permanent basis), and dependence on hemodialysis (HD-a life-sustaining treatment for kidney failure that acts as an artificial kidney, filtering waste, toxins and excess water from the person's body using a machine).<br><br>During a review of Resident 40's H&P dated 2/19/2026, the H&P indicated Resident 40 had a capacity to understand and make decisions.<br><br>During a review of Resident 40's MDS dated [DATE], the MDS indicated Resident 40 had intact cognition for daily decision-making and with varying needs on assistance from being independent to maximal assistance from staff for ADLs.<br><br>During a review of Resident 40's vaccine consent form dated 8/18/2025, the vaccine consent form indicated Resident 40 declined flu vaccine.<br>(continued on next page) |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During a concurrent interview and record review on 4/30/2026 at 1:30 PM, with the Infection Preventionist Nurse (IPN), Resident 40's Care Plan Report was reviewed. Resident 40's Care Plan Report indicated missing refusal of flu vaccine care plan. The IPN stated that Resident 40 refused flu vaccine and was supposed to have to have a care plan for refusal of the flu vaccine.<br><br>During an interview on 4/30/2026 at 2:02 PM with the DON, the DON stated it was important to develop a care plan when a resident (in general) refused medication, treatment and/or any care services provided by the facility. The DON stated that when a resident refused vaccines, the facility was supposed to develop a care plan for refusal since Resident 40 would be at risk for infection.<br><br>-During a review of Resident 40's MDS dated [DATE], the MDS indicated the resident received dialysis (a medical treatment that acts as an artificial kidney, filtering waste products, toxins, and excess water from the blood when a person's kidneys can no longer perform these tasks properly).<br><br>During a review of Resident 40's Order Summary Report dated 11/3/2025, the Order Summary Report indicated dialysis on Tuesday, Thursday, and Saturday using right chest Permacath (a flexible, soft tube placed into a large vein to use for short term dialysis) access site.<br><br>During a review of Resident 40's Order Summary Report dated 1/26/2026, the Order Summary Report indicated HD access site monitoring location on the left arm shunt.<br><br>During a review of Resident 40's Order Summary Report dated 1/26/2026, the Order Summary Report indicated to remove the dressing from Resident 40's left arm shunt post-dialysis treatment.<br><br>During a review of Resident 40's Order Summary Report dated 1/30/2025, the Order Summary Report indicated Resident 40 had an external HD Permacath on the right chest.<br><br>During a review of Resident 40's Order Summary Report dated 2/16/2026, the Order Summary Report indicated not to perform blood pressure (BP, the force of blood pushing against the artery walls as the heart pumps it around the body) measurements, venipunctures (blood draws), or intravenous (IV, fluids given directly into the blood stream) therapy on the access arm (unidentified arm).<br><br>During a review of Resident 40's Care Plan Report dated 2/16/2026, the Care Plan Report indicated HD access site monitoring of the left arm shunt. The Care Plan Report indicated Do not perform BP measurements, venipunctures, or IV therapy on the access arm. The Care Plan Report indicated dialysis on Tuesday, Thursday, and Saturday using left chest Permacath access site.<br><br>During a review of Resident 40's Body Check dated 2/19/2026, the report indicated Right medial of upper arm surgical incision with dermabond [a skin adhesive that holds wound edges together following surgical incisions].<br><br>During a review of Resident 40's Access Details undated, the report indicated Resident 40's left upper arm AV fistula was permanently unusable on 9/26/2024. The report did not indicate a removal date for the left upper arm AV fistula. The report indicated a chest Permacath actively in use starting 9/26/2024. The report indicated the previous chest Permcath was removed on 10/9/2023. The report indicated an AV fistula was placed in Resident 40's right upper arm on 2/11/2026.<br><br>During a concurrent observation and interview on 4/27/2026 at 11:37 AM with Resident 40 in Resident 40's room, Resident 40 had a Permacath on the right upper chest. Resident 40 stated the left upper (continued on next page) |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | arm AV fistula was removed and he (Resident 40) currently would get dialysis through the temporary Permcath. Resident 40 stated the right upper arm fistula was placed a couple months ago, but it could not be used until May 2026.<br><br>During a concurrent interview and record review on 4/29/2026 at 9:20 AM with Licensed Vocational Nurse 2 (LVN 2), Resident 40's Special Instructions, undated was reviewed. The instructions indicated, No BP on left arm. LVN 2 stated new orders should have been obtained to ensure staff do not take BP on the right upper arm with the AV fistula.<br><br>During an interview on 4/29/2026 at 9:29 AM with Registered Nurse (RN) 1, RN 1 stated Resident 40's AV shunt site should have been updated in the chart but was not. RN 1 stated it is important for care plan interventions to be accurate because staff might take BP on the right arm which has the AV fistula. RN 1 stated pressure from the BP cuff can damage the AV fistula, cause clotting and make the HD access unusable.<br><br>During an interview on 4/29/2026 at 2:39 PM with the Minimum Data Set Coordinator (MDSC), the MDSC stated the dialysis order, AV fistula location, and BP restrictions should have been clarified with the doctor. The MDSC stated orders and care plans must be updated for accuracy of care. The MDSC stated taking BP on the access site can damage the AV fistula. The MDSC stated Resident 88 could not get HD if there was no usable access site, so the toxins would build up in the body, and the resident would end up hospitalized .<br><br>During a concurrent interview and record review on 4/30/2026 at 10:20 AM with the DON, the facility's policy and procedure (P&P) titled, Dialysis Care, dated August 2021 was reviewed. The P&P indicated The Interdisciplinary Team (IDT) will ensure that the resident's care plan includes documentation of the resident's renal condition and necessary precautions (e.g., shunt site, weights, dietary and fluid restrictions, no BP on affected side, lab draws, IV, injection on arm with shunt, observe for signs and symptoms of infection, etc.). The DON stated the P&P was not followed because Resident 40's orders and care plan were not updated to reflect the resident's current condition. The DON stated it was important to update care plans so staff (would know what care activities residents need.<br><br>5. During a review of Resident 88's admission record, the admission record indicated the facility originally admitted Resident 88 on 6/30/2022 and was readmitted on [DATE] with diagnoses including epilepsy (a disorder in which a nerve cell activity in the brain is disturbed causing seizure [a sudden, uncontrolled electrical disturbance in the brain]), cerebral infarction (also called stroke, a result of inadequate blood flow to the brain) and gastrostom |

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| F 0726<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure two out of six sampled employees (Registered Nurse 1 [RN 1] and Licensed Vocational Nurse 1 [LVN 1]) performing medication administration had yearly annual employee evaluations (a yearly, formal check-in between an employee and their manager to discuss achievements, set goals for the coming year, and identify professional development needs) including medication administration competencies (the core skills and knowledge health providers must have to safely give medications, focusing on preventing errors and ensuring patient safety) in their employee files. This deficient practice had the potential to affect residents' (in general) safety and had the potential for unsafe medication administration. Cross reference F759Findings: During a concurrent interview and record review on [DATE] at 10:06 AM with the Director of Staff Development (DSD), RN 1 and LVN 1's employee records were reviewed. The employee records indicated RN 1 and LVN 1's license and CPR (cardiopulmonary resuscitation - an emergency, life-saving procedure performed when someone's breathing or heartbeat has stopped) were up to date. RN 1 and LVN 1's records did not indicated when RN 1 and LVN 1 had their last annual evaluation (a yearly, formal conversation between a manager and employee to look back at the past year's work, celebrate achievements, identify areas for improvement, and set goals for the year ahead) or when RN 1 and LVN 1 had their last evaluation for medication administration competency (the knowledge, skill, and judgment to safely give medicine to a patient every time). The DSD stated the Director of Nursing (DON) was responsible for monitoring the timely and proper administration of medication (the safe, precise process of giving a patient prescribed medicine) by the facility's licensed staff (LVNs and RNs in general). The DSD stated the DON had the documentation of when RN 1 and LVN 1 last received their (RN 1 and LVN 1) evaluation/education for medication administration competency and annual evaluation. During an interview on [DATE] at 12:32 PM with the DON, the DON stated the DSD, facility's pharmacy, and the DON were responsible for evaluating the licensed staff (in general) for medication administration competency. The DON stated she (the DON) asked the facility's pharmacist consultant (PC -a specialized medication safety expert who reviews patient medications in nursing homes or assisted living facilities to ensure they are safe, necessary, and effective) to evaluate RN 1 and LVN 1's medication administration competency. The DON stated she (the DON) could not recall when RN 1 and LVN 1 last received education for medication administration. The DON stated she asked the PC to train the facility's licensed staff (in general), including new hires, on medication administration three months ago because the DON stated she was preparing for survey (on-site inspection of healthcare facilities like nursing homes to ensure they follow federal safety and quality rules). The DON stated she thought RN 1 and LVN 1 received the medication administration training and stated the PC would either hand in the proof of training or email it. The DON stated she could not provide proof that RN 1 and LVN 1 received the training. The DON admitted to not having RN 1 and LVN 1's medication administration competencies readily available. The DON stated if she did not have the records for RN 1 and LVN 1, she (the DON) could not guarantee RN 1 and LVN 1 could give medications to residents (in general) safely. The DON stated RN 1 and LVN 1 would need to receive training for medication administration competency before they (RN 1 and LVN 1) would be able to give resident medications again. The DON then called the facility's consultant company and stated she (the DON) was told the PC no longer worked for the company. The DON stated she (the DON) should have performed the medication administration competencies more often to ensure the facility's nurses (in general) could give medication to residents (in general) safely. During a concurrent interview and record review on [DATE] at 1:34 PM, with the DON, RN 1's medication administration competency dated [DATE] was reviewed. RN 1's medication administration competency indicated RN 1 was last evaluated for medication administration competency on [DATE].<br>(continued on next page) |

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| F 0726<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | The DON could not provide any documentation on medication administration annual competency for RN 1 for years 2025 or 2026. The DON could not provide any documentation that LVN 1 ever had medication administration competency performed. The DON stated the facility should have done the annual medication administration competency for RN 1 and LVN 1. During a review of the facility's policy and procedure (P&P) titled, Job Descriptions and Performance Evaluations, last reviewed on [DATE], the P&P indicated Performance evaluations measure the standards against job performance. The P&P indicated performance evaluations aid management in analyzing and improving the facility's services. During a review of the facility's P&P titled, Competency of Nursing Staff , last reviewed on [DATE], the P&P indicated the following Policy Statement: 1. All nursing staff must meet the specific competency requirements of their respective licensure and certification requirements defined by State law.2. In addition, licensed nurses and nursing assistants employed (or contracted) by the facility will:a. participate in a facility-specific, competency-based staff development and training program; andb. demonstrate specific competencies and skill sets deemed necessary to care for the needs of residents, as identified through resident assessments and described in the plans of care. Rhe P&P indicated its Policy Interpretation and Implementation included the following: 1. The staff development and training program is created by the nursing leadership, with input from the medical director, and is designed to train nursing staff to deliver individualized, safe, quality care and services for the residents 2. The following factors are considered in the creation of the competency-based staff development and training program (a training approach focused on mastering specific, practical job skills rather than just attending training hours ): a. An evaluation of the current program to ensure basic nursing competencies; b. Any gaps in education or training that may be contributing to poor outcomes; c. Specialized skills or training needed based on the resident population; d. A method to track, assess, plan, implement and evaluate the effectiveness of training; and e. A method to evaluate critical thinking skills and management of care in complex environments with multiple interruptions. 4. The facility assessment (a required annual check-up a nursing home performs on itself to ensure it has enough staff, equipment, and resources to safely care for its residents ) includes an evaluation of the staff competencies that are necessary to provide the level and types of care specific to the resident population. 5. Competency in skills and techniques necessary to care for residents' needs includes but is not limited to competencies in areas such as: f. Basic nursing skills i. Medication management 8. Facility and resident-specific competency evaluations will be conducted upon hire, annually and as deemed necessary based on the facility assessment. 9. Facility and resident-specific competency evaluations will include: e. Demonstrated ability to perform activities that are within the scope of practice (defines the specific procedures, actions, and processes a licensed professional is permitted to undertake, based on their training, education, and legal licensing) an individual is licensed or certified to perform. 11. Competency demonstrations will be evaluated based on the staff member's ability to use and integrate knowledge and skills obtained in training, which will be evaluated by staff already deemed competent in that skill or knowledge. |

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| F 0759<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure medication error rates are not 5 percent or greater.<br><br>Based on observation, interview, and record review, the facility failed to ensure its medication error rate was less than five percent (%). Ten errors out of 29 total opportunities contributed to an overall error rate of 34.48 % affecting six of six (sampled) residents (Resident 44, Resident 47, Resident 86, Resident 96, Resident 97, and Resident 105) observed for medication administration.The errors noted were as follows:1. Licensed Vocational Nurse 1 (LVN1) administered the incorrect dose of thiamine (a vitamin supplement) to Resident 44 on 4/28/2026. 2.Registered Nurse 1 (RN1) omitted (medication not provided) vitamin D (a vitamin supplement) and a multivitamin (a vitamin supplement) for Resident 47 on 4/28/2026. 3.LVN 1 administered the incorrect doses of the following medications: aspirin (a medication used to prevent stroke [poor blood flow to a part of the brain causes cell death]), fish oil (a dietary supplement), vitamin D, and ferrous sulfate (an iron supplement) to Resident 86 on 4/28/2026. 4.RN1 administered carvedilol (a medication used to treat high blood pressure) late to Resident 96 on 4/28/2026. 5. RN1 omitted clopidogrel (a medication used to prevent stroke) for Resident 97 on 4/28/2026. 6. RN1 administered levothyroxine (a medication used to treat low thyroid levels) late to Resident 105 on 4/28/2026. The deficient practice of failing to administer medications in accordance with the physician's orders or professional standards increased the risk that Resident 44, Resident 47, Resident 86, Resident 96, Resident 97, and Resident 105 may have experienced medical complications possibly resulting in hospitalization.Findings: 1.During a review of Resident 44's admission Record (a document containing diagnostic and demographic information) dated 4/29/2026, the admission Record indicated the facility admitted Resident 44 on 3/12/2026 with diagnosis including paroxysmal atrial fibrillation (an irregular heartbeat due to a blood clot that increases the risk of stroke). During a review of Resident 44's History and Physical (H&P -a record of a physician's comprehensive medical assessment) dated 3/13/2026, the H&P indicated Resident 44 had a diagnosis of atrial fibrillation. During a review of Resident 44's Order Summary Report (a monthly summary report of all active physician orders) dated 4/29/2026, the Order Summary indicated Resident 44's physician prescribed the following:-Thiamine 250 milligrams (mg - a unit of measure for mass) by mouth one time a day for supplement. During an observation of medication administration on 4/28/2026 at 8:08 AM with LVN 1, LVN 1 was observed preparing the following medication for Resident 44:-One tablet of thiamine 100 mg. During an observation on 4/28/2026 at 8:13 AM, Resident 44 was observed taking the thiamine 100 mg tablet along with other medications by mouth with water. During an interview on 4/28/2026 at 11:02 AM, with LVN 1, LVN 1 stated Resident 44's order for thiamine was for 250 mg and she (LVN 1) administered 100 mg. LVN 1 stated she (LVN 1) failed to clarify with the physician if it was okay to administer a different dose prior to giving it to the resident. LVN 1 stated failing to administer the correct dose of medications could cause medical complications. LVN 1 stated she (LVN 1) failed to check the products she (LVN 1) had available in her (LVN 1) cart against the physician's orders. LVN 1 stated she (LVN 1) usually would give what she (LVN 1) had on hand out of convenience rather than trying to follow the physician's orders or to clarify the order first. LVN 1 stated she (LVN 1) failed to contact the physician to clarify the orders to see if the deviation in dosage was acceptable. LVN 1 stated failing to administer the correct dosage of medications could cause medical complications possibly resulting in a decline in health status or quality of life. 2. During a review of Resident 47's admission Record dated 4/29/2026, the admission Record indicated the facility admitted Resident 47 on 12/22/2025 with diagnoses including cerebral infarction (stroke). During a review of Resident 47's H&P dated 12/22/2025, the H&P indicated Resident 47 had a diagnosis of cerebral infarction. During a review of Resident 47's Order Summary Report dated 4/29/2026, the Order Summary Report indicated Resident 47's physician prescribed the following medications to be administered during the 9 AM medication pass:-Vitamin D 2000 International Units (IU - a unit of measure for vitamins) by mouth one time a day for supplement-Multivitamin tablet by mouth one time a day for supplement During an observation of<br>(continued on next page) |

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| F 0759<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | medication administration on 4/28/2026 at 9:33 AM with RN 1, RN 1 was observed preparing the following medications for Resident 47:-One tablet of clopidogrel 75 mg.-One tablet of aspirin 81 mg chewable.-One tablet of vitamin B12 1000 micrograms (mcg - a unit of measure for mass).-One tablet of ferrous sulfate 325 mg. During an interview on 4/28/2026 at 9:40 AM with RN 1, RN 1 stated there were four total medications to administer to Resident 47 at this time. During an observation on 4/28/2026 at 9:44 AM, Resident 47 was observed taking the four medications listed above by mouth with water. During an interview on 4/28/2026 at 10:56 AM with RN 1, RN 1 stated Resident 47 was scheduled to receive Vitamin D and a multivitamin at 9 AM but she (RN1) failed to see these when reviewing the medications for Rsident1. RN 1 stated she (RN1) omitted them by accidental oversight. RN 1 stated not giving vitamins as prescribed could cause a decline in Resident 47's quality of life. 3. During a review of Resident 86's admission Record dated 4/29/2026, the admission Record indicated the facility admitted Resident 86 on 8/27/2023 with diagnoses including hypertension (high blood pressure). During a review of Resident 86's H&P dated 1/6/2026, the H&P indicated Resident 86 had a diagnosis of hypertension. During a review of Resident 86's Order Summary Report dated 4/29/2026, the Order Summary Report indicated Resident 96's physician prescribed the following medications:-Ferrous Sulfate 75 mg by mouth one time a day for supplement.-Vitamin D 1000 IU by mouth one time a day for low vitamin D. During an observation of medication administration on 4/28/2026 at 8:20 AM with LVN 1, LVN 1 was observed preparing the following medications for Resident 86:-One tablet of aspirin 81 mg chewable.-One soft gel capsule of fish oil 500 mg.-One capsule of vitamin D 400 IU.-One tablet of ferrous sulfate 325 mg. During an observation on 4/28/2026 at 8:22 AM, LVN 1 was observed crushing each medication individually in a plastic pill pouch then adding the powdered or crushed contents to a small plastic medication cup. During an observation on 4/28/2026 at 8:28 AM, LVN 1 was observed knocking over the plastic medication cup containing the powdered aspirin and spilling approximately half of the pink powder onto the top of the medication cart. LVN 1 was then observed wiping up the spilled aspirin powder with a disinfectant wipe. LVN 1 was observed placing the medication cup containing the remaining aspirin powder back onto the medication tray without replacing the contents with a new tablet. During an observation on 4/28/2026 at 8:31 AM, LVN 1 was observed placing one 500 mg fish oil soft gel capsule into a plastic medication pouch and crushing it with the pill crusher. LVN 1 was then observed trying to squeeze out the fish oil into the medication cup. The medication pouch was observed to still contain a significant amount of residual fish oil. LVN 1 was observed discarding the medication pouch containing the residual fish oil. During an observation on 4/28/2026 at 8:35 AM, LVN 1 was observed mixing each crushed medication with a small quantity of applesauce and then spoon feeding each medication mixture separately to Resident 86. During an interview on 4/28/2026 at 8:43 AM, LVN 1 stated she (LVN1) spilled some of the aspirin powder and did not replace it because she (LVN1) did not think it was very much that she (LVN1) spilled. LVN 1 stated as a result, Resident 86 did not get the full dose of aspirin. LVN 1 stated Resident 86 would take aspirin for stroke prevention and if Resident 86 missed the full dose of aspirin it may increase the risk for stroke. LVN 1 stated she (LVN1) crushed the fish oil capsule in the medication pouch rather than cutting it open. LVN 1 stated she (LVN1) thought that cutting it open might cause it to spill. LVN 1 stated she (LVN1) was not instructed to crush soft gel capsules and prepare them this way but did not know of any other way to do it. LVN 1 stated a significant amount of the fish oil remained in the medication pouch after crushing it and as a result, Resident 86 did not receive the fully intended dose of fish oil. LVN 1 stated fish oil is used for cholesterol (a fat-like substance that is found in all the cells in the body), and stroke prevention. LVN 1 stated if Resident 86 did not receive the full dose of her fish oil, it could also make her more at risk for a stroke long term. During an interview on 4/28/2026 at 11:02 AM, with LVN 1, LVN 1 stated Resident 86's order for fish oil was 1000 mg per day. LVN 1stated she (LVN1) administered one 500 mg dose. LVN 1 stated Resident 86's order for Vitamin D was for 1000 IU and she (LVN1) administered 400 IU. LVN 1 stated Resident 86's order for Ferrous Sulfate was for 75 mg and she (LVN1) administered 325 mg. LVN 1 (continued on next page) |

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| F 0759<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | stated she (LVN1) failed to clarify with the physician if it was okay to administer a different dose prior to giving it to the resident. LVN 1 stated failing to administer the correct dose of medications could cause medical complications. LVN 1 stated she (LVN1) failed to check the products she (LVN1) had available in her (LVN1) cart against the physician's orders. LVN 1 stated she (LVN1) usually would give what she (LVN1) had on hand out of convenience rather than trying to follow the physician's orders or to clarify the order first. LVN 1 stated she (LVN1) failed to contact the physician to clarify any of the above orders to see if the deviation in dosage was acceptable. LVN 1 stated failing to administer the correct dosage of medications could cause medical complications possibly resulting in a decline in health status or quality of life. 4. During a review of Resident 96's admission Record dated 4/29/2026, the admission Record indicated the facility admitted Resident 96 on 4/21/2026 with diagnoses including hypertension. During a review of Resident 96's H&P dated 4/22/2026, the H&P indicated Resident 96 had a diagnosis of hypertension. During a review of Resident 96's Order Summary Report dated 4/29/2026, the Order Summary Report indicated Resident 96's physician prescribed the following medication:-Carvedilol 3.125 mg by mouth two times a day at 8 AM and 5 PM for hypertension. During an observation of medication administration on 4/28/2026 at 9:47 AM with RN 1, RN 1 was observed preparing the following medications for Resident 96:-One carvedilol 3.125 mg tablet. During an observation on 4/28/2026 at 9:54 AM, Resident 96 was observed taking the carvedilol 3.125 mg tablet by mouth with water. 5. During a review of Resident 97's admission Record dated 4/29/2026, the admission Record indicated the facility admitted Resident 97 on 4/24/2026 with diagnosis including hypertensive chronic kidney disease (kidney disease caused by high blood pressure). During a review of Resident 97's H&P dated 4/28/2026, the H&P indicated Resident 97's diagnosis of hypertensive chronic kidney disease. During a review of Resident 97's Order Summary Report dated 4/29/2026, the Order Summary Report indicated Resident 97's physician prescribed the following medication to be administered during the 9AM medication pass:-Clopidogrel 75 mg by mouth one time a day to prevent blood clots. During an observation of medication administration on 4/28/2026 at 9:59 AM with RN 1, RN 1 was observed preparing the following additional medications for Resident 97:-One capsule of omeprazole (a medication used to treat heartburn) 20 mg.-Three capsules of balsalazide (an anti-inflammatory medication) 750 mg. During a concurrent observation on 4/28/2026 at 9:59 AM, RN 1 was observed leaving Resident 97's omeprazole and balsalazide unattended on the top of the medication cart when she (RN1) reentered the room to retake Resident 97's blood pressure. During an observation on 4/28/2026 at 10:03 AM, RN 1 was observed preparing the following medications for Resident 97: -One tablet of aspirin 81 mg chewable.-One tablet of ferrous sulfate 325 mg. During an observation and concurrent interview on 4/28/2026 at 10:06 AM, Resident 97 was observed taking the omeprazole, balsalazide, aspirin, and ferrous sulfate by mouth with water. RN 1 stated these four medications in addition to the four given earlier were all the medications due for Resident 97 at this time. RN 1 stated she (RN1) left Resident 97's omeprazole and balsalazide unattended on top of the medication cart when she (RN1) went into the room to retake the blood pressure. RN 1 stated she (RN1) failed to lock the medication in the medication cart to ensure resident safety per facility policy. During an observation of medication administration on 4/28/26 at 9:14 AM with RN 1, RN 1 was observed preparing the following medications for Resident 97:-One tablet of amlodipine (a medication used to treat high blood pressure) 10 mg.-One tablet of losartan (a medication used to treat high blood pressure) 100 mg.-One tablet of metoprolol succinate ER (a medication used to treat high blood pressure) 50 mg.-One tablet of hydralazine (a medication used to treat high blood pressure) 25 mg. During a concurrent interview and observation on 4/28/2026 at 9:24 AM, RN 1 stated she (RN1) would administer Resident 97's four blood pressure medications now due to a high blood pressure reading and then return in approximately 30 minutes to check the blood pressure again and administer the rest of Resident 97's medications. Resident 97 was observed taking the four medications listed above by mouth with water. During an interview on 4/28/2026 at 10:56 AM with RN 1, RN 1 stated Resident 97 was also scheduled to<br>(continued on next page) |

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| F 0759<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | receive clopidogrel 75 mg at 9AM, but she (RN1) failed to administer it due to accidental oversight. RN 1 stated the resident was having episodes of high blood pressure and was distracted by this and other tasks. RN 1 stated failing to administer clopidogrel increased the risk that Resident 97 could have a stroke possibly leading to hospitalization or death. RN 1 stated the carvedilol for Resident 96 was scheduled for 8 AM, but she (RN1) gave it at 9:54 AM. RN 1 stated the latest she (RN1) could give it and still be considered on time was 9 AM. RN 1 stated giving this medication too late could cause issues with blood pressure management since it was dosed twice daily. RN 1 stated giving it too close to the next scheduled dose could cause low blood pressure possibly resulting in dizziness or falls with injury. 6. During a review of Resident 105's admission Record dated 4/29/2026, the admission Record indicated the facility admitted Resident 105 on 4/27/2026 with diagnosis including hypothyroidism (low thyroid level). During a review of Resident 105's H&P dated 4/28/2026, the H&P indicated Resident 105's diagnosis of hypothyroidism. During a review of Resident 105's Order Summary Report dated 4/29/2026, the Order Summary Report indicated Resident 105's physician prescribed the following:-Levothyroxine 125 mcg by mouth every morning at 6 AM. During an observation of medication administration on 4/28/2026 at 8:55 AM with RN 1, RN 1 was observed preparing the following medication for Resident 105:-One tablet of levothyroxine 125 mcg.During an observation on 4/28/2026 at 8:57 AM, Resident 105 was observed taking the levothyroxine 125 mcg tablet by mouth with water. During an interview on 4/28/2026 at 9:02 AM with RN 1, RN 1 stated Resident 105's levothyroxine was scheduled for a 9 AM administration, but this medication (levothyroxine) was more commonly given around 6:30 AM. RN 1 stated levothyroxine was usually scheduled for administration around 6:30 AM so it could be given on an empty stomach before breakfast to ensure it absorbs fully. RN 1 stated she (RN 1) failed to follow up with the prescriber prior to administering the medication to clarify if there was a clinical reason for the deviation from the usual administration instructions for this medication. RN 1 stated if it was given too close to food or other medications, it might cause symptoms of hypothyroidism which could negatively affect her quality of life. During an interview on 4/28/2026 at 9:09 AM with RN 1, RN 1 stated after talking to the prescriber, the order was wrong and should have been written for administration at 6:30 AM. RN 1 stated the order was changed to reflect the standard administration for levothyroxine. During a review of the facility's undated policy Administering Medications indicated Medications are administered in accordance with prescriber orders, including any required time frame. medications are administered within one (1) hour of their prescribed time, unless otherwise specified. The individual administering the medication checks the label THREE (3) times to verify the right resident, right medications, right dosage, right time and right method (route) of administration before giving the medications. During administration of medications, the medication cart is kept closed and locked when out of sight of the medications nurse. no medications are k |

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| F 0803<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident.<br><br>Based on observation, interview and record review, the facility failed to ensure residents received meals that met their assessed nutritional needs and prescribed Kosher diet requirements for three of three meal trays reviewed for therapeutic diets. Kosher diet (Kosher foods meet the regulations established by Jewish dietary law and include requirements related to the preparation and serving of foods, including separation of meat and dairy products.) and protein (an essential nutrient necessary for growth, tissue repair, immune function, and maintenance of muscle mass) requirements were not followed when: 1. Two Kosher diet trays were served pureed green beans, pureed potato, and pureed bread without a protein source. 2. One Kosher diet was served pureed lasagna prepared with beef and dairy products in the same meal, which was not consistent with Kosher dietary requirements. These deficient practices had the potential to result in inadequate nutritional intake, failure to meet therapeutic dietary needs, and resident dissatisfaction with meals. Findings: During an observation of the tray line service for lunch (tray line-a system of food preparation, in which trays move along an assembly line) on 4/27/2026 at 12:00PM, the cook (cook1) was observed serving pureed green beans, pureed bread and mashed potatoes on two pureed diet texture and kosher lunch trays. A review of the tray card (a printed sheet that includes resident diet order, preferences and dislikes) on the lunch tray dated 4/27/2026, the tray card indicated the tray was for a resident on a pureed texture and kosher diet. The tray card indicated to serve pureed lasagna, pureed green beans, pureed garlic bread, pureed frosted cupcake and water. A second tray card for lunch in the food cart was observed on 4/27/2026, the tray was for a resident on a pureed texture diet, mildly thick liquids and kosher. The tray card indicated to serve pureed lasagna, pureed green beans, pureed garlic bread, pureed frosted cupcake, mildly thick milk. During a review of the facility menu for lunch on 4/27/2026, the menu indicated the following food items were to be served on the pureed texture diet: pureed lasagna 1 cup; pureed green beans (3 ounces (oz)); pureed garlic bread; pureed frosted cupcake and a beverage. During a concurrent observation in the facility kitchen and interview with cook1 and Dietary Supervisor (DS) on 4/27/2026 at 12:00PM, cook1 stated kitchen staff did not serve meat to residents on kosher diet. [NAME] 1 stated the lasagna was made with ground meat, beef and turkey combined. Cook1 stated for kosher diets, cook 1 only served pureed green beans, pureed bread and mashed potatoes. Cook1 stated kitchen staff did not serve protein on kosher diet trays and only served the side dishes. The DS stated no meat was served on kosher diet trays and disposable plates and utensils covered with plastic wrap were used. During a concurrent interview and test tray (sampling the flavor and texture of the prepared meal) with the DS on 4/27/2026 at 1:00PM, the DS stated for kosher diets I don't know any specifics about the diet, but all I know is that they are not supposed to eat the meat and food should be served with disposable utensils. The DS stated the facility used to provide ready-made frozen kosher meals but stopped that. The DS said after speaking with the residents and explaining the facility did not have a kosher kitchen, the families agreed not to receive the meat and to use disposable utensils. The DS stated the facility did not have any other food alternatives or options for the kosher diet. The DS stated residents who were not on a kosher diet received protein every meal and the two residents on the kosher diet do not receive protein with every meal. During an interview with the registered Dietitian (RD2) on 4/28/2026 at 9:30AM, RD2 stated the kosher diet was a religious diet and was mainly no pork allowed, meats and dairy products were not to be cooked in the same area or served together. RD2 stated residents on a kosher diet could have meat if they were prepared the kosher way and not mixed with dairy products. RD2 reviewed the facility menu and serving guide and stated the facility's menu did not indicate a kosher option and the residents who were on pureed texture and kosher diet did not receive an alternative meal that was nutritionally equivalent to the regular diet. RD2 stated residents who were pureed texture and kosher were missing the protein from the meals which could lead to nutritional deficiency. During a concurrent observation<br>(continued on next page) |

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| F 0803<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | of the lunch trays and interview with cook1 on 4/28/2026 at 12:00PM, cook1 stated the lunch for that day (4/28/2026) was pork, vegetables and mashed potato. Cook1 stated the residents on the pureed diet and kosher did not receive meat or pork and only received pureed Italian blend vegetables (carrots, cauliflower, broccoli), pureed bread and mashed potato with no protein on the tray. During a review of facility's policy and procedures (P & P) titled Dining and Food Preferences (revised 10/2022) the p & p indicated, The Registered Dietitian /Nutritionist RD/RDN or other clinically qualified nutrition professional will review, and after consultation with the resident, adjust the individual meal plan to ensure adequate fluid volume and appropriate nutritional content for residents/patients that do not consume certain foods or food groups. 2. During an observation of lunch service in the kitchen on 4/27/2026 at 12:00 PM one pureed texture diet and kosher tray was observed to have pureed lasagna, pureed green beans and pureed bread. The tray card indicated a pureed texture diet and kosher and was okay with meat. Cook1 stated the meal tray that indicated the kosher diet was okay with meat was served the pureed lasagna. Cook1 stated the lasagna was a mixture of ground beef and ground turkey and three different types of cheese. When asked if it was okay to mix dairy products with meat in a kosher diet, cook 1 replied yes because the resident was ok with meat. During an interview with the DS on 4/27/2026 at 1:00PM, the DS did not know kosher diet guidelines and did not know if it was okay to mix dairy products with meats on a kosher diet. During an interview with RD2 on 4/28/2026 at 9:30AM, RD2 stated a kosher diet was a strict religious diet and it could vary but mainly it was no pork, meats were okay when prepared kosher, dairy products and meats were not to be cooked in the same area or served together. RD2 stated the facility menu did not include kosher diet guidelines for cooks to follow. During a review of facility's policy and procedures (p & p) tilted Menus (revised 10/2022) the p & p indicated, Menus will be planned in advance to meet the nutritional needs of the residents in accordance with established national guidelines. Menu cycles will be developed and tailored to meet the needs and requirements of the facility. Menu cycles will include nutrient analysis to ensure that all client nutritional needs are met. A registered Dietitian or other clinically qualified nutrition professional review and approves the menus. The RD will adjust the individual meal plan to meet the individual requests, including cultural, religious or ethnic preferences as appropriate. |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure safe and sanitary food storage and preparation practices in the kitchen when: 1.Bulk food (sugar, flour, breadcrumbs) were stored in bins lined with trash bags that were not food grade (refers to materials that are safe for direct contact with food, free from harmful substances, and designed to prevent contamination).2.The temperature of bottled juice and a gallon of milk used for lunch service was kept out at room temperature, not at safe temperatures (refrigerated). 3. Food brought to residents from outside of the facility, including leftovers were stored in the resident food refrigerator located in the facility's utility room with no label or received date. These deficient practices had the potential to result in harmful bacteria growth and cross contamination of food (transfer of harmful bacteria and chemicals from one place to another) that could lead to food borne illness in 81 out of 84 residents who received food from the facility.Findings: 1. During a concurrent observation in the kitchen and interview on 4/27/2026 at 10:00AM, bulk food (sugar, flour, breadcrumbs) was observed to be stored in large bins that were lined with plastic bags. The Dietary Supervisor (DS) stated the plastic liners inside the bins were regular trash bags and were not specific for food storage. The DS stated there was no policy regarding food storage liners and trash bags had always been used to store bulk food. The DS stated it would be sanitary and clean if the food was stored directly inside clean bins instead of plastic liners. The DS stated the plastic liners tended to tear and could have chemicals in the plastic touching food. During a concurrent observation and interview with the DS and Dietary District manager (DM) on 4/28/2026 at 11:00AM, the DS stated all the plastic trash bags were removed and food was stored directly inside bins. The DM stated food storage bins should not have been lined with trash bags. During a review of facility's policy and procedures (P&P) titled Food Storage: Dry Goods (revised 2/2023), the P&P indicated All dry goods will be appropriately stored in accordance with FDA Food Code, Toxic materials will not be stored with food. During a review of the 2022 U.S. Food and Drug Administration Food Code titled Characteristics code 4-102.11, the code indicated, The safety and quality of food can be adversely affected through single service and single use articles that are not constructed of acceptable materials. The migration of components of those materials to food they contact could result in chemical contamination and illness to the consumer. In addition, the use of unacceptable materials could adversely affect the quality of the food because of odors, tastes, and colors transferred to the food. 2. During a concurrent observation of the lunch service and interview on 4/27/2026 at 12:00PM, a temperature check of the juices using facility thermometer registered at 54 degrees F and the Milk was at 46.7 degrees F. The DS stated kitchen staff usually stored the beverages in the refrigerator so the beverages could stay cold for lunch service and stated, but I guess we didn't today. The DS stated when beverages were not cold some residents could complain and refuse to eat or drink. The DS stated if the milk sat out long in the warm temperature it could go bad. During an interview with Regional Registered Dietitian (RD1) and Dietary District manager (DM) on 4/28/2026 at 2:00PM, RD1 stated beverages had to be kept on ice during lunch service to maintain temperatures at 41degrees or below for cold items. During a review of facility policy and procedure (p & p) titled Food: Preparation (Revised 2/2023) the p & p indicated, All foods will be held at appropriate temperatures, greater than 135 degrees F (or as state regulation requires) for hot holding, and less than 41 degrees F for cold food holding. During a review of the 2022 U.S. Food and Drug Administration Food Code 3-501.16 titled Time/Temperature control for safety food, hot and cold holding indicated, except during preparation, cooking or cooling, time/temperature control for safety food shall be maintained at 135 degrees F or above, and at 41 degrees F or below. 3. During an observation of the resident refrigerator located in the facility's utility room on 4/27/2026 at 10:30AM, one container of soup was observed with no label sitting on top of the resident refrigerator. Inside the<br>(continued on next page) |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | refrigerator one large bag with multiple small containers for leftover soup and stews was observed, with no date. Another large bag with two store bought frozen dinners ([NAME] calendar's frozen turkey pot pie dinners) was observed with no date. One of the turkey pot pie dinner boxes was broken and the contents were out of the box. During a concurrent observation of the resident refrigerator and interview with the Maintenance Director (MTD) and Infection prevention nurse (IPN) on 4/27/2026 at 10:30AM, the MTD stated the soup on top of the refrigerator should not have been on top of the refrigerator and should have been placed inside the refrigerator. The IPN instructed the MTD not to put anything back in the refrigerator that was sitting outside, the IPN then removed the soup to discard. The IPN stated all food that was brought by visitors or ordered from outside for residents was to be checked by nursing staff then labeled and dated with a use by date. The IPN stated the facility stored food for 48 hours and if there were no dates facility staff could not tell how long food had been in the refrigerator. The IPN stated frozen food like the T.V. dinners had to be stored frozen for safe storage. The IPN removed the frozen dinners with no dates and food that was open and contaminated to discard. During a review of facility's policy and procedures (p & p) titled Food Brought in By Visitors (Revised 3/28/2024), the p & p indicated, All food brought in for a resident: a. will be checked by a licensed nurse for appropriate diet texture. When food items are intended for later consumption, the staff responsible will: c. Label foods with the resident's name and the receive date. Items will be thrown out after 48 hours. Refrigerator/freezer for storage of foods brought in by visitors will be properly maintained and d. Daily monitoring for refrigerated storage duration and discard of any food items that have been stored for >2 days. |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide and implement an infection prevention and control program.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to implement infection control practices for three of five sampled residents (Resident 17, 19 and 28) by failing to: 1. Ensure Resident 17, who was re-admitted to the facility with a Peripherally Inserted Central Catheter (PICC-a long, thin flexible tube inserted through a vein in the upper arm, extending to the supervisor vena cava [a large valve in the heart] near the heart) and surgical wound, was placed in enhanced barrier precautions (EBP-infection control strategy for nursing home, requiring gowns and gloves to be used during high-contact care for residents with or at high risk for multidrug-resistant organisms [MDRO: bacteria, often called superbugs, that have evolved to resist the antibiotics designed to kill them]). 2. Ensure Certified Nursing Assistant 10 (CNA 10) wore proper personal protective equipment (PPE-wearable gear-like gloves, mask, goggles, gowns-designed to protect person from injuries, illness or hazardous materials) during Resident 19's incontinence (loss of bowel and or bladder control) care, who was on EBP. 3. Ensure Certified Nursing Assistant 6 (CNA 6) wore proper PPE while feeding Resident 28, who was also on EBP. These deficient practices had the potential to result in the spread of MDRO and/or infection to Resident 17, 19 and 28, as well as to the other residents that were at risk of infection. Findings:<br><br>1. During a review of Resident 17's admission Record, the admission Record indicated the facility originally admitted Resident 17 on 3/22/2026 and was re-admitted on [DATE] with diagnoses including left femur fracture (a break, crack or crush injury of the thigh bone), presence of left artificial hip joint (a man-made, mechanical joint used to replace a diseased or damaged hip) and infection following a surgical procedure.<br><br>During review of Resident 17's Minimum Data Set (MDS - a standardized assessment tool), dated 3/27/2026, the MDS indicated Resident 17 had intact cognition (mental action or process of acquiring knowledge and understanding) for daily decision-making and varying assistance from setup to maximal (helper does more than half the effort) assistance from staff for activities of daily living (ADLs-bed mobility, surface transfer, eating, walk in room, dressing, toileting, and personal hygiene).<br><br>During a review of Resident 17's History and Physical (H&P) dated 4/28/2026, the H&P indicated Resident 17 had the capacity to make medical decisions.<br><br>During an observation of Resident 17's room on 4/27/2026 at 10:39 AM, no EBP signage and/or PPE cart were observed in front of Resident 17's room.<br><br>During a follow up observation of Resident 17's room on 4/28/2026 at 8:25 AM, no EBP signage and/or PPE cart were observed in front of Resident 17's room.<br><br>During an interview with the Infection Preventionist Nurse (IPN) on 4/29/2026 at 3:04 PM, the IPN stated that Resident 17 should have been in EBP due to Resident 17's surgical wound. The IPN stated that she (IPN) had not had time to check on the resident information and criteria since Resident 17 was recently re-admitted on [DATE]. The IPN stated she (IPN) was the only person that evaluated if a resident needs to be placed in EBP.<br><br>During an interview on 4/30/2026 at 11:51 AM, with the Director of Nursing (DON), the DON stated that Resident 17 should have been in EBP as soon as the resident was re-admitted due to high risk of infection. The DON stated Resident 17 was admitted with surgical wounds and a PICC line, which (continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | should have prompted the nurses to put Resident 17 in EBP upon admission.<br><br>During a review of the facility's policy and procedure (P&P), titled, Infection Prevention and Control Program, reviewed on 12/18/2025, the P&P indicated that the facility established and maintained an infection prevention and control program (IPCP) to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable disease and infections.<br><br>During a review of facility's P&P, titled, Enhanced Standard/Barrier Precautions: Infection Control, reviewed on 12/18/2025, the P&P indicated that facility implemented the EBP for the prevention of transmission of MDRO via prompt recognition of need, initiation and implementation of EBP.<br><br>2. During a review of Resident 19's admission Record, the admission Record indicated the facility originally admitted Resident 19 on 12/19/2025 and re-admitted the resident on 3/11/2026 with diagnoses including but not limited to unspecified protein caloric malnutrition (condition caused by a lack of enough calories and protein in the diet), muscle weakness, and essential hypertension (blood pushes too hard against artery walls without a known, specific medical cause).<br><br>During a review of Resident 19's MDS dated [DATE], the MDS indicated Resident 19 rarely made himself understood and rarely understood others. The MDS indicated Resident 19's cognition (mental abilities that profoundly impact their daily life and independence) was severely impaired and the resident required maximum assistance with toileting, transferring and mobility.<br><br>During a review of Resident 19's Order Summary Report dated 4/30/2026, the Order Summary Report indicated Resident 19 had EBP orders related to Resident 19's gastrostomy tube (a surgical procedure to insert a tube through the abdomen and into the stomach used for feeding, usually via a feeding tube).<br><br>During an observation on 4/27/2026 at 10:05 A.M. outside of Resident 19's room, there was a green dot sticker next to Resident 19's name plate that was observed. EBP signage was observed by the door indicating those that entered the room were to wear a gown, a mask and gloves.<br><br>During an observation on 4/272026 at 10:15 A.M in Resident 19's room, CNA 10 was observed performing an incontinent brief change wearing gloves and a mask but with no gown on.<br><br>During an interview on 4 /272026 at 10:31 A.M., CNA 10 stated Resident 19 was in EBP, and he (CNA 10) had just performed an incontinent brief change. CNA10 stated Resident 19 was in EBP related to Resident 19 's gastrostomy tube. CNA 10 stated he (CNA 10) should have worn the gown when he performed incontinent brief change to Resident 19. CNA stated that PPE was necessary to prevent infection and cross contamination from body fluids and bacteria. CNA 10 stated he (CNA 10) got distracted and did not wear a gown. CNA 10 stated it was a failure to not failure to follow infection protocol.<br><br>During an interview on 4 /29/2026 at 11:55 A.M., Licensed Vocational Nurse LVN 3 stated there were signs outside the resident rooms and a green dot next to resident's name let staff know when to wear PPE. LVN 3 stated if a resident was on EBP, the CNA had to wear PPE when performing incontinent brief changes. LVN 3 stated if CNA 10 did not wear a gown when performing an incontinent brief change it was not a safe infection control practice. LVN 3 stated CNA 10 not wearing a gown during incontinent care was a failure in infection control.<br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During an interview on 4 /30/2026 at 11:55 A.M, the IPN stated her role was to educate and train staff and residents focused on Infection Control. The IPN stated EBP required the use of PPE. The IPN stated the EBP was indicated for residents with catheters, tubes feedings, dialysis catheter and wounds. The IPN stated Resident 19 was on EBP related to having a G-Tube. The IPN stated CNA 10 should have worn a gown when performing an incontinent brief change. The IPN stated the EBP signs were posted and a green dot next to resident's name meant EBP.<br><br>A review of the facility's policy and procedure titled, Enhanced Standard /Barrier Precaution, dated 12/18/2025, the P&P indicated:<br><br>POLICY<br><br>It is the policy of this facility to implement enhanced barrier precaution for the prevention of transmission of multidrug-resistant organisms<br><br>Policy Explanation<br><br>3.Implementation of enhanced Barrier Precaution:<br><br>PPE is necessary for High Contact care activities.<br><br>High Contact Care Activities included.<br><br>f. Changing briefs or assisting with toileting<br><br>g. Device care or use: feeding tubes.<br><br>3. During a review of Resident 28's admission Record, the admission Record indicated the facility admitted the resident on 9/11/2019, with diagnoses that included Parkinson's Disease (a progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movements), dysphagia (difficulty swallowing) and hypothyroidism (a condition where the thyroid gland does not make enough hormones).<br><br>During a review of Resident 28's MDS dated [DATE], the MDS indicated the resident required moderate assistance (helper lifts, holds, or supports trunks or limbs, but provides less than half the effort) from facility staff with eating.<br><br>During a review of Resident 28's Order Summary Report, dated 4/21/26, the report indicated Resident 28 was on Enhanced Barrier Precautions (EBP, the use of gown and gloves during high-contact resident care activities to reduce multidrug resistant organism [MDRO] transmission) related to an open wound on the sacral coccyx (tailbone).<br><br>During a review of Resident 28's care plan report with an intervention titled At risk for infection – general, revised on 4/28/26, the care plan indicated, Enhanced barrier precautions related to sacral coccyx open wound.<br><br>During an observation on 4/27/26 at 11:37 a.m. in Resident 28's room, an EBP sign was observed posted at the doorway entrance and a green dot sticker was placed on Resident 28's name plate. A cart filled with personal protective equipment (PPE, clothing and equipment that is worn or used to<br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | provide protection against hazardous substances and/or environments) was observed near Resident 28's room entrance.<br><br>During a concurrent observation in Resident 28's room and interview on 4/27/26 at 12:50 p.m. with Certified Nursing Assistant (CNA) 6, CNA 6 was observed feeding Resident 28 with only gloves on. CNA 6 stated the green dot sticker on the resident's name plate meant the resident was on some type of precaution (an infection control intervention to prevent the spread of infections among residents, staff, and visitors) which required staff to wear PPE while providing care.<br><br>During an interview on 4/29/26 at 11:05 a.m. with Registered Nurse (RN), RN 1 stated staff had to wear PPE when helping residents with activities of daily living such as changing diapers, feeding, and showering. RN 1 stated it was important to wear PPE to avoid the spread of infection, avoid possible contamination, and for the safety of residents and nurses.<br><br>During a concurrent interview and record review on 4/29/26 at 11:19 a.m. with the Infection Preventionist Nurse (IPN), the local health department document titled, Enhanced Barrier Precautions, dated September 2021 was reviewed by the IPN. The IPN stated it was important to follow EBP to prevent infection and cross contamination.<br><br>During a concurrent interview and record review on 4/30/26 at 10:13 a.m. with the Director of Nursing (DON), the facility's policy and procedure (P&P) titled, Enhanced Standard/Barrier Precautions, revised on February 2025 was reviewed by the DON. The DON stated the P&P was not followed. The DON stated facility staff were expected to wear a gown and gloves for EBP.<br><br>During a review of the local health department document titled, Enhanced Barrier Precautions, dated September 2021, the document indicated that facility staff was to wear gloves and a gown for high-contact resident care activities such as dressing, grooming, bathing, changing bed linens, and feeding.<br><br>During a review of the facility's P&P titled Enhanced Standard/Barrier Precautions, revised by the facility on February 2025, the P&P indicated PPE for enhanced barrier precautions is only necessary when performing high-contact care activities. |

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| F 0552<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that residents are fully informed and understand their health status, care and treatments.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to renew an antidepressant medication (drugs that balance chemicals in the brain) informed consent (a process during which residents or caregivers are educated regarding the potential risks and benefits of medication therapy) for one of five sampled residents (Resident 78) by failing to: -Ensure to renew Resident 78's Mirtazapine (a medication used to treat depression [a mood disorder marked by varying degrees of sadness]) informed consent from 11/15/2024 from Resident 78's responsible party (a person delegated to make medical decisions for the resident in the event they are unable to do so). This failure had the potential for Resident 78's responsible party to be denied the opportunity to give informed consent.Findings:During a review of Resident 78's admission Record, the admission Record indicated the facility admitted Resident 78 on 4/22/2023 with diagnoses that included adult failure to thrive(a syndrome in older adults characterized by a decline in physical, cognitive, and functional abilities), unspecified mood affective disorder (a mental health condition that causes marked disruptions in emotions), major depressive disorder unspecified and anxiety. During a review of Resident 78's medical record for Psychotropic Medication (drugs that alter brain chemistry) Administration Informed Consent dated 11/15/2024 for Mirtazapine, the informed consent indicated verbal consent was obtained from Resident 78's responsible party via (by way of) telephone. The Informed Consent indicated the responsible party was provided with information regarding the risks and benefits of the medication. The consent had not been renewed since 11/15/2024. During a review of Resident 78's Care Plan Report dated 1/31/2026, the Care Plan report indicated to provide an informed consent to Resident 78 or healthcare decision maker. The Care Plan Report did not indicate a time frame when the informed consent should be renewed.During a review of Resident 78's Minimum Data Set (MDS- a resident assessment tool), dated 2/6/2026, the MDS indicated Resident 78 had severe cognitive (ability to think and reason) impairment. During a review of Resident 78's Order Summary Report dated 4/15/2026, the Order Summary Report indicated Resident 78's physician order for Mirtazapine 7.5 milligrams (mg - a unit of measure for mass) by mouth at bedtime for depression manifested(shown) by loss of appetite. During a concurrent interview and record review on 4/30/2026 at 1:07 PM, with Assistant Director of Nursing (ADON), Resident 78's medical record and informed consents were reviewed for Mirtazapine. The ADON stated initial informed consent was required for antidepressants and was obtained from a resident if they have capacity(ability) to sign the consent form or from the family/representative if they were unable to. The ADON stated a new informed consent would have been needed if there was a change in the dosage(amount), such as an increase or decrease in the medication. The ADON confirmed a signed informed consent in Resident 78's medical record was signed and dated on 11/15/2024, and an unsigned informed consent for Mirtazapine 30mg was observed in Resident 78's medical record. The ADON stated that without informed consent for mirtazapine, Resident 78's representative did not have the opportunity to decide if they wanted the medication to be given or not. The ADON stated if Resident 78 could not receive the antidepressant, the resident could have had further depression and weight loss. During a concurrent interview and record review on 4/30/2026 at 1:18 PM, with RN 2, Resident 78's medical record and informed consents were reviewed for Mirtazapine 7.5 milligrams. RN 2 stated informed consent for antidepressants and psychotropics were needed prior to starting the medication and was obtained upon admission to the facility. RN 2 stated Resident 78 was admitted to the facility on [DATE] and did not have the capacity to make medical decisions. RN 2 stated Resident 78 had a power of attorney (POA, a legal document that lets you appoint a trusted person to act on your behalf regarding medical decisions if you cannot do so) and was started on mirtazapine for antidepression and to stimulate the resident's appetite on 4/23/2023 and was always on 7.5 mg for the dosage. RN 2 confirmed a signed informed consent in Resident 78's medical record for mirtazapine 7.5 mg was dated 11/15/2024. RN 2<br>(continued on next page) |

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| F 0552<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | stated the purpose of informed consent was to provide education for residents or their responsible party, so they understood the medication being given. RN 2 stated without informed consent, the antidepressant should not have been given, the facility staff could not give the medication for depression. RN 2 stated without informed consent, giving the antidepressant could have been considered a chemical restraint. During a concurrent interview and record review on 4/30/2026 at 2:11 PM with the Director of Nursing (DON), Resident 78's medical record for informed consents, the facility policy and procedures (P&P) titled, Informed Consent for Psychotropic Drugs(CALIFORNIA), revised 12/18/2025, and All Facilities Letter (AFL, an official bulletin or memo sent by a government agency[most commonly the California Department of Public Health (CDPH)] to keep healthcare facilities informed about new rules, safety alerts, or changes in the law) dated10/27/2025 was reviewed. The DON stated antidepressants needed informed consent and were obtained before the medication was given to residents (in general). The DON stated residents needed to have informed consent on admission to the facility if a psychotherapeutic drug was ordered, and if there was an increase to the dosage. The DON stated if there was a decrease for the antidepressant informed consent was not needed but the facility needed to inform the responsible party of the change in medication dosage. The DON stated if a resident was confused or did not have the capability of signing their own informed consent, the informed consent was obtained from the responsible party (in general). The DON stated Resident 78 had a POA since Resident 78 did not have capacity for medical decisions. The DON stated the medical doctor would obtain informed consent from the responsible party and the licensed nursing staff would verify informed consent was obtained. The DON stated there was an informed consent on 11/15/2024 for mirtazapine 7.5 mg and confirmed that was the most recent signed informed consent in Resident's 78 medical record. The DON stated part of the informed consent was an agreement from the responsible party to give the medication to the resident and involved education about the antidepressant. The policy for informed consent for psychotropics drugs was reviewed with the DON. The DON stated the facility policy indicated This policy applies to all residents in the skilled nursing facility (SNF) prescribed psychotropic drugs, including new initiations, dose increases or changes. The DON stated antidepressant are included in psychotherapeutic drugs. The AFL 25-27 was reviewed with the DON, and the DON stated the AFL indicated .facilities must include the written consent form in the resident's health record for treatment using psychotherapeutic drugs and renew the consent form every six months thereafter. The DON stated if Resident 78 did not have an updated informed consent the facility would not know if the responsible party would want to continue the antidepressant or not. The DON stated the facility did not renew the informed consent for Resident 78, and the possibility that the resident could have had an adverse effect (unwanted, uncomfortable, or dangerous effects that a drug may have) related to mirtazapine such as decreased ability to move if Resident 78 became too drowsy. During a review of the facility's (P&P) titled, Informed Consent for Psychotropic Drugs (CALIFORNIA), reviewed 12/18/2025, indicated This policy applies to all residents in the skilled nursing facility (SNF) prescribed psychotropic drugs, including new initiations, dose increases. or changes. The P&P indicated no mention of the time frame when the psychotherapeutic consent should be renewed. During a review of the facility's (P&P) titled, PSYCHOTROPIC MEDICATION USE , reviewed 12/18/2025, indicated The Facility should comply with the State Operations Manual, and all other Applicable Law relating to the use of psychoactive medications. The P&P indicated It is the responsibility of the attending health care practitioner to inform the resident and/or resident representative of the initiation, reason for use, and the risks associated with the use of psychotropic medications, per faci1ity policy or applicable state regulation. The informed consent will be obtained by the Prescriber prior to initiation of the psychotropic medication. The P&P indicated The Facility shall verify informed consent prior to the administration of a psychotropic medication for a resident. During a review of the AFL 25-27 dated 10/27/2025, the AFL indicated .facilities must include the written consent form in the resident's health record for treatment using psychotherapeutic drugs and renew the consent form every six months thereafter. |

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| F 0558<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Reasonably accommodate the needs and preferences of each resident.<br><br>Based on observation, interview, and record review the facility failed to answer the call light (a device used by a resident to signal his or her need for assistance) for one of one sampled resident (Resident 103) as soon as possible, but no later than five minutes as indicated in the facility's policy. This failure had the potential not to meet Resident 103's needs timely.Findings:During a review of Resident 103's admission Record, the admission record indicated the facility admitted Resident 103 on 4/24/2026 with diagnoses that included history of falling, acute on chronic diastolic congestive heart failure (a person with long-term, stiff-heart disease suddenly experiences a severe, dangerous spike in symptoms, usually due to fluid overload, requiring urgent medical care), malignant neoplasm of stomach (stomach cancer), muscle weakness, essential hypertension (high blood pressure when blood pushes too hard against artery walls without a known, specific medical cause), syncope and collapse (fainting or passing out, which occurs when a temporary drop in blood flow causes a brief loss of consciousness and collapse), pleural effusion (abnormal buildup of excess fluid between the thin membranes lining the lungs and the inside of the chest cavity), and acute kidney failure (a sudden, rapid, and often temporary loss of kidney function, occurring over hours or days). During a review of Resident 103's Care Plan Report dated 4/25/2026, the Care Plan Report indicated Resident 103 was a risk for falls/injury related to history of fall, impaired mobility (having difficulty moving around, walking, or controlling body movements, often limiting independence), weakness, and near syncope. The Care Plan Report indicated interventions (any action or procedure used to make a patient better, safer, or healthier) for the staff to assist Resident 103 with getting in and out of bed, assistance with ambulation (walking), and monitoring for and assisting with toileting needs. The Care Plan Report indicated an intervention to remind Resident 103 to use the call light when attempting to ambulate or transfer. During a review of Resident 103's Care Plan Report dated 4/25/2026, the Care Plan Report indicated Resident 103 required assistance related to weakness and impaired mobility. The Care Plan Report indicated an intervention for staff to encourage Resident 103 to use the call light for assistance. During a review of Resident 103's History and Physical (H&P) dated 4/27/2026, the H&P indicated Resident 103 had fluctuating capacity (a person's ability to make specific decisions changes over time where they may be capable of understanding and deciding one day or hour, but not the next) to make medical decisions. During a review of Resident 103's Order Summary Report, dated 4/29/2026, the Order Summary Report indicated Resident 103 had a physician order for isolation with droplet precautions (safety measures used in nursing homes to stop the spread of germs that travel in short-distance spray [droplets] from a person's cough, sneeze, or conversation) due to parainfluenza (a common group of viruses that cause respiratory [the body's system for breathing] infections, mostly resembling a cold, cough, or sore throat). During an interview on 4/27/2026 at 9:45 AM with Resident 103 in Resident 103's room, Resident 103 stated the facility's staff (unidentified) did not answer his (Resident 103) call light in a timely manner. Resident 103 stated he (Resident 103) felt the facility staff did not go to his room because he (Resident 103) had an infectious disease (illnesses caused by tiny organisms such as germs like bacteria, viruses, fungi, or parasites that enter the body, multiply, and damage cells). During an observation on 4/27/2026 at 9:47 AM, Resident 103 was observed pressing his call light to see how long it would take the facility staff to answer his (Resident 103) call light. During an observation on 4/27/2026 at 9:50 AM, Certified Nursing Assistant 11 (CNA 11) was observed assisting a resident (unidentified) in the room directly across from Resident 103's room. CNA 11 was observed wheeling a resident (unidentified) down the hall. During an observation on 4/27/2026 at 9:52 AM, CNA 11 was observed returning to the room directly across from Resident 103's room and was observed wiping clean the first bed in the room directly across from Resident 103's room while Resident 103's call light was on. The Activities Director (AD) was observed in the hallway to the right side face out of Resident 103's room. The AD was heard asking who's resident (Resident 103) is that his call light is on. The AD was observed walking away from<br>(continued on next page) |

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| F 0558<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Resident 103's room towards the Director of Staff Development. No staff was observed responding to Resident 103's call light. During an observation on 4/27/2026 at 9:54 AM, the Director of Nursing (DON) and CNA 11 were observed answering Resident 103's call light. During an interview on 4/27/2026 at 10:11 AM with CNA 11, CNA 11 stated anyone could have answered Resident 103's call light. CNA 11 stated if she (CNA11) had seen or heard Resident 103's call light, she (CNA 11) would have answered it. During an interview on 4/27/2026 at 10:13 AM with Licensed Vocational Nurse 7 (LVN 7), LVN 7 stated a resident's (in general) call light should be answered within three minutes and it does not have to be a CNA (in general) that answered the call light. LVN 7 stated any staff could answer a resident's (in general) call light. LVN 7 stated a resident's (in general) call light should be answered promptly in case the resident (in general) soiled (urinated or pooped on) themselves or if a resident (in general) who was at risk for falls might try to get up by themselves. LVN 7 stated a resident (in general) may feel ignored if their call light is not answered properly. LVN 7 reviewed and verified what was written in the investigation note. During a concurrent interview and record review on 4/30/2026 at 1:06 PM with the DON, the facility's policy and procedure (P&P) titled, Call System, Resident, last reviewed 12/18/2025, was reviewed. The DON verified the P&P indicated Calls for assistance are answered as soon as possible, but no later than 5 minutes. Urgent requests for assistance are addressed immediately. The DON stated a CNA (in general) should be able to hear and see the call light for Resident 103's room if the CNA (in general) was in the room across from Resident 103's room. The DON stated the facility staff (in general) should have answered Resident 103's call light as soon as possible. The DON stated if Resident 103's call light was not answered; the facility would not be able to provide for Resident 103's needs in a timely manner. The DON stated the facility staff (in general) did not follow the facility's policy. |

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| F 0578<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure 2 of 4 sampled residents (Resident 43 and 78) had documentation in the active medical record showing the residents and/or resident representatives were provided an Advanced Directives (written statement of a person's wishes regarding medical treatment made to ensure those wishes are carried out should the person be unable to communicate them to a doctor) Acknowledgement Forms (a signed acknowledgment indicating the resident and/or resident representative were provided with information regarding creating an Advanced Directive. By failing to: Ensure Resident 43's Advanced Directed Acknowledgement Form dated 2/28/2026 was completed in its entirety. Ensure Resident 78 had a documented Advanced Directive Acknowledgement Form documented in the resident's medical record. These deficient practices violated the residents' rights and/or representative's right to be fully informed of the option to request or refuse medical care and treatment. Findings: During a review of Resident 43's admission Record, the admission Record indicated the facility admitted the resident on 2/28/2026 with diagnoses that included muscle weakness, abnormalities of gait (a person's specific manner or pattern of walking or moving on foot) and history of falling. During a review of Resident 43's Minimum Data Set (MDS: standardized assessment tool) dated 3/5/2026, the MDS indicated Resident 43 was able to make self-understood and understood others. The MDS indicated Resident 43's cognitive functioning (mental processes that enable people to think, understand, make decisions, and complete tasks) was intact. The MDS indicated Resident 43 required partial to moderate assist with mobility from facility staff. During a review of Resident 43's Advanced Directive Acknowledgement form dated 2/28/2026, the Advanced Directive Acknowledgement form indicated the check box that indicated whether Resident 43 Wished or Declined to execute and advanced directive was blank.During a concurrent interview and record review on 4/28/2026 at 3:09 P.M. with the Director of Admissions (DA), Resident 43's advanced directive acknowledgement form was reviewed. The DA stated an advance directive ensured a resident's healthcare wishes were identified and respected if they become unable to speak for themselves. The DA stated the advance directive acknowledgement form in Resident 43's medical record was incomplete. The DA stated that the check box that indicated whether Resident 43 Wished or Declined to execute and advanced directive was blank. The DA stated it was important to complete the check boxes to document Resident 43's decision. The DA stated not having checked option boxes meant no education on advance directive was offered or a followed up on. The DA stated all boxes on the advanced directive acknowledged should have been completed. During a review of Resident 78's admission Record, the admission Record indicated the facility admitted the resident on 4/22/2026 with diagnoses that included right and left contracture (a permanent tightening or shortening of muscles, tendons, skin, or nearby soft tissues that causes joints to become stiff and rigid), anemia (a common blood condition where you have a lower-than-normal amount of red blood cells or hemoglobin), and calculus ( hard, solid deposits made of minerals and salts (such as calcium or uric acid) that form inside the kidneys). During a review of Resident 78's MDS dated [DATE], the MDS indicated Resident 78 sometimes made herself understood and sometimes understood others. The MDS indicated Resident 4 had severely impaired cognition (significant decline in a resident's mental abilities that profoundly impacts their daily life and independence). During a concurrent interview and record review on 4/28/2026, at 3:12 P.M. with the DA, Resident 78's advanced directive acknowledgement form was reviewed. The DA confirmed by stating there was no Advance Directive Acknowledgement Form in Resident 78's medical record. The DA stated there should have been an advance directive acknowledgement form in Resident 78's medical record. The DA stated that without the advanced directive acknowledgement form, the facility had no documentation of Resident 78's advance directive information or if the resident<br>(continued on next page) |

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| F 0578<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | declined information on advanced directives. During a concurrent interview and record review on 4/28/2026 at 3:20 P.M., with the Social Worker Director (SWD), the SWD stated the completion of advanced directive acknowledgement form should have been completed for Resident 43. The SWD was unable to locate the Advance Directive Acknowledgement Form for Resident 78. The SWD stated information on advanced directives was important because it stipulated patient wishes and if they could make decisions for their care. The SWD stated that the advanced directive acknowledgement form was a documentation of Resident's choice. During a concurrent interview and record review on 4/30/2026 at 8:37 A.M., with the Director of Nursing (DON), the DON stated the Advance Directive was a legal document for health care decision making. The DON stated the Advance Directive Acknowledgement Form was a documentation process of resident's admission Advanced directive information and education. The DON stated Resident 43's Advance Directive Acknowledgement Form was incomplete. The DON stated that there was no Advance Directive Acknowledgement Form for Resident 78. The DON stated, it was a required document by the State. The DON stated every resident had to have a completed Advance Directive Acknowledgement Form. The DON stated that there was a failure to provide the Advance Directive information Form documentation to Resident 78. A review of the facility's policy and procedure titled, Advance Directives, dated 12/18/2025, indicated: PURPOSETo provide residents with the opportunity to make decisions regarding their health care.POLICYAt the time of admission, admission staff or designee will inquire about the existence of an Advance Directive.If no Advance Directive exists, the facility provides the resident with an opportunity to complete the Advance Directive Form upon resident request. PROCEDUREUpon admission, admission staff or designee will inform the resident of their right to execute and Advance Directive form, if one does not already have. |

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| F 0583<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Keep residents' personal and medical records private and confidential.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to protect private health information by leaving confidential medical information easily accessible for two of two sampled residents (Resident 9 and Resident 40).This deficient practice had the potential to result in violation of Resident 9 and Resident 40's right to personal privacy and confidentiality of their medical records. Findings:<br><br>1.During a review of Resident 9's admission Record, the admission Record indicated the facility admitted the resident on 3/21/2026, with diagnoses that included Atherosclerotic Heart Disease (a chronic condition caused by plaque buildup inside artery walls, causing them to narrow and harden), dementia (a progressive state of decline in mental abilities), and hypertension (high blood pressure).<br><br>During a review of Resident 9's Minimum Data Set (MDS, a resident assessment tool), dated 3/30/2026, the MDS indicated the resident was severely cognitively impaired (significant difficulty with memory, orientation, and recalling information).<br><br>During a concurrent observation and interview on 4/29/2026 at 8:57 AM with Restorative Nurse Assistant 1 (RNA 1) in the front lobby, Resident 9's meal ticket was found in an open box of medium-sized gloves on the table with the visitor sign-in sheet. Observed Resident 9's full name, room number, mealtime/date, and diet order on the meal ticket. RNA 1 stated that it was a HIPPA (Health Insurance Portability and Accountability Act) violation because visitors who sign in and sign out could easily see Resident 9's personal information on the meal ticket.<br><br>During an interview on 4/29/2026 at 11:05 AM with Registered Nurse (RN 1), RN 1 stated Resident 9's meal ticket should not have been in the box of the gloves. RN 1 stated all documents with resident information must be disposed of in designated shred bins to protect against unauthorized use.<br><br>During a concurrent interview and record review on 4/30/2026 at 9:58 AM with the Director of Nursing (DON), the facility's policy and procedure (P&P) titled, Protected Health Information (PHI), Management and Protection of, revised on April 2014 was reviewed. The P&P indicated, It is the responsibility of all personnel who have access to resident and facility information to ensure that such information is managed and protected to prevent unauthorized release or disclosure. The DON stated residents have a right to privacy and confidentiality of their records. The DON stated the P&P was not followed.<br><br>2. During a review of Resident 40's admission Record, the admission Record indicated the facility originally admitted Resident 40 on 7/12/2023 and was re-admitted on [DATE] with diagnoses including end stage renal disease (ESRD-a medical condition in which a person's kidney [organ in the body that filters waste and excess fluid from the blood] stop functioning on a permanent basis), epilepsy (a disorder in which a nerve cell activity in the brain is disturbed causing seizure [a sudden, uncontrolled electrical disturbance in the brain]) and anemia (disorder in which red blood cells [cells that carry oxygen to all parts of body] are destroyed faster than they can be made).<br><br>During review of Resident 40's MDS dated [DATE], the MDS indicated Resident 40 had intact cognition (mental action or process of acquiring knowledge and understanding) for daily decision-making and with moderate assistance (helper does less than half the effort) from staff for activities of daily living (ADLs-bed mobility, surface transfer, eating, walk in room, dressing, toileting, and personal hygiene).<br>(continued on next page) |

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| F 0583<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During a review of Resident 40's H&P dated 2/19/2026, the H&P indicated Resident 40 had the capacity to make medical decisions (a person's ability to make their own medical decisions changes based on the complexity of the decision and their current mental state).<br><br>During a concurrent observation and interview on 4/29/2026 at 9:28 AM, with RN 1, in nurse station B, Resident 40's electronic medical record (EMR-digital, computer-based version of patient's paper medical record) was left open and unattended. RN 1 stated that she (RN 1) should not leave resident's EMR unattended and added importance of logging off when not needed or stepping out to protect resident's privacy and confidentiality.<br><br>During an interview on 4/30/2026 at 11:51 AM, with the DON, the DON stated that staff (in general) should log off right away or close residents' EMR when leaving the workstation to protect residents' privacy and confidentiality.<br><br>During a review of the facility's policy and procedure (P&P), titled, Resident Rights, reviewed on 12/18/2025, the P&P indicated that facility guaranteed basic rights to all residents of the facility including the right for privacy and confidentiality.<br><br>During a review of facility's P&P, titled, Protected Health Information (PHI), Management and Protection of, reviewed on 12/18/2025, the P&P indicated that it is the responsibility of all personnel who have access to resident and facility information to ensure that such information is managed and protected to prevent unauthorized release or disclosure. |

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| F 0640<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Encode each resident?s assessment data and transmit these data to the State within 7 days of assessment.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews the facility failed to submit the required complete information contained in the Minimum Data Set (MDS- standardized data collection tool used to assess cognitive and functional status, and care needs) for one of one sampled residents (Resident 84) within 14 days after discharge date (2/14/2026) to the Centers for Medicare & Medicaid Services (CMS: a federal agency within the United States Department of Health and Human Services) System. This deficient practice had the potential to deny Resident 84 proper healthcare monitoring to ensure all the necessary care and services were provided and had the potential for residents to be improperly billed for services not provided.Findings: During a review of Resident 84's admission Record, the admission Record indicated the facility admitted the resident on 1/4/2025 and readmitted on [DATE] with diagnoses including encephalopathy (a change in how the brain functions) unspecified, chronic kidney disease (a condition in which the kidneys are damaged and cannot filter blood as well as they should,) muscle wasting and atrophy(shrinking or loss of muscle tissue)multiple sites, muscle weakness(generalized), hypertension(high blood pressure), hypothyroidism(the thyroid gland does not make enough hormones, causing the body's metabolism to slow down), unspecified dementia(a progressive state of decline in mental abilities), unspecified severity, without behavioral disturbance (acting out, agitated, aggressive or mood/personality changes), psychotic disturbance (hallucinations or strong delusions), mood disturbance (disruptive sadness, irritability), and anxiety (excessive worry, fear, and nervousness), osteoporosis (weak and brittle bones due to lack of calcium and Vitamin D), anemia (a condition where the body does not have enough healthy red blood cells). During a review of Resident 84's MDS assessment dated [DATE], the MDS indicated Resident 84 had severe cognitive (had the ability to think, understand, and reason) impairment. The MDS indicated Resident 84 required partial/moderate assistance (helper lifts, holds, or supports trunk or limbs and provides less than half the effort) for) from the staff for toilet transfer, chair/bed to chair transfer, toileting hygiene, tub/shower transfer, shower/bathe self, lower body dressing, putting on/taking off footwear. During a review of Resident 84's Clinical Census dated 2/2/2026, the Clinical Census indicated the facility discharged Resident 84 from the facility to the general acute care hospital (GACH) on 2/2/2026. During a review of Resident 84's Clinical MDS dated [DATE], the Clinical MDS indicated Resident 84 was discharged from the facility and return not anticipated (no plans to come back). The Clinical MDS indicated the status of the MDS was exported (sending the completed resident assessment to CMS). The Clinical MDS did not indicate a completion date. During a review of Resident 84's Minimum Data Set (MDS 3.0) Summary dated 2/14/2026, the MDS Data Set Summary indicated a completion date of 4/28/2026 for the MDS. During a concurrent interview and record review on 4/30/2026 at 8:52 AM, with the Minimum Data Set Coordinator (MDSC), Resident 84's MDS 3.0 Summary dated 2/14/2026 was reviewed. The MDSC stated the MDS for Resident 84's discharge from the facility was on 2/14/2026 and was completed on 4/28/2026. The MDSC stated the completion date of 4/28/2026 was too long of a timeframe. The MDSC stated she (MDSC) did not know what the required time frame was for submitting the MDS and would get back to the surveyor after having looked at the MDS manual to provide an accurate answer. The MDSC stated by not having submitted the MDS timely, CMS was not notified of Resident 84's discharge from the facility and the discharge would not have reflected the plan of care for Resident 84. The MDSC stated the MDS was used for financial purposes, and billing for the services provided to the residents in the facility. The MDSC stated that she (MDSC) could not remember and did not know what had occurred as to why Resident 84's discharge MDS completion date was late. During a concurrent interview and record review on 4/30/2026 at 9:39 AM with the Director of Nursing (DON), the DON stated the MDS was an assessment interview (a mandatory, structured conversation where a nurse asks a nursing home resident direct questions<br>(continued on next page) |

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| F 0640<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | about their physical health, mood, preferences, and pain) of the resident and complete skilled assessment. The DON stated the MDS was used for billing CMS for facility services such as physical therapy, occupational therapy (a healthcare service that helps people of all ages regain, develop, or maintain the skills needed for daily living or [occupations] after injury, illness, or disability), and all nursing services. The DON stated the comprehensive (including everything needed) discharge assessment had to be completed within 14 days of the date the resident was discharged from the facility. The DON stated the discharge completion assessment date for Resident 84 of 4/28/2026 was not completed within the 14-day timeframe. The DON stated a late completion date could have caused a problem with billing. The DON stated the facility billed while the resident was in the facility for services. The DON stated the discharge assessment was completed too late and was not accurate.<br>During a review of the facility's Policy & Procedure (P&P) titled Resident Assessment and Care Planning dated 12/18/2025, the P&P indicated A comprehensive assessment of each resident is completed at intervals designated by OBRA regulations and PPS requirements. Data from the Minimum Data Set (MDS) is submitted to the Internet Quality Improvement Evaluation System (iQIES) as required. During a review of the facility's (P&P) titled, MDS Completion and Submission Timeframes, dated 12/18/2025, indicated The assessment coordinator or designee is responsible for ensuring resident assessments are submitted to CMS' Internet Quality Improvement Evaluation System {iQIES) in accordance with current federal and state guidelines. The P&P indicated Timeframes for completion and submission of assessments is based on the current requirements published in the Resident Assessment Instrument Manual. During a review of the facility's CMS's Resident Assessment Instrument (RAI) Version 3.0 Manual titled, CH 5: Submission and Correction of the MDS Assessments dated October 2025, the manual indicated Completion Timing: For all non-admission OBRA and PPS assessments, the MDS Completion Date (Z0500B) must be no later than 14 days. |

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| F 0641<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure each resident receives an accurate assessment.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to accurately code the Minimum Data Set (MDS - a resident assessment tool) for two out of five sampled residents (Resident 10 and Resident 43) by failing to: 1. Document Resident 10's peripheral vascular disease (PVD - a slow progressive narrowing of the blood flow to the arms and legs) wounds 2. Document Resident 43's tobacco use. These failures had the potential to result in a delay in the necessary care and treatment for Resident 10 and Resident 43.Findings:<br><br>1.During a review of Resident 10's admission Record, the admission Record indicated the facility originally admitted Resident 10 on 11/10/2021 and readmitted Resident 10 on 6/28/2023 with diagnoses that included multiple sclerosis (MS- a chronic, progressive disease involving damage to the nerve cells in the brain and spinal cord), bilateral primary osteoarthritis of knee (a degenerative, age-related condition where protective cartilage breaks down in both knees at the same time without a specific injury, resulting in pain, stiffness, and reduced mobility), essential hypertension (he most common form of high blood pressure, where blood pushes too hard against artery walls without a known, specific medical cause), anemia (a condition where the body does not have enough healthy red blood cells), other spondylosis cervical region (age-related wear and tear affecting the spinal disks in your neck), and unspecified atherosclerosis of native arteries of extremities left leg (blockages or hardening in the natural, original arteries of your left leg due to plaque buildup).<br><br>During a review of Resident 10's Interdisciplinary Care Conference (ICC -a meeting where a resident's health team that can include doctors, nurses, therapists, social workers, and sometimes family, gather to discuss, plan, and coordinate aspects of the resident's care together) note dated 3/10/2025, the ICC note indicated Resident 10 had a PVD wound on the left lateral lower leg (outer side of your left leg). The ICC note indicated Resident 10 had a PVD wound on the right dorsal foot.<br><br>During a review of Resident 10's History and Physical (H&P) dated 6/17/2025, the H&P indicated Resident 10 had a left lateral ankle (the outside bony bump of your left foot and the surrounding soft tissues) PVD wound. The H&P indicated Resident 10 had PVD. The H&P indicated Resident 10 had the capacity (ability) to understand and make decisions.<br><br>During a review of Resident 10's Progress Note dated 4/9/2026, the Progress Note indicated Resident 10 had a right dorsal of foot (the top surface of your right foot) PVD fragile tissue (a chronic sore, usually on the legs or feet, that won't heal because poor circulation deprives the skin of necessary oxygen and nutrients) and to continue Xeroform dressing (a yellow, petroleum-soaked, medicated gauze dressing used to cover wounds). The Progress Note indicated Resident 10 had a left lateral malleolus (the bony, knobby bump on the outside of your left ankle) to foot PVD with fragile tissue and to cleanse with normal saline (sterile mixture of water and salt), pat dry and apply Mupirocin (a prescription-strength antibiotic cream or ointment used to kill bacteria on the skin, most commonly treating impetigo and small infected cuts) to open to wound beds and cover with Xeroform dressing.<br><br>During a review of Resident 10's Order Summary Report dated 4/29/2026, the Order Summary Report indicated Resident 10 had physician orders for treatment to the lower leg to foot PVD multiple scattered open wounds. The Order Summary Report indicated Resident 10 had a physician order for treatment to right dorsal of foot pemphigus (a group of rare skin disorders that cause blisters and sores on the skin)/PVD. The Order Summary Report indicated Resident 10 had a physician order for treatment of right lower leg to foot PVD multiple scattered open wounds.<br>(continued on next page) |

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| F 0641<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During a concurrent interview and record review on 4/28/2026 at 2:42 PM with the MDS Coordinator (MDSC) Resident 10's Body Check, dated 2/6/2026 was reviewed. The Body Check indicated Resident 10 had a right dorsal foot to plantar (bottom of foot) PVD scattered fragile tissue. The MDS nurse verified Resident 10 had a right dorsal foot to plantar PVD wound.<br><br>During a concurrent interview and record review on 4/28/2026 at 2:42 PM with the MDSC, Resident 10's MDS Assessment Section M – Skin Conditions, dated 3/13/2026 was reviewed. The MDS Assessment indicated the facility's MDS Nurse (MDSN) entered 0 under the question titled Enter the total number of venous and arterial ulcers (slow-healing, painful sores on the legs/feet resulting from poor circulation). The MDSC stated Resident 10's MDS Assessment was not accurate and should have indicated Resident 10 had PVD wounds. The MDSC stated an inaccurate MDS Assessment could affect Resident 10's plan of care.<br><br>During a concurrent interview and record review on 4/30/2026 at 2:15 with the Director of Nursing (DON) Resident 10's Body Check, dated 2/6/2026 was reviewed. The Body Check indicated Resident 10 had a right dorsal foot to plantar PVD scattered fragile tissue. The DON stated Resident 10 had a right dorsal foot to plantar PVD wound.<br><br>During a concurrent interview and record review on 4/30/2026 at 2:15 PM with the DON, Resident 10's MDS Assessment Section M – Skin Conditions, dated 3/13/2026 was reviewed. The MDS Assessment indicated the facility's MDS Nurse (MDSN) entered 0 under the question titled Enter the total number of venous and arterial ulcers (slow-healing, painful sores on the legs/feet resulting from poor circulation). The DON stated the Resident 10's MDS Assessment was not accurate.<br><br>During a concurrent interview and record review on 4/30/2026 at 2:41 PM with the DON, the facility's policy and procedure (P&P) titled MDS Assessment Coordinator, last reviewed on 12/18/2025, was reviewed. The P&P indicated Each individual who completed a portion of the assessment (MDS) must certify the accuracy of that portion of the assessment. The DON stated the MDS Assessment should be done accurately. The DON stated the facility did not follow their policy.<br><br>2.During a review of Resident 43's admission Record, the admission Record indicated the facility admitted the resident on 2/28/2026 with diagnoses that included but not limited to muscle weakness, abnormalities of gait (a person's specific manner or pattern of walking or moving on foot) and history of falling.<br><br>During a review of Resident 43's MDS dated [DATE], the MDS indicated Resident 43 made herself understood and understood others. The MDS indicated Resident 43's cognitive functioning (mental processes that enable people to think, understand, make decisions, and complete tasks) is intact. The MDS indicated Resident 43 required partial to moderate assist with mobility. The MDS indicated Resident 43 did not use tobacco.<br><br>During a review of Resident 43's Care Plan Report dated 3/4/2026, the Care Plan Report indicated Resident 43 smoked independently. The Care Plan Report indicated the nursing intervention was to monitor Resident 43's compliance with the smoking policy.<br><br>During an interview on 4/27/2026 at 10:58 AM with Resident 43, Resident 43 stated she (Resident 43) smoked. Resident 43 stated she was told about her smoking schedule and received information about risks of smoking.<br>(continued on next page) |

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| F 0641<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During a concurrent interview and record review on 4/29/2026 at 11:23 AM with the Activities Director (AD), Resident 43's Progress Notes dated 3/4/2026 were reviewed. The AD stated Resident 43 smoked.<br><br>During an interview on 4/29/2026 at 1:54 PM with the MDSC, the MDSC stated she (MDSC) was responsible for completing residents' MDS assessments (in general). The MDSC stated that the MDS was a tool to assess the resident's clinical status, activities, and care needs. The MDSC stated the MDS smoking assessment provided information about resident's use of tobacco.<br><br>During a concurrent interview and record review on 4/29/2026 at 3:30 PM with the DON, Resident 43's Care Plan Report dated 3/4/2026 and Resident 43's MDS dated [DATE] were reviewed. The DON stated that the care plan indicated Resident 43 smoked. The DON stated she (DON) would see Resident 43 smoked at the patio. The DON stated the MDS assessment of Resident43 indicated not a tobacco user. The DON Stated it should have been documented as a yes. The DON stated Resident 43's MDS did not reflect that Resident 43 smoked tobacco.<br><br>During a review of the facility's Policy & Procedure (P&P) titled MDS Assessment Coordinator last reviewed on 12/18 2025, the P&P indicated each individual who completes the portion of the assessment (MDS) must certify the accuracy of that portion of the assessment by dating and signing the assessment (MDS); and identifying each section completed. |

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| F 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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.<br><br>Based on observation, interview and record review the facility failed to update and revise 1 of 3 sampled residents (Resident 78's) care plan titled The resident is at risk for fall dated 7/9/2025, after a physician's order for a low bed with bilateral floor mats for safety was received on 8/24/2024. This deficient practice had the potential to result in a delay of nursing care.Findings:During a review of Resident 78's admission Record, the admission Record indicated the facility admitted the resident on 4/22/2026 with diagnoses that included right and left contracture (a permanent tightening or shortening of muscles, tendons, skin, or nearby soft tissues that causes joints to become stiff and rigid), Anemia (a common blood condition where you have a lower-than-normal amount of red blood cells or hemoglobin), and calculus ( hard, solid deposits made of minerals and salts (such as calcium or uric acid) that form inside the kidneys). During a review of Resident 78's Minimum Data Set (MDS: standardized assessment tool) dated 3/5/2026, the MDS indicated Resident 78 sometimes made herself understood and sometimes understood others. The MDS indicated Resident 4's had severely impaired cognition (significant decline in a resident's mental abilities that profoundly impacts their daily life and independence). The MDS indicated Resident 78 required maximal assistance with mobility from facility staff. During a review of Resident 78's Order Summary Report dated 4/30/2026, the Order Summary Report indicated low bed with bilateral floor mats for safety was ordered on 8/24/2024. During a review of Resident 78's care plan titled The resident is at risk for fall dated 7/9/2025, the care plan indicated Resident 78 was at risk for falls. The care plan indicated no updated interventions for a low bed with bilateral floor mats for safety were documented. During a concurrent interview and record review on 4/28/2026 at 12:10 P.M, with Licensed Vocational Nurse (LVN) 6, Resident 78's physician's order dated 8/4/2024 and Resident 78's care plan titled The resident is at risk for fall dated 7/9/2025 were reviewed. LVN 6 stated Resident 78 was a fall risk. LVN 6 stated the care plan told nurses how to care for residents based on their needs. LVN 6 Stated she was able to create a care plan. LVN 6 stated a care plan was initiated upon admission and updated when there was a change of condition or if a physician wrote new orders. LVN 6 stated Resident 78's order on 8/24/2024 indicated the physician ordered a low bed position and bilateral floor mats for safety. LVN 6 stated the physician ?s orders for Resident 78 were not updated in the care plan. LVN 6 stated the care plan did not reflect the intervention for safety. LVN 6 stated the care plan failed to reflect Resident 87's needs for safety. During a concurrent observation and interview on 4/29/2026 at 10:05 a.m., with Certified Nursing Assistant (CNA)12, CNA12 was observed at bedside repositioning Resident 78. CNA 12 stated the floor mats were for fall risk precautions to protect Resident 78's head or any part of the body from hitting the floor. CNA12 stated the bed was in a low position for precaution if a resident tried to get out of bed. CNA 12 stated the licensed nurses documented the care plan. During a concurrent interview and record review on 4/30/2026 at 10:05 a.m., with the Director of Nursing (DON), Resident 78's physician orders dated 8/24/24 and Resident 78's care plan titled The resident is at risk for fall dated 7/9/2025, were reviewed. The DON stated fall precautions meant to prevent a fall. The DON stated that Resident 78's care plan was not updated with physician's orders of low bed with bilateral floor mats for Resident 78. The DON stated it was a failure to not update the care plan with Residents ?s 78 safety needs ordered by the physician. During a review of the facility's recent P&P titled Care Plan Comprehensive: last reviewed on 12/18/25, the P&P indicated: The Comprehensive care plan includesThe services that are to be furnished to attain or maintain the residents highest practicable physical, mental and psychological being. During a review of the facility's recent P&P titled Fall Management last reviewed on 12/18/25, the P&P indicated: Purpose-To reduce risk for fall and minimize the actual occurrence of falls.-To address injury and provide care for a fall.PROCEDURE-Develop individualized plan of care-Review and revise care plan as indicated. |

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| F 0679<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide activities to meet all resident's needs.<br><br>Based on observation, interview, and record review the facility failed to ensure an activity assessment was completed for one of one sampled resident (Resident 99) to evaluate the resident's preferences for activities. This failure had the potential for Resident 99 to feel bored and to affect Resident 99's quality of life.Findings: During a review of Resident 99's admission Record, the admission Record indicated the facility admitted the resident on 4/22/2026 with diagnoses that indicated hydrocephalus (a condition characterized by the abnormal buildup of cerebrospinal fluid (CSF) within the brain), hyperlipidemia (high levels of cholesterol in the blood), hypertension (high blood pressure), and muscle weakness. During a review of Resident 99's History and Physical (H&P) dated 4/23/2026, the H&P indicated the resident was alert and oriented times two (A&Ox2, when a resident is awake and aware of their surroundings, specifically knowing their own name and where they are). During a concurrent interview and record review on 4/27/2026 at 10:42 AM, in Resident 99's room, Resident 99 was observed sitting up in bed. Resident 99 stated he (Resident 99) was bored. Resident 99 stated there were no activities to do in the facility. During an observation on 4/28/2026 at 10:50 AM, in the activities room, Resident 99 was observed sitting at a table coloring. Resident 99 was observed talking to the Activities Director (AD) and showing the AD the picture Resident 99 was coloring. During an interview on 4/29/2026 at 8:27 AM with the AD, the AD stated every morning Resident 99 came to the activities room. The AD stated Resident 99 followed instructions and answered questions. The AD stated he (the AD) was supposed to do an activity assessment for Resident 99 to know which activities Resident 99 preferred and liked to do. The AD stated he (the AD) had five days from the date of admission to perform an activity assessment. The AD stated an activity assessment was not yet done for Resident 99. During an observation on 4/29/2026 at 8:31 AM, in the activities room, Resident 99 was observed sitting in a wheelchair. Resident 99 was not observed performing any activities. Resident 99 was observed staring at the ceiling. During an interview on 4/29/2026 at 4:20 PM with the Director of Nursing (DON), the DON stated activity assessments were done within 72 hours of admission. The DON stated assessing activity preferences should be done to better serve resident needs (in general) and preferences. The DON stated there was potential for Resident 99 to get bored which could affect the resident's happiness if activities preferences were not checked and the resident was not provided with the type of activities the resident enjoyed. During a review of the facility's Policy and Procedure (P&P) titled Activities and Social Services dated 12/18/2025, the P&P indicated Residents are encouraged to choose the types of recreational, cultural, and religious activities and social events in which they prefer to participate. The Interdisciplinary Care Team will evaluate the individual's personal history and preferences and will consider his/her medical condition and prognosis in identifying relevant recreational and cultural activities. |

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| F 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate pressure ulcer care and prevent new ulcers from developing.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide skin and pressure ulcer (injuries to the skin and underlying tissue, primarily caused by prolonged pressure on the skin) prevention care consistent with professional standards of practice and per physician's orders for two of four sampled residents (Resident 2 and Resident 8) on Low Air Loss Mattresses (LALM - a pressure-relieving mattress used to prevent and treat pressure injuries). By failing to: 1. Ensure Resident 2's low air loss mattress (LAL-a mattress designed to prevent and treat pressure wounds) was at a proper setting per manufacturer's guideline.2. Ensure Resident 8's LAL mattress was working properly. This deficient practice had the potential to delay healing, placed Resident 2 and Resident 8 at risk for developing new pressure injuries, worsening of existing ones, and complications resulting from untreated or improperly treated pressure injuries which could result in systemic infections that could lead to death.Findings:<br><br>1.During a review of Resident 2's admission record, the admission record indicated the facility originally admitted Resident 2 on 7/16/2025 and re-admitted the resident on 9/17/2025 with diagnoses including gastrostomy (GT- a flexible tube surgically inserted through the abdomen into the stomach for feeding, fluid, and medication administration), malnutrition (lack of sufficient nutrients in the body), and generalized muscle weakness (weakening, shrinking, and loss of muscle).<br><br>During a review of Resident 2's History and Physical (H&P) dated 9/3/2025, the H&P indicated Resident 2 did not have the capacity to understand and make decisions.<br><br>During a review of Resident 2's physician order, dated 12/29/2025, the physician order indicated that Resident 2 had an order for a LAL mattress every dayshift for wound care management and the setting was not to exceed current weight.<br><br>During a review of Resident 2's Minimum Data Set (MDS - a standardized assessment tool), dated 3/20/2026, the MDS indicated Resident 2 had impaired cognition (mental action or process of acquiring knowledge and understanding) for daily decision-making and maximal assistance (helper does more than half the effort) to dependent (helper does all the effort) from staff for activities of daily living (ADLs-bed mobility, surface transfer, eating, walk in room, dressing, toileting, and personal hygiene). The MDS indicated Resident 2 was at risk of developing pressure ulcers/injuries with treatment for pressure reducing devices for bed.<br><br>During a review of Resident 2's Braden Scale (pressure ulcer risk predictor tool) for predicting pressure ulcer risk (BSPPUR) dated 4/14/2026, the BSPPUR indicated Resident 2 was at risk for pressure ulcer development.<br><br>During a review of Resident 2's care plan revised on 4/14/2026, care plan indicated Resident 2 was at risk for skin breakdown with an intervention for a LAL mattress as per guidelines.<br><br>During a review of Resident 2's Weights and Vitals Summary Report, on 4/28/2026, Resident 2's weight indicated the following:<br><br>4/1/2026 72 pounds (lbs.)<br><br>3/5/2026 71.7 lbs.<br>(continued on next page) |

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| F 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 2/8/2026 70 lbs.<br><br>1/5/2026 71 lbs.<br><br>During a concurrent observation and interview on 4/28/2026 at 10:20 a.m., with Licensed Vocational Nurse 3 (LVN 3), inside Resident 2's room, Resident 2's LAL mattress setting was at 150 lbs. LVN 3 stated that Resident 2's LAL mattress setting should have been at 80 lbs. due to Resident 2's weight.<br><br>During an interview on 4/30/2026 at 11:51 a.m., with the Director of Nursing (DON), the DON stated that Resident 2's LAL mattress should have been set according to Resident 2's comfort and weight for pressure injury prevention. The DON stated the importance of following manufacturer's guidelines.<br><br>During a review of the LAL Operator's Manual (LAL OM), undated, the LAL OM indicated the facility needed to determine the patient's weight and set the control knob to the specific weight setting.<br><br>2. During a review Resident 8's admission record, the admission record indicated the facility admitted the resident on 10/3/2025, with diagnoses that included heart failure (a heart disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling), aftercare following joint replacement surgery (a surgery to replace all or some of a joint), and osteoarthritis (a degenerative joint disease in which tissues in the joint break down over time).<br><br>During a review of Resident 8's MDS dated [DATE], the MDS indicated the resident required maximum assistance (helper does more than half the effort) from staff to complete activities of daily living (ADLs, activities a person performs daily such as bathing, dressing, and toileting). The MDS indicated Resident 8 was at risk for developing pressure ulcers and had a pressure-reducing device for bed.<br><br>During a review of Resident 8's BSPPUR dated 4/16/2026, the BSPPUR indicated the resident was at moderate risk (prevention is needed to avoid progression to high risk levels) for developing pressure ulcers.<br><br>During a review of Resident 8's Order Summary Report, dated 1/8/2026, the report indicated LAL mattress every dayshift for comfort per resident request.<br><br>During a review of Resident 8's care plan, revised on 1/8/2026, the care plan indicated, LAL mattress to bed as per guideline.<br><br>During a concurrent observation and interview on 4/27/2026 at 10:44 a.m. with Resident 8 in Resident 8's room, the LAL mattress was deflated. Resident 8 stated she felt the metal bar on her back, and it was uncomfortable. Resident 8 stated the LAL mattress starting to feel less firm after staff had changed her diaper earlier that day (4/27/2026).<br><br>During a concurrent observation and interview on 4/27/2026 at 11:17 a.m. with Licensed Vocational Nurse (LVN) 6 in Resident 8's room, the LAL mattress was not plugged into the wall socket. LVN 6 stated the LAL mattress should have been on. LVN 6 stated that when LAL mattresses were not properly functioning, it increased the residents' risk for developing pressure ulcers.<br><br>During an interview on 4/28/2026 at 11:05 a.m. with Certified Nursing Assistant (CNA) 5, CNA 5 stated CNAs had to notify a registered nurse if a LAL was turned off or if the mattress seemed low on (continued on next page) |

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| | 055755 | A. Building<br>B. Wing | 04/30/2026 |

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| F 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | air.<br><br>During an interview on 4/28/2026 at 11:12 a.m. with Treatment Nurse (TN) 1, TN 1 stated LAL mattresses reduced pressure on boney prominences. TN 1 stated incorrect use of LAL mattresses could cause skin breakdown due to increased pressure on the skin.<br><br>During a concurrent interview and record review on 4/30/2026 at 10:38 a.m. with the DON, the facility's policy and procedure (P&P) titled, Positioning/Transfer and Changing Resident with Airloss Mattress, revised on October 2024 was reviewed. The P&P indicated, Air continually flows through tiny laser-made holes in the top of the mattress surface so that the user floats on a soft cushion of air. The DON stated the P&P was not followed because Resident 8's LAL mattress was unplugged and deflated. |

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| F 0690<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.<br><br>Based on observation, interview, and record review, the facility failed to ensure one of one sampled resident (Resident 3) reviewed for urinary indwelling catheter (a hollow tube that is inserted into the bladder to drain or collect urine) received the necessary urinary catheter care by failing to: -Monitor Resident 3's urinary indwelling catheter for signs and symptoms of infection This failure had the potential for Resident 3 to develop an infection that was not timely identified or treated.Findings:During a review of Resident 3's admission Record, the admission Record indicated the facility admitted the resident on 9/30/2025 with diagnoses that included urinary tract infection (UTI, an infection in the bladder/urinary tract), benign prostatic hyperplasia (enlargement of the prostate gland), and obstructive uropathy (a blockage in the urinary tract that prevents normal urine flow). During a review of Resident 3's Order Summary Report, the Order Summary Report indicated the resident had a physician order dated 1/21/2026 to monitor the resident for signs and symptoms of infection to the foley catheter every shift. The physician order indicated to notify Resident 3's physician if any signs and symptoms of infection were noted. During a review of Resident 3's Care Plan Report dated 2/8/2026, the Care Plan Report indicated the resident had a foley catheter (indwelling catheter). The Care Plan Report indicated Resident 3 was at risk of infection. The Care Plan Report indicated a goal for Resident 3 to show no signs or symptoms of infection. The Care Plan Report indicated interventions to monitor Resident 3 for signs and symptoms of infection and to manage the resident's indwelling catheter to minimize the risk of infection. During a review of Resident 3's Minimum Data Set (MDS, a resident assessment tool) dated 4/2/2026, the MDS indicated Resident 3 was cognitively intact (had the ability to think understand and reason). The MDS indicated Resident 3 was independent with eating, oral hygiene, and personal hygiene. The MDS indicated Resident 3 required set up or clean up assistance (helper sets up or cleans up; resident completes activity) for upper body dressing. The MDS indicated Resident 3 required partial/moderate assisting (helper does less than half the effort) for toileting hygiene, showring/bathing self, lower body dressing and putting on/taking off footwear. The MDS indicated Resident 3 had an indwelling catheter. During a concurrent observation and interview on 4/27/2026 at 11:05 AM, in Resident 3's room, the resident was observed sitting up in bed. Resident 3 stated he (Resident 3) had a foley catheter. Resident 3's foley catheter was observed with a privacy bag and yellow colored clear liquid in the foley catheter tubing. During a review of Resident 3's Medication Administration Record (MAR) dated 4/1/2026 to 4/29/2026, the MAR did not indicate the resident's foley catheter was monitored for signs and symptoms of infection. During a concurrent interview and record review on 4/29/2026 at 11:48 AM with Registered Nurse 1 (RN 1), Resident 3's physician order dated 1/21/2026 and MAR dated 4/1/2026 - 4/29/2026 were reviewed. RN 1 stated Resident 3 had a physician order to monitor the resident for signs and symptoms of infection to the foley catheter. RN 1 stated monitoring of signs and symptoms of infection would be documented on the resident's MAR. RN 1 stated there was no documentation for the monitoring of signs and symptoms of infection to Resident 3's Foley Catheter on the resident's MAR. RN 1 stated monitoring for signs and symptoms of infection to Resident 3's foley catheter should be done. RN 1 stated monitoring for signs and symptoms of infection should be on Resident 3's MAR so the nurses are aware that it should be done every shift. RN 1 stated there was potential for the nurses (in general) to not be aware that Resident 3 was having symptoms of an infection, which could cause a delay in the treatment of the infection. During a concurrent interview and record review on 4/29/2026 at 4:12 PM with the Director of Nursing (DON), Resident 3's physician order dated 1/21/2026 and MAR dated 4/1/2026 - 4/29/2026 were reviewed. The DON stated Resident 3 had a physician order to monitor the resident for signs and symptoms of infection to the resident's foley catheter. The DON stated there was no monitoring for signs and symptoms of infection of the foley catheter on Resident 3's MAR. The DON stated signs and symptoms of infection<br>(continued on next page) |

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| F 0690<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | should be monitored and documented on Resident 3's MAR so the nurses (in general) would be prompted (reminded) to look for signs of infection. The DON stated there was potential for Resident 3 to have an infection that was not identified and treated timely if the resident's foley was not monitored for signs and symptoms of infection. During a review of the facility's Policy and Procedure (P&P) titled Urinary Catheter dated 12/18/2025, the P&P indicated Purpose: To ensure there is a valid medical justification for use of an indwelling catheter and that the catheter is discontinued as soon as clinically warranted. To decrease/eliminate difficulties associated with urinary catheter use. Policy: Patients who enter the Center without an indwelling catheter will not be catharized unless the patient's clinical condition demonstrates that catheterization is necessary. Patients who have urinary catheters upon admission or subsequently receive one will be assessed for removal of the catheter as soon as possible based on the following criteria: Procedure: Indwelling catheters will not be changed on a routine basis and will only be changed if needed due to leakage or becoming dislodged or clogged. Intermittent: Treating acute or chronic urinary retention. Treating overflow incontinence, inoperable obstruction. It is the treatment choice of physician/APP/patient/family based on conditions.External condom: For short-term management of incontinence. For nighttime management of incontinence. Choice of physician/Resident/Responsible Party. The P&P did not address the care of or the monitoring of signs in symptoms of infection for a urinary catheter. During a review of the facility's P&P titled Physician Orders dated 12/18/2025, the P&P indicated Whenever possible, the Licensed Nurse receiving the order will be responsible for documenting and implementing the order. Medication/treatment orders will be transcribed onto the appropriate resident administration record.Documentation pertaining to physician orders will be maintained in the resident's medical record. Current month's administration records will be maintained in the MAR/TAR binders. |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide safe and appropriate respiratory care for a resident when needed.<br><br>Based on observation, interview, and record review the facility failed to label with a date on the oxygen tubing and humidifier (a small plastic bottle filled with water that attaches to an oxygen concentrator [medical device that gives you extra oxygen] or tank that allows the oxygen to pass through the water to add moisture to the oxygen before it reaches the resident's nose to prevent dryness) for one out of one sampled resident (Resident 46). This failure had the potential for Resident 46 to experience respiratory infections (infection of the parts of the body involved in breathing) associated with using an unsanitary (dirty, unhealthy, or unclean way that could endanger health) oxygen tubing or humidifier.Findings: During a review of Resident 46's admission Record, the admission Record indicated the facility originally admitted Resident 46 on 11/8/2018 and readmitted Resident 46 on 1/13/2022 with diagnoses that included amyotrophic lateral sclerosis (also known as Lou Gehrigsdisease that destroys nerve cells in the brain and spinal cord) that worsens over time), morbid obesity (abnormal or excessive fat accumulation that presents a risk to health), malignant neoplasm of unspecified site of the unspecified female breast (cancer found in a female breast where the exact location has not yet been documented or finalized in the medical record), muscle weakness, unspecified dementia (a progressive state of decline in mental abilities), and personal history of transient ischemic attack (short period of symptoms similar to those of a stroke caused by a brief blockage of blood flow to the brain) and cerebral infarction (stroke, loss of blood flow to a part of the brain). During a review of Resident 46's History and Physical (H&P) dated 4/20/2026, the H&P indicated Resident 46 had variable capacity to make medical decisions (a person's ability to make their own medical decisions changes based on the complexity of the decision and their current mental state). During a review of Resident 46's Minimum Data Set (MDS - a resident assessment tool), dated 4/24/2026, the MDS indicated Resident 46 had the ability to make herself (Resident 46) understood and had the ability to understand others. During a review of Resident 46's Order Summary Report, dated 4/29/2026, the Order Summary Report indicated a physician order for Resident 46 to receive oxygen at 2 liters per minute (very 60 seconds, two liters of pure oxygen flow through your delivery device into your lungs) via NC (nasal cannula - a lightweight, flexible plastic tube used to deliver extra oxygen directly into a person's nostrils) as needed. The Order Summary Report indicated a physician order to change Resident 46's oxygen tubing weekly on Wednesday. During a concurrent observation and interview on 4/27/2026 at 11:39 AM with Registered Nurse 1 (RN 1), Resident 46's oxygen tubing and humidifier was observed to be missing a label with a date the last time the oxygen tubing and humidifier were changed. RN 1 stated the facility would not be able to determine when the oxygen tubing and humidifier was last changed without a label and date. RN 1 stated Resident 46's oxygen tubing and humidifier should be changed weekly for infection control (prevents or stops the spread of infections in healthcare settings). RN 1 reviewed and verified what was written in the investigation note. During an interview on 4/29/2026 at 10:20 AM with the Assistant Director of Nursing (ADON), the ADON stated Resident 46's oxygen tubing and humidifier would need to be changed weekly when we discussed why the oxygen tubing and humidifier needed to have a label and date. During a concurrent interview and record review on 4/30/2026 at 1:17 PM with the Director of Nursing (DON) the facility's policy and procedure (P&P) titled Infection Prevention and Control Program, last reviewed on 12/18/2025, was reviewed. The DON stated the P&P indicated An infection prevention and control program (IPCP) is established and maintained to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. The DON stated Resident 46's oxygen tubing and humidifier should be changed weekly. The DON stated if there was no date on Resident 46's oxygen tubing and humidifier, Resident 46 was at risk for respiratory infection (infection of the parts of the body involved in breathing) because the oxygen tubing and humidifier could be contaminated. The DON stated the facility did not follow their infection control policy. During a review of the facility's P&P titled, Changing Disposable Humidifier<br>(continued on next page) |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Botte, last reviewed on 12/18/2025, the P&P indicated This policy is to ensure the correct and safe changing of humidifier bottles on a routine bases to reduce the risk of nosocomial infections (illnesses a resident catches while receiving care for a different issue in a nursing home). The P&P indicated the facility would need to change humidifier bottles weekly or as needed when empty. |

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| F 0698<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide safe, appropriate dialysis care/services for a resident who requires such services.<br><br>Based on observation, interview, and record review, the facility failed to obtain updated hemodialysis (HD, a treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidney(s) have failed) access site (a surgically created site used to remove and return blood during HD) monitoring orders for one of two sampled residents (Resident 40) reviewed for dialysis by failing to: -Ensure to address Resident 40's right arm arteriovenous (AV) fistula/shunt (a surgically created connection linking an artery [a type of blood vessel that carries oxygen-rich blood the entire body] directly to a vein [a type of blood vessel that collected oxygen-poor blood and returns it to the heart]). This failure had the potential to damage Resident 40's (AV) fistula/shunt and compromised the HD access site.Findings:During a review of Resident 40's admission Record, the admission Record indicated the facility readmitted the resident on 6/13/2025, with diagnoses that included end stage renal disease (ESRD, irreversible kidney failure), epilepsy (a brain disorder that causes reoccurring seizures), and diabetes (a disorder characterized by difficulty in blood sugar control and poor wound healing). During a review of Resident 40's Minimum Data Set (MDS, a resident assessment tool), dated 1/30/2026, the MDS indicated the resident was cognitively intact (able to independently make decisions regarding tasks of daily life). The MDS indicated the resident received dialysis (a medical treatment that acts as an artificial kidney, filtering waste products, toxins, and excess water from the blood when a person's kidneys can no longer perform these tasks properly). During a review of Resident 40's Order Summary Report dated 11/3/2025, the Order Summary Report indicated dialysis on Tuesday, Thursday, and Saturday using right chest Permacath (a flexible, soft tube placed into a large vein to use for short term dialysis) access site. During a review of Resident 40's Order Summary Report dated 1/26/2026, the Order Summary Report indicated HD access site monitoring location on the left arm shunt. During a review of Resident 40's Order Summary Report dated 1/26/2026, the Order Summary Report indicated to remove the dressing from Resident 40's left arm shunt post-dialysis treatment. During a review of Resident 40's Order Summary Report dated 1/30/2025, the Order Summary Report indicated Resident 40 had an external HD Permacath on the right chest. During a review of Resident 40's History and Physical (H&P) dated 2/19/2026, the H&P indicated the resident had the capacity to understand and make decisions. During a review of Resident 40's Order Summary Report dated 2/16/2026, the Order Summary Report indicated not to perform blood pressure (BP, the force of blood pushing against the artery walls as the heart pumps it around the body) measurements, venipunctures (blood draws), or intravenous (IV, fluids given directly into the blood stream) therapy on the access arm (unidentified arm). During a review of Resident 40's Care Plan Report dated 2/16/2026, the Care Plan Report indicated HD access site monitoring of the left arm shunt. The Care Plan Report indicated, Do not perform BP measurements, venipunctures, or IV therapy on the access arm. The Care Plan Report indicated dialysis on Tuesday, Thursday, and Saturday using left chest Permacath access site. During a review of Resident 40's Access Details, undated, the report indicated Resident 40's left upper arm AV fistula was permanently unusable on 9/26/2024. The report did not indicate a removal date for the left upper arm AV fistula. The report indicated a chest Permacath actively in use starting 9/26/2024. The report indicated the previous chest Permcath was removed on 10/9/2023. The report indicated an AV fistula was placed in Resident 40's right upper arm on 2/11/2026. During a review of Resident 40's Body Check, dated 2/19/2026, the report indicated, Right medial of upper arm surgical incision with dermabond [a skin adhesive that holds wound edges together following surgical incisions]. During a concurrent observation and interview on 4/27/2026 at 11:37 AM with Resident 40 in Resident 40's room, Resident 40 had a Permacath on the right upper chest. Resident 40 stated the left upper arm AV fistula was removed and he currently gets dialysis through the temporary Permcath. Resident 40 stated the right upper arm fistula was placed a couple months ago, but it could not be used until May 2026. During a concurrent interview and record review on 4/29/2026 at 9:20 AM with Licensed Vocational Nurse 2 (LVN 2), Resident 40's Special<br>(continued on next page) |

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| F 0698<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Instructions, undated was reviewed. The instructions indicated, No BP on left arm. LVN 2 stated new orders should have been obtained to ensure staff did not take the BP on the right upper arm with the AV fistula. During an interview on 4/29/2026 at 9:29 AM with Registered Nurse 1 (RN 1), RN 1 stated Resident 40's AV shunt site should have been updated in the chart but was not. RN 1 stated it was important for orders and care plans to be accurate because staff (in general) might take the BP on the right arm which had the AV fistula. RN 1 stated pressure from the BP cuff could damage the AV fistula, could cause clotting, and make the HD access unusable. During an interview on 4/29/2026 at 2:39 PM with the Minimum Data Set Coordinator (MDSC), the MDSC stated the dialysis order, AV fistula location, and BP restrictions should have been clarified with the doctor. The MDSC stated orders and care plans must be updated for accuracy of care. The MDSC stated taking BP on the access site could damage the AV fistula. The MDSC stated the resident could not get HD if there was no usable access site, so the toxins will build up in the body, and the resident would end up hospitalized . During a concurrent interview and record review on 4/30/2026 at 10:20 AM with the Director of Nursing (DON), the facility's policy and procedure (P&P) titled, Dialysis Care, dated August 2021 was reviewed. The P&P indicated, The Interdisciplinary Team (IDT) will ensure that the resident's care plan includes documentation of the resident's renal condition and necessary precautions (e.g., shunt site, weights, dietary and fluid restrictions, no BP on affected side, lab draws, IV, injection on arm with shunt, observe for signs and symptoms of infection, etc.). The DON stated the P&P was not followed because Resident 40's orders and care plan were not updated to reflect the resident's current condition. The DON stated miscommunication between staff about resident care could occur if orders and care plans were not updated. During a review of the facility's P&P titled, Care Plan - Baseline, dated August 2021, the P&P indicated, The baseline care plan includes the minimum healthcare information necessary to properly care for a resident including, but not limited to . physician orders. During a review of the facility's P&P titled, Care Plan Comprehensive, dated August 2021, the P&P indicated, Assessments of residents are ongoing and care plans are reviewed and revised as information about the resident and the resident's condition change. |

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| F 0756<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures.<br><br>Based on interview and record review, the facility failed to respond to the pharmacist's recommendation from February 2026 to remove heart rate hold parameters (clinical conditions that would require a medication to not be given) from amlodipine (a medication used to treat high blood pressure) in one of five residents sampled for unnecessary medications (Resident 4). The deficient practice of failing to respond to the pharmacist's recommendation to remove heart rate monitoring parameters for amlodipine increased the risk that Resident 4 may not have received his amlodipine regularly, possibly leading to an increase in blood pressure and an increased risk of heart attacks and strokes.Findings: During a review of Resident 4's admission Record (a record containing diagnostic and demographic resident information) dated 4/29/2026, the admission Record indicated the facility admitted Resident 4 on 3/2/2021 and readmitted the resident on 8/26/2024 with diagnosis including essential hypertension (high blood pressure not caused by another medical condition.) During a review of Resident 4's History and Physical (H&P - a record of a physician's comprehensive medical assessment and plan) dated 9/16/2025, the H&P indicated Resident 4 had a diagnosis of essential hypertension. During a review of Resident 4's current Order Summary Report (a report of all currently active physician's orders) dated 4/29/2026, the Order Summary Report indicated Resident 4 was taking amlodipine 5 milligrams (mg - a unit of measure for mass) by mouth one time a day for hypertension with hold parameters for systolic blood pressure (SBP - the top number of a blood pressure reading) less than 110 millimeters of mercury (mmHg - a unit of measure for blood pressure readings) and a heart rate (HR) less than 60 beats per minute. During a of the pharmacist's recommendation dated 2/23/2026, the pharmacist's recommendation indicated the pharmacist recommended to consult with the physician regarding removing the HR hold parameters from Resident 4's amlodipine as it was not routinely monitored for HR. Further review of the pharmacist's recommendation indicated there was no apparent physician or facility response to the recommendation regarding HR monitoring for Resident 4's amlodipine. During a of review Resident 4's clinical record indicated there was no apparent response from the physician or the facility concerning the pharmacist's recommendation to consider removing HR monitoring and hold parameters for Resident 4's amlodipine. During an interview on 4/29/2026 at 1:25 PM with the Director of Nursing (DON), the DON stated there was no apparent response to the pharmacist's recommendation from February 2026 to remove heart rate hold parameters from Resident 4's order for amlodipine. The DON stated failing to respond to the pharmacist recommendations could lead to adverse effects (a harmful, unintended result). The DON stated if Resident 4's amlodipine was held unnecessarily due to heart rate parameters, it could cause the blood pressure to be too high, increasing the risk of heart attacks or strokes. During a review of the facility's policy Medication Regimen Review (Monthly Report), dated June 2021, indicated .Recommendations are acted upon and documented by the facility staff and or the prescriber. Physician accepts and acts upon suggestion or rejects and provides and explanation for disagreeing by the next physician visit. |

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| F 0757<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure each resident?s drug regimen must be free from unnecessary drugs.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure two of five sampled residents (Resident 1 and 94) were free from unnecessary drugs (a medication that may be doing more harm than good or isn't needed for the resident's current condition) by failing to: 1. Limit the duration of treatment for Resident 1's metoclopramide (a medication used to treat nausea and vomiting) to 12 weeks or less as per Resident 1's care plan (a document containing a resident-specific plan of care for a resident's concerns or problems) for GERD, dated 2/8/26.2. Ensure Resident 94's blood pressure (BP-the force of your blood pushing against the walls of your arteries as the heart pumps it around the body) was monitored and documented prior to administering Resident 94's Midodrine (a medication used to treat hypotension [low blood pressure]) 5 mg by mouth in the morning every Monday, Wednesday and Friday for hypotension before dialysis and hold if systolic blood pressure (SBP: measures the maximum pressure in the arteries [blood vessel that transport blood away from the heart to the rest of the body] when the heart beats and contracts) more than 100 millimeters of mercury (mmHg). These deficient practices had the potential to result in Resident 1 and 94 receiving unnecessary medications. The failure to limit the duration of treatment with metoclopramide to 12 weeks or less increased the risk of Resident 1 developing movement disorders such as tardive dyskinesia (TD - a movement disorder characterized by repetitive involuntary movements such as lip-smacking, tongue protrusion, and facial grimacing) possibly leading to impairment or decline in her mental or physical condition or functional or psychosocial status. Administering Resident 94's Midodrine without proper monitoring and documentation of blood pressure had the potential to result in Resident 94's blood pressure to increase possibly leading to life-threatening damage including stroke (when a blood flow to a part of brain is stopped either by blockage or rupture of a blood vessel), heart attack (when blood flow to a part of the heart muscle gets blocked), and kidney issues.Findings:<br><br>During a review of Resident 1's admission Record dated 4/29/26, the admission Record indicated the resident was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including gastro-esophageal reflux disease (GERD – a medical condition characterized by chronic heartburn.)<br><br>During a review of Resident 1's History and Physical (H&P – a record of a physician's comprehensive medical assessment and plan) dated 1/23/26, the H&P confirmed Resident 1's diagnosis of GERD.<br><br>During a review of Resident 1's current Order Summary Report (a report of all currently active physician's orders), dated 4/29/26, the Order Summary Report indicated the resident was taking metoclopramide 5 milligrams (mg – a unit of measure for mass) by mouth 30 minutes before meals and at bedtime for nausea and vomiting.<br><br>During a review of Resident 1's physician orders for metoclopramide, dated between 3/27/25 and 1/22/26, the physician order indicated Resident 1 had been taking metoclopramide regularly since 3/27/25 (over one year continuously).<br><br>During a review of Resident 1's care plan for GERD, dated 2/8/26, the care plan indicated the use of metoclopramide was listed as a targeted intervention for GERD and nausea/vomiting. The care plan indicated that metoclopramide increased the risk of tardive dyskinesia which is often irreversible and treatment should be limited to 12 weeks or less.<br>(continued on next page) |

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| F 0757<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During a review of Resident 1's complete clinical record, the complete clinical record review indicated there was no specific provider-documented clinical rationale indicating the benefits of treatment with metoclopramide for longer than 12 weeks outweighed the risks.<br><br>During a review of Resident 1's Medication Administration Record (MAR – a record of medications administered, and monitoring documented for a resident) for April 2026, the MAR indicated the facility was not monitoring or documenting episodes of nausea and vomiting related to Resident 1's use of metoclopramide.<br><br>During an interview on 4/29/2026 at 10:14 AM, with the Director of Nursing (DON), the DON stated Resident 1 had been on metoclopramide for 13 months continuously. The DON stated that the facility was not monitoring Resident 1 for nausea and vomiting to determine whether the resident needed metoclopramide continuously. The DON stated per Resident 1's care plan, therapy with metoclopramide should have been limited to 12 weeks or less due to risk of developing tardive dyskinesia. The DON stated there was no evidence or clinical justification documented for continuing metoclopramide longer than 12 weeks in Resident 1's clinical record. The DON stated continuing the use of metoclopramide and failing to monitor nausea and vomiting increased the risk that Resident 1 could experience adverse effects of metoclopramide including movement disorders like tardive dyskinesia.<br><br>During a review of the facility's policy (P&P) titled Medication Utilization and Prescribing – Clinical Protocol, revised April 2018, the P&P indicated The physician will provide and/or document a rationale when the indication, dose, duration, or frequency of a prescribed medication is greater than commonly accepted practice or the manufacturer's recommendations or the medication is considered high-risk compared to other available, relevant alternatives. the physician will document a clinically pertinent rationale for not modifying a medication in a situation where an adverse drug reaction is likely. The staff and physician will periodically re-evaluate the conditions and symptoms for which each resident is receiving medication to determine if the medication and doses are still relevant and are not causing undesired complications.<br><br>2. During a review of Resident 94's admission Record, the admission Record indicated the facility originally admitted Resident 94 on 11/8/2025 and re-admitted the resident on 12/31/2025 with diagnoses including right hip wound, end stage renal failure (ESRD-a medical condition in which a person's kidney [organ in the body that filters waste and excess fluid from the blood] stop functioning on a permanent basis) and dependence on hemodialysis (HD-a life-sustaining treatment for kidney failure that acts as an artificial kidney, filtering waste, toxins and excess water from the person's body using a machine).<br><br>During a review of Resident 94's H&P dated 1/2/2026, the H&P indicated Resident 94 had the capacity to make medical decisions (a person's ability to make their own medical decisions changes based on the complexity of the decision and their current mental state).<br><br>During a review of Resident 94's physician order dated 1/2/2026. The physician order indicated Resident 94 had an order for midodrine 5 mg by mouth one time a day every Monday, Wednesday and Friday for hypotension before dialysis and was discontinued on 2/22/2026.<br><br>During review of Resident 94's Minimum Data Set (MDS - a standardized assessment tool), dated 2/10/2026, the MDS indicated Resident 94 had intact cognition (mental action or process of acquiring knowledge and understanding).<br>(continued on next page) |

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| F 0757<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During a review of Resident 94's Order Summary Report (OSR) dated 2/22/2026, the OSR indicated Resident 94 had a physician order for midodrine 5 mg by mouth in the morning every Monday, Wednesday and Friday for hypotension before dialysis and hold if systolic blood pressure more than 100 mmHg.<br><br>During a review of Resident 94's Medication Administration Record (MAR), dated between 1/1/2026 to 1/31/2026, the MAR indicated missing blood pressure monitoring and documentation of blood pressure for midodrine 5 mg by mouth one time a day every Monday, Wednesday and Friday for hypotension before dialysis on the following days: 1/5/2026, 1/12/2026, 1/14/2026, 1/16/2026, 1/19/2026, 1/21/2026, 1/23/2026, 1/28/2026, and 1/30/2026.<br><br>During a review of Resident 94's MAR dated between 2/1/2026 to 2/22/2026, the MAR indicated missing blood pressure monitoring and documentation of blood pressure for midodrine 5 mg by mouth one time a day every Monday, Wednesday and Friday for hypotension before dialysis on the following days: 2/4/2026, 2/6/2026, 2/9/2026, 2/11/2026, 2/16/2026, 2/18/2026, and 2/20/2026.<br><br>During a review of Resident 94's MAR, dated between 2/22/2026 to 2/28/2026, the MAR indicated missing blood pressure monitoring and documentation of blood pressure for midodrine 5 mg by mouth in the morning every Monday, Wednesday and Friday for hypotension before dialysis and hold if SBP was more than 100 mmHg on the following days: 2/23/2026 and 2/27/2026.<br><br>During a review of Resident 94's MAR dated between 3/1/2026 to 3/31/2026, the MAR indicated missing blood pressure monitoring and documentation of blood pressure for midodrine 5 mg by mouth in the morning every Monday, Wednesday and Friday for hypotension before dialysis and hold if SBP was more than 100 mmHg on the following days: 3/4/2026 and 3/6/2026.<br><br>During an interview with the Licensed Vocational Nurse 5 (LVN 5) on 4/30/2026 at 9:53 AM, LVN 5 stated that it was important to check and monitor Resident 94's blood pressure before administering midodrine to Resident 94 since nurses had to hold the midodrine for SBP more than 100mmHg due to possibility of high blood pressure.<br><br>During an interview on 4/30/2026 at 11:51 AM, with the Director of Nursing (DON), the DON stated that when administering midodrine, the charge nurses should check, monitor and document resident's blood pressure prior to giving midodrine and follow physician order. The DON stated that administering midodrine without monitoring and documenting blood pressure was inappropriate since it could cause high blood pressure.<br><br>During a review of the facility's P&P titled, Administering Medications, reviewed on 12/18/2025, the P&P indicated that the facility would administer medications in a safe and timely manner, and as prescribed. The P&P indicated that vital signs were one of the following types of information that was to be checked/verified for each resident prior to administering medications.<br><br>During a review of the facility's P&P titled, Specific Medication Administration Procedures, reviewed on 12/18/2025, the P&P indicated that the facility would administer medications in a safe and effective manner. The P&P indicated that the facility would obtain and record any vital signs as necessary for the type of medication prior to medication administration. |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to remove one expired fluticasone/salmeterol (a medication used to treat breathing problems) inhaler from the medication cart affecting Resident 6 in one of two inspected medication carts (Medication Cart 3.) The deficient practice of failing to remove expired products from the medication cart increased the risk that Resident 6 could have received medication that had become ineffective or toxic due to improper storage possibly leading to health complications resulting in hospitalization or death.Findings:During a concurrent observation and interview on [DATE] at 11:48 AM of Medication Cart 3 with Licensed Vocational Nurse 2 (LVN 2), the following medications were found either expired, stored in a manner contrary to their respective manufacturer's requirements, or not labeled with an open date as required by their respective manufacturer's specifications:One open fluticasone/salmeterol inhaler for Resident 6 labeled with an open date of [DATE]A review of the product labeling indicated opened fluticasone/salmeterol inhalers should be used or discarded within one month of opening. During a concurrent interview on [DATE] at 11:48 AM with LVN 2, LVN 2 stated the fluticasone/salmeterol inhaler for Resident 6 was expired as it had been open for longer than one month. LVN 2 stated failing to remove expired inhalers from the medication cart increased the risk that the inhaler might not work as well as intended for Resident 6's breathing problems possibly leading to hospitalization or death. During a review of the facility's policy Storage of Medications, revised [DATE], the Storage of Medication policy indicated Medications and biologicals are stored safely, securely, and properly, following manufacturer's recommendations or those of the supplier. Outdated, contaminated, or deteriorated medications. are immediately removed from stock, disposed of according to procedures for medications disposal, and reordered form the pharmacy if a current order exists. |

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| F 0805<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs.<br><br>Based on observation, interview and record review, the facility failed to ensure the minced and moist texture green bean was prepared according to the International Dysphagia Diet Standardization Initiative (IDDSI: standardized framework (0-7 levels) that uses consistent terminology, colors, and testing methods to define texture-modified foods and thickened liquids for people with swallowing difficulties [dysphagia] Level Five minced and moist foods - (All foods prepared for this diet must be soft, moist with all excess fluid drained, and minced to size no larger than 4mm fits through the gaps of fork prongs). This deficient practice had the potential to result in meal dissatisfaction, decreased nutritional intake and increase choking risk for residents receiving a minced and moist diet due to food textures not prepared in accordance with IDDSI Level 5 requirements. Findings: During an observation in the kitchen on 4/27/2026 at 12:00PM, a meal tray preparation for a minced and moist diet was observed, cook 1 removed a portion of the lasagna and chopped the lasagna into small and Mashable pieces using a flat square end lasagna cutting and serving utensil. Cook1 then served green beans prepared soft and bite size (1/2 inch x 1/2 inch size pieces). During a review of the tray card (including resident diet order, and food preferences) for lunch service on 4/27/2026, the tray card indicated a Cardiac (low fat, low cholesterol, 3 grams sodium) Diet, Minced and Moist texture and moderately thickened liquid consistency. During a review of the facility Menu and Spreadsheet for lunch (spreadsheet-menu extension, lists food portions and serving guide) on 4/27/2026, the menu indicated for Cardiac Diet Minced and Moist (MM) serve: MM Lasagna; MM green beans 1/2 cup; Pureed Garlic Bread, Pureed Frosted Cupcake and beverage. During a concurrent observation of the minced and moist meal tray and interview with cook1 on 4/27/2026 at 12:15PM, cook1 stated minced and moist diets had to be very soft and small, almost the size of a grain of rice. Cook1 said the food had to fit between the fork gaps. Cook1 said minced and moist lasagna and green beans were not prepared to be minced and moist and [NAME] 1 had to mash the lasagna on the plate. Cook1 said the lasagna was soft, but there were some pieces that were not very small. Cook1 said the green beans were not small and didn't fit through the fork gaps. Cook1 said the green bean that was served was not adequate for minced and moist diet because there were some pieces that were large. During an observation of the minced and moist meal tray and interview with regional Registered Dietitian (RD1) and Dietary Supervisor (DS) on 4/27/2026, RD1 stated the green beans were not minced there were large pieces. RD1 stated cook 1 should have prepared the minced moist texture food in advance to make sure the texture was correct. The DS stated the green beans were not minced and moist and could cause swallowing problems for the residents who were on the minced and moist diet. During a review of the facility's recipe titled Seas [NAME] Beans Method (dated Spring 2026) the recipe indicated, MM5: Mince regular cooked portions, with no separate thin liquid prior to service. (4mm x 4mm. Approximately 1/8th inches) Use slot between fork prongs to determine whether minced pieces are correct size. Reheat to 165degrees Fahrenheit. During a review of the facility's Policy and Procedure (p & p) titled, Therapeutic Diets (revised 10/2022), the p & p indicated, All residents have a diet order, including regular, therapeutic, and texture modification, that is prescribed by the attending physician.Therapeutic diet is defined as a diet ordered by a physician, or delegated registered or licensed dietitian, as part of the treatment for a disease or clinical condition. The purpose of a therapeutic diet is .to provide food that a resident is able to eat (e.g. mechanically altered diet), Mechanically altered diet means one in which the texture of the diet is altered, when the texture is modified, the type of texture must be specific and part of the physicians' or delegated registered or licensed dietitians order. During a review of facility's job description titled Healthcare Services Group, Inc Job Description Title: Cook (no date) the jobs description indicated, The [NAME] prepares and serves food including texture modified and therapeutic diets according to the facility menu. Job Functions: 1) Pre-preparation, Review menus prior to preparation of food. 2)Food<br>(continued on next page) |

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| F 0805<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | preparation/Delivery, prepares food for meals, including modified textures for restricted and therapeutic diets, Inspects special diet trays to ensure that the correct diet is served to the resident; adhere to menus and portion control standards, including those for special diets when preparing and serving meals. During a review of the IDDSI guideline website titled IDDSI, dated 7/2019, the IDSSI guideline indicated that Level 5 Minced and Moist is usually eaten with spoon or fork, for people who cannot bite off pieces of food safely but have some basic chewing ability. It is important that food is not sticky. You should be able to scoop food onto a fork, with no liquid dripping and no crumbles falling off the fork. Size of the food is 4mm, which is about the gap between the prongs of a standard dinner fork. Food testing method: Spoon tilt test and Fork drip test. |

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| F 0806<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide food that accommodated resident preferences for two of four sampled residents (Resident 68 and Resident 72) by failing to: -Provide Resident 68 with food that did not contain beef. -Review and update Resident 72's food preferences quarterly (three-monthly).-Provide Resident 72 with a vegetarian diet (excludes meat, poultry, and fish, often focusing on plant-based foods like vegetables, fruits, whole grains, beans, and nuts). These failures resulted in Resident 68 and 72 not having their food preferences honored by the facility, which had the potential for Resident 68 and Resident 72 to experience weight loss due to not liking or eating the food provided by the facility.Findings:<br><br>1.During a review of Resident 68's admission Record, the admission Record indicated the facility originally admitted Resident 68 on 6/21/2023 and readmitted Resident 68 on 11/6/2023 with diagnoses that included other seizures (a sudden, uncontrolled electrical disturbance in the brain which can cause uncontrolled jerking, blank stares, and loss of consciousness), monoplegia of upper limb following cerebral infarction affecting right dominant side (permanent paralysis, weakness, or loss of voluntary movement in their right arm/hand due to a stroke), muscle weakness, hyperlipidemia (having too many fats, such as cholesterol and triglycerides, in the blood), anemia (a condition where the body does not have enough healthy red blood cells), gastro-esophageal reflux without esophagitis (a condition where you experience chronic acid reflux symptoms (heartburn, regurgitation) without any visible damage, burns, or inflammation in your esophagus, the hollow, muscular tube that carries food and liquid from your throat down to your stomach) and muscle weakness.<br><br>During a review of Resident 68's History and Physical (H&P) dated 6/23/2025, the H&P indicated Resident 68 had the capacity to make medical decisions.<br><br>During a review of Resident 68's Minimum Data Set (MDS – a resident assessment tool) dated 3/20/2026, the MDS indicated Resident 68 usually could make himself understood and usually had the ability to understand others.<br><br>During a review of Resident 68's Dietary Profile dated 4/16/2026, the Dietary Profile indicated Resident 68's dislikes were beef and pork.<br><br>During an interview on 4/27/2026 at 12:07 PM with Resident 68, Resident 68 stated he (Resident 68) did not want to eat red meat. Resident 68 stated he (Resident 68) had told the facility of his preference not to eat red meat but stated the facility continued to give him red meat.<br><br>During a review of Resident 68's Order Summary Report, dated 4/29/2026, the Order Summary Report indicated a physician order for Resident 68 to receive a regular diet with regular texture, thin consistency (eating normal, everyday foods without any restrictions on size or hardness, along with drinking normal liquids like water, coffee, or milk that have not been thickened), no bread slice/roll with meals, NF (non-fat) milk when offered, NS (no salt) packet for diet.<br><br>During a concurrent interview and record review on 4/30/2026 at 10:10 AM with the Dietary Supervisor (DS), Resident 68's noon tray card (a simple, personalized label used in nursing homes that tells staff exactly what food to put on a resident's tray that ensures the resident receives the correct meal based on their specific, doctor-ordered diet, food allergies, and preferences, acting as a (continued on next page) |

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| F 0806<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | final check to prevent errors) dated 4/27/2026 and lasagna recipe dated Spring 2026 was reviewed. The noon tray card indicated Resident 68 did not like beef. The lasagna recipe indicated it contained ground beef. The DS stated the lasagna was made with ground beef and stated Resident 68 received ground beef when he (Resident 68) did not want it (beef). The DS stated Resident 68's likes and dislikes should be honored. The DS stated if the residents' (in general) preferences are not honored there is a potential for the residents' (in general) not to like the food, not eat, and experience weight loss.<br><br>During a concurrent interview and record review on 4/20/2026 at 1:52 PM with the Director of Nursing, Resident 68's tray card dated 4/27/2026 and lasagna recipe dated Spring 2026 was reviewed. The DON verified Resident 68 was served lasagna and verified the lasagna had ground beef. The DON stated the facility should have honored Resident 68's food preferences.<br><br>During a review of the facility's policy and procedure (P&P) titled, Resident Food Preferences, last reviewed 12/18/2025 was reviewed. The P&P indicated The Dietary Manager will complete a Dietary Profile for residents to reflect current food preferences and nutritional needs upon admission, readmission, quarterly, annually or as needed. The P&P indicated The Dietary Department will provide residents with meals consistent with their preferences, as indicated on their tray card.<br><br>2.During a review of Resident 72's admission Record, the admission Record indicated the facility admitted the resident on 3/12/2025 with diagnoses that included type 2 diabetes (DM, a disorder characterized by difficulty in blood sugar control and poor wound healing), protein-calorie malnutrition (inadequate intake of protein and calories), cirrhosis of the liver (a severely scarred and permanently damaged liver), hyperlipidemia (high levels of cholesterol in the blood), hypertensive heart disease (heart damage caused by long term high blood pressure), and dysphagia (difficulty swallowing).<br><br>During a review of Resident 72's Dietary Profile dated 3/25/2025, the Dietary Profile indicated the resident disliked chicken, beef, pork, turkey, and fish.<br><br>During a review of Resident 72's MDS dated [DATE], the MDS indicated the resident was cognitively intact (had the ability to think, understand, and reason). The MDS indicated Resident 72 was independent with eating. The MDS indicated Resident 72 was on a therapeutic diet (a meal plan that controls the intake of certain foods or nutrients).<br><br>During a review of Resident 72's Order Summary Report dated 4/30/2026, the Order Summary Report indicated the resident had a physician order for a Cardiac diet (a diet that restricts salt, saturated fat, and added sugars to manage heart health) with regular texture (diet that does not require any modifications in size) and thin consistency (liquids that flow freely like water, such as milk, coffee, tea, and juice).<br><br>During an interview on 4/27/2026 at 10:07 AM with Resident 72, Resident 72 stated she (Resident 72) was a vegetarian. Resident 72 stated she (Resident 72) would buy her own food because the facility did not accommodate her diet.<br><br>During a concurrent observation and interview on 4/27/2026 at 12:45 PM in Resident 72's room, the resident was observed eating food from a container with a label. Resident 72 stated the food came from a supermarket. Resident 72 stated she (Resident 72) was eating yogurt and an avocado sandwich. Resident 72 stated she (Resident 72) had been buying her food for six months. Resident 72 (continued on next page) |

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| F 0806<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | stated she (Resident 72) refused meal trays from the facility's kitchen because she (Resident 72) could not eat the food. Resident 72 stated the meals from the facility's kitchen always contained meat. Resident 72 stated she (Resident 72) had told the Dietary Supervisor (DS) about being vegetarian, but nothing was done about it.<br><br>During a concurrent observation and interview on 4/27/2026 at 12:51 PM with Certified Nursing Assistant 3 (CNA 3), Resident 72's lunch meal tray was observed. CNA 3 stated Resident 72's lunch tray card (a document placed on a resident's food tray to ensure the resident receives the correct meal based on their dietary needs, allergies, and preferences) indicated the Resident was on a regular diet with a regular texture and thin consistency. CNA 3 stated the meal tray card did not indicate Resident 72 had any dislikes. CNA 3 stated Resident 72's lunch tray had lasagna with meat. CNA 3 stated she (CNA3) did not take the lunch tray to Resident 72 because the resident (Resident 72) refused the meal. CNA 3 stated she (CNA3) did not know why Resident 72 refused meal trays. CNA 3 stated Resident 72 bought her own food.<br><br>During a concurrent interview and record review on 4/30/2026 at 10:02 AM with the Dietary Supervisor (DS), Resident 72's Dietary Profile dated 3/25/2025, physician diet order, and lunch tray card dated 4/27/2026 were reviewed. The DS stated she (the DS) was responsible for checking resident food preferences. The DS stated resident food preferences were checked on admission, quarterly and annually. The DS stated she (the DS) asked the residents (in general) about their likes, dislikes, and allergies when checking food preferences. The DS stated a resident's food preferences were documented on the resident's Dietary Profile. The DS stated Resident 72's last Dietary Profile was completed on 3/24/2025. The DS stated Resident 72's Dietary Profile indicated the resident disliked beef, pork, turkey, chicken, and fish. The DS stated Resident 72's Dietary Profile should have been completed and updated quarterly. The DS stated it had been a year since Resident 72's likes and dislikes had been reviewed. The DS stated she (the DS) must have missed that Resident 72's Dietary Profile was due to be completed. The DS stated Resident 72's lunch tray card dated 4/27/2026 did not indicate what Resident 72's dislikes were. The DS stated Resident 72's physician diet order did not indicate the resident was vegetarian. The DS stated Resident 72 received lasagna for lunch on 4/27/2026 which had ground beef and ground turkey. The DS stated Resident 72 received meat as part of lunch on 4/27/2026 but should not have because the resident was vegetarian and did not like meat. The DS stated if Resident 72's food preferences were not honored there was potential for the resident not to eat and experience weight loss. The DS stated the facility's kitchen did not have a vegetarian menu, but could offer Resident 72 alternatives such as a quesadilla, grilled cheese, or a fruit plate.<br><br>During a concurrent interview and record review on 4/30/2026 at 11:14 AM with the Director of Nursing (DON), Resident 72's Dietary Profile dated 3/25/2025, physician diet order, and lunch tray card dated 4/27/2026 were reviewed. The DON stated that according to Resident 72's Dietary Profile dated 3/24/2025, the resident was vegetarian and did not like meat. The DON stated Resident 72's food preferences were not honored when the resident received lunch that had lasagna with meat on 4/27/2026. The DON stated there was potential for Resident 72 to not eat because she (Resident 72) did not like the food from the kitchen. The DON stated there was potential for Resident 72 to have weight loss.<br><br>During a review of the facility's Job Description (JD) titled Certified Dietary Manager dated 7/2024, the JD indicated the primary purpose of this position is to plan, organize, develop an direct the operations of the food and nutrition services department in accordance with current federal, state and local standards, guidelines and regulations and as directed by the Administrator.Duties and<br>(continued on next page) |

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| F 0806<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Responsibilities.Visit residents periodically to evaluate the quality of meals served, likes and dislikes, etc.<br><br>During a review of the facility's Policy and Procedure (P&P) titled Resident Food Preferences dated 12/18/2025, the P&P indicated The Dietary Manager will complete a Dietary Profile for residents to reflect current food preferences and nutritional needs upon admission, readmission, quarterly, annually, or as needed. The Dietary Manager will meet with the resident within 72 hours of admission or readmission, quarterly, and annually to review the following: Responsibilities of the Dietary Department; The attending physician's diet order; The schedule of mealtimes; Discuss the resident's food preferences/allergies if applicable; The weekly menu and location of the posted menu. The Dietary Department will provide residents with meals consistent with their preferences, as indicated on their tray card. If a preferred item is not available, a suitable substitute should be provided. |

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| F 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to maintain accurate and complete medical records for one of five sampled residents (Resident 94) by failing to ensure the electronic medication administration record (MAR) for Resident 94's midodrine (a medication used to treat hypotension [low blood pressure]) indicated if the medication was administered or held on 2/13/2026 and 2/25/2026. This deficient practice placed Resident 94 at risk of not receiving appropriate care due to inaccurate medical care information and the potential to result in confusion in the care and services provided to Resident 94. Findings: During a review of Resident 94's admission Record, the admission Record indicated the facility originally admitted Resident 94 on 11/8/2025 and was re-admitted on [DATE] with diagnoses including right hip wound, end stage renal failure (ESRD-a medical condition in which a person's kidney [organ in the body that filters waste and excess fluid from the blood] stop functioning on a permanent basis) and dependence on hemodialysis (HD-a life-sustaining treatment for kidney failure that acts as an artificial kidney, filtering waste, toxins and excess water from the person's body using a machine). During a review of Resident 94's History and Physical (H&P- a record of a physician's comprehensive medical assessment and plan), dated 1/2/2026, the H&P indicated Resident 94 had the capacity to make medical decisions. During review of Resident 94's Minimum Data Set (MDS - a resident assessment tool), dated 2/10/2026, the MDS indicated Resident 94 had intact cognition (mental action or process of acquiring knowledge and understanding) for daily decision-making and with varying assistance from being independent to maximal (helper does more than half the effort) assistance from staff for activities of daily living (ADLs-bed mobility, surface transfer, eating, walk in room, dressing, toileting, and personal hygiene). During a review of Resident 94's previous physician order, dated 1/2/2026. The physician order indicated Resident 94 had a physician order for midodrine 5 mg by mouth one time a day every Monday, Wednesday and Friday for hypotension before dialysis that was discontinued on 2/22/2026. During a review of Resident 94's Order Summary Report (OSR), dated 2/22/2026, the OSR indicated Resident 94 had a physician order for midodrine 5 mg by mouth in the morning every Monday, Wednesday and Friday for hypotension before dialysis and hold if systolic blood pressure (SBP-top number in a blood pressure reading, measuring the maximum pressure in the arteries [blood vessel that transport blood away from the heart to the rest of the body] when the heart beats and contracts) more than 100 millimeters of mercury (mmHg). During a concurrent interview and record review on 4/30/2026 at 9:53 AM with Licensed Vocational Nurse 5 (LVN 5), Resident 94's MAR dated between 2/1/2026 to 2/22/2026 was reviewed. Resident 94's MAR indicated missing documentation (blank) for midodrine 5 mg by mouth one time a day every Monday, Wednesday and Friday for hypotension before dialysis on 2/13/2026. Resident 94's MAR, dated between 2/22/2026 to 2/28/2026 was also reviewed and indicated missing documentation (blank) for midodrine 5 mg by mouth in the morning every Monday, Wednesday and Friday for hypotension before dialysis and hold if SBP was more than 100 mmHg on 2/25/2026. LVN 5 stated and verified there was no documentation on Resident 94'a MAR on 2/13/2026 and 2/25/2026 indicating if the midodrine was administered or held. LVN 5 stated the nurse should have documented if the midodrine was administered or not. LVN 5 stated that if the midodrine was not administered, nurses were supposed to document the reason for not administering the midodrine. During an interview on 4/30/2026 at 11:51 AM, with the Director of Nursing (DON), the DON stated it was important for nurses to document on the MAR whether the nurse's administered medication or not. The DON stated that if the nurse did not administer medication, the nurse had to document the reason why medication was not administered. The DON stated proper documentation ensured safe tracking of medication provided to the residents. During a review of the facility's policy and procedure (P&P) titled, Medication Administration-General Guidelines reviewed on 12/18/2025, the P&P indicated under<br>(continued on next page) |

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| F 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | documentation that the individual who administered the medication dose was to record the administration on the resident's MAR directly after the medication was given. The P&P indicated at the end of each medication pass, the person administering the medications was to review the MAR to ensure necessary doses were administered and documented. The P&P indicated in no case should the individual who administered the medication report off duty without first recording the administration of any medications. The P&P indicated that if a dose of regularly scheduled medication was withheld, refused, or given at other than the scheduled time (e.g. the resident is not in the facility at scheduled dose time, or a starter dose of antibiotic is needed), the space provided on the front of the MAR for that dosage administration was to be initialed and circled and an explanatory note had to be entered. |

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| F 0883<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Develop and implement policies and procedures for flu and pneumonia vaccinations.<br><br>Based on interview and record review, the facility failed to implement and maintain an effective infection prevention and control program for one of eight residents (Resident 76) sampled for immunizations, by failing to: 1. Ensure Resident 76 was assessed for and offered the influenza (Flu-common viral infection that can be deadly, especially in high-risk groups) vaccine, including documentation of administration and/or refusal, in accordance with facility policy and procedures (P&P) titled Influenza Vaccine reviewed by the facility on 12/18/2025 and current standards of practice. 2.Ensure Resident 76 was assessed for and offered the pneumococcal (Pneumonia [PNA]-infection that inflames air sacs in one or both lungs which may fill with fluid) vaccine, including documentation of administration and/or refusal, in accordance with facility policy and procedures (P&P) titled Pneumococcal Vaccine reviewed by the facility on 12/18/2025 and current standards of practice. These deficient practices placed Resident 76 at a higher risk of acquiring and transmitting vaccine-preventable respiratory infections, including influenza and pneumonia, to other residents, visitors and staff within the facility.Findings: During a review of Resident 76's admission Record, the admission Record indicated the facility admitted Resident 76 on 11/8/2025 with diagnoses including left radius fracture (a break, crack or crush injury of the forearm bone), heart failure (chronic condition where the heart muscle becomes too weak or stiff to pump blood efficiently) and pleural effusion ( water on the lungs, excess buildup of fluid between the thin membranes lining the lungs and chest cavity). During a review of Resident 76's vaccine consent form, dated 11/10/2026, the vaccine consent form indicated Resident 76 consented to receive both flu and PNA vaccines. During a review of Resident 76's vaccine consent form, dated 11/13/2026, vaccine consent form indicated Resident 76 consented to receive both flu and PNA vaccines. During a review of Resident 76's Order Summary Report (OSR), dated 12/4/2025, the OSR indicated Resident 76 had a physician order for Fluzone (type of flu vaccine) 0.7 milliliter (ml) intramuscular (IM-injection administration of medication deep into the muscle) as needed for vaccination yearly. During a review of Resident 76's OSR, dated 12/4/2025, the OSR indicated Resident 76 had a physician order for Pneumococcal 13 (type of PNA vaccine) vaccine 0.5 ml IM as needed for vaccination. During a review of Resident 76's History and Physical (H&P- a record of a physician's comprehensive medical assessment and plan), dated 12/10/2025, the H&P indicated Resident 76 was alert and oriented to name, place, time and situation. During review of Resident 76's Minimum Data Set (MDS - a resident assessment tool), dated 2/12/2026, the MDS indicated Resident 76 had intact cognition (mental action or process of acquiring knowledge and understanding) for daily decision-making and varied with assistance needs from staff from being independent to supervision (helper provides verbal cues and/or touching/steadying and/or contact guard assistance) for activities of daily living (ADLs-bed mobility, surface transfer, eating, walk in room, dressing, toileting, and personal hygiene). During a concurrent interview and record review on 4/30/2026 at 1:30 PM with the Infection Preventionist Nurse (IPN), Resident 76's immunization record was reviewed via CAIR (California Immunization Registry: secure web-based system that stores immunization records for children and adults in California) as of 4/30/2026. Resident 76's immunization record indicated last flu vaccine was received on 11/4/2024 with recommendation for a flu vaccine. Resident 76's immunization record also indicated PNA vaccine was received on 7/18/2014 with recommendation for the second dose of PNA vaccine. IPN stated the facility was able to get flu and PNA vaccines from the pharmacy with no issues. IPN stated Resident 76 refused on 1/13/2026 when re-offered for flu and PNA vaccines. During an interview on 4/30/2026 at 11:51 AM, with the Director of Nursing (DON), the DON stated that Resident 76 should have received flu and PNA vaccines as soon as consent was received by Resident 76. The DON also stated that Resident 76 was at risk for flu and PNA infections. During a review of the facility's P&P titled, Influenza Vaccine, reviewed by the facility on 12/18/2025, the P&P indicated the facility was to offer flu vaccines to the residents annually between October 1st to<br>(continued on next page) |

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| F 0883<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | March 31st. During a review of facility's P&P, titled, Pneumococcal Vaccine, reviewed by the facility on 12/18/2025, the P&P indicated that all residents were to be offered pneumococcal vaccines to aid in preventing PNA infections. |

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| F 0917<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Make sure each resident has 1) at least one window to the outside in a room; 2) a room at or above ground level; 3) adequate bedding; 4) furniture that meets the resident's needs; or 5) adequate closet space.<br><br>Based on observation, interview, and record review, the facility failed to ensure accessible and adequate private closet space for one of one residents (Resident 88) reviewed for dignity and resident rights. By failing to ensure facility staff did not store pillows in Resident 88's assigned closet space. This deficient practice prevented Resident 88 from storing personal belongings in the closet and had the potential to cause Resident 88 emotional distress, loss of dignity, and compromised privacy.Findings: During a review of Resident's 88 admission Record, the admission Record indicated the facility readmitted the resident on 2/9/2026, with diagnoses that included cerebral infarction (stroke, loss of blood flow to a part of the brain), epilepsy (brain disorder that causes recurring seizures), and dysphagia (difficulty swallowing). During a review of Resident 88's Minimum Data Set (MDS, a standardized assessment tool), dated 3/27/2026, the MDS indicated the resident was dependent on facility staff to complete activities of daily living (ADLs, activities a person performs daily such as bathing, dressing, and toileting). During a review of Resident 88's History and Physical (H&P), dated 2/12/2026, the H&P indicated the resident had the capacity to make medical decisions. During a review of Resident 88's care plan report titled At risk for pest and infection control issues related to keeping multiple items on bedside table, including food/drinks revised on 1/15/2025, the care plan indicated a goal of Resident's rights will be honored and respected. During an interview on 4/27/2026 at 10:17 AM, Resident 88 stated he wanted his own closet and did not want to share a closet with his roommate. Resident 88 stated he wanted his own space to put his belongings instead of having his stuff scattered around the room. During a concurrent observation and interview on 4/27/2026 at 10:20 AM with Certified Nursing Assistant (CNA) 9 in Resident 88's room, Resident 88's backpack was observed on the floor and clothing items were piled up on a chair in the back corner of the room. Multiple pillows and two sweaters were observed on a hanger in Resident 88's closet. CNA 9 stated there was not enough room for Resident 88's personal belongings in the closet because the pillows took up most of the space. During an interview on 4/28/2026 at 9:30 AM with the Housekeeping Manager (HKM), HKM stated it was not appropriate to store facility pillows in residents' closets. HKM stated residents' closets were used to store residents' personal belongings and not facility supplies. During an interview on 4/28/2026 at 9:40 AM with Licensed Vocational Nurse (LVN) 1, LVN 1 stated residents had a right to their property and right to private closet space. LVN 1 stated Resident 88's rights were not respected because the pillows took up all the space in the closet and caused Resident 88 to not have space to store anything. During a concurrent interview and record review on 4/30/2026 at 10:30 AM with the Director of Nursing (DON), the facility's policy and procedure (P&P) titled, Resident Rights, revised in December 2025 was reviewed. The P&P indicated, Retain and use personal possessions to the maximum extended space and safety permit. The DON stated resident belongings were to be stored in their own assigned closet or alternative storage furniture. The DON said the P&P was not followed because Resident 88's had insufficient closet space for personal belongings. During a review of the facility's P&P titled, Dignity, revised on October 2025, the P&P indicated, Residents' private space and property are respected at all times. |

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| F 0919<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Make sure that a working call system is available in each resident's bathroom and bathing area.<br><br>Based on observation, interview, and record review the facility failed to ensure the call light (a device used by a resident to signal his or her need for assistance) was within reach for one of four sampled residents (Resident 51). This failure resulted in Resident 51's call light resting on the floor, out of Resident 51's reach and had the potential to result in staff delay in meeting Resident 23's needs.Findings:During a review of Resident 51's admission Record, the admission Record indicated the facility admitted Resident 51 on 7/6/2022 with diagnoses that included benign neoplasm of meninges, unspecified (a slow-growing, typically noncancerous tumor arising from the protective membranes covering the brain and spinal cord), altered mental status unspecified (a person is not acting like their normal self mentally, but the specific cause isn't yet known), generalized muscle weakness, difficulty walking, lack of coordination, and adult failure to thrive (a decline caused by chronic diseases and functional impairments which can cause weight loss, decreased appetite, poor nutrition, and inactivity). During a review of Resident 51's History and Physical (H&P) dated 6/17/2025, the H&P indicated Resident 51 did not have the capacity (ability) to understand and make decisions. During a review of Resident 51's Minimum Data Set (MDS - a resident assessment tool, dated 3/24/2026, the MDS indicated Resident 51 sometimes had the ability to make herself (Resident 51) understood and sometimes had the ability to understand others. The MDS indicated Resident 51 needed supervision or touching assistance (helper provides verbal cues and/or touch/steadying and/or contact guard [medical safety technique where a caregiver keeps their hands on a person usually via a gait belt or a light touch on the shoulder/hip to provide stability] assistance as the resident completes the activity). During a concurrent observation and interview on 4/27/2026 at 11:04 AM with Certified Nursing Assistant 4 (CNA 4) in Resident 51's room, Resident 51's call light was observed on the floor. CNA 4 stated the call light should not be on the floor. During an interview on 4/27/2026 at 11:08 AM with CNA 5, CNA 5 stated Resident 51's call light should not be on the floor. During an interview on 4/27/2026 at 11:28 AM with Registered Nurse 1 (RN 1), RN 1 stated if Resident 51's call light was on the floor, Resident 51 would not be able to call staff. RN 1 stated the call light on the floor could pose an infection control issue. During an interview on 4/30/2026 at 1:21 PM with the Director of Nursing (DON), the DON stated if the call light was on the floor, Resident 51 could not be able to call for help. The DON stated if a resident (in general) did not have the cognitive ability (your brain's overall power to think, learn, remember, and solve problems) to call for help, the facility would round (check on) the residents (in general) every two hours. The DON stated the facility staff (in general) would round on residents (in general) more often if the residents were cognitively impaired (the brain isn't processing information as well as it used to, making everyday tasks, decision-making, or communication difficult). The DON stated Resident 51 was cognitively impaired. The DON stated she (DON) did not have a rounding log (checklist used by nursing staff to document that they have proactively checked on a resident) for Resident 51. The DON stated the staff would need to clean the call light and clip it to prevent the call light from falling to the floor. During a concurrent interview and record review on 4/30/2026 at 1:21 PM with the DON, the facility's policy and procedure (P&P) titled, Call System, Resident, last reviewed on 12/18/2025, was reviewed. The DON stated the P&P indicated Residents are provided with a means to call staff for assistance through a communication system that directly calls a staff member or a centralized workstation. The DON stated the facility did not follow their call light policy. |

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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 0912<br><br>Level of Harm - Potential for minimal harm<br><br>Residents Affected - Some | Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure 14 of 33 residents' rooms (room [ROOM NUMBER], room [ROOM NUMBER], room [ROOM NUMBER], room [ROOM NUMBER], room [ROOM NUMBER], room [ROOM NUMBER], room [ROOM NUMBER], room [ROOM NUMBER], room [ROOM NUMBER], room [ROOM NUMBER], room [ROOM NUMBER], room [ROOM NUMBER], and room [ROOM NUMBER]) met the space requirements of 80 square feet (sq ft - a unit of area measuring the total space inside a room) for each resident in a room with multiple beds. This failure had the potential to result in inadequate (not enough) space to provide safe nursing care and privacy for the impacted residents (unidentified).Findings:During a review of the facility's room waiver request untitled letter dated 4/29/2026, the untitled room waiver request letter indicated the Administrator (ADM) requested for a room waiver for room [ROOM NUMBER], room [ROOM NUMBER], room [ROOM NUMBER], room [ROOM NUMBER], room [ROOM NUMBER], 1 room [ROOM NUMBER], room [ROOM NUMBER], room [ROOM NUMBER], room [ROOM NUMBER], room [ROOM NUMBER], room [ROOM NUMBER], room [ROOM NUMBER], room [ROOM NUMBER], room [ROOM NUMBER], and room [ROOM NUMBER]. The untitled room waiver request letter indicated each room listed on the Client Accommodation Analysis form (identifies the approved use of individual rooms and approved capacities) had no projections or other obstructions that would interfere with the free movement of wheelchairs and/or sitting devices. The untitled room waiver request letter indicated there was enough space to provide for each resident's care, dignity, and privacy, and the rooms were in accordance with the special needs of the residents and would not have an adverse (negative) effect on the residents' health and safety or impede (slow down or block) the ability of any residents in these rooms to attain his or her highest practical well-being. The untitled room waiver request letter indicated all measures would be taken to ensure the comfort of each resident and the granting of this variance would not adversely affect the residents' health and safety and would be in accordance with any special needs of each resident. During an interview on 4/29/2026 at 9:06 AM with Certified Nursing Assistant 1 (CNA 1), CNA 1 stated she (CNA 1) felt there was enough room to perform her work in room [ROOM NUMBER]. During an interview on 4/29/2026 at 9:11 AM with Resident 73 inside room [ROOM NUMBER], Resident 73 stated there was enough room to move around and perform activities. Resident 73 stated there were no issues with the space in room [ROOM NUMBER]. During an interview on 4/29/2026 at 9:19 AM with Resident 83 in room [ROOM NUMBER], Resident 83 stated there was enough room to move and that he (Resident 83) did not have any issues with the space in room [ROOM NUMBER]. During an interview on 4/29/2026 at 9:22 AM with CNA 2, CNA 2 stated there was enough room to provide care to residents (in general) in room [ROOM NUMBER]. During an interview on 4/49/2026 at 9:26 AM with Licensed Vocational Nurse 3 (LVN 3), LVN 3 stated she (LVN3) felt there was enough room in room [ROOM NUMBER] for residents (in general) to move around, get up, and for therapy. During a concurrent observation and interview on 4/29/2026 at 9:26 AM with the Assistant Director of Nursing (ADON), room [ROOM NUMBER], room [ROOM NUMBER], room [ROOM NUMBER], room [ROOM NUMBER], room [ROOM NUMBER], room [ROOM NUMBER], room [ROOM NUMBER], room [ROOM NUMBER], room [ROOM NUMBER], room [ROOM NUMBER], room [ROOM NUMBER], room [ROOM NUMBER], and room [ROOM NUMBER] were observed to have no more than three residents in each room. The ADON stated she (ADON) felt there was enough room in each of the rooms (room [ROOM NUMBER], room [ROOM NUMBER], room [ROOM NUMBER], room [ROOM NUMBER], room [ROOM NUMBER], room [ROOM NUMBER], room [ROOM NUMBER], room [ROOM NUMBER], room [ROOM NUMBER], room [ROOM NUMBER], room [ROOM NUMBER], and room [ROOM NUMBER]) for the residents (in general) to move around and receive activities of daily living<br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 055755 | A. Building<br>B. Wing | 04/30/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Sharon Care Center | 8167 West Third St.<br>Los Angeles, CA 90048 |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0912<br><br>Level of Harm - Potential for minimal harm<br><br>Residents Affected - Some | (ADLs- activities such as bathing, dressing and toileting a person performs daily). During an interview on 4/29/2026 at 8:34 AM with the Director of Rehabilitation (DOR) and Assistant Director of Rehabilitation (ADOR), the DOR and ADOR stated they (DOR and ADOR) did not have any issues with the space they (DOR and ADOR) needed for therapy in any of the resident rooms. During an interview on 4/29/2026 at 9:41 AM with the Director of Nursing (DON) and the ADM the DON and ADM stated there was enough room in all the rooms for therapy, ADLs, and for resident movement. During a review of the facility's Client Accommodation Analysis dated 4/29/2026 indicated the following rooms with their corresponding measurements: Room # and Total Sq ft Number of Beds Sq ft per Resident1228.6 3 76.2 8229.7 3 76.69236.7 3 78.911233.7 3 77.914234.7 3 78.215236.7 3 78.916229.7 3 76.617234.7 3 78.218216.3 3 72.119239.3 3 79.821225.5 3 75.223237.7 3 79.224235.7 3 78.625237.7 3 79.2 The Client Accommodation Analysis indicated the above rooms measured less than the required 80 sq ft per resident in multiple resident bedrooms. For a three-bed capacity room the square footage requirements would be at least 240 sq ft. The Department is recommending continuation of the room waiver request. |