STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055797	A. Building B. Wing	06/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Gilroy Healthcare and Rehabilitation Center	8170 Murray Avenue Gilroy, CA 95020

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure needs were accommodated for three of 26 sampled residents (Residents 100, 96, and 52) when: 1. Resident 100 and Resident 96's call light button (a red or white button used to call for assistance) were not within their reach for use; and 2. Resident 52 did not receive the appropriate call system (a device used to communicate a need for help) based on his needs. These failures had the potential for a delayed response and not meeting Resident 100, Resident 96 and Resident 52's needs. Findings: 1a. Review of Resident 100's clinical record titled, admission Record, dated 6/13/2025, indicated Resident 100 was admitted to the facility with diagnoses including wedge compression fracture (a type of spinal fracture where one or more vertebrae [back bones] collapse due to pressure, often resulting in a wedge shape) of first lumbar vertebrae (the five bones that make up the lower part of the spine, situated between the thoracic vertebrae and the sacrum) acquired deformity of chest and rib, passenger injured in collision with other motor vehicles in traffic accident and other amnesia (the loss of memory, which can involve forgetting past events or the inability to form new memories). Review of Resident 100's quarterly minimum data set (MDS - a federally mandated resident assessment tool) assessment dated [DATE], indicated Resident 100's brief interview for mental status (BIMS- an assessment tool used by facilities to screen and identify memory, orientation, and judgement status of the resident) score was 09 (a score of 0 to 7 indicates severe cognitive impairment, 8-12 moderate impairment, 13-15 patient is cognitively intact). During a concurrent observation and interview with Resident 100 on 6/9/2025 at 9:34 a.m., inside Resident 100's room, Resident 100 was in bed and his call light button was on the floor. Resident 100 stated he did not know how long the call light was on the floor. Resident 100 further stated, .I just want my call light. During a concurrent observation and interview with restorative nursing assistant T (RNA T) on 6/9/2025 at 9:43 a.m., inside Resident 100's room, RNA T confirmed the call button was on the left side of the bed's floor. (continued on next page)

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

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

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1b. Review of Resident 96's clinical record titled, admission Record, indicated Resident 96 was admitted to the facility with diagnoses including metabolic encephalopathy (a problem with how the brain works because of an underlying condition that disrupts the body's metabolism), epilepsy (an abnormal activity in the brain causing uncontrollable jerking movements of the arms and legs, and loss of consciousness), dysphagia (difficulty in swallowing), aphasia (a language disorder that affects a person's ability to communicate) and hemiplegia (paralysis of one side of the body) , unspecified affecting right dominant side (frequently used or stronger side of the body).\ Review of Resident 96's 5-day/quarterly MDS assessment dated [DATE], indicated Resident 96 had the ability to make self-understood and understand others. Further review indicated Resident 96's BIMS score was 05 (a score of 0 to 7 indicates severe cognitive impairment, 8-12 moderate impairment, 13-15 patient is cognitively intact). During a concurrent observation and interview with Resident 96 on 6/9/2025 at 10:11 a.m., inside Resident 96's room, Resident 96 was in bed and the call button was on the left side of the bed's floor. Resident 96 tried to state he couldn't find my cord [call light]. During a concurrent observation and interview with certified nursing assistant U (CNA U) on 6/9/2025 at 10:12 a.m., inside Resident 96's room, CNA U confirmed Resident 96's call light was on the floor. CNA U stated there should be a clip to hold the call light on residents' bed sheet to prevent it from sliding down to the floor. During an interview with registered nurse H (RN H) on 6/12/2025 at 9:42 a.m., RN H stated there should be a clip attached to the call light cord to clipped it on residents' pillowcase or bed sheet to prevent the call light from sliding down to the floor. During an interview with the director of nursing (DON) on 6/13/2025 at 2:05 p.m., DON stated staff should make sure there was a clip available to help hold the call light for it to be within each resident's reach for use. DON further stated each manager had a room assignment where they had to check each residents' call lights were available and could be reached for use. During a review of the facility's policy and procedure titled, Call Lights: Accessibility and Timely Response, date revised 10/21/2024, indicated, Staff will ensure the call light is within reach of resident and secured, as needed. The call system will be accessible to residents while in their bed or other sleeping accommodations within the resident's room. 2. Review of Resident 52's clinical record titled, admission Record, indicated, Resident 52 was admitted to the facility on [DATE] (original admission date 3/11/25) with diagnoses including hemiplegia and hemiparesis (a condition that causes partial paralysis or weakness on one side of the body) following cerebral infarction (also called stroke) affecting left non-dominant side (the part of the body [like hand, foot or eye] that is less preferred nor used for tasks compared to its paired counterpart, which is the dominant side), muscle weakness (generalized) and aphasia following cerebral infarction. During an observation on 6/9/25 at 8:53 a.m. in Resident 52's room, the call light button for Resident 52 was positioned hanging from the urinary catheter (a thin, flexible tube inserted into the bladder to drain urine) tubing, at the right bed rail, resting on the floor, and was not within Resident 52's reach for use. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview on 6/11/25 at 9:00 a.m. with Licensed Vocational Nurse (LVN) G in Resident 52's room, the call light button was found on the floor. LVN G confirmed the above observation and stated Resident 52 never used his call light button. LVN G further stated that a different call system would be more beneficial and appropriate for Resident 52. During a concurrent interview and record review with RN H, on 6/12/25 at 8:52 a.m., RN H described Resident 52 as very dependent, having limited movement, and bed bound. RN H further stated that if the call light button was not appropriate for Resident 52, nurses should have reassessed Resident 52 and implement specific interventions based on his needs. During a review of the facility's policy and procedure titled, Accommodation of Needs, date revised 12/4/24, the P&P indicated, The facility will treat each resident with respect and dignity and will evaluate and make reasonable accommodation for the individual needs . During a review of the facility's policy and procedure titled, Call Lights: Accessibility and Timely Response, date revised 10/21/2024, indicated, Each resident will be evaluated for unique needs and preferences to determine any special accommodations that may be needed in order for the resident to utilize the call system. Special accommodations will be identified on the resident's person-centered plan of care, and provided accordingly. (Examples include touch pads, larger buttons, bright colors, etc.)

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F 0577 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. Based on observation, interview and document review, the facility failed to ensure the residents were made aware of the location of the latest facility's State inspection result (Statement of Deficiencies and Statement of Isolated Deficiencies generated by the most recent standard survey and any subsequent extended surveys, and any deficiencies resulting from any subsequent complaint investigations) and available to read for six out of seven residents (Residents 34, 7, 55, 88, 68, and 71). This failure had the potential to result in residents being uninformed. Findings: During an interview in the Resident Council (a group of people living in a shared space [like a nursing home, public housing, or assisted living facility] who organize to represent the interests of all residents) meeting on 6/10/2025 at 9:56 a.m., when asked if the State inspection results were available to read without asking, Residents 34, 7, 55, 88, 68, and 71 stated they were not aware of where to find the survey results. They further stated no one from the facility told them where to find it. During an observation at the front lobby on 6/10/2025 at 1:45 p.m., there was no State inspection result posted, or binder placed in the lobby's desk. There were two other white binders found on top of the lobby's desk, but they did not indicate the State inspection result or survey results. During observation at nurse station 1 and 2 on 6/10/2025 at 1:47 p.m., there was no State inspection result posted, or binder placed at the nurse station. During observation at nurse station 3 and 4 on 6/10/2025 at 1:50 p.m., there was no State inspection result posted, or binder placed at the nurse station. During a concurrent observation and interview with activities supervisor (AS) on 6/11/2025 at 3:47 p.m., in front of nurse station 1 and 2, AS whispered at the administrator's (ADM) right ear, when asked where to find the latest State survey results. Both AS and ADM started to look for the State survey results. AS stated, the State survey results were in a binder, and it should be placed at the front lobby's desk. During an interview with the unit clerk (UC) on 6/11/2025 at 3:50 p.m., UC confirmed the red binder (State survey results) was not available at the lobby desk when she came at the facility at 2:30 p.m. UC stated she called the morning UC and was told that the red binder was not also at the lobby's desk in the morning. During an interview with registered nurse H (RN H) on 6/12/2025 at 10:05 a.m., when asked where to find the State survey results, RN H did not answer the question but stated, I know it's in the binder. (continued on next page)

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F 0577 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with certified nursing assistant V (CNA V) on 6/13/2025 at 8:42 p.m., when asked where to find the State survey results, CNA V stated, It's in the DON's [director of nursing) office. When asked where it was filed, and described it, CNA smiled and stated, Oh you got me there. I failed. During an interview with the DON on 6/13/2025 at 2:09 p.m., DON stated the latest State survey binder should always be available for residents, and staff should know where it was located. DON further stated, the activities staff should inform the residents where to find the latest State survey binder. During a review of the facility's policy and procedure titled, Availability of Survey Results, date implemented 3/1/2025, indicated, The survey binder is located (in the main lobby) and is available for review by interested persons who wish to review information relative to our company's compliance with federal or state rules, regulations, and guidelines governing our company's operation.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure their policy and procedure (P&P) for completion of physician orders for life-sustaining treatment (POLST: a document that specifies the medical treatments the resident wants to receive during serious illness) form for six of eight sampled residents (Resident 34, 42, 57, 83, 104 and 106). This failure could lead to the delivery of unnecessary or inappropriate medical services against sampled residents' goals and wishes. Findings: Review of Resident 34's face sheet (FS: a document that gives a resident's information at a quick [NAME]) indicated Resident 34 was admitted to facility on 1/16/2019. Review of Resident 34's POLST form date prepared on 4/12/2024 indicated section for advance directive (AD: a written instruction, such as a living will or durable power of attorney [a document that authorizes a person to act on behalf of resident] for healthcare when the individual is incapacitated) not completed, left blank. Review of Resident 42's FS indicated Resident 42 was admitted to facility on 1/19/2025. Review of Resident 42's POLST form date prepared on 1/20/2025 indicated section D for AD was not completed, left blank. Review of Resident 57's FS indicated Resident 57 was admitted to facility on 3/3/2025. Review of Resident 57's POLST form date prepared on 3/4/2025 indicated section D for AD was not completed, left blank. Review of Resident 83's FS indicated Resident 83 was admitted to facility on 3/12/2024. Review of Resident 83's POLST form date prepared on 3/12/2024 indicated section D for AD was not completed, left blank. Review of Resident 104's FS indicated Resident 104 was admitted to facility on 2/17/2025. Review of Resident 104's POLST form date prepared on 2/17/2025 indicated section D for AD was not completed, left blank. Review of Resident 106's FS indicated Resident 42 was admitted to facility on 2/26/2025. Review of Resident 106's POLST form date prepared on 2/26/2025 indicated section D for AD was not completed, left blank. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent record review of POLST form and interview with facility's director of nursing (DON) on 6/13/2025 at 2:16 p.m., DON reviewed POLST forms for Residents 34, 42, 57, 83, 104, and 106. DON confirmed section D for AD not completed for all these residents. DON stated nursing staff should have completed all sections of POLST form for residents. Review of facility's P&P titled, Promoting the right of self-determination for healthcare decisions and advanced healthcare directives, dated, November 2016, the P&P indicated, A completed, fully executed form is a legal physician order and is immediately actionable. Review of facility's P&P titled, Residents' Rights Regarding Treatment and Advance Directives, revised 3/4/2024, the P&P indicated, Any decision making regarding the resident's choices will be documented in the resident's medical record and communicated .

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. Based on observation, interview, and facility's document review, the facility failed to maintain resident's rights to privacy and confidentiality to three of 26 sampled residents (Resident 371, Resident 372, and Resident 373) when: 1. Resident 371's Foley catheter drainage bag, (a device inserted into the bladder [organ that collects urine] to drain urine, made of a semi-flexible plastic tube, one end inserted into the bladder and the other end attached to a bag that collects urine) drain bag was left uncovered; and 2. Resident 372 and Resident 373's personal information and care instructions were posted in the room visible to roommate and visitors. These failures had the potential to compromise resident's rights and dignity. Findings: 1. During an observation on 6/9/25 at 2:08 p.m., in Resident 371's room, Resident 371 was sharing a room with another resident. Resident 371's bed was towards the entrance door and privacy curtains were open. Resident 371's foley catheter drainage bag with yellow colored urine about 150 ml (milliliter) was left uncovered with privacy bag that can be seen from the hallway. During a follow-up observation on 6/10/25 at 9:15 a.m., Resident 371 was observed lying in bed. Resident 371's foley catheter drainage bag with yellow colored urine about 200 ml (milliliter) was still uncovered with privacy bag the uncovered foley catheter drainage bag can be seen from hallway. Review of Resident 371's clinical record titled, admission Record, dated on 6/12/2025, it indicated Resident 371 was admitted to the facility with diagnoses includes muscle weakness and benign prostatic hyperplasia (BPH, which is a non-cancerous enlargement of the prostate gland). During a review of Resident 371's physician order indicated an order for Foley Catheter: 16 French 10 ml balloon to gravity Drainage and change catheter and drainage bag monthly order, dated 4/17/25. During a concurrent interview and record review on 6/12/25 at 10:40 a.m., with Registered Nurse H (RN H) She confirmed Resident 371's foley catheter bag was uncovered on 6/9/25 and 6/10/25. She further stated it should be covered mostly for infection and to protect privacy and dignity, not exposed to everyone. During an interview on 6/13/25 at 1:47 p.m., with the Director of Nursing (DON) about Resident 371's foley catheter drainage bag was left uncovered. The DON stated they changed the foley catheter drainage bag with cover. During a review of facility's policy and procedure (P&P) titled Catheter Care dated 12/2/24, indicated, Policy: It is the policy of this facility to ensure that residents with indwelling catheters receive appropriate catheter care and maintain their dignity and privacy when indwelling catheters are in use . 2.Privacy bags will be available and catheter drainage bags will be covered at all times while in use.3.Privacy bags will be changed out when soiled, with a catheter change or as needed . (continued on next page)

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2.a. During an observation on 6/10/25 at 10:15 a.m., in Resident 372's room, Resident 372 was sharing a room with one other resident. Resident 372 was awake sitting on his wheelchair and there was a big care instruction posted at the wall above Resident 372's head of bed (HOB) the care instruction indicated *Please remove Dentures at night!!! * Please put on Dentures back on AM!!! Resident 372 stated he doesn't know who posted it. During a concurrent observation and interview on 6/12/25 at 10:33 a.m., with Registered Nurse H (RN H), she confirmed the care instruction posted at the wall above Resident 372's head of bed was uncovered. She stated posting care instruction signs should have a cover for Resident 372. Review of Resident 372's clinical record titled, admission Record, dated on 6/12/2025, it indicated Resident 372 was admitted to the facility with diagnoses including type 2 diabetes mellitus (a condition which affects the way the body processes blood sugar) without complications. 2.b. During an observation on 6/10/25 at 10:18a.m., in Resident 373's room, Resident 373 was sharing a room with one other resident. Resident 373 was awake lying on his bed and there were two big care instructions posted on the wall above Resident 373's head of bed (HOB) the care instructions indicated 1. Important!!! Neck brace must be on at all times (spinal Injury Preve .). 2. PLEASE USE CAUTION WHEN WORKING WITH RESIDENT; ESPECIALLY NECK AREA. Resident 373 stated a nurse or therapy posted the care instructions on the wall. During a concurrent observation and interview on 6/12/25 at 10:34 a.m., with Registered Nurse H (RN H), she confirmed the care instructions posted at the wall above Resident 373's head of bed was uncovered. She stated posting care instructions should have a cover for privacy. Review of Resident 373's clinical record titled, admission Record, dated on 6/12/2025, it indicated Resident 373 was admitted to the facility with diagnoses including type 2 diabetes mellitus (a condition which affects the way the body processes blood sugar) without complications. During a review of Resident 373's physician order indicated an order dated 6/6/25, Cervical collar at all times. During an interview on 6/13/25 at 1:53 p.m., with the Director of Nursing (DON), the DON stated care instructions supposed to have a cover or placed not visible to others. During a review of facility's policy and procedure (P&P) titled Resident Rights dated 3/4/25, indicated, .7. Privacy and confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. a. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care .

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, and record review, the facility failed to ensure 2 of 5 sampled residents (Residents 14 and 21) were free from unnecessary psychotropic medications (drugs that affects brain activities associated with mental processes and behavior) when: 1. Resident 21 received a high dose of quetiapine (generic: Seroquel: an antipsychotic medication, used to regulate the functioning of brain circuits that control thinking, mood, and perception) without documented necessity for its use and without demonstration of how the behavioral symptoms caused harm to the resident/others or causing significant distress to the resident; 2. Resident 14 received Seroquel and Fluoxetine (an anti-depressant) with no documented non-drug interventions for both medication; 3. Resident 83 received pro re nata (PRN: as needed or as the situation arises) psychotropic medication with no stop date. These failures resulted in inadequate indication and unnecessary medications which had the potential for increased risks associated with psychotropic medication use that include but are not limited to sedation, respiratory depression, falls, constipation, anxiety, agitation, and memory loss. Findings: 1. A review of Resident 21's clinical record indicated she was admitted to the facility with diagnoses including Alzheimer's disease (progressive disease that destroys memory and other important mental functions) and dementia [impaired ability to remember, think, or make decisions that interferes with doing everyday activities] in other diseases. A review of Resident 21's clinical record indicated she had been receiving Seroquel routinely since admission in January 2025. Her current physician's order, dated 5/26/25, was for quetiapine 25 milligrams (mg, unit of measurement), give 4 tablets (100 mg) by mouth in the afternoon, and 1 tablet (25 mg) by mouth at bedtime for psychosis (a mental disorder characterized by a disconnect from reality) manifested by auditory hallucinations. A review of Resident 21's medication administration record (MAR where the staff documented behavioral symptoms), the progress notes, and the care plan for Seroquel use did not indicate what type of auditory hallucinations the resident was experiencing, such as what she hears (e.g., voices), and how the behavioral symptoms caused harm to the resident/others or significant distress to the resident. During the survey, on 6/11/25 at 9:21 a.m., Resident 21 was observed in the activity room, participating in an activity with four other residents. She was observed being calm, pleasant, and without distress or behaviors. During an interview with the Activity Director (AD) on 6/11/25 at 9:26 a.m., the AD stated Resident 21 comes to activities every day which happens throughout the day. The AD stated Resident 21 does not have any behaviors during activities that are concerning or disruptive. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/11/25 at 11:27 a.m., Resident #21 was observed again sitting in activity room with other residents. She was quiet and participating in the current activity. There was no behaviors or distress noted. On 6/11/25 at 12:38 p.m., Resident 21 was observed self-feeding lunch in the the dining/activity room. No behaviors or distress was observed. In an interview with Certified Nursing Assistant (CNA) D on 6/11/25 at 1:34 p.m., CNA D stated Resident 21 is sometimes moody whenever she did not sleep well the night before, but she was not aware of Resident 21 having any auditory hallucinations such as hearing voices. During an interview with CNA E on 6/11/25 at 1:40 p.m., she stated she was not aware of Resident 21 ever exhibiting any visual or auditory hallucinations. During an interview with CNA F on 6/11/25 at 1:45 p.m., CNA F stated she has not witnessed any hallucinations by Resident 21. During an interview on 6/11/25 at 01:49 p.m. with Licensed Vocational Nurse (LVN) G, when asked about the Seroquel use for Resident 21, LVN G stated Resident 21 was on Seroquel for auditory hallucinations and that her Seroquel dose was higher than other residents here. When asked to show what auditory hallucinations the resident was exhibiting and how they affected the resident, LVN G reviewed Resident 21's clinical record and stated, I am not seeing anything. During a concurrent interview and record review with the Director of Nursing (DON) and Assistant DON (ADON) on 6/11/25 at 2:19 p.m., the ADON reviewed Resident 21's clinical record and acknowledged it only indicated auditory hallucinations for Seroquel use in the medication order and in the care plan without demonstration how it affects the resident, causing significant distress, or harm to herself or to others. During an interview with Resident 21's family member (FM) on 6/11/25 at 4:02 p.m., she stated, prior to coming to the facility, Resident 21 had behavioral symptoms of hearing and seeing things, such as believing that someone invaded their house and shot her loved ones, which caused her a lot of fear and distress. This was the reason why her psychiatrist prescribed a high dose of Seroquel. During an interview with DON on 6/12/25 at 1:17 p.m., the DON acknowledged none of these behaviors described by Resident 21's FM was in the clinical record to support the necessity for Seroquel use, and for staff to monitor. A review of the facility's policy and procedures titled Use of Psychotropic Medication, dated 12/2017, indicated, when psychoactive [drug affecting the mind] medications are prescribed, the clinical record should reflect the diagnosis and specific condition or target behavior being treated and Care plans should be updated to reflect behavior(s) causing functional, emotional, or safety impairment. A review of the American Psychiatric Association [APA] Practice Guidelines on the use of Antipsychotics to Treat Agitation or Psychosis in Patients with Dementia, 2016 indicated, APA recommends that nonemergency antipsychotic medication should only be used for the treatment of agitation or psychosis in patients with dementia when symptoms are severe, are dangerous, and/or cause significant distress to the patient. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Findings: 2. Review of Resident 14's face sheet (FS: a document that gives a resident's information at a quick [NAME]) indicated Resident 14 was admitted to facility on 3/12/2024. Review of Resident 14's FS indicated Resident 14's diagnoses included bipolar disorder (a disorder associated with episodes of mood swings ranging from depressive lows to manic highs) and depression (a mood disorder that causes a persistent feeling of sadness and loss of interest in daily active living). Review of Resident 14's physician orders (PO) indicated fluoxetine (prescribed medication used to treat depression) 60 milligrams (mg: a unit of mass equal to one-thousandth of a gram) one time a day, dated 3/7/2025 . Review of Resident 14's PO also indicated quetiapine (prescribed antipsychotic medication used to treat mental health condition) 200 mg at bedtime, dated 5/16/2025 . Review of clinical record for Resident 14 indicated there was no documented evidence of non-drug interventions/approaches attempted before administered above both psychotropic medications for Resident 14. Resident 83: 3. Review of Resident 83's FS indicated Resident 83 was admitted to facility on 3/12/2024. Review of Resident 83's FS indicated Resident 83's diagnoses included depression. Review of Resident 83's PO indicated, dated 2/12/2025, lorazepam (prescribed medication used to treat anxiety [persistent, excessive fear or worry in day to day situations that are not threatening] 0.5 mg every 12 hours as needed with no stop date . Review of electronic medication administration record (EMAR: digital system for documenting medication administration) for April/2025 indicated Resident 83 received 25 doses, EMAR for May/2025 indicated 24 doses and EMAR for July/2025 indicated 10 doses till 6/12/2025. Review of Resident 83's clinical record indicated there was no documented evidence of medical doctor (MD) assessed Resident 83's medical condition, progress and evaluated the need to continue as needed lorazepam 14 days after 2/12/2025. During concurrent record review of Resident 14 for non-drug approaches for medications fluoxetine and quetiapine and interview with facility's director of nursing (DON) on 6/13/2025 at 1:42 p.m., DON confirmed there was no documentation of nursing attempted non-drug interventions/approaches before administered both medications for Resident 14. DON stated nursing staff should have attempted non-drug interventions before administered psychotropic medications for resident to minimize the use of these medications for Resident 14. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During concurrent record review of Resident 83 for lorazepam as needed order, medical doctor's notes and interview with facility's DON on 6/13/2025 at 2:09 p.m., DON confirmed Resident 83 has an order for lorazepam PRN with no stop date since 2/12/2025. DON also confirmed there was no documented evidence of MD re-evaluated Resident 83's medical condition and needed to continue PRN lorazepam beyond 14 days. DON stated MD should have documented the appropriate reason to continue PRN lorazepam or ordered a stop date for PRN lorazepam for Resident 83. Review of facility's policy and procedure (P&P) titled, Use of Psychotropic Medication (s), revised 2/5/2025, the P&P indicated, Non-pharmacological approaches must be attempted, unless, clinically contraindicated, to minimize the need for psychotropic medications, use the lowest possible dose, or discontinue the medications. PRN orders for psychotropic medications, excluding antipsychotics, shall be limited to no more than 14 days, unless the attending physician or prescribing practitioner believes it is appropriate to extend the order beyond 14 days.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to accurately complete the Minimum Data Set (MDS, an assessment tool) for two residents (83 and 119) when: 1. For Resident 119, the facility failed to accurately complete the discharge status; 2. For Resident 83, the facility did not code the use of injectable medication and incorrectly coded Resident 83's falls. Failure to accurately assess the residents had the potential to result in inadequate or inappropriate care planning and interventions. Findings: 1. Review of Resident 119's physician order, dated 3/18/25, indicated Discharge to home with medications on 3/18/25. Home Health Services for PT (Physical Therapy) OT (Occupational Therapy) and nursing services. Review of Resident 119's discharge MDS, dated [DATE], indicated she was discharged to the acute hospital. During an interview and concurrent record review with the Minimum Data Set Manager (MDSM) on 6/11/25 at 9:13 a.m., the MDSM confirmed Resident 119 was discharged to her home on 3/18/25. The MDSM verified that Resident 119's discharge MDS was coded incorrectly. The MDSM stated that Resident 119 was discharged home, not to the acute hospital as was coded on Resident 119's 3/18/25 discharge MDS. Review of the Centers for Medicare and Medicaid Services (CMS) 10/2019 Resident Assessment Instrument 3.0 User's Manual (RAI Manual, MDS coding instructions) indicated for section A2100, Discharge Status, Code 01, community, if discharge location is a private home. Findings: Review of Resident 83's face sheet (FS: a document that gives a resident's information at a quick glance) indicated Resident 83 was admitted to facility on 3/12/2024. Review of Resident 83's diagnoses included diabetes type 2 (a chronic condition that happens with persistent high blood sugar levels) and ataxic gait (lack of coordination and balance resulting in unsteady, jerky and irregular body movements). Review of Resident 83's physician orders indicated an order dated 2/20/2025 for Ozempic (medication used to treat diabetes) 1milligram (mg: Unit of mass equal to one thousandth of a gram) inject subcutaneously (SQ: a method of administering medication by injecting into the layer just below the skin) every Friday for diabetes. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 83's electronic medication administration record (EMAR: digital system for documenting medication administration) for May/2025 indicated Resident 83 received SQ injection every Friday on 5/2, 5/9, 5/16, 5/23, and 5/30/2025. Review of Resident 83's fall report of incidents indicated Resident 83 had a fall with no injury on 3/27/2025. Review of Resident 83's minimum data set (MDS: clinical and functional assessment tool) dated 5/14/2025, section N medications for injections indicated 0 received during the last 7 days or since admission/entry or reentry if less than 7 days. Review of section J health conditions for number of falls since admission/entry or reentry or prior assessment indicated 1 fall with no injury and 1 fall with injury (except major). During concurrent record review of Resident 83's EMAR and fall report of incident and interview with minimum data set coordinator manager (MDSCM) on 6/11/2025 at 11:51 a.m., MDSCM confirmed Resident 83 received SQ injections once a week and had a fall with no injury on 3/27/2025. MDSCM also reviewed MDS assessment dated [DATE] for sections N and J. MDSCM also confirmed above findings for both sections for MDS assessment. MDSCM stated MDS assessment for injections and fall were not completed accurately for this resident. MDSCM also stated MDS staff should have assessed and completed MDS assessment accurately for Resident 83. During an interview with facility's director of nursing (DON) on 6/13/2025 at 2:12 pm., DON stated facility's MDS staff should have assessed and completed MDS assessment accurately for Resident 83. Review of facility's policy and procedures (P&P) titled, Resident Assessment-RAI (resident assessment instrument), revised 9/24/2024, the P&P indicated, The current version of the RAI (MDS 3.0) will be utilized when conducting a comprehensive assessment of each resident in accordance with instructions found in the RAI Manual (official guidance for using the RAI process, ensuring consistent and accurate assessments and care planning).

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to develop and implement comprehensive care plans that included target symptoms, measurable objectives, and interventions for nine out of 26 sampled residents (Resident 5, Resident 96, Resident 109, Resident 10, Resident 106, Resident 111, Resident 89, Resident 91, and Resident 52) when: 1. Resident 5 had no care plan developed related to nebulization treatment (using a machine called a nebulizer to convert liquid medicine into a fine mist that can be inhaled into the lungs); 2. Resident 96 had no care plan developed for diagnosis of epilepsy (an abnormal activity in the brain causing uncontrollable jerking movements of the arms and legs, and loss of consciousness); 3. Resident 109 had no care plans developed for the use of craniotomy helmet (a protective medical device worn by patients who have undergone a craniotomy [a surgical procedure that involves cutting into the skull to access the brain] or craniectomy [a surgical procedure where a portion of the skull is removed to relieve pressure on the brain, often due to swelling or bleeding]) and Resident 109's non-compliance of helmet use; 4. Resident 10 had no care plans developed for wheezing/shortness of breath (SOB); 5. Resident 106 had no care plans developed for infection; 6. Resident 111 and Resident 89 had no care plan developed for Eliquis (blood thinner); 7. Resident 91 had no care plan developed for Warfarin (blood thinner); and 8. Resident 52's care plan did not reflect the appropriate call bell system (a device used to communicate a need for help) needs. These failures had the potential for the residents not attaining their highest practicable physical, mental, and psychosocial well-being. Findings: 1. Review of Resident 5's clinical record titled, admission Record, dated 6/12/2025, indicated Resident 5 was admitted to the facility on [DATE] with diagnoses including type 2 diabetes mellitus (DM, a condition which affects the way the body processes blood sugar), with diabetic neuropathy (nerve damage caused by DM), chronic kidney disease (a condition where the kidneys are damaged and cannot filter blood as well as they should, leading to a buildup of waste and excess fluid in the body), atrial fibrillation (a common heart rhythm disorder where the heart's upper chambers [atria} beat irregularly and often rapidly) and heart failure (a condition where the heart muscle is unable to pump enough blood to meet the body's needs). (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 5's Order Summary Report, with order dated 3/9/2025, indicated, Ipratropium-Albuterol Inhalation Solution [a medicine used to treat breathing problems] 0.5-2.5 (3) MG [milligrams, unit of measurement]/3 ML [milliliters, volume of measurement] (Ipratropium-Albuterol) 3 ml inhale orally every 4 hours as needed for Wheezing [a high pitched whistling sound that occurs during breathing, typically when air passes through narrowed or obstructed airways in the lungs]. Review of Resident 5's care plans revealed there was no care plan developed for Resident 5's nebulization therapy for wheezing. During a concurrent interview with registered nurse H (RN H) and record review on 6/12/2025 at 9:33 a.m., RN H reviewed Resident 5's list of plans and confirmed there was no care plan developed for Resident 5's nebulization treatment. RN H stated Resident 5 had episodes of wheezing which was a change in his condition and nebulization therapy was new. RN H further stated we should have care planned it. During an interview with the director of nursing (DON) on 6/13/2025 at 1:39 p.m., DON confirmed nurses should developed a care plan, if a resident had a problem with respiratory (the network of organs that enables breathing, the process of taking in oxygen and expelling carbon dioxide). and needed nebulization. 2. Review of Resident 96's clinical record titled, admission Record, indicated Resident 96 was readmitted to the facility on [DATE] with diagnoses including metabolic encephalopathy (a problem with how the brain works because of an underlying condition that disrupts the body's metabolism), epilepsy (an abnormal activity in the brain causing uncontrollable jerking movements of the arms and legs, and loss of consciousness), dysphagia (difficulty in swallowing), aphasia (a language disorder that affects a person's ability to communicate) and hemiplegia (paralysis of one side of the body) , unspecified affecting right dominant side (frequently used or stronger side of the body). Review of Resident 96's evaluation on 3/29/2025, it indicated Resident 96 was found unresponsive and was sent out to the hospital on 3/29/2025 for further evaluation and management. Review of Resident 96's admission notes dated 4/3/2025, it indicated Resident 96 was readmitted to the facility with diagnoses including metabolic encephalopathy and epilepsy. Reviewed Resident 96's Order Summary Report, with order dated 4/3/2025, indicated, Keppra tablet 500 MG (LevETIRAcetam) [a medication used to treat certain types of seizures caused by epilepsy] Give 1 tablet by mouth two times a day for Seizure [a sudden, uncontrolled surge of electrical activity in the brain that can cause a range of symptoms, from brief lapses in awareness to convulsion]. Review of Resident 96's care plans, revealed Resident 96 did not have a care plan developed for epilepsy and used of Keppra. During a concurrent interview with RN H and record review on 6/12/2025 at 9:24 a.m., RN H reviewed Resident 96's clinical records and list of care plans and confirmed Resident 96 was readmitted to the facility with diagnosis of epilepsy and had been receiving Keppra. RN H further confirmed Resident 96 had no care plan developed for diagnosis of epilepsy and used of Keppra. RN H stated, the admission nurse was responsible for initiating a care plan and the minimum data set nurse (MDSN) should review the resident's chart and should add any missing care plans. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with DON on 6/13/2025 at 1:38 p.m., DON confirmed Resident 96 was readmitted to the facility with diagnosis of epilepsy and had a new order of Keppra. DON stated nurses should have developed a care plan to address Resident 96's diagnosis of epilepsy with the use of Keppra. 3. Review of Resident 109's clinical record titled, admission Record, dated 6/12/2025, indicated Resident 109 was admitted to the facility with diagnoses including hemiplegia (paralysis of one side of the body) and hemiparesis (a condition that causes partial paralysis or weakness on one side of the body) following cerebral infarction (commonly referred to as stroke) affecting left non-dominant side (the part of the body [like hand, foot or eye] that is less preferred nor used for tasks compared to its paired counterpart, which is the dominant side), atrial fibrillation, heart failure, aphasia and unspecified convulsions (a medical event characterized by involuntary, violent muscle contractions that can cause sudden, uncontrolled shaking of the body). Review of Resident 109's Order Summary Report, order dated 4/7/2025, indicated Craniotomy helmet to be worn when OOB [out of bed] During an observation on 6/9/2025 at 9:21 a.m., inside Resident 109's room, Resident 109 was seated on a wheelchair, with splint to his left hand, and a helmet placed on his lap. During a concurrent observation and interview with Resident 109 on 6/10/2025 at 1:06 p.m., inside Resident 109's room, Resident 109 was seated on a wheelchair and the helmet was on his bed. No staff supervision. Resident 109 stated he removed the helmet because it was heavy. During a concurrent observation and interview with RN H on 6/10/2025 at 1:08 p.m., inside Resident 109's room, RN H confirmed the above observation and stated Resident 109 removed his helmet. Review of Resident 109's list of care plans revealed there was no care plan developed for craniotomy helmet use and Resident 109's non-compliance with it's use. During a concurrent interview with RN H and record review on 6/12/2025 at 9:01 a.m., RN H reviewed Resident 109's care plans and confirmed she just added the care plan related to the use of Resident 109's helmet and his noncompliance on 6/10/2025. RN H stated the care plan related to the use of helmet should have been developed since admission because Resident 109 was admitted with the craniotomy helmet on 4/7/2025. During an interview with DON on 6/13/2025 at 1:41 p.m., DON stated care plan should be developed by the MDS nurse, assistant director of nursing (ADON) and DON. DON further stated, we have 21 days from resident's admission to complete the comprehensive care plans. 4. Review of Resident 10's face sheet (FS: a document that gives resident's information at a quick glance) indicated Resident 10 was admitted to facility on 4/8/2019. Review of Resident 10's diagnoses included wheezing (a high-pitched whistling sound made while breathing). (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 10's order listing summary indicated order for ipratropium-albuterol (a combination of liquid medication used to control and treat air flow blockage to facilitate breathing) solution 0.5-2.5 (3) MG/3 ML (MG: milligram, unit of mass equal to one-thousandth of a gram, ML: milliliters: a measure of volume equal to one-thousandth of a liter) inhale (to breath in) orally (by mouth) every 8 hours for SOB (shortness of breath, difficulty breathing) and every 6 hours as needed for SOB dated 4/7/2025. Review of 10's electronic medication administration record (EMAR: digital system for documenting medication administration) for June/2025 indicated Resident 10 receiving above medication every 8 hours every day and every 6 hours as needed. Review of Resident 10's care plans indicated there was no documented evidence of care plan for wheezing/SOB. 5. Review of Resident 106's FS indicated Resident 106 was admitted to facility on 2/26/2025. Review of Resident 106's diagnoses included diabetes type 2 (a chronic condition that happens with persistent high blood sugar levels) and peripheral vascular disease (a circulatory condition in which narrowed blood vessels reduce blood flow to arms and legs). Review of Resident 106's order listing report indicated Levaquin 500 mg one time a day for infection until 6/24/2025, date ordered on 5/28/2025. Review of Resident 106's EMAR for May/2025 indicated Resident 106 received Levaquin on 5/28/2025 till 5/31/2025 at 9:00 a.m. Review of EMAR for June/2025 indicated Resident 106 currently receiving Levaquin every day at 9:00 a.m. Review of Resident 106's care plans indicated there was no documented evidence of care plan for infection. During an interview with facility's director of nursing (DON) on 6/13/2025 at 1:38 p.m., DON confirmed there was no care plan for SOB for Resident 10 and infection for Resident 106. DON stated nursing staff should have implemented care plan for both resident 10 and 106. 6.a. Review of Resident 111's clinical record titled, admission Record, dated on 6/12/2025, it indicated Resident 111 was admitted to the facility with diagnoses includes atrial fibrillation (a common heart condition where the heart's upper chambers (atria) beat irregularly and often rapidly) and muscle weakness. During a review of Resident 111's physician orders indicated an order dated 4/29/25 Eliquis tablet 5 mg (milligram, unit of measurement) give 1 tablet by mouth two times a day for atrial fib (fibrillation). During a concurrent interview and record review on 6/12/25 at 10:47 a.m., with Registered Nurse H (RN H), she reviewed Resident 111's care plan and she confirmed there was no care plan developed for Eliquis. She stated no care plan pertaining to blood thinner. She further stated they should have used the templates care plan for residents using blood thinner. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	6.b. Review of Resident 89's clinical record titled, admission Record, dated on 6/12/2025, it indicated Resident 89 was admitted to the facility with diagnoses includes Alzheimer's disease (a progressive disease that destroys memory and mental functions) and unspecified atrial fibrillation (a common heart condition where the heart's upper chambers (atria) beat irregularly and often rapidly). During a review of Resident 89's physician orders indicated an order, dated 4/16/25 Eliquis tablet 2.5 mg (milligram, unit of measurement) give 1 tablet by mouth two times a day for Atrial fibrillation. During a review of Resident 89's clinical record indicated there was no care plan developed related to use of Eliquis. During a concurrent interview and record review om 6/12/25 at 10:51 a.m., with Registered Nurse H (RN H), she reviewed Resident 89's care plan. RN H confirmed there was no care plan developed for Eliquis. She further stated she [Resident 89] should have a care plan for Eliquis. 7. Review of Resident 91's clinical record titled, admission Record, dated on 6/12/2025, it indicated Resident 91 was admitted to the facility with diagnoses includes unspecified atrial fibrillation (a common heart condition where the heart's upper chambers (atria) beat irregularly and often rapidly) and muscle weakness. During a review of Resident 91's Medication Administration Records (MAR) May 2025 indicated an order, dated 5/29/25 for Warfarin (blood thinner) Sodium tablet 2.5 mg (milligram, unit of measurement) give 1 tablet by mouth one time a day for atrial fib (fibrillation). During a concurrent interview and record review of Resident 91's care plan on 6/13/25 at 11:30 a.m., with Registered Nurse H (RN H), she confirmed there was no care plan developed for warfarin. She stated she cannot see a care plan for warfarin. She further stated Resident 91 should have a care plan for warfarin. During an interview on 6/13/25 at 1:38 p.m., with the Director of Nursing (DON), the DON stated they review the new admit resident the next day probably missed the care plans. She further stated if the care plan is not there is not there. During a review of facility's policy and procedure (P&P) titled Comprehensive Care Plans dated 2/5/25, indicated, Policy: It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs and ALL services that are identified in the resident's comprehensive assessment and meet professional standards of quality. 8. Review of Resident 52's clinical record titled, admission Record, indicated, Resident 52 was admitted to the facility on [DATE] (original admission date 3/11/25) with diagnoses including hemiplegia and hemiparesis (a condition that causes partial paralysis or weakness on one side of the body) following cerebral infarction (also called stroke) affecting left non-dominant side (the part of the body [like hand, foot or eye] that is less preferred nor used for tasks compared to its paired counterpart, which is the dominant side), muscle weakness (generalized) and aphasia following cerebral infarction. (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)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 6/9/25 at 8:53 a.m. in Resident 52's room, the call light button for Resident 52 was positioned hanging from the urinary catheter (a thin, flexible tube inserted into the bladder to drain urine) tubing, at the right bed rail, resting on the floor, and was not within Resident 52's reach for use. During a concurrent observation and interview on 6/11/25 at 9:00 a.m. with Licensed Vocational Nurse (LVN) G in Resident 52's room, the call light button was found on the floor. LVN G confirmed the above observation and stated Resident 52 never used his call light button. LVN G further stated that a different call system would be more beneficial and appropriate for Resident 52. During a concurrent interview and record review with RN H, on 6/12/25 at 8:52 a.m., RN H reviewed Resident 52's clinical records and list of care plans and confirmed Resident 52 was very dependent, had limited movement, and bed bound. RN H further stated that if the call light button was not appropriate for Resident 52, nurses should have reassessed Resident 52 and implement specific interventions based on his needs. RN H further confirmed there was no care plan developed to address Resident 52's call system needs. During an interview with the DON on 6/13/2025 at 1:34 p.m., DON stated the resident's needs for an appropriate call light system should have been assessed within two hours upon resident's admission. During a review of the facility's policy and procedure titled, Call Lights: Accessibility and Timely Response, date revised 10/21/2024, indicated, Each resident will be evaluated for unique needs and preferences to determine any special accommodations that may be needed in order for the resident to utilize the call system. Special accommodations will be identified on the resident's person-centered plan of care, and provided accordingly. (Examples include touch pads, larger buttons, bright colors, etc.) During a review of the facility's policy and procedure titled, Comprehensive Care Plans, date revised 2/5/2025, indicated, It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs and ALL services that are identified in the resident's comprehensive assessment and meet professional standards of quality. The comprehensive care plan will describe, at a minimum, the following: a. The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. b. Any services that would otherwise be furnished, but are not provided due to the resident's exercise of his or her right to refuse treatment.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. Based on observation, interview and record review, the facility failed to ensure to provide necessary treatment and services consistent with professional standards of practice to promote healing, prevent infection and prevent new pressure injuries/ulcers (injury to skin from prolonged pressure on the skin) from developing for one of four sampled resident (Resident 57) when: 1. No dressing on right outer ankle pressure injury for Resident 57; 2. No prevalon (a medical device designed to prevent and treat heel pressure injury/ulcer) heel protector boot on to right foot for Resident 57. Above failures had the potential for delayed pressure ulcer healing and developing new pressure injuries for Resident 57. Findings: During a concurrent observation and interview with certified nursing assistant P (CNA P) on 6/10/2025 at 9:26 a.m., CNA P also observed Resident 57's right foot and confirmed right outer ankle open area with no dressing or prevalon boot were not on while Resident 57 was in bed with bare feet. CNA P confirmed prevalon boot was left on nightstand next to Resident 57's bed. CNA P stated she forgot to verify and place the boot on to right foot for Resident 57. During a second concurrent observation and interview with registered nurse H (RN H) on 6/10/2025 at 9:32 a. m., RN H confirmed there was no dressing covered right outer ankle pressure injury and heel protector (a device designed to cushion, support, or protect the heel area of the foot) boot (prevalon boot) was not on while Resident 57 was in bed with bare feet. RN H also stated license nurse will apply dressing to pressure injury in few minutes and instructed CNA P to apply boot to right foot for Resident 57. Review of Resident 57's face sheet (FS: a document that gives resident's information at a quick glance) indicated Resident 57 was admitted to facility on 3/3/2025. Review of Resident 57's order summary report indicated an order, dated 6/11/2025, Cleanse PU (pressure ulcer) to right outer ankle with NS (normal saline, salt water used to clean skin open areas), pat dry, apply medihoney (natural, non-toxic agent used to treat pressure injuries) to the wound bed, and cover with dry dressing every day shift and as needed . Review of another order, dated 4/18/2025, Prevalon Heel Protector to R (right) foot for PU to R outer ankle. During an interview with RN H on 6/11/2025 at 9:39 a.m., RN H stated license staff should have applied dressing as ordered for right outer ankle pressure injury for Resident 57 to prevent delayed healing of pressure injury. RN H also stated CNA staff should have verified right foot and placed heel protector boot for Resident 57 to promote pressure injury healing. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with facility's director of nursing (DON) on 6/13/2025 at 2:14 p.m., DON stated nursing staff applied dressing and heel protector boot as ordered by medical doctor (MD) for Resident 57's right ankle to promote pressure injury healing and prevent new pressure injuries. Review of facility's policy and procedure (P&P) titled, Pressure Injury prevention and Management, revised 12/3/2024, the P&P indicated, Redistribute pressure (such as repositioning, protecting and /or offloading heels, etc.) Evidence-based treatments in accordance with current standards of practice will be provided for all residents who have a pressure injury present.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on interview and record review, the facility failed to ensure controlled medications (those with a high abuse potential) were fully accounted when controlled medication use audit for three out of seven sampled residents (Residents 53, 106, and 109) did not reconcile. The residents' medications were signed out of the Controlled Drugs Records (CDR, inventory record of controlled drugs) but not documented on the Medication Administration Record (MAR, record of medications administered to a resident) to indicate they were administered to the residents. The failure resulted in inaccurate accountability and had the potential for abuse and diversion (unlawful distribution or use) of controlled medications. Findings: During the survey, the CDRs for seven random residents receiving as-needed (PRN) controlled medications were selected for review. On 6/10/25 at 1:41 p.m., a concurrent interview and record review was conducted with the Director of Nursing (DON) and Assistant Director of Nursing (ADON). The ADON stated any time a PRN controlled medication was requested from the resident, the nursing staff would assess the resident's pain; review the medication order, and if within the time frame, open the narcotic bin, retrieve the medication; sign medication out from the CDR; give the medication; and document the administration on the MAR. a. A review of Resident 53's physician's orders indicated an order for hydrocodone-acetaminophen (brand name: Norco, a potent narcotic for pain) 5-325 milligrams (mg, unit of measurement), give 1 tablet by mouth every 6 hours as needed for moderate to severe pain, dated 5/16/25. On 6/10/25 at 1:50 p.m., a review of Resident 53's CDR for Norco 5/325 mg and May 2025 MAR with the DON and ADON indicated the nursing staff signed 1 tablet out of the CDR but did not document the administration on the MAR: on 5/25/25 at 2:48 a.m. After reviewing the resident's clinical record including the MAR and the nursing progress notes, the ADON stated, Yeah I can't see it. She stated it should have been documented on the MAR to show it was administered to the resident. b. A review of Resident 106's clinical record indicated he had a physician's order for hydrocodone/acetaminophen (Norco)10-325 mg, give 1 tablet by mouth every 3 hours PRN pain management, dated 02/28/25. On 6/10/25 at 1:54 p.m., a review of Resident 106's CDR for Norco 10-325 mg and the May 2025 MAR with the DON and ADON indicated the nursing staff signed 1 tablet out of the CDR but did not document the administration on the MAR: on 5/21/25 at 4:45 a.m. Both the DON and ADON confirmed this finding after reviewing the resident's clinical record and stated it should have been documented on the MAR. c. A review of Resident 109's clinical record indicated he had a physician's order, dated 4/22/25, for oxycodone (a potent narcotic for pain) 5 mg, give 0.5 tablet every 8 hours PRN pain. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/10/25 at 1:56 p.m., a review of Resident 109's CDR for oxycodone 5 mg and the June 2025 MAR with the DON and ADON indicated the nursing staff signed out 1 tablet from the CDR but did not document the administration on the MAR: on 6/3/25 at 10 a.m. Both the DON and ADON reviewed the resident's clinical record, including the MAR and the progress notes, and confirmed this finding. During an interview on 6/10/25 at 1:59 p.m., the DON stated sometimes the staff get busy and rushed, and forget to document on the MAR. However, both the DON and ADON confirmed all controlled medications would need to be documented on the MAR to account for the medications. Review of facility's policy and procedures titled Medication Administration, reviewed/revised 3/28/25, indicated the nursing staff administering the medications to [s]ign MAR after administered. A review of facility's policy and procedures titled Inventory Control of Controlled Substances, revised 08/01/24, indicated the facility should maintain controlled substance records including Date and time of administration and Name and signature of person administering the medication.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. Based on interview and record review, the facility failed to ensure the Consultant Pharmacist (CP) identified and reported irregularities during the medication regimen review (MRR) for one out of 26 sampled residents (Resident 373) when Resident 373 had two similar orders for Dilaudid (brand name for hydromorphone, a potent opioid medication used to treat moderate to severe pain).This deficient practice had the potential for excessive dose/adverse effects for Resident 373. Finding: Review of Resident 373's clinical record titled, admission Record, dated on 6/12/2025, it indicated Resident 373 was admitted to the facility with diagnoses including type 2 diabetes mellitus (a condition which affects the way the body processes blood sugar) without complications. During a review of Resident 373's physician order, dated 5/26/25 indicated an order for Dilaudid oral tablet 2 mg (milligram, unit of measurement) give 4 tablet by mouth every 3 hours as needed for pain. During a review of Resident 373's physician order, dated 5/26/25 indicated an order for hydromorphone [brand name for Dilaudid] oral tablet 8 mg give 1 tablet by mouth every 3 hours as needed for pain max (maximum) 4 tabs per day. During a review of Resident 373's physician order, dated 5/26/25 indicated an order for Fentanyl (is more potent [powerful] than many other opioid drugs.) Patch 72 hours 100 mcg (microgram)/hr (hour) apply 1 patch transdermally (the administration of medication through the skin, typically via a patch or ointment, where it is absorbed into the bloodstream for systemic effects) for pain management. During a concurrent interview and record review on 6/12/25 at 10:37 a.m., with Registered Nurse H (RN H) she reviewed Resident 373's physician order she confirmed the two similar orders for Dilaudid. She stated the Dilaudid 2 mg give 4 tabs order is for e-kit (emergency kit) upon admission for one time order. She further stated she will clarify with the doctor. During an interview and record review on 6/13/25 at 1:54 p.m., with the Director of Nursing (DON) the DON look at Resident 373's physician order for Dilaudid and hydromorphone. The DON stated if you look at the orders it's the same dose and frequency. During a review of the MRR, dated 5/29/25 indicated there were no reports about the two similar orders of Dilaudid. During a phone interview on 6/13/25 at 4:06 p.m., with the Consultant Pharmacist (CP), about Resident 373's two similar Dilaudid orders she stated, it's duplicate. She reviewed the MRR, dated 5/29/25. She stated her colleague missed it. The CP was asked if she will recommend discontinuing if not missed CP answered of course. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 6/13/25 at 4:23 p.m., with the Assistant Director of Nursing (ADON) she reviewed Resident 373's Controlled Drug Records (CDR, inventory record of controlled drugs) for hydromorphone 8 mg. The ADON counted the CDR for date 6/8/25 and she confirmed hydromorphone 8 mg was signed 5 times on 6/8/25 indicated hydromorphone was taken 5 times in one day more than the order of max (maximum) 4 tabs per day. During a review of the facility's policy and procedures titled, Medication Regime Review, revised 4/9/25, indicated, 1. Medication Regimen Review (MRR), or Drug Regimen Review, is a thorough evaluation of the medication regimen of a resident, with the goal of promoting positive outcomes and minimizing adverse consequences and potential risks associated with medication. The MRR includes: a. Review of the medical record in order to prevent, identify, report, and resolve medicationrelated problems, medication errors, or other irregularities .

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F 0757 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review , the facility failed to ensure 67 out of 67 residents (residents who received Levaquin [a brand name for levofloxacin, a type of antibiotic known as fluoroquinolone used to treat bacterial infections] and Metformin [a medication that helps control the amount of glucose (sugar) in the blood]) (Residents 392, 389, 122, 130, 127, 124, 383, 393, 132, 83, 126, 391, 125, 129, 388, 68, 7, 10, 82, 52, 41, 394, 123, 390, 70, 384, 21, 387, 133, 93, 74, 385, 326, 381, 103, 47, 377, 222, 89, 49, 46, 106, 131, 323, 16, 22, 33, 63, 50, 23, 386, 128, 111, 322, 4, 71, 80, 99, 15, 382, 2, 64, 26, 17, 380, 90, and 65) were free from unnecessary medications when there was inadequate monitoring and systemic failure in management of residents on medications with black box warning (BBW, is the strongest warning the Food and Drug Administration [FDA-it is a federal agency responsible for protecting and promoting public health by regulating and supervising food safety, medications, medical devices, cosmetics, and other products] gives for prescription drugs. It highlights serious or life-threatening risks associated with a medication, signaling to healthcare professionals and patients that they should be aware of potential dangers and use the drug with caution) like Levaquin and Metformin. They are as follows: 1. During a record review of the pharmacy list of residents who had Levaquin from January 2025 to June 2025, it revealed the following: 1a. 54 out of 54 residents (Residents 392, 389, 122, 130, 127, 124, 383, 393, 132, 83, 126, 391, 125, 129, 388, 68, 7, 10, 82, 52, 41, 394, 123, 390, 70, 384, 21, 387, 133, 93, 74, 385, 326, 381, 103, 47, 377, 222, 89, 49, 46, 106, 131, 323, 16, 22, 33, 63, 50, 23, 386, 128, 111, and 322) who received Levaquin, did not have documentation that the BBW was being monitored related to Levaquin use; 1b. 54 out of 54 residents (Residents 392, 389, 122, 130, 127, 124, 383, 393, 132, 83, 126, 391, 125, 129, 388, 68, 7, 10, 82, 52, 41, 394, 123, 390, 70, 384, 21, 387, 133, 93, 74, 385, 326, 381, 103, 47, 377, 222, 89, 49, 46, 106, 131, 323, 16, 22, 33, 63, 50, 23, 386, 128, 111, and 322) who received Levaquin, did not have a care plan developed related to Levaquin's BBW; and 1c. 30 out of 54 residents (Residents 392, 389, 122, 130, 127, 383, 391, 125, 129, 7, 394, 123, 390, 70, 384, 387, 133, 93, 103, 122, 89, 49, 106, 16, 50, 23, 386, 74, 128, and 385) who received Levaquin did not have an appropriate indication or diagnosis (specific and accurate identification of a disease, condition, or injury based on a patient's signs, symptoms, and medical history. 2. During a record review of the facility's list of residents who received Metformin from June 1, 2025, to June 17, 2025, it revealed the following: 2a. 19 out of 19 residents (Residents 4, 71, 80, 99, 15, 47, 222, 382, 83, 2, 64, 26, 17, 7, 10, 82, (380, 90, and 65) who received Metformin did not have documentation that the BBW was being monitored related to Metformin use; and 2b. 19 out of 19 residents (Residents 4, 71, 80, 99, 15, 47, 222, 382, 83, 2, 64, 26, 17, 7, 10, 82, 380, 90, and 65) who received Metformin did not have a care plan developed related to Metformin's BBW. (continued on next page)

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F 0757 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	3. Six out of six residents (Residents 47, 222, 83, 7, 10, and 82) received both Levaquin and Metformin without proper documentation of the medications BBW monitoring and had no care plan developed related to the medications' BBW. 4. The facility's Infection Preventionist (IP) failed to identify and report the facility's irregularities related to frequent prescription and Levaquin use, missed BBW monitoring, inappropriate diagnosis of antibiotic use and no care plans for Levaquin use with BBW; . 5. The facility's Consultant Pharmacist (CP) failed to identify and report the facility's irregularities related to frequent prescription and Levaquin use, missed BBW monitoring, inappropriate diagnosis of antibiotic use and no care plans for Levaquin use with BBW during the medication regimen review (MRR) for 67 out of 67 residents. Due to these systemic failures (as stated above) with potential to affect all residents who received or still receiving Levaquin and Metformin medications, the facility needed to take immediate action to correct the noncompliance. On 6/18/2025 at 2:56 p.m., an Immediate Jeopardy (IJ, a situation in which the facility's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident) was identified and declared, in the presence of the facility's Administrator (ADM) and director of nursing (DON) related to above failures. On 6/23/2025 at 3:56 p.m., the IJ was removed after the ADM submitted an acceptable IJ Removal Plan (IJRP, a plan with interventions to immediately correct the deficient practices), and after the survey team verified and confirmed the corrective actions while onsite. The failures had the potential for residents to suffer a serious adverse effect on: A. Levaquin use including tendinitis (the inflammation or irritation of a tendon, [the fibrous tissue that connects muscles to bones]), tendon rupture (a tear in a tendon, it can result in significant pain, swelling, and inability to move the affected joint), numbness or tingling or pricking sensation pins and needles in arms or legs, muscle weakness, muscle pain, joint pain, joint swelling, anxiety, depression, hallucinations, suicidal thoughts, confusion, worsening of myasthenia gravis (a chronic autoimmune disorder in which antibodies destroy the communication between nerves and muscles, resulting in weakness of the skeletal muscles), and abnormal, rapid or strong heartbeat; and B. Metformin use including lactic acidosis (a condition where too much lactic acid [a chemical your body produces when your cells break down carbohydrates for energy] builds up in the body, causing the blood to become too acidic) especially on residents with impaired kidney function, heart failure, or other conditions that can reduce oxygen supply to tissues. Findings: 1a. During a concurrent interview with the IP and document review of the facility's Infection Prevention and Control Surveillance Log on 6/12/2025 at 1:23 p.m., the IP confirmed Resident 68 and Resident 89 received Levaquin, and both residents did not have any documentation of BBW monitoring. (continued on next page)

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F 0757 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview with the director of nursing (DON) on 6/13/2025 at 3:10 p.m., DON stated staff used the Medication Administration Record (MAR - a daily documentation record used by a licensed nurse to document medications and treatments given to a resident) to document the medication's black box warning. DON further stated, the nurse would click on the black box beside the medication and the BBW would show up and nurses should document their monitoring in the progress notes. During a concurrent interview with both DON and IP and record review of Resident 68 and Resident 89's e-MAR (electronic MAR) on 6/13/2025 at 3:45 p.m., IP stated whenever nurses would administer the Levaquin to the resident, the BBW would pop up in their system and nurses would document in the resident's progress note if they monitored the BBW. IP further stated nurses from three different shifts (Days, Evening, and Night shift) monitored Resident 68 and Resident 89 related to Levaquin's BBW. During an interview on 6/13/25 at 3:50 p.m. with licensed vocational nurse L (LVN L) she was asked about her understanding of the BBW for the medication Levaquin. She responded that Levaquin has a rare side effect of tendonitis, it is very painful, can be excruciating pain in a tendon. This must be addressed right away. The doctor should be called right away if the resident experiences this side effect. LVN L also stated in the MAR, the medication will have a black box that nurses will click on prior to administering the medication which will show what precautions to observe for. During an interview with registered nurse I (RN I) on 6/13/2025 at 3:51 p.m., RN I stated they monitored Levaquin's adverse side effects, but she was not sure about the BBW. During an interview with licensed vocational nurse J (LVN J) on 6/13/2025 at 3:57 p.m., LVN J stated the BBW warning should be documented in the progress notes. LVN J confirmed only day shift licensed nurses would be alerted about the Levaquin's BBW because they were the ones who administered the medication. LVN J stated evening and night shift nurses would not be alerted to monitor the BBW because they did not administer the medication. During an interview with licensed vocational nurse K (LVN K) on 6/16/2025 at 10:02 a.m., LVN K confirmed the BBW for Levaquin use would show up before the medication administration and nurses should document that the Levaquin's BBW were monitored. LVN K stated evening and night shift nurses would not be able to document because the BBW would not pop up in their electronic documentation. During an interview with medical director (MD) on 6/18/2025 at 9:45 a.m., MD confirmed she was aware that Levaquin was being prescribed especially by old, schooled doctor, and we talked about this before. MD stated when a medication with BBW was ordered, she expected licensed nurses (LN) to monitor residents on medication with BBW and to communicate with the doctors and pharmacists. During a review of the facility's policy and procedure titled, Black Box Warning Medication Policy, date revised 2/5/2025, indicated, Purpose: To ensure the safe use, monitoring, and documentation of medications that carry an FDA Black Box Warning, which indicates a serious or life-threatening risk associated with the drug. Policy: All medications with a Black Box warning must be reviewed for clinical appropriateness and administered with careful monitoring .4. Documentation: Nursing progress notes must reflect monitoring and resident response. Due to the inconsistencies with staff statements and the above policy and procedure review, the survey team reviewed all residents who received Levaquin from January 2025 to June 17, 2025. (continued on next page)

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F 0757 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	For Resident 21: Review of Resident 21's clinical record titled, admission Record, indicated she was admitted on [DATE] with diagnoses including infection and inflammatory reaction (the body's immune system's response to injury or infection, characterized by redness, swelling, heat, pain, and sometimes loss of function) due to internal left hip prosthesis (artificial hip joint), aortic valve stenosis (narrowing of the valve in the large vessel branching off the heart {aorta} and hypertension (high blood pressure). Review of Resident 21's physician order, dated 2/21/25, indicated Levaquin 750 mg once daily for wound infection until 3/5/25. Review of Resident 21's 2/2025 and 3/2025 MAR , indicated Resident 21 received Levaquin 750 mg daily at 8 p.m. from 2/21/25 until 3/5/25. Review of Resident 21's nursing progress notes dated 2/21 - 3/10/2025, indicated there was no documented monitoring by licensed staff related to the BBW potential serious adverse effects for the use of Levaquin. For Resident 33: Review of Resident 33's clinical record titled, admission Record, indicated she was admitted on [DATE] with diagnoses including fracture right pubis (a break in the pubic bone, part of the pelvis), osteoarthritis (degenerative joint disease , a condition where the protective cartilage within joints gradually wears down, leading to pain, stiffness, and reduced range of motion) and hypertension (high blood pressure). Review of Resident 33's physician order, dated 5/4/25, indicated Levaquin 500 mg one time only for suspected UTI (Urinary Tract Infection , a bacterial infection that affects any part of the urinary system, including the kidneys, bladder, ureters, and urethra). An additional physician order, dated 5/6/25, indicated Levaquin 500 mg STAT (immediately) for UTI. An additional physician order dated 5/7/25 indicated Levaquin 500 mg one time a day for UTI for 2 days. Review of Resident 33's 5/2025 MAR indicated Resident 33 received Levaquin 500 mg on 5/4/25 at 5:05 p.m. , 500 mg at 5:31 p.m. on 5/6/25, and 500 mg at 9:00 a.m. on 5/7/25 and 5/8/25. Review of Resident 33's nursing progress notes dated 5/4 - 5/15/2025, indicated there was no documented monitoring by licensed staff related to the BBW potential serious adverse effects for the use of Levaquin. For Resident 74: Review of Resident 74's clinical record titled, admission Record, indicated she was admitted on [DATE] with diagnoses including acute kidney failure, rhabdomyolysis (breakdown of muscle tissue that releases damaging protein into the blood) and hypertension (high blood pressure). (continued on next page)

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Gilroy Healthcare and Rehabilitation Center	8170 Murray Avenue Gilroy, CA 95020

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F 0757 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of Resident 74's physician order, dated 1/5/25, indicated Levaquin 500 mg daily for infection for 5 days. An additional physician order, dated 2/10/25, indicated Levaquin 500 mg daily for suspected URI (upper respiratory infection , a common illness caused by viruses or bacteria that infect the nose, throat, and sinuses) for 6 days. An additional physician order, dated 4/26/25, indicated Levaquin 250 mg two tablets STAT for suspected UTI. Review of Resident 74's 1/2025, 2/2025 and 4/2025 MAR indicated Resident 74 received Levaquin 500 mg at 1:00 p.m. from 1/5/25 through 1/9/25, 500 mg at 9:00 a.m. from 2/10/25 through 2/16/25, and 500 mg at 7:53 p.m. on 4/26/25. Review of Resident 74's 1/2025, 2/2025 and 4/2025 nursing progress notes indicated there was no documented monitoring by licensed staff related to the BBW potential serious adverse effects for the use of Levaquin. For Resident 93: Review of Resident 93's clinical record titled, admission Record, indicated he was admitted on [DATE] with diagnoses including chronic peripheral venous insufficiency (veins have problems sending blood from the legs back to the heart), idiopathic peripheral autonomic neuropathy (damage to the nerves that control automatic body functions) and hypertension (high blood pressure). Review of Resident 93's physician order, dated 2/2/25, indicated Levaquin 500 mg one time only for possible UTI. An additional physician order, dated 2/6/25, indicated Levaquin 500 mg daily for suspected UTI for 6 days. An additional physician order, dated 3/5/25, indicated Levaquin 500 mg one time only for UTI. An additional physician order, dated 3/7/25, indicated Levaquin 500 mg daily for UTI for 7 days. Review of Resident 93's 2/2025 and 3/2025 MAR indicated Resident 93 received Levaquin 500 mg at 7:51 p.m. on 2/2/25, 500 mg at 9:00 a.m. from 2/6/25 through 2/11/25, 500 mg at 5:12 p.m. on 3/5/25, and 500 mg at 9:00 a.m. from 3/8/25 through 3/14/25. Review of Resident 93's 2/2025 and 3/2025 nursing progress notes indicated there was no documented monitoring by licensed staff related to the BBW potential serious adverse effects for the use of Levaquin. For Resident 122: Review of Resident 122's clinical record titled, admission Record, indicated he was admitted on [DATE] with diagnoses including intracardiac thrombosis (formation of clots within the chambers of the heart), chronic kidney disease, chronic embolism (a blockage in your blood vessel usually from a blood clot) and thrombosis of deep vein of lower extremity Blood clot present in deep vein of leg for an extended period of time), long term use of anticoagulants (medication to prevent or treat blood clots). (continued on next page)

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F 0757 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of Resident 122's physician order, dated 3/3/25, indicated Levaquin 500 mg STAT for suspected UTI. An additional physician order, dated 3/13/25, indicated Levaquin 500 mg one time only for UTI. An additional physician order, dated 3/14/25, indicated Levaquin 500 mg one time only daily for UTI for 6 days. An additional physician order dated 4/13/25 indicated Levaquin 500 mg daily for suspected UTI for 2 days. Review of Resident 122's 3/2025 and 4/2025 MAR indicated Resident 122 received Levaquin 500 mg at 8:37 a.m. on 3/3/25, 500 mg at 11:04 p.m. on 3/13/25, 500 mg at 9:00 a.m. from 3/14/25 through 3/19/25, 500 mg at 5:12 p.m. on 3/5/25, 500 mg at 9:00 a.m. from 3/8/25 through 3/14/25, 500 mg at 2:38 p.m. on 4/13/25, and 500 mg at 9:00 a.m. on 4/14/25. Review of Resident 122's 3/2025 and 4/2025 nursing progress notes indicated there was no documented monitoring by licensed staff related to the BBW potential serious adverse effects for the use of Levaquin. For Resident 123: Review of Resident 123's clinical record titled, admission Record, indicated she was admitted on [DATE] with diagnoses including pneumonia (an infection of the lungs that causes inflammation of the air sacs [alveoli]), diabetes mellitus (blood sugar levels are too high), congestive heart failure (heart does not pump the blood efficiently), chronic pain syndrome, and obesity. Review of Resident 123's physician order, dated 1/4/25, indicated Levaquin 500 mg daily for infection for 5 days. An additional physician order, dated 2/18/25, indicated Levaquin 500 mg daily for bronchitis for 5 days. Review of Resident 123's 1/2025 and 2/2025 MAR indicated Resident 123 received Levaquin 500 mg at 9:00 a.m. from 1/4/25 through 1/8/25, and 500 mg at 9:00 a.m. from 2/18/25 through 2/22/25. Review of Resident 123's 1/2025 and 2/2025 nursing progress notes indicated there was no documented monitoring by licensed staff related to the BBW potential serious adverse effects for the use of Levaquin. For Resident 124: Review of Resident 124's clinical record titled, admission Record, indicated he was admitted on [DATE] with diagnoses including infection and inflammatory reaction due to internal prosthetic devices (an artificial device or implant that is surgically placed inside the body to replace a missing or damaged internal body part or function), polyneuropathy, (nerves in different parts of the body are damaged), diabetes mellitus (blood sugar levels are too high), Chronic Obstructive Pulmonary Disease (COPD, progressive lung disease that makes it hard to breathe), end stage renal disease (ESRD, irreversible kidney failure), dependance on renal dialysis (a treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidney(s) have failed). Review of Resident 124's physician order, dated 1/8/25, indicated Levaquin 500 mg daily every 2 days for Acute UTI for 6 administrations. (continued on next page)

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F 0757 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of Resident 124's 1/2025 MAR indicated Resident 21 received Levaquin 500 mg daily at 8:00 p.m. on 1/8/25, 1/10/25, 1/12/25, 1/14/25, 1/16/25, and 1/18/25. Review of Resident 124's nursing progress notes dated 1/8 -1/25/25, indicated there was no documented monitoring by licensed staff related to the BBW potential serious adverse effects for the use of Levaquin. For Resident 125: Review of Resident 125's clinical record titled, admission Record, indicated he was admitted on [DATE] with diagnoses including acute kidney failure, disease of the pancreas (a gland located in the abdomen, behind the stomach. It plays a crucial role in digestion, and blood sugar regulation), chronic viral hepatitis C (infection caused by a virus that attacks the liver) Review of Resident 125's physician order, dated 1/16/25, indicated Levaquin 500 mg one time only for suspected infection. Review of Resident 125's 1/2025 MAR indicated Resident 125 received Levaquin 500 mg daily one time only at 12:47 p.m. on 1/16/25. Review of Resident 125's nursing progress notes dated 1/16 -1/25/2025, indicated there was no documented monitoring by licensed staff related to the BBW potential serious adverse effects for the use of Levaquin. For Resident 126: Review of Resident 126's clinical record titled, admission Record, indicated he was admitted on [DATE] with diagnoses including pneumonia (inflammation or infection in the lungs), diabetes mellitus (blood sugar levels are too high), hypertension (high blood pressure), pulmonary embolism (arteries in the lungs become blocked by a blood clot). Review of Resident 126's physician order, dated 1/6/25, indicated Levaquin 500 mg daily for pneumonia for 6 days. Review of Resident 126's 1/2025 MAR , indicated Resident 126 received Levaquin 500 mg daily at 9:00 a.m. from 1/7/25 through 1/10/25. Review of Resident 126's nursing progress notes dated 1/7 - 1/15/2025, indicated there was no documented monitoring by licensed staff related to the BBW potential serious adverse effects for the use of Levaquin. For Resident 388: Review of Resident 388's clinical record titled, admission Record, indicated she was admitted on [DATE] with diagnoses including chronic kidney disease, hypertensive heart disease (heart problems that develop with chronic high blood pressure), atherosclerosis of aorta (build-up of plaque (a localized, abnormal patch or deposit on a body part or surface, often composed of accumulated substances) in the aorta {main artery of the heart}, pleural effusion ((build-up of fluid around the lungs). (continued on next page)

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F 0757 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of Resident 388's physician order, dated 1/15/25, indicated Levaquin 750 mg one time only for pneumonia. Review of Resident 388's 1/2025 MAR indicated Resident 388 received Levaquin 750 mg daily at 9:58 p.m. on 1/14/25. Review of Resident 388's nursing progress notes dated 1/14 - 1/20/2025, indicated there was no documented monitoring by licensed staff related to the BBW potential serious adverse effects for the use of Levaquin. During an interview and concurrent record review on 6/18/25 at 10:00 a.m. with registered nurse H (RN H), she reviewed the records for Residents 21, 33, 74, 93, 122, 123, 124, 125, 126, and 388. RN H confirmed there was no monitoring documented on the MAR or in the licensed nurse progress notes related to the BBW potential serious adverse effects for the use of Levaquin for the above - mentioned residents. RN H stated the nurses progress notes do identify the residents are receiving an antibiotic but there is no specific mention of Levaquin's BBW. For Resident 10: Review of Resident 10's face sheet (FS: a document that gives resident's information at a quick glance) indicated Resident 10 was admitted to facility on 4/8/2019. Review of Resident 10's diagnoses included diabetes type 2 (a chronic condition that happens with persistent high blood sugar levels) and psoriasis (a condition in which skin cells build up and form scales and itchy, dry patches). Review of Resident 10's physician orders dated 2/7/2025 indicated Levaquin 500 milligram (mg: a unit of mass equal to one-thousandth of a gram) one time a day for 6 days for respiratory infection. Review of Resident 10's electronic medication administration record (EMAR: digital system for documenting medication administration) for February/2025 indicated Resident 10 received Levaquin from 2/7/2025 to 2/13/2025 at 9:00 a.m. Review of Resident 10's nursing progress notes for February/2025 indicated there was no documented evidence that nursing staff monitored and documented BBW serious adverse reactions every shift for Levaquin use. Resident 377: Review of Resident 377's FS indicated Resident 377 was admitted to facility on 4/10/2025. Review of Resident 377's diagnoses included diverticulosis (when small, bulging pouches [called diverticula] form in the lining of your intestine, usually the colon) of large intestine (part of body organ responsible for processing indigestible food materials) and infection (inflamed and infected lining of the large intestine) and inflammatory reaction (complication following knee surgery with infection inflammation) due to internal right knee prothesis (an artificial device that replaces a missing or impaired part of the body). (continued on next page)

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F 0757 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of Resident 377's order summary report, date ordered 5/20/2025, indicated an order of Levaquin 500 mg one time a day for 5 days for respiratory infection. Review of Resident 377's EMAR for May/2025 indicated Resident 377 received Levaquin from 5/20/2025 to5/25/2025 at 9:00 a.m. Review of Resident 377's nursing progress notes for May/2025 and June/2025 till 6/14/2025 indicated there was no documented evidence that nursing staff monitored and documented BBW serious adverse reactions every shift for Levaquin use. Resident 222: Review of Resident 222's FS indicated Resident 222 was admitted to facility on 5/22/2025. Review of Resident 222's diagnoses included cellulitis of right lower limb (a skin infection of right leg). Review of Resident 222's order summary report, date ordered 5/22/2025, it indicated an order of Levofloxacin 750 mg one time a day until 5/25/2025 for cellulitis. Review of Resident 222's EMAR for May/2025 indicated Resident 222 received Levofloxacin from 5/23/2025 to 5/25/2025 every day at 9:00 a.m. Review of Resident 222's nursing progress notes for May/2025 and June/2025 till 6/14/2025 indicated there was no documented evidence that nursing staff monitored and documented BBW serious adverse reactions every shift for Levaquin use. Resident 49: Review of Resident 49's FS indicated Resident 49 was admitted to facility on 2/5/2025. Review of Resident 49's diagnoses included urinary tract infection (an infection of system of body organs that makes urine) and unspecified Escherichia coli (common bacteria found in human gut, commonly harmless. However, certain strains cause infections and illnesses). Review of Resident 49's order summary report, date ordered 5/29/2025, it indicated an order of Levaquin 500 mg one time for infection for 1 day. Review of Resident 49's EMAR for May/2025 indicated Resident 49 received Levaquin on 5/29/2025 (one dose) at 7:23 p.m. Review of Resident 49's nursing progress notes for May/2025 and June/2025 till 6/14/2025 indicated there was no documented evidence that nursing staff monitored and documented BBW serious adverse reactions every shift for Levaquin use. Resident 106: Review of Resident 106's FS indicated Resident 106 was admitted to facility on 2/26/2025. (continued on next page)

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F 0757 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of Resident 106's diagnoses included diabetes type 2 and peripheral vascular disease (a circulatory condition in which narrowed blood vessels reduce blood flow to arms and legs). Review of Resident 106's order listing report date ordered 5/28/2025, it indicated an order of Levaquin 500 mg one time a day for infection until 6/24/2025. Review of Resident 106's EMAR for May/2025 indicated Resident 106 received Levaquin on 5/28/2025 till 5/31/2025 at 9:00 a.m. Review of EMAR for June/2025 indicated Resident 106 currently receiving Levaquin every day at 9:00 a.m. Review of Resident 106's nursing progress notes for May/2025 and June/2025 till 6/14/2025 indicated there was no documented evidence that nursing staff monitored and documented BBW serious adverse reactions every shift for use of Levaquin. Resident 323: Review of Resident 323's FS indicated Resident 323 was admitted to facility on 2/7/2025 and discharged home on 5/18/2025. Review of Resident 323's diagnoses included diabetes type 2 and pseudomonas as the cause of diseases (type of bacteria common cause of infections from mild skin rashes to severe, life-threatening illnesses). Review of Resident 323's order summary report, date ordered 5/15/2025, it indicated an order of Levaquin 500 mg one time a day for right thigh wound infection for 14 days, and this order had been discontinued on 5/18/2025. Review of Resident 323's EMAR for May/2025 indicated Resident 323 received Levaquin on 5/16/2025 and 5/17/2025 at 5:00 p.m., (2 doses). Review of Resident 323's nursing progress notes for May/2025 and June/2025 till 6/14/2025 indicated there was no documented evidence that nursing staff monitored and documented BBW serious adverse reactions every shift for Levaquin use. Resident 16: Review of Resident 16's FS indicated Resident 16 was admitted to facility on 3/1/2025 and discharged from facility on 6/6/2025. Review of Resident 16's diagnoses included diabetes type 2 and aftercare following neoplasm surgery (monitoring healing, managing potential complications and ensuring overall well-being during recovery after tumor [abnormal tissue growth] surgery). Review of Resident 16's order listing report, date ordered 5/21/2025, it indicated an order of Levofloxacin 500 mg stat (immediately or at once) for cough. Review of Resident 16's EMAR for May/2025 indicated Resident 16 received Levofloxacin on 5/21/2025 at 12:06 pm., (one dose). (continued on next page)

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F 0757 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of Resident 16's nursing progress notes for May/2025 and June/2025 till 6/6/2025 indicated there was no documented evidence that nursing staff monitored and documented BBW serious adverse reactions every shift for Levofloxacin use. For Resident 22: Review of Resident 22's FS indicated Resident 22 was admitted to facility on 1/30/2023. Review of Resident 22's diagnoses included congestive heart failure (chronic condition where the heart muscle is unable to pump enough blood to meet body's needs) and disorder of urinary system (a condition impacts the body's ability to filter and pass urine). Review of Resident 22's order listing report, date ordered 5/8/2025, it indicated an order of Levaquin 250 mg one time a day for respiratory infection for 7 days. Review of Resident 22's EMAR for May/2025 indicated Resident 22 received Levaquin from 5/8/2025 till 5/14/2025 at 9:00 a.m. Review of Resident 22's nursing progress notes for May/2025 and June/2025 indicated there was no documented evidence that nursing staff monitored and documented BBW serious adverse reactions every shift for use of Levaquin. Resident 63: Review of Resident 63's FS indicated Resident 63 was admitted to facility on 3/1/2025. Review of Resident 63's diagnoses included hypertension (a condition in which the force of the blood against the artery [a blood vessel that carries blood from heart to tissues and organs in the body] walls is too high). Review of Resident 63's order summary report, date ordered 5/15/2025, it indicated an order of Levaquin 500 mg one time only for PNA (pneumonia: inflammation and fluid in lungs [a pair of spongy. Pinkish-gray organs essential for breathing and gas exchange] caused by infection) and this order had been extended for 6 more days till 5/21/2025. Review of Resident 63's EMAR for May/2025 indicated Resident 63 received Levaquin from 5/15/2025 till 5/21/2025 (7 doses) at 9:00 a.m. Review of Resident 63's nursing progress notes for May/2025 and June/2025 till 6/14/2025 indicated there was no documented evidence that nursing staff monitored and documented BBW serious adverse reactions every shift for use of Levaquin. For Resident 322: Review of Resident 322's FS indicated Resident 322 was admitted to facility on 11/4/2024 and discharged from facility on 2/7/2025. (continued on next page)

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F 0757 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of Resident 322's diagnoses included diabetes type 2 and chronic kidney (kidney: body organ that filters waste and excess fluid from blood) disease (progressive damage and loss of function in the kidneys). Review of Resident 322's order listing report, date ordered 12/28/2024, it indicated an order of Levaquin 500 mg one time a day for respiratory infection for 6 days. Review of Resident 322's EMAR for December/2024 and January/2025 indicated Resident 322 received Levaquin on 12/29/2024 to 1/3/2025(6 doses) at 9:00 a.m. Review of Resident 322's nursing progress notes for December/2024 and January/2025 indicated there was no documented evidence that nursing staff monitored and documented BBW serious adverse reactions every shift for use of Levaquin. During an interview with RN O on 6/16/2025 at 4:00 pm, RN O stated medications' severe allergic reaction was different from BBW serious adverse reactions . RN O also stated there was no monitoring of BBW serious adverse reactions for residents on medications with BBW. RN O further stated nursing staff should have[TRUNCATED]

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. Based on observation, interview, and record review, the facility had a medication error rate of 18.18% when 6 medication errors occurred out of 33 opportunities during the medication administration for three out of eight residents (Resident 52, 106, and 112). For Resident 106, the nursing staff did not prime (the process of removing air from the insulin pen and needle before each injection) the insulin (medication to lower blood sugar) pen and needle before giving insulin. Resident 112 received fluticasone nasal spray (a medication for seasonal allergies) not as ordered. Resident 52 received 4 medications that were combined, crushed, administered together via the gastrostomy tube (G-tube, a tube inserted through the abdomen that delivers nutrition and medications directly to the stomach), a practice contrary to the facility's policy and procedures (P&P). The failures resulted in a medication not given as ordered; potential for too low or high dose of insulin that could lead to adverse effects; and potential for physical and chemical incompatibilities (undesirable chemical or physical reactions that occur when two or more drugs are mixed) and tube occlusion (blockage) when medications are crushed and mixed together given via the feeding tube. Findings: 1. During the medication administration observation on 6/9/25 at 9:42 a.m., at Resident 106's bedside, Licensed Vocational Nurse (LVN) C was observed pricking Resident 106's right middle finger to obtain a blood sample to get a blood sugar reading. Returning to the medication cart, on 6/9/25 at 9:47 a.m., LVN C was observed removing an insulin pen called Tresiba Flextouch (a pre-filled pen containing insulin degludec, an ultra-long-acting insulin, which works steadily throughout the day to control blood sugar between meals and overnight) from the medication cart. Then she removed the pen cap, wiped the rubber seal, placed a needle on the rubber seal, and turned the dose dial to 40 units. She stated she will give 40 units to the resident. During this process, LVN C did not prime the pen and needle. On 6/9/25 at 9:48 a.m., at Resident 106's bedside, LVN C injected Tresiba dose into the resident's abdomen. During an interview with LVN C on 6/9/25 at 9:52 a.m., when asked about priming insulin pen before injection, LVN C stated, I am supposed to prime with 3 units but I did not. A review of Resident 106's clinical record indicated a physician's order, dated 3/19/25, for Insulin Degludec FlexTouch, inject 40 units subcutaneously (under the skin) one time a day for diabetes (a condition that happens when your blood sugar is too high). During an interview with the Director of Nursing (DON) on 6/10/25 at 9:54 a.m., she stated, You prime the insulin pen before administration. During a telephone interview with the Consultant Pharmacist (CP) on 6/12/25 at 1:49 p.m., when asked about insulin pen administration, the CP stated the pen has to be primed before each administration. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the facility's P&P titled Insulin Pen, reviewed/revised 4/9/25, indicated the following: 6. Insulin pens will be primed prior to each use to avoid collection of air in the insulin reservoir . h. Prime the insulin pen: i. Dial 2 units by turning the dose selector clockwise. ii. With the needle pointing up, push the plunger, and watch to see that at least one drop of insulin appears on the tip of the needle. If not, repeat until at least one drop appears. i. Set the insulin dose: i. Turn the dose selector to ordered dose . 2. During a medication administration observation on 6/9/25 at 10:01 a.m., LVN A was observed preparing 7 medications for Resident 112 including a nasal spray bottle called fluticasone 50 micrograms (mcg, unit of measurement) per spray. A review of the pharmacy label on the fluticasone bottle indicated to administer 2 sprays into each nostril. On 6/9/25 at 10:12 a.m., at Resident 112's bedside, LVN A was observed administering only 1 spray of fluticasone into each of the resident's nostrils. During an interview with LVN A on 6/9/25 at 10:23 a.m., when asked how many fluticasone sprays should be administered per nostril, LVN A reviewed the physician's order on her laptop and stated, It says two. She confirmed she administered only 1 spray per nostril and will give another spray now. A review of Resident 112's clinical record indicated a physician's order, dated 4/10/25, for Fluticasone Propionate Nasal Suspension 50 MCG/ACT[uation] . 2 spray[s] in each nostril one time a day for Allergy. A review of the facility's P&P titled Medication Administration, revised on 3/28/25, indicated the staff administering medications ensure the six rights of medication administration including the right dose. 3. During a medication administration observation on 6/9/25 at 4:37 p.m., Registered Nurse (RN) B was observed preparing 4 medications for Resident 52, who was receiving medications via the G-tube. The 4 medications were: 1 tablet of carvedilol (for hypertension or high blood pressure) 3.125 mg, 1 tablet of docusate sodium (a laxative) 100 mg, 1 tablet of famotidine (medication to reduce acid in the stomach) 20 mg, and 1 tablet of hydralazine (for hypertension) 50 mg. During the preparation on 6/9/25 at 4:53 p.m., RN B was observed placing all 4 tablets into a small plastic bag and crushed them together into fine powder by using the pill crusher. Then she transferred the medication mixture powder into the medication cup and added some water to dilute the powder. (continued on next page)

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	055797	A. Building B. Wing	06/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Gilroy Healthcare and Rehabilitation Center	8170 Murray Avenue Gilroy, CA 95020

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 6/9/25 at 4:55 p.m., at Resident 52's bedside, RN B was observed flushing the resident's G-tube with about 20 milliliters (mL) of water using a large syringe. Next, she drew the diluted medication mixture from the cup into the syringe, attached the syringe to the resident's G-tube, and pushed it into the G-tube. Then she did the final flushing of the tubing with some water. During an interview on 6/9/25 at 4:58 p.m., RN B was asked about medications being crushed and administered together via the feeding tube. She stated, I should have done separate. It didn't come to my mind. She stated there was no hold parameters for the medications so she thought it was okay to give them together. A review of Resident 52's clinical record indicated the following physician's orders: a. Carvedilol 3.125 mg, give 1 tablet via G-tube two times a day for hypertension, dated 4/3/25; b. Docusate sodium 100 mg, give 1 tablet via G-tube two times a day for constipation, dated 4/19/25; c. Famotidine 20 mg, give 1 tablet two times a day for gastrointestinal protection, dated 5/29/25; and d. Hydralazine 50 mg, give 1 tablet via G-tube two times a day for hypertension, dated 4/3/25. On 6/10/25 at 9:54 a.m., in an interview with the DON regarding medication administration via the feeding tube, she stated medications are not to be combined together; they are to be crushed separately and administered separately with flushing of water before, between, and after medication administration. During a telephone interview with the CP on 6/12/25 at 1:49 p.m., she stated there has been a lot of reminders to the nursing staff not to mix medications together via enteral tube administration. She stated, Meds have to be separated and flushing of water before, and in between each med, and afterwards. A review of the facility's P&P titled Medication Administration via Enteral Tube, revised 4/09/25, indicated: Each medication will be administered separately, not combined or added to an enteral feeding formula . Flush enteral tube with at least 15 mL of water prior to administering medication . Dilute the solid or liquid medication as appropriate and administer using a clean oral syringe . Flush tube again with at least 15 mL water taking into account resident's volume status.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observation and interview the facility failed to ensure food served was palatable and attractive. This failure had the potential to affect the amount of food residents consume, which could decrease their food intake and lead to poor nutrition and health outcomes. Findings: During an interview on 6/9/25 at 9:34 a.m. with Resident 17, Resident 17 stated that Breakfast this morning was terrible, no taste, and bland. She also stated the food overall in the facility was terrible most of the days. During an interview on 6/9/25 at 10:10 a.m. with Resident 42, Resident 42 stated The breakfast is not exciting, same food every day, no change, eggs every day. Resident 42 also stated that the meals had no flavor and no taste and that she does not like the food. During an interview on 6/9/25 at 10:15 a.m. with Resident 98, Resident 98 stated Breakfast is just OK, nothing exciting. She stated she is getting eggs with no taste and the edges are too dry. During an interview on 6/9/25 at 11:09 a.m. with Resident 321, Resident 321 stated the food is terrible, no taste, and the same food every day. As a result of multiple resident complaints about the food, a test tray evaluation was conducted during the lunch service on 6/11/25 at 1:28 p.m. The registered dietician (RD) and the dietary manager (DM) were in attendance when the test tray contents were sampled by seven surveyors. One item on the test tray was green beans, an alternate vegetable for those residents who disliked broccoli. The surveyors stated the green beans did not look appealing at all, had very little green color, and appeared overcooked. The surveyors who sampled the green beans stated the green beans had no flavor. The DM tasted the green beans and stated, The green beans are mushy and don't have any flavor. The RD stated, I did not even taste them, they do not look appetizing to me, I would not eat them. A review of the facility document titled, Job Description: Cook, dated 1/1/08, indicated essential duties of the cook were to Ensure that all food has an appealing presentation (we eat with our eyes). A review of the facility document titled, Job Description: Registered Dietician, dated 4/1/11, indicated job duties included Observes and assesses residents to monitor food acceptance and nutritional status and Evaluates and monitors the operations of the Dietary Department to assure the provision of adequate, high-quality food.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview and record review, the facility failed to ensure food was stored, prepared, distributed, and served in accordance with professional standards for food safety when pans used for food preparation and food service were stacked and stored wet. This failure had the potential to cause food contamination and food-borne illness to 117 of 118 residents who received their food from the kitchen. Findings: During an initial kitchen tour on 6/9/25 at 9:30 a.m., accompanied by the dietary manager (DM), there were 11 metal pans of various sizes, observed to be stored under the steam table. The pans were stacked upside down inside of one another and were wet inside and outside of the pan's surfaces. The DM confirmed the pans were wet and he stated they should have been air dried before being stacked and stored. According to the 2022 Food and Drug Administration (FDA) Food Code, Section 4-901.11 Equipment and Utensils, Air-Drying Required, After cleaning and sanitizing, equipment and utensils: shall be air-dried . According to the FDA Food Code 2022 4-903 Storing, Clean equipment and utensils shall be stored in a self-draining position that allows air drying.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 5. On [DATE] at 9:19 a.m., Licensed Vocation Nurse (LVN) C was observed removing a glucometer from the medication cart. On [DATE] at 9:22 a.m., at Resident 5's bedside, LVN C was observed pricking the resident's left middle finger to get a blood sample for the blood sugar reading. On [DATE] at 9:28 a.m., LVN C was observed removing a pre-saturated chlorox disinfectant wipe and wrapping it around the glucometer without wipping it down first. Then she placed it on top of the medication cart. On [DATE] at 9:38 a.m., LVN C used the same glucometer and entered Resident 106's room to obtain his blood sugar reading. She stated she could not get a reading because the battery in the glucometer died. Two minutes later, on [DATE] at 9:40 a.m., LVN C returned to the medication cart, and again, used the chlorox disinfectant wipe to wrap around the glucometer without cleaning it first with the wipe. On [DATE] at 9:42 a.m., LVN C returned to Resident 106's room with another glucometer and was able to obtain a blood sugar reading. On [DATE] at 9:45 a.m., LVN C returned to the medication cart and again wrapped the glucometer with a chlorox disinfectant wipe. On [DATE] at 9:52 a.m., LVN C was asked to show the label on the chlorox disinfectant wipe, which indicated to allow wet time for one minute. LVN C stated she disinfects the glucometer by wrapping a wipe around the glucometer and allow it to stay wet between resident uses. She acknowledged she did not use the wiping motion to cover the surfaces of the glucometer for 1 minute as instructed on the bottle. During an interview with the Infection Preventionist (IP) in the presence of the Director of Nursing (DON) on [DATE] at 10:15 a.m., the IP stated the nurse needs to wipe down the glucometer for 1 minute and wrap it afterwards. She further stated they need to wipe down first before wrapping. A review of the facility's P&P titled Glucometer Disinfection, dated [DATE], indicated, Glucometers will be cleaned and disinfected after each use . Procedure: . i. Retrieve (2) disinfectant wipes from container. j. Using first wipe, clean first to remove heay soil, blood and/or other contaminants left on the surface of the glucometer. k. After cleaning, use second wipe to disinfect the glucometer thoroughly with the disinfectant wipe, following the manufactuer's instructions. Allow the glucometer to air dry. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	6. On [DATE] at 9:19 a.m., upon meeting with LVN C, she stated she had already prepared the morning medications for Resident 5. She placed the medication cup along with the glucometer in the medication tray and took it to Resident 5's room. On [DATE] at 9:22 a.m., at Resident 5's bedside, LVN C placed the medication tray on the resident's over-bed table. After administering the medications and obtaining the blood sugar reading, LVN C took the medication tray, returned to the medication cart in the hall way, and placed the tray on top of the cart. LVN C did not wipe or clean the medication tray. On [DATE] at 9:32 a.m., LVN C started preparing 6 medications for the next resident, Resident 106. After finished, she placed Resident 106's medication cup, along with a cup of water, into the same medication tray. On [DATE] at 9:38 a.m., at Resident 106's bedside, LVN C placed the medication tray on the resident's over-bed table and administered the medications to the resident. On [DATE] at 9:45 a.m., LVN C returned to the medication cart and and placed the medication tray on top of it without cleaning or disinfecting it. During an interview on [DATE] at 9:52 a.m., LVN C confirmed she did not disinfect the medication tray between the uses for Resident 5 and Resident 106. LVN C stated she should have. A review of the facility's P&P titled Infection Prevention and Control Program revised [DATE], indicated, All staff shall assume that all residents are potentially infected or colonized with an organism that could be transmitted during the course of providing resident care services and All reusable items and equipment . shall be cleaned in accordance with our current procedures governing the cleaning and sterilization of soiled or contaminated equipment. 7. During a medication administration observation on [DATE] at 4:37 p.m., Registered Nurse (RN) B was observed preparing 4 medications for Resident 52, who was receiving medications via the G-tube. A signage indicating ENHANCED BARRIER PRECAUTIONS was observed posted at the door outside of Resident 52's room. On [DATE] at 4:55 p.m., RN B brought the prepared medications into Resident 52's bedside and administered the medications via G-tube with gloves on but without wearing a gown. During an interview on [DATE] at 4:58 p.m., when asked whether she should have worn a gown for the G-tube administration for Resident 52, RN B stated the gown was required only for anything with high contact. I didn't touch his skin. During an interview with the DON on [DATE] at10:05 a.m., she stated nurses are required to wear gloves and gown during enteral tube medication administration according to the facility's EBP policy. A review of the facility's P&P titled Enhanced Barrier Precautions, dated [DATE], indicated personal protective equipment (PPE) with gowns and gloves for EBP is only necessary when performing high-contact activities. The P&P further indicated, High-contact resident care activities include . Device care or use . feeding tubes . (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Review of Resident 5's clinical record titled, admission Record, dated [DATE], indicated Resident 5 was admitted to the facility on [DATE] with diagnoses including type 2 diabetes mellitus (DM - a condition which affects the way the body processes blood sugar), with diabetic neuropathy (nerve damage caused by DM), chronic kidney disease (a condition where the kidneys are damaged and cannot filter blood as well as they should, leading to a buildup of waste and excess fluid in the body), atrial fibrillation (a common heart rhythm disorder where the heart's upper chambers [atria} beat irregularly and often rapidly) and heart failure (a condition where the heart muscle is unable to pump enough blood to meet the body's needs). Review of Resident 5's Order Summary Report, with order dated [DATE], indicated, Ipratropium-Albuterol Inhalation Solution [a medicine used to treat breathing problems] 0.5-2.5 (3) MG [milligrams, unit of measurement]/3ML [milliliters, volume of measurement] (Ipratropium-Albuterol) 3 ml inhale orally every 4 hours as needed for Wheezing [a high pitched whistling sound that occurs during breathing, typically when air passes through narrowed or obstructed airways in the lungs]. During an observation on [DATE] at 9:39 a.m., inside Resident 5's room, Resident 5 was in bed and observed his used nebulizer kit with mask and tubing was on top of his other belongings in the bedside drawer, unlabeled and undated. Picture taken. During a concurrent observation and interview with restorative nursing assistant T (RNA T) on [DATE] at 9:43 a.m., inside Resident 5's room, Resident 5's used nebulizer kit with mask and tubing were still on top of Resident 5's personal belongings in the bedside drawer, unlabeled and undated. RNA T confirmed the above observation and stated the nebulizer kit with mask and tubing should be placed inside a plastic bag when not in used. RNA T further confirmed, the nebulizer kit with mask or its tubing did not have any label. During a concurrent interview with case manager W (CM W) and photo review on [DATE] at 8:38 a.m., CM W reviewed the photo of Resident 5's nebulizer kit with mask and tubing placed on top of Resident 5's belongings in the bedside drawer. When asked about the facility's policy and procedure of how to care of residents' nebulizer kit with mask and how often should they change it, CM W was unable to answer the question and stated, I'll get back to you. During an interview with licensed vocational nurse G (LVN G) on [DATE] at 9:04 a.m., LVN G stated the nebulizer mask should be changed monthly and they did not have to label it with the date because it was already indicated in the resident's medication administration record (MAR - a daily documentation record used by a licensed nurse to document medications and treatments given to a resident). LVN G further stated, after the resident had completed the nebulization, licensed nurses had to rinse the nebulizer kit with mask, air dried and placed inside the plastic bag. During a follow-up concurrent interview with CM W and record review on [DATE] at 9:20 a.m., CM W reviewed Resident 5's Order Summary Report, and stated the order indicated to change the nebulizer mask and tubing monthly. When asked to view the order audit details, the order revealed it was created by CM W on [DATE] at 9:24 a.m. after this surveyor spoke to her. CM W confirmed and stated, to be honest with you, I entered the order [above order] yesterday [[DATE]]. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with registered nurse H (RN H) on [DATE] at 9:33 a.m., RN H stated, after resident's nebulization, they would place the nebulizer kit with mask inside the plastic bag. RN H further stated she was not sure if they needed to clean the nebulizer kit first. RN H confirmed they would just place the kit inside the plastic bag after each use and never cleaned it. RN H stated she would check the manufacturer's guideline and would get back to this surveyor. During an interview with the facility's infection preventionist (IP) on [DATE] at 1:23 p.m., IP stated the nebulizer kit with mask and tubing should be rinsed after used and placed inside the plastic bag. IP stated she was not sure about the policy but the nebulizer kit with mask and tubing should be changed every 30 days, and they did not need to label it because the date changed was documented in the resident's MAR. During a review of the facility's policy and procedure titled, Nebulizer Therapy, date revised [DATE], indicated, When medication delivery is complete, turn the machine off .Disassemble and rinse the nebulizer with sterile or distilled water and allow to air dry. Care of the Equipment: 1. Clean after each use. 2. Wash hands before handling equipment. 3. Disassemble part after every treatment. 4. Rinse the nebulizer cup and mouthpiece with sterile or distilled water. 5. Shake off excess water. 6. Air dry on an absorbent towel. 7. Once completely dry, store the nebulizer cup and the mouthpiece in a zip lock bag. 8. Change nebulizer tubing every 7 days and prn [as needed]. 8. Periodically disinfect unit per manufacturer's recommendations. 3. During a concurrent observation and interview with RNA T on [DATE] at 9:47 a.m., inside a shared bathroom of Room AA and Room BB, a used and unlabeled basin was found on top of the toilet's tank. RNA T confirmed the above observation and stated the bathroom was shared by four residents. RNA T stated the used basin should have been labeled with resident's name and room number. RNA T was unable to state where the used basin should have been stored. During an interview with the facility's IP on [DATE] at 1:23 p.m., IP stated non-critical items such as a basin should have been rinsed after use and placed in a bag. IP stated it should also be labeled with a resident's name. During a review of the facility's undated policy and procedure titled, Labeling Critical and Non-Critical Personal Belongings Policy 409, indicated, All personal belongings of residents as well as items supplied by the facility (such as urinals, bedpans, etc.) will be labeled .Store all items in appropriate place. 4. During a concurrent observation and interview with IP on [DATE] at 11:41 a.m., in front of the facility's soiled linen room, a plastic bag of dirty towels was observed on the floor beside the soiled linen room door. IP confirmed the above observation and stated the plastic bag of soiled towels should not be on the floor. During a concurrent observation and interview with laundry staff X (LS X) on [DATE] at 11:43 a.m., in front of the soiled linen room, LS X stated (as translated by the IP) she had no idea who placed the plastic bag of dirty towels on the floor, and she immediately tossed it in the soiled linen basket inside the soiled linen room. LS X confirmed the plastic bag contained dirty towels. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's policy and procedure titled, Infection Prevention and Control Program, date revised [DATE], indicated, Soiled linen shall be collected at the bedside and placed in a linen bag. When the task is complete, the bag shall be closed securely and placed in the soiled utility room. Soiled linen shall not be kept in the resident's room or bathroom. 8. During an observation on [DATE] at 9:50 a.m., noted undated and uncovered nasal cannula left on bed for Resident 34 while O2 not in use. Another undated and uncovered NC wrapped around emergency oxygen tank (a portable oxygen cylinder) while O2 not in use for Resident 34. Review of Resident 34's face sheet (FS: a document that gives resident's information at a quick glance) indicated Resident 34 was admitted to facility on [DATE]. Review of Resident 34's diagnoses included chronic obstructive pulmonary disease (a group of lung [a pair of spongy body organs crucial for breathing and gas exchange] diseases that block airflow and make it difficult to breathe). Review of Resident 34's order summary report indicated oxygen at 2 LPM (LPM: liters per minute, flow rate of supplemental oxygen deliver to resident) via NC as needed ., dated [DATE]. During an interview with certified nursing assistant Q (CNA Q) on [DATE] at 9:55 a.m., CNA Q confirmed above undated and uncovered NCs for Resident 34. 9. During an observation on [DATE] at 10:36 a.m., noted undated nebulizer face mask with tubing placed in a plastic bag left on nightstand next to Resident 8's bed. Observation of undated NC attached to RAC while O2 in use for Resident 8. Review of Resident 8's FS indicated Resident 8 was admitted to facility on [DATE]. Review of Resident 8's diagnoses included chronic respiratory failure (a long term condition which causes low levels of O2 in blood) and congestive heart failure (a chronic condition in which the heart doesn't pump blood as well as it should). Review of Resident 8's order summary report indicated ipratropium-albuterol ((a combination of liquid medication used to control and treat air flow blockage to facilitate breathing) solution 0.5-2.5 (3) MG/3ML (MG: milligram, unit of mass equal to one-thousandth of a gram, ML: milliliters: a measure of volume equal to one-thousandth of a liter) inhale (to breath in) orally (by mouth) every 6 hours as needed for SOB/wheezing (shortness of breath, difficulty breathing/ a high-pitched whistling sound made while breathing) dated [DATE]. Another order dated [DATE] indicated, oxygen at 2 LPM via NC continuous every shift for SOB. 10. During an observation on [DATE] at 10:43 a.m., noted nebulizer face mask with tubing undated, left in a plastic bag located on night stand next to Resident 10's bed. Review of Resident 10's face sheet (FS: a document that gives resident's information at a quick glance) indicated Resident 10 was admitted to facility on [DATE]. Review of Resident 10's diagnoses included wheezing. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 10's order listing summary indicated order for ipratropium-albuterol solution 0.5-2.5 (3) MG/3ML inhale orally every 8 hours for SOB (shortness of breath, difficulty breathing) and every 6 hours as needed for SOB dated [DATE]. During an interview with CNA P on [DATE] at 10:52 a.m., CNA P confirmed above findings for undated face mask and NC for Resident 8 and 10. 11. During an observation on [DATE] at 10:56 a.m., noted Resident 104's foley catheter's urine collection drain bag anchored to bed, was touched the floor. Review of Resident 104's FS indicated Resident 104 was admitted to facility on [DATE]. Review of Resident 104's diagnoses included urinary obstruction (a condition that occurs when urine flow obstructed that inhibits the flow of urine through its normal path). Review of Resident 104's order summary report indicated, Foley Catheter: 14 French 10 ML (F/C size) to Gravity (downward flow) Drainage . During an interview with CNA R on [DATE] at 10:59 a.m., CNA R confirmed above finding for Resident 104's urine collection bag touched the floor. CNA R adjusted the bag to off the floor and stated urine collection drain bag should be above the floor for infection control. During an interview with registered nurse S (RN S) on [DATE] at 9:30 a.m., RN S stated NC and nebulizer mask with tubing should be changed every week, labeled with date when changed and NC should be stored in a plastic bag when O2 not in use for infection control. RN S also stated if not dated nursing staff would not know when they were changed for residents. RN S further stated F/C urine collection drain bag should not touched floor. During an interview with facility's infection preventionist (IP) on [DATE] at 9:54 a.m., IP stated nursing staff should have labeled NC when changed for residents. IP also stated nursing staff should have placed F/C urine collection drain bag above the floor or placed in a plastic container, so bag do not touch the floor for infection control practice. IP further stated NC should be stored in a plastic bag when O2 not in use for infection control. During another interview with IP on [DATE] at 9:54 a.m., IP stated nursing staff should have dated nebulizer mask/tubing when changed for residents. IP also stated facility's policy to change NC and nebulizer mask once a month. During continuation of the interview, IP stated NC and nebulizer mask with tubing should be changed once a week not once a month and then IP stated not sure how often they needed to change. During an interview with facility's DON on [DATE] at 11:21 a.m., DON stated currently nursing staff changing NC every week for residents. DON also stated facility changing policy to change NC every week, not once a month as current policy indicated. Review of facility's policy and procedure (P&P) titled, Nebulizer Therapy, revised on [DATE], the P&P indicated, Change nebulizer tubing every 7 days and prn (as needed). (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of facility's P&P titled, Oxygen Administration, revised on [DATE], the P&P indicated, Nasal Cannula-Oxygen is administered through plastic cannulas in the nostrils. Review of facility's P&P titled, Catheter Care, revised on [DATE], the P&P indicated, It is the policy of this facility to ensure that residents with indwelling catheters (F/C) receive appropriate catheter care . Based on observation, interview, and record review, the facility failed to ensure infection control practices were implemented when: 1. Resident 111's room there were no Enhanced Barrier Precautions (EBP, are a set of infection control measures used in nursing homes to reduce the spread of multidrug-resistant organisms [MDROs. It refers to a microorganism, usually bacteria, that has developed resistance to multiple classes of antimicrobial agents, such as antibiotics and antifungals.]) signage posted outside the room; 2. Resident 5's used nebulizer kit with mask and tubing (a medical device that turns liquids into fine mist that can be inhaled easily) were placed on top of Resident 5's personal belongings in the bedside drawer, unlabeled and undated; 3. Used basin was found unlabeled and stored on top of a toilet's tank in a shared bathroom; 4. A bag of dirty towels was observed on the floor beside the soiled linen room door; 5. One of two nurses observed during the medication administration did not correctly clean and disinfect the glucometer (blood glucose meter to measure and display the amount of sugar in the blood); 6. One of seven nurses observed during the medication administration did not disinfect the medication tray between resident uses; 7. One of one nurse observed during medication administration did not wear a gown during the administration of medications via enteral tube (a tube inserted into the stomach to deliver nutrition and medications) in accordance with the facility policy and procedures (P&P) for enhanced barrier precautions (EBP); 8. Resident 34's nasal cannula (NC: a medical device used to deliver supplemental oxygen [O2: a colorless, odorless, and tasteless gas essential to living organisms] to a resident through the nostrils) attached to room air concentrator (RAC: a machine that takes in room air and filters to produce a concentrated supply of O2 for residents who needed supplemental O2) was undated and uncovered; 9. Resident 8's nebulizer (delivers liquid medication in the form of mist typically used for respiratory treatment) face mask (medical device that fits over the nose and mouth, allows the resident to inhale medication as they breath normally) was undated; 10. Resident 10's nebulizer face mask tubing was undated; 11. Resident 104's foley catheter (F/C: a thin flexible tube inserted into the bladder [a body organ that stores urine before it is expelled from body] to drain urine)'s urine collection drain bag anchored to bed, was touched the floor; and (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	12. Resident 52's urinary catheter drainage bag (is a container/bar that collects urine drained from the bladder through a urinary catheter [a thin tube inserted into the bladder to help it empty]) was observed touching the floor. These failures had the potential to compromise resident's health and safety, and spread infections to residents, staff, and visitors. Findings: 1. Review of Resident 111's clinical record titled, admission Record, dated on [DATE], it indicated Resident 111 was admitted to the facility with diagnoses includes atrial fibrillation (a common heart condition where the heart's upper chambers (atria) beat irregularly and often rapidly) and muscle weakness. During a review of Resident 111's physician order dated [DATE] indicated Cleanse PU (pressure ulcer, also known as bedsore or pressure sore) on left gluteus (three large skeletal muscles that form the buttock and move the thigh.) with NS (normal saline), pat dry, apply medi-honey (medical-grade honey product used for wound care) and cover with foam dressing. During a review of Resident 111's clinical records indicated a care plan titled St (stage) 3 PU to left buttock, dated [DATE]. During an observation on [DATE] at 11:42 a.m., in Resident 111's room there was no EBP signage posted outside the room. During an interview on [DATE] at 11:38 a.m., with the Treatment Nurse (TN), TN stated Resident 111 has stage 3 wound to gluteus. During an interview on [DATE] at 1:23 p.m., with the Infection preventionist (IP), the IP stated she is familiar with Resident 111. She stated Resident 111 does have a wound stage 3 and she is aware now that she doesn't have EBP signage posted outside Resident 111's room. She further stated she will go and fix it now. During a review of facility's policy and procedure (P&P) titled Enhanced Barrier Precautions dated [DATE], indicated, . 2. Initiation of Enhanced Barrier Precautions: b. An order for enhance barrier precautions will be obtained for residents with any of the following: i. Wounds (e.g., chronic wounds such as pressure ulcers .). 12. During observations on [DATE] at 10:02 a.m., and on [DATE] at 1:05 p.m., inside Resident 52's room, Resident 52's urinary catheter drainage bag was observed touching the floor. During a concurrent observation and interview on [DATE] at 9:00 a.m. with Licensed Vocational Nurse (LVN) G, in Resident 52's room, Resident 52's urinary catheter drainage bag was touching the floor. LVN G confirmed the above observation and stated, the urinary catheter bag should be hanging and not be touching the floor for infection control issues. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 52's care plan, date initiated [DATE], titled, Foley/Urinary Care/ CAUTI [catheter associated urinary tract infection] Prevention Care Bundle to prevent detection of UTI and prevention of urinary complications, the Interventions/Tasks indicated, . Keep urinary bag below level of bladder, but off the floor . A review of facility's policy and procedure (P&P) titled, Infection Prevention and Control Program, date revised [DATE], the P&P indicated, .This facility established and maintains of infection prevention .to provide a safe sanitary, and comfortable environment and to help prevent development and transmission of communicable disease and infections .

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement a program that monitors antibiotic use. Based on observation, interview and record review, the facility failed to follow their Antibiotic Stewardship Program when six of 18 residents (Residents 89, 68, 108, 23, 47, and 373) who received antibiotics (medications that kill or inhibit the growth of bacteria) did not meet the Loeb's criteria [a set of minimum clinical guidelines used in long-term care facilities (LTCFs) to help healthcare providers decide when to initiate antibiotic treatment for suspected infections in residents]. These failures had the potential to increase the prevalence of multi-drug resistance organism (MDRO - these are microorganisms, mostly bacteria, that have become resistant to multiple types of antibiotics) or bacteria. Findings: 1. Review of Resident 89's clinical record titled, admission Record, dated on 6/12/2025, it indicated Resident 89 was admitted to the facility with diagnoses includes Alzheimer's disease (a progressive disease that destroys memory and mental functions) and urinary tract infection (UTI, an infection that can occur in any part of the urinary system, including the kidneys, bladder, or urethra). Review of Resident 89's clinical record titled, Order Listing Report, indicated the following order of Levaquin (levofloxacin, a powerful antibiotic that belongs to a class of drugs called fluoroquinolones) dated 6/10/2025, to give one tablet of 500 milligrams (mg - unit of measurement) by mouth one time a day for suspected UTI for 3 days and another order dated 6/13/2025, to give one tablet of 500 mg one time a day for suspected UTI until 6/15/2025. During a concurrent interview with IP and record review on 6/12/2025 at 1:23 p.m., IP reviewed Resident 89's clinical records and the Infection Prevention and Control Surveillance Log and confirmed Resident 89's used of antibiotic in June did not meet the Loeb's criteria. Further review of the change in condition documentation, IP confirmed Resident 89's symptoms were only knee pain and increased confusion. Resident 89 had no fever, no dysuria (painful, uncomfortable, or burning sensations during urination), and no complaint of urgency in urination. IP stated she was aware that Resident 89 did not meet the Loeb's criteria, but she would wait for the doctor to respond to her. IP further stated, they were waiting for the urine culture (a laboratory test used to detect bacteria or other microorganisms in a urine sample, which can indicate a UTI) result. During a concurrent interview with IP and record review on 6/13/2025 at 11:30 a.m., IP reviewed Resident 89's nursing progress notes and confirmed Resident 89's urine culture result indicated that the bacteria was resistant to levofloxacin (meaning this antibiotic did not work to stop the growth or kill the bacteria causing the infection). 2. Review of Resident 68's clinical record titled, admission Record, indicated Resident 68 was admitted to the facility with diagnoses including paralysis of vocal cords and larynx (a condition where one or both vocal cords [or vocal folds] in the larynx [voice box] can't move properly), localized swelling, mass, and lump, neck, type 2 diabetes mellitus (DM, a condition which affects the way the body processes blood sugar) and muscle weakness. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview with IP and record review on 6/12/2025 at 1:30 p.m., IP reviewed Resident 68's clinical records and confirmed Resident 68 had a fever of 103.5 and complained of sore throat on 6/8/2025. IP further confirmed, the physician ordered Levaquin on 6/8/2025 500 mg one tablet one time a day for Pharyngitis (inflammation of the pharynx, the area at the back of the throat). IP stated Resident 68 had no other symptoms documented in the progress notes and the physician had no documented assessment on Resident 68 prior to prescription of the antibiotics. During an interview with IP on 6/13/2025 at 11:13 a.m., IP stated, I haven't spoken to the medical director (MD) for a while now regarding the increased use of antibiotics. I should probably talk to the MD again. IP further stated, Antibiotic Stewardship program was important to prevent MDROs. 3. Review of Resident 108's clinical record titled, admission Record, indicated Resident 108 was admitted to the facility with diagnoses including metabolic encephalopathy (a brain dysfunction caused by a systemic illness or condition that disrupts normal metabolic processes), UTI, retention of urine (inability to completely empty the bladder of urine) and dementia (decline in mental capacity affecting daily function). During a concurrent interview with IP and record review on 6/13/2025 at 11:30 a.m., IP reviewed Resident 108's clinical records and the Infection Prevention and Control Surveillance Log, IP confirmed Resident 108 was prescribed with Nitrofurantoin (an antibiotic) on 6/2/2025 for UTI for 7 days. IP further confirmed Resident 108 only had confusion with behaviors, no fever or documented symptoms of UTI. IP stated Resident 108 received antibiotics and did not meet the Loeb's criteria. 4. Review of Resident 23's clinical record titled, admission Record, dated 6/13/2025, indicated Resident 23 was admitted to the facility with diagnoses including breakdown of internal fixation device (a surgical implement, like plates, screws, or rods, used to stabilize and align fractured bones, allowing them to heal properly) of vertebrae (the individual bones that stack on top of each other to form the spine, or vertebral column), age-related osteoporosis (a condition characterized by weakened and brittle bones, as a natural consequence of aging), and osteoarthritis (a common joint disease that causes the breakdown of cartilage, the smooth tissue that cushions and protects the ends of bone). Review of Resident 23's June 2025 MAR, indicated an order dated 6/2/2025 at 2:00 a.m., Levaquin Tablet 500 MG (Levofloxacin) Give 1 tablet by mouth one time a day for infection for 5 days. Further review indicated, Resident 23 received a total of four doses of Levaquin without documented monitoring of BBW related to the use of Levaquin in the MAR. During a concurrent interview with IP and record review on 6/13/2025 at 11:32 a.m., IP reviewed Resident 23's clinical records and the Infection Prevention and Control Surveillance Log, IP confirmed Resident 23 was prescribed with Levaquin for abdominal pain and no other documented symptoms like fever, dysuria or urgency in urination. IP further confirmed Resident 23's symptoms did not meet the Loeb's criteria and had received antibiotics. Review of Resident 23's urine culture result dated 6/4/2025, it indicated the microorganism was resistant to Levofloxacin. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5. Review of Resident 47's clinical record titled, admission Record, dated on 6/13/2025, it indicated Resident 47 was admitted to the facility with diagnoses including diverticulosis (a condition where small, bulging pouches [diverticula] form in the lining of the colon) of large intestine, type 2 diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), acidosis (a condition where there is too much acid in the body fluids), unspecified, pain in right hip and muscle weakness. Review of Resident 47's clinical record titled, Order Listing Report, it revealed a STAT (means immediately or without delay) order of Levaquin on 6/3/2025, 500 milligrams (mg - unit of measurement) by mouth for urinary tract infection (UTI - a bacterial infection that affects any part of the urinary system, including the kidneys, ureters, bladder, and urethra). Further review indicated another order on the same day to continue the Levaquin 500 mg by mouth once a day for UTI for 4 days. During a concurrent interview with IP and record review on 6/13/2025 at 11:34 a.m., IP reviewed Resident 47's clinical records and the Infection Prevention and Control Surveillance Log, IP confirmed Resident 47 received Levaquin for Asymptomatic UTI [a condition where bacteria are present in the urine but without any of the typical symptoms of UTI]. 6. Review of Resident 373's clinical record titled, admission Record, indicated Resident 373 was admitted to the facility with diagnoses including aftercare following surgery for neoplasm (cancer), type 2 DM, and secondary malignant neoplasm of bone. Review of Resident 373's order listing report indicated an order dated 6/3/2025 of Amoxicillin-Pot Clavulanate (antibiotic) Tablet 875-125 MG Give 1 tablet by mouth every 12 hours for bacterial infection for 10 days. During a concurrent interview with IP and record review on 6/13/2025 at 11:36 a.m., IP reviewed Resident 373's clinical records and the Infection Prevention and Control Surveillance Log, IP confirmed Resident 373 received the antibiotic prescribed without symptoms of infection except the licensed nurse only documented Resident 373 had a deep tissue injury (DTI, a type of tissue damage that occurs beneath the skin's surface, often resulting from pressure or shear forces) in the sacrum (a triangular bone located at the base of the spine, connecting the spine to the pelvis), a blister (a small, raised area on the skin filled with fluid, often clear or bloody, caused by friction, burns, or other injuries) to the penile area and a slough (a type of dead tissue, often yellow or white in color, that can accumulate on the wound surface) in the spinal surgical incision. IP confirmed Resident 373 received antibiotic and did not meet the Loeb's criteria. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and observation with IP, in the presence of the director of nursing (DON) on 6/17/2025 at 2:44 p.m., inside the conference room, IP stated they held the antibiotic stewardship program monthly. Before IP's statement, she looked at the DON and stated the Antibiotic (ATB) stewardship program meeting was being attended by, sometimes the pharmacist, sometimes the medical director and the IDT (Social Service, DON, nursing, MDS, myself and Executive Director) [interdisciplinary team - a group of health care professionals from diverse fields who work toward a common goal for residents]. IP stated their last ATB Stewardship Program meeting was in April 2025. IP further stated the frequent use of antibiotics was brought up in the last meeting, and she stated, but I have spoken to the doctors individually and according to them, it was better to start the residents with antibiotic before they became septic (related to or caused by sepsis, a life-threatening condition where the body's response to an infection damages its own tissues and organs). When asked if it was appropriate to prescribe an antibiotic resistant to the microorganism, IP looked at the DON and was not able to answer the question. During an interview with the medical director (MD) on 6/18/2025 at 9:45 a.m., MD stated she had read about the ATB Stewardship Program, and she would attend the meeting by phone. MD confirmed they prescribed antibiotics while waiting for the culture result because they wanted to be proactive and they would just adjust the ATB when the culture result was received. MD stated the prescribing physician should also review the previous culture result for possible ATB resistance to microorganisms. During a review of the facility's policy and procedure titled, Antibiotic Stewardship Program, date revised 5/30/2023, indicated, The purpose of the program is to optimize the treatment of infections while reducing the adverse events associated with antibiotic use. The Medical Director, Director of Nursing, and Consultant Pharmacist serve as the leaders of the Antibiotic Stewardship Program and receives support from the Administrator and other governing officials of the facility. Infection Preventionist - utilizes expertise and data to inform strategies to improve antibiotic use to include tracking of antibiotic starts, monitoring adherence to evidence-based published criteria during the evaluation and management of treated infections, and reviewing antibiotic resistance patterns in the facility to understand which infections are caused by resistant organisms. The program includes antibiotic use protocols and a system to monitor antibiotic use. Antibiotic use protocols: Nursing staff shall assess residents who are suspected to have an infection and notify the physician. Laboratory testing shall be in accordance with current standards of practice .The Loeb Minimum Criteria may be used to determine whether to treat an infection with antibiotics. All prescriptions for antibiotics shall specify the dose, duration, and indication for use. Whenever possible, narrow-spectrum antibiotics that are appropriate for the condition being treated shall be utilized.