STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055833	A. Building B. Wing	05/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fulton Gardens Post Acute, LLC	537 E. Fulton Street Stockton, CA 95204

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety for 103 residents when;1) Staff did not have their facial hair covered while present in the kitchen;2) Opened cake mix, olive oil, shredded cheese, and five bags of pasta, were not labeled completely and accurately with open dates, use-by dates, or discard dates, and one previously opened bag of pasta was not securely sealed after opening; 3) The dry storage floor was worn with a black discoloration;4) Frozen hotdogs stored in the reach-in freezer had moderate ice crystal buildup or freezer burn, frozen turkey stored in the walk-in freezer had heavy ice crystal buildup or freezer burn, and frozen pork chops stored in the walk-in freezer had freezer burn, were not securely closed, and were left exposed to air; 5) A fry pan stored in a ready-to-use area had whitish residue, oil/grease buildup and worn surfaces; a steam table pan and ˆthree muffin tins stored in a ready-to-use area had moderate yellow residue and dark brown build up; and a blender stored in a ready-to-use area had visible moisture buildup and pooled water around the blade assembly;6) Twoˆcutting boards used for food preparation had multiple deep gouges on the cutting surfaces;ˆ 7) [NAME] (CK) 1's apron tie contacted the cooked fish twice when transferring the fish from the sheet pans to a steam table pan, and CK 1's apron contacted the broccoli in the steam table while preparing a resident plate; and 8) Lunch meal plating ran out of standard heated dish plates with covers, leading to resident meals being served in disposable clamshell food containers. These failures had the potential to put residents at risk for foodborne illnesses (nausea, vomiting, and/or diarrhea). Findings: 1.During the initial kitchen tour on 4/28/26 at 8:25 AM, the Environmental Services Director (ESD) was observed walking inside the kitchen without a beard restraint (covering used to prevent beard hair from falling into food).ˆ During an interview on 4/28/26 at 8:30 AM with the ESD, the ESD stated that he was in the kitchen fixing a leaking drainpipe in the floor sink. During an interview on 4/30/26 at 2:28 PM with the Infection Preventionist (IP), the IP stated that staff were expected to wear protective covers for hair and facial hair, including beards, whenever they were in the kitchen to prevent loose hair from falling into food.ˆThe IP further stated that loose hair could contaminate food served to residents and could cause food borne illness. During a joint subsequent interview on 4/30/26 at 3:40 PM with the Dietary Supervisor (DS) and the Registered Dietitian (RD), the DS and the RD acknowledged that staff were expected to wear hair restraints, including beard covers, in the kitchen as hair could contaminate the food served to residents. ˆ During a review of the facility's policy and procedure (P&P) titled, DIETETIC SERVICE - BASIC KITCHEN SANITATION, revised in 1/2025, the P&P indicated, .To ensure that the facility's kitchen and food service areas maintain basic standards of cleanliness and sanitation to prevent food borne illness.Hair must be restrained. Review of facility's policy and procedure (P&P) titled, FOOD SERVICE, dated 1/2025, the P&P indicated, .The facility follows proper sanitation.to reduce the potential for a foodborne illness outbreak.All food shall be protected against contamination. According to the 2022 Federal Food and Drug Administration (FDA) Food Code 2-402.11, Food employees shall wear hair restraints such as . beard restraints, . that are designed and worn to effectively keep their hair from . clean equipment, utensils, and linens; and unwrapped single-service and single-use (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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	articles. 2. During a concurrent initial kitchen tour observation, interview, and record review on 4/28/26 at 8:55 AM in the dry storage area, the food storage chart was reviewed with the DS. The following items were observed: There was a previously opened cake mix stored on a shelf, labeled with an open date of 4/21/26 and a use-by date of 5/6/26 and a box of olive oil with a faucet dispenser was stored on a shelf and labeled with an open date of 1/16/26 but did not include a use-by or discard date. A review of the food storage chart posted on the dry storage door indicated the recommended storage time for cake mix (biscuit, brownie, and muffin mix), was nine months, while the recommended storage time for olive oil (salad oils) was up to three months when stored in the refrigerator after opening. The DS confirmed the cake mix was not labeled according to the food storage chart and the olive oil lacked a use-by or discard date. The DS acknowledged that because the olive oil did not have a use-by or discard date, it was not discarded in a timely manner and remained in the dry storage area even though it may have exceeded the recommended storage time frame. The DS stated that the olive oil should have been refrigerated after opening and may no longer have been good for consumption. During a concurrent observation and interview on 4/28/26 at 9:14 AM with the DS in the dry storage area while doing the initial kitchen tour, five previously opened original bags of pasta were found stored on a shelf. Four bags of pasta were closed and labeled with open dates (2/5/26, 2/16/26, 4/13/26, and 4/17/26) but did not have use-by or discard dates. One bag of pasta labeled with an open date of 12/30/25 but did not have a use-by or discard date, was not securely closed, and was partially open to air. The DS confirmed the five bags of pasta did not have use-by or discard dates and confirmed one bag of pasta was not securely closed after opening. The DS stated kitchen staff were expected to label opened food items with the date opened and, with a use-by or discard date. The DS further stated the opened bag of pasta should have been tightly sealed after opening. During a subsequent observation and interview on 4/28/26 at 9:22 AM with the DS in the walk-in refrigerator while doing the initial kitchen tour, a previously opened and closed bag of shredded cheese stored on the left shelf was labeled with an open date of 4/26/26 and a use-by date of 5/1/26. The DS confirmed the use-by date was not consistent with the recommended storage time frame of one month from the open date. During an interview on 4/30/26 at 2:28 PM with the IP, the IP stated it was important to label opened food items with the date opened and a use-by date so staff could determine how long the products had been stored and discard them timely to prevent foodborne illness. The IP stated opened food items stored in the dry storage area should be securely closed after opening to prevent pest entry and contamination from pest feces, which could be harmful or infectious if consumed by humans. During an interview on 4/30/26 at 3:40 PM with the DS and the RD, the RD stated correct labeling of opened food items was necessary to ensure safe food products. Review of facility's policy and procedure (P&P) titled, DIETETIC SERVICE - BASIC KITCHEN SANITATION, revised in 1/2025, the P&P indicated .Label and date all food items. All food.must be stored in pest-proof containers. Review of facility's policy and procedure (P&P) titled, FOOD RECEIVING AND STORAGE, revised in 1/2026, the P&P indicated .Desirable practices include.removing foods not safe for consumption, keeping dry food products in closed containers. Review of facility's policy and procedure (P&P) titled, FOOD SERVICE, dated 1/2025, the P&P indicated .All foods shall be.stored.and served to ensure all food is free from contamination.and shall be fit for human consumption. The Food and Drug Administration (FDA) Food Code 2022, 3-501.17 (A) (B) (C) (D) indicated required food labeling and dating. It states the day the original container is opened in the food establishment shall be counted as Day 1.The date marked shall not exceed a manufacturer's use-by date.mark the date or day of preparation, with a procedure to discard the food on or before the last date or day by which the food must be consumed on the premises. The Food and Drug Administration (FDA) Food Code 2022, 3-305.13, titled, Vended Time/Temperature Control for Safety Food, Original Container, 1/18/23 version, indicated, The possibility of product contamination increases whenever food is exposed .Once the original seal is broken, the food is vulnerable to contamination. 3. During the initial kitchen tour on 4/28/26 at 9:14 AM in the dry storage area, the (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	white tile floor was observed worn and had black discoloration. During an interview on 4/30/26 at 2:28 PM with the IP, the IP stated facility floors should be clean and free of discoloration, as floor discoloration could be from dirt or other build up that may harbor bacterial overgrowth and pests.ˆ The IP further stated that a floor that was not clean in the kitchen dry storage area increased the risk of food contamination. During a joint interview on 4/30/26 at 3:40 PM with the DS and the RD, the DS and the RD acknowledged that the floor in the kitchen dry storage area was an area of concern for cross-contamination (spread of germs from one surface or item to another), as the floor was worn with black discoloration. Review of facility's policy and procedure (P&P) titled, DIETETIC SERVICE - FOOD STORAGE, dated 1/2025, the P&P indicated .Food storage areas shall be clean at all times. The Food and Drug Administration (FDA) Food Code 2022, Section 6-501.12, titled Cleaning, Frequency and Restrictions, indicated .PHYSICAL FACILITIES shall be cleaned as often as necessary to keep them clean. 4.During the initial kitchen tour on 4/28/26 at 9:22 AM in the reach-in freezer, a closed clear plastic bag containing frozen hotdogs that had been removed from the original packaging had visible ice crystal buildup or freezer burn throughout the bag. During a subsequent interview with the DS, the DS confirmed freezer burn was present throughout the bag of hotdogs and indicated improper storage. During a concurrent observation and interview on 4/30/26 at 9:30 AM with the DS in the walk-in freezer while doing the initial kitchen tour, a closed clear plastic storage bag containing frozen turkey that had been removed from the original packaging had heavy ice crystal buildup or freezer burn covering most of the turkey inside the bag. A cardboard box containing a clear plastic bag of frozen pork chops in the original packaging was not securely closed, exposing the pork chops to air, and had visible ice crystal buildup or freezer burn covering portions of the light brown pork chops inside the package. The DS confirmed the turkey was heavily covered with ice crystals or freezer burn and the pork chops were not securely closed and were exposed to air.ˆ The DS stated food items stored in the freezer should be tightly or securely closed. During an interview on 4/30/26 at 2:28 PM with the IP, the IP stated that food not stored properly was at risk for contamination and could cause foodborne illness. During a joint interview on 4/30/26 at 3:40 PM with the DS and the RD, the DS and the RD acknowledged the frozen hotdogs, turkey and pork shops stored in the freezer had freezer burn, and the pork chops were not securely closed and were left exposed to air, which indicated poor food storage.ˆThe RD stated that freezer burn changed the taste, texture, and quality of food and that poor storage or exposing food items to air placed food at risk for cross-contamination. Review of facility's policy and procedure (P&P) titled, FOOD SERVICE, dated 1/2025, the P&P indicated, .All foods shall be.stored.and served to ensure all food is free from contamination.and shall be fit for human consumption.All foods shall be protected against contamination. The Food and Drug Administration (FDA) Food Code 2022, 3-305.13, titled, Vended Time/Temperature Control for Safety Food, Original Container, 1/18/23 version, indicated, The possibility of product contamination increases whenever food is exposed .Once the original seal is broken, the food is vulnerable to contamination. 5. During the initial kitchen tour and interview on 4/28/26 at 9:42 AM in the cook's area, a small shallow fry pan with a worn, coated cooking surface was stored in the ready-to-use area and observed with a whitish residue on the dark gray cooking surface. Multiple visible scratch marks and worn areas were present throughout the interior surface of the pan, with black residue along portions of the inner rim. During a subsequent interview with the RD, the RD stated that the fry pan had food debris and was not cleaned properly. During a concurrent observation and interview on 4/28/26 at 9:43 AM with the DS in the cook's area while doing the initial kitchen tour, a large steam table pan stored in a ready-to-use area had moderate amounts of dried yellowish food residue and dark discoloration along the interior sides and bottom corners of the pan, and it was sticky to the touch. Three muffin tins stored in a ready-to-use area had moderate yellow residue and discoloration around the inner edges and seams of multiple muffin cups. The DS stated that the steam table pan and the three muffin tins were not cleaned properly. During subsequent observation and interview on 4/28/26 at 9:44 AM with the DS and the RD while in the cook's area (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	while doing the initial kitchen tour, a blender with the cap placed on top of the container was stored in a ready-to-use area, but when opened it was wet with visible water residue, moisture buildup, and pooled water around the blender blade assembly. The DS and RD confirmed that the blender was wet inside with pooled water at the bottom. The RD stated that the blender was stored wet and at risk for mildew (a type of mold that grows on wet or damp surfaces) growth. During an interview on 4/30/26 at 2:28 PM with the IP, the IP stated that staff were expected to clean kitchen equipment before storing it in a ready-to-use area.ˆThe IP further stated storing kitchen equipment with food residue or while wet placed the equipment at risk for mold and bacteria overgrowth, which could cause foodborne illness. During a joint interview on 4/30/26 at 3:40 PM with the DS and RD, the DS and RD stated that storing a fry pan, steam table pan, muffin tins that were not properly cleaned was a risk for cross-contamination and that a blender stored wet could develop mold and mildew.ˆ ˆ Review of facility's policy and procedure (P&P) titled, FOOD SERVICE, dated 1/2025, the P&P indicated, .All equipment.shall be kept clean and maintained in safe condition.Equipment necessary for storage, preparation and service of food.shall be well-maintained. Review of facility's policy and procedure (P&P) titled, DIETETIC SERVICE - BASIC KITCHEN SANITATION revised in 1/2025, the P&P indicated .equipment shall be kept clean, maintain in good repair .Air dry all equipment . The Food and Drug Administration (FDA) Food Code 2022, 4-602.11, titled, Equipment Food-Contact Surfaces and Utensils, indicated, (A) Equipment food-contact surfaces and utensils shall be cleaned. The Food and Drug Administration (FDA) Food Code 2022, 4-604.14, titled, Wet Cleaning, Indicated, (A) EQUIPMENT FOOD-CONTACT SURFACES AND UTENSILS shall be effectively washed to remove or completely loosen soils. The Food and Drug Administration (FDA) Food Code 2022, 4-901.11, titled, Equipment and Utensils, Air-Drying Required, indicated, After cleaning and SANITIZING, EQUIPMENT and UTENSILS: (A) Shall be air-dried. 6. During a concurrent initial kitchen tour, interview with the RD, and record review on 4/28/26 at 9:45 AM in the cook's area, the cutting board chart was reviewed. The RD confirmed the two cutting boards that were green and red had multiple deep gouges on the cutting surface. A review of the cutting board chart indicated that the red cutting board was used for meat, and the green cutting board was used for fruits and vegetables. During an interview on 4/30/26 at 2:28 PM with the IP, the IP stated that cutting boards should not have deep gouges because bacteria could penetrate the gouges which could not be reached through routine cleaning and could contaminate food leading to foodborne illness.ˆThe IP further stated that cutting boards with deep gouges should be replaced. During a joint interview on 4/30/26 at 3:40 PM with the DS and the RD, the DS and the RD acknowledged that the green and red cutting boards had deep gouges.ˆThe RD stated that deep gouges interfered with cleaning and affected the ability to properly sanitize the cutting boards.ˆ ˆ Review of facility's policy and procedure (P&P) titled, DIETETIC SERVICE - BASIC KITCHEN SANITATION, revised in 1/2025, the P&P indicated .equipment shall be kept clean, maintain in good repair. Review of facility's policy and procedure (P&P) titled, FOOD SERVICE, dated 1/2025, the P&P indicated .All equipment.shall be kept clean and maintained in safe condition.Equipment necessary for storage, preparation and service of food.shall be well-maintained. The Food and Drug Administration (FDA) Food Code 2022, 4-501.12, titled, Cutting Surfaces, indicated, Wet Cleaning Indicated, Surfaces such as cutting blocks and boards that are subject to scratching and scoring shall be resurfaces if they can no longer be effectively cleaned and SANITIZED, or discarded. 7.) During a subsequent visit to the kitchen on 4/29/26 at 11:20 AM in the cook's area, [NAME] (CK) 1 wore a white plastic apron tied at the waist with the bow in front. CK 1 took sheet pans from the oven and transferred the cooked fish to a steam table pan. As CK 1 was doing the transfer, the apron ties contacted the cooked fish twice. During an observation on 4/29/26 at 12:40 PM at the steam table area, CK 1 leaned forward while plating broccoli for a resident, causing the front of the apron to contact the broccoli and leaving a half fist-sized green residue mark on the left waist area of the apron. During an interview on 4/30/26 at 2:28 PM with the IP, the IP stated an apron worn by kitchen staff must be securely tied around the neck and waist, with the ties secured at the back, to prevent (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	the apron ties from contacting food. The IP further stated the apron was not assured to be clean because it could have contacted dirty surfaces during kitchen operations, causing contamination of the food. During a joint interview on 4/30/26 at 3:40 PM with the DS and the RD, the DS and the RD acknowledged the apron contacted food during meal preparation in the kitchen. The RD stated the apron contacting cooked food placed the food at risk for cross-contamination. Review of facility's policy and procedure (P&P) titled, FOOD SERVICE, dated 1/2025, the P&P indicated .All people engaged in food preparation and service shall observe personal hygiene and food services sanitation practices which protect the food from contamination. The Food and Drug Administration (FDA) Food Code 2022, 2-304.11, titled, Clean Condition indicated, Food employees shall wear clean outer clothing to prevent contamination of food, equipment, utensils, linens, and single-service and single-use articles. 8.) During a subsequent visit to the kitchen on 4/29/26 at 1:00 PM at the steam table food area while kitchen staff were conducting the tray line (meal plating and meal distribution process), CK 1 used disposable clamshell food containers for the last four resident lunches instead of a heated plate with a plate warmer and cover. During a subsequent interview with CK 1, CK 1 stated the facility ran out of standard dish plates, which was why disposable food containers were used for the remaining residents' lunches. During a concurrent observation and interview on 4/29/26 at 1:05 PM with the RD in the steam table food area, the RD confirmed disposable clamshell food containers were used for the remaining residents because the facility did not have enough standard dish plates available during meal service. During a joint interview on 4/30/26 at 3:40 PM with the DS and the RD, the DS and the RD stated the facility served resident meals in disposable food containers after the facility ran out of standard dishware during meal service. The DS and the RD acknowledged the use of disposable food containers had the potential to affect food temperature during meal distribution and service, placing the food at risk for bacterial overgrowth. Review of facility's policy and procedure (P&P) titled, FOOD SERVICE, dated 1/2025, the P&P indicated .Tableware and tables, dishes, and utensils shall be provided in the quantity necessary to serve the clients. The Food and Drug Administration (FDA) Food Code 2022, 3-501.16, titled, Time/Temperature Control for Safety Food, Hot and Cold Holding indicated, .TIME/TEMPERATURE CONTAROL FOR SAFEZTY FOOD shall be maintained.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. Based on observation, interview, and record review, the facility failed to ensure supplemental (additional) oxygen was administered in accordance with professional standards of practice for 2 out of 29 sampled residents (Resident 19 and Resident 80) when:1.Resident 19's oxygen humidifier bottle (a device designed to add moisture to dry oxygen from a concentrator, preventing irritation to the nose, throat, and airways during oxygen therapy) was empty and labeled with a date of 4/7/26 (observation was on 4/28/26) and there was no medical doctor order for the use of a humidifier to be used with oxygen therapy; and2.Resident 80's oxygen humidifier bottle was observed empty and was not labeled with a date.These failures had the potential to place Resident 19 and Resident 80 at risk for respiratory discomfort or distress that could negatively impact their health conditions. Findings: 1.a. A review of Resident 19's admission RECORD, indicated Resident 19 was admitted to the facility with multiple diagnoses including chronic obstructive pulmonary disease with acute exacerbation (CODP, a progressive, long-term long disease that restricts airflow, making it difficult to breathe),and type 2 diabetes mellitus (a chronic disorder characterized by high blood sugar in blood - people with diabetes have a higher risk of infection such as pneumonia [inflammation of the air sacs in one or both lungs]). During a concurrent observation and interview on 4/28/26 at 12 PM, with Certified Nursing Assistant (CNA) 1, in Resident 19's room, Resident 19's oxygen concentrator had an empty bottle humidifier. CNA 1 confirmed the finding. A review of Resident 19's medical record titled, Order Review History Report, dated 4/1/26 through 4/30/26, included following active orders: Oxygen at 1LPM [L/min, litter per minute, a unit of measurement] via NC [nasal cannula] to keep O2 [oxygen] sat [saturation]> [above] 90% [percentage- unit of measurement out of 100] as needed for SOB [shortness of breath] related to CHRONIC OBSTRUCTIVE PULMONARY DISEASE WITH (ACUTE [new onset]) EXACERBATION. started on 3/24/26. During a concurrent observation and interview on 4/29/26 at 8:55 AM with Licensed Nurse (LN) 6 in Resident 19's room, LN 6 changed the oxygen concentrator humidifier bottle. LN 6 confirmed the humidifier bottle was empty. LN 6 stated that humidifier bottles should have been replaced when it was no longer bubbling and should not be allowed to become completely empty before replacement. LN 6 explained that once humidifier bottle was empty, the oxygen delivered becomes dry air, which might irritate the respiratory system and contribute to breathing difficulties due to lack of moisture. LN 6 further stated Resident 19 had a diagnosis of COPD and breathing dry air could lead to exacerbation of the condition. 1.b. During a concurrent observation and interview on 4/28/26 at 12 PM with CNA 1 in Resident 19's room, Resident 19's oxygen concentrator had an empty bottle humidifier which was labeled 4/7/26. CNA 1 confirmed the finding. During a concurrent observation and interview on 4/29/26 at 8:55 AM with LN 6 in Resident 19's room, LN 6 was observed changing the oxygen concentrator humidifier bottle. LN 6 confirmed the humidifier bottle was empty and labeled 4/7/26. LN 6 further confirmed that the bottle was labeled RX (a common medical abbreviation for a prescription or a pharmaceutical drug that requires authorization from a healthcare professional) and stated that all RX items were considered (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	medications and therefore should have a physician's order specifying administration and the replacement/change frequency. During a phone interview on 4/30/2026 2:51 PM with Medical Director (MD) 1, MD 1 stated her expectation was for nurses to obtain a physician's order for all items labeled as RX, prior to administration. MD 1 stated oxygen humidifier bottles labeled as RX should have had a corresponding physician's order. MD 1 further stated she reviewed and signed all orders; however, she overlooked and did not notice the absence of the order for the oxygen humidifier bottle. During an interview on 5/1/26 at 10:04 AM with the Infection Preventionist (IP), the IP explained that nurses were expected to administer oxygen, change oxygen tubing and masks as ordered by the physician, and check oxygen humidifier bottles every 24 hours. The IP stated that humidifier bottles should have been replaced according to manufacture guidelines and it was the responsibility of the nightshift (a specific block of time worked) nurses. The IP further explained that if a resident received 3 L/min or more of PRN (as needed) oxygen, a humidifier should be used to moisturize the airflow. The IP stated that Resident 19 had an active order to administer 1 L/min oxygen PRN, and added Resident 19 preferred the use of an oxygen humidifier for comfort and moisture. The IP stated that when the oxygen humidifier bottle became empty, the resident's airway passages could dry out, causing cracking inside the nose and resulting in nosebleeds. The IP further added based on her experiences, humidifier bottles should be replaced when they were no longer producing bubbles to prevent respiratory distress and/or damage to Resident 19's nasal passages from breathing dry air. During a review of Resident 19's medical record titled Care Plan Report, revealed a care plan titled Focus. resident [Resident 19] has Emphysema/COPD. Interventions/Tasks. Change oxygen humidifier in accordance with manufacturer's guidelines. and was initiated on 11/30/21. 2. During a review of Resident 80's admission RECORD, dated 4/9/26, the record indicated, Resident 80 was admitted to the facility with diagnoses which included necrotizing fasciitis (a rare, rapid, and life-threatening bacterial infection that destroys the skin, fat, and fascia [tissue covering muscle]), Fournier Gangrene (a rare, rapidly progressing, and life-threatening necrotizing fasciitis [flesh-eating infection] of the genital, perineal, or perianal regions), and chronic obstructive pulmonary disease (a progressive, treatable lung disease that causes obstructed airflow, making it hard to breathe). During an initial tour of Resident 80's room on 4/28/26 at 2.44 PM, an oxygen humidifier bottle was observed empty and without a label that indicated the date the humidifier bottle was set up for the resident's use. During an interview on 4/28/26 at 2:54 PM with Licensed Nurse (LN) 4, LN 4 acknowledged that the humidifier oxygen bottle was both empty and unlabeled. She explained that the bottle should have been replaced when it ran out and properly labeled, adding that she would change it immediately. During an interview on 4/29/26 at 4:27 PM with the Infection Preventionist (IP), the IP explained that an empty oxygen humidifier was ineffective and should have been replaced immediately when it was empty and should have also been properly labeled and dated. During an interview on 5/1/26 at 11:17 AM with the Director of Nursing (DON), the DON stated that an empty humidifier was not effective. The DON also explained that an oxygen humidifier bottle needed to be labeled, as without a label, date and time, it was impossible to know when it was last changed. The DON added that without a date and time, there was no way to determine how long the bottle had (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	been in use. A review of the facility policy and procedure (P&P) titled, [Brand Name] AS0352 HUMIDIFICATION, revised January 2025, indicated, .The facility shall ensure that oxygen humidification.is provided, maintained and replaced in a manner that prevents infection, ensures proper device function, and complies with manufacturer instructions and accepted standards of practice.prefilled humidifier is designed for single-patient use and should be replaced whenever the sterile water is empty.

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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, interview, and record review, the facility failed to conserve the nutritive value and flavor of pureed food (a cooked food that has been ground, pressed, or blended into a smooth, thick, and creamy paste or liquid, often with a pudding-like consistency) for a total of six out of seven residents (Resident 6, Resident 9, Resident 15, Resident 63, Resident 64, and Resident 112) who received puree food from the facility kitchen, when the facility did not follow the recipe for pureed lemon rice pilaf (seasoned rice dish).This failure had the potential to affect the nutritive value, flavor, and consistency of the pureed food, which could lead to reduced food intake, malnutrition, and negative health outcomesFindings:During a review of the facility's daily cook's menu for lunch on 4/29/26, the menu indicated lemon rice pilaf would be served to residents on the following diets: regular, chop/easy chew, soft bite-sized, minced and moist (finely chopped and moist food), and pureed textures.During a joint concurrent observation and interview on 4/29/26 at 10:59 AM with [NAME] (CK) 1 and the Registered Dietitian (RD) in the kitchen by the cook's area, CK 1 measured ten and a half cups of rice pilaf from the steam table pan and placed into the container for the blender. CK 1 then added an unmeasured amount of thin yellow liquid from a full pitcher, which CK 1 stated was chicken broth, and blended the mixture for a few seconds. CK 1 stated more chicken broth was needed and added another unmeasured amount from the pitcher into the blender, then blended the rice pilaf and chicken broth again for a few seconds. CK 1 tested the blended rice pilaf for pureed texture by scooping the blended rice pilaf from the blender with a spoon and letting the mixture flow back into the blender. CK 1 was unhappy with the texture and stated it needed thickener (used to modify the consistency of foods and beverages). CK 1 proceeded to add two large scoops of thickener to achieve the correct pureed texture and blended the mixture again for a few seconds. The RD performed IDDSI (International Dysphagia Diet Standardization Initiative - standardized texture consistency testing for swallowing safety) testing and stated the texture for the pureed rice pilaf was not correct.During a concurrent interview and review of the facilities recipe for pureed lemon rice pilaf on 4/29/26 at 11:05 AM with the RD, the recipe directions indicated,.PLACE PORTIONS NEEDED OF PREPARED PRODUCT IN BLENDER/FOOD PROCESSOR. ADD 2 TBSP [tablespoon-unit measure] MILK FOR EACH PORTION. The RD stated the recipe for rice pilaf was not followed because unmeasured chicken broth was used instead of two TBSP of milk for each portion of rice pilaf. The recipe also did not indicate a need for thickener.During an interview on 4/30/26 at 3:40 PM with the Dietary Supervisor (DS) and RD, the RD stated pureed rice pilaf should not have additional thickener added. The DS and RD acknowledged not following the recipe for the menu item could affect the nutritive value, flavor, and consistency of the food, which could lead to reduced food intake, malnutrition, and negative health outcomes.Review of facility's policy and procedure (P&P) titled, ASSISTED NUTRITION AND HYDRATION, revised in 1/2025, the P&P indicated .The intent of this requirement is to provide staff guidelines to ensure that the resident maintains, to the extent possible, acceptable parameters of nutritional and hydration status.Provide a therapeutic diet that considers the resident's clinical condition. when there is a nutritional indication.The Food and Drug Administration (FDA) Food Code 2022, 3-101.11 titled, Safe, Unadulterated, and Honestly Presented indicated, FOOD shall be safe, unadulterated, and.honestly presented.

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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. Based on observation, interview, and record review, the facility failed to practice appropriate infection prevention and control measures for a census of 103, when:1. Resident 6 and Resident 80's urinals were not labeled to indicate whom the urinals belonged to; and2. Multiple boxes of soda were observed stored directly on the floor in Resident 19's room and the there were multiple dark brown/black stains on the floor;These failures had the potential to spread infection and cause health problems to the residents in the facility.Findings: 1a. During a review of Resident 6's admission RECORD, dated 4/9/26, the record indicated, Resident 6 was admitted to the facility with diagnoses that included Hemiplegia (severe or total paralysis affecting one side of the body) and Hemiparesis (mild or moderate weakness affecting one side of the body) and cognitive communication deficit (a communication impairment stemming from underlying cognitive issues, such as memory, attention, or executive function deficits). During an initial tour of Resident 6's room on 4/28/26 at 2:38 PM., a urinal was observed on the nightstand without a label indicating the resident's name. During a concurrent observation and interview on 4/28/26 at 2:54 PM with LN 4, LN 4 confirmed Resident 6's urinal was not labeled. LN 4 stated that an unlabeled urinal could lead to cross contamination of bacteria. 1b. During a review of Resident 80's admission RECORD, dated 4/9/26, the record indicated Resident 80 was admitted to the facility with a diagnosis that included necrotizing fasciitis (a rare, rapid, and life-threatening bacterial infection that destroys the skin), Fournier Gangrene, (a rare, rapidly progressing, and life-threatening necrotizing fasciitis [flesh-eating infection] of the genital, perineal, or perianal regions) and Cellulitis of corpus cavernosum and penis (a serious bacterial infection causing swelling, pain, warmth, and redness in the penile shaft, often in uncircumcised or immunocompromised individuals). During an initial tour of Resident 80's room on 4/28/26 at 2:41 PM, a urinal was observed on the bedside table without any label. During a concurrent observation and interview on 4/28/26 at 2:54 PM with LN 4, LN 4 confirmed the urinal was not labeled. LN 4 stated that an unlabeled urinal could lead to cross contamination. During an interview on 4/29/26 at 4:27 PM with the IP, the IP stated the urinal should have been labeled, as without proper labeling there was no way to know who the urinal belonged to. The IP stated without a proper label, the urinal could be used by another resident and could lead to infections. IP further stated it was important to have the urinals labeled to prevent the risk of infections. During an interview on 5/1/26, at 11:17 AM with the DON, the DON explained that failing to label the urinal posed a concern, as without proper identification, there was no way to determine who it belonged to, and another individual might inadvertently use it. 2a. A review of Resident 19's admission RECORD, indicated Resident 19 was admitted to the facility with multiple diagnoses including chronic obstructive pulmonary disease (CODP, a progressive, long-term long disease that restricts airflow, making it difficult to breathe), type 2 diabetes mellitus (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	(a chronic disorder characterized by high blood sugar - residents with diabetes have a higher risk of infection such as pneumonia [lung infection]), and malignant neoplasm of prostate (a cancerous tumor in the prostate - residents with prostate cancer have a higher risk of developing infections). During a concurrent observation and interview on 4/28/26 at 12 PM with Certified Nursing Assistant (CNA) 1 in Resident 19's room, multiple boxes of soda were stored directly on the floor against the wall with the window. Several boxes were open, and visible dust accumulation was observed on the boxes. CNA 1 confirmed the sodas belonged to Resident 19 and stated staff routinely provide cans to the resident upon request. CNA 1 added Resident 19 was able to independently retrieve soda cans while sitting in his wheelchair, and there was a risk for Resident 1 to touch the floor while retrieving cans and to consume beverages from dusty cans, raising infection control concerns. During an interview on 4/28/26 at 12:12 PM with Resident 19, Resident 19 stated he had been diagnosed with cancer and reported that after each treatment he experienced weakness and was unable to transfer independently between the bed and wheelchair. Resident 19 stated he would ask staff to provide cans of soda from the boxes stored on the floor when needed. Resident 19 further stated he was also able to independently retrieve cans of soda from the boxes observed on the floor while seated in his wheelchair. During an interview on 4/29/26 at 8:55 AM with LN 6, LN 6 stated Resident 19 mostly requested staff assistance to obtain sodas from the boxes stored in his room; however, LN 6 also stated Resident 19 was able to independently retrieve soda cans from the boxes placed directly on the floor in his room. LN 6 further stated that consuming beverages from cans that might have accumulated dust could present infection control concerns and increase the risk of exacerbation of Resident 19's COPD due to exposure to dust particles. During an interview on 4/30/26 at 8:45 AM with LN 1, LN 1 stated that Resident 19 wanted to store boxes of soda on the floor in his room. LN 1 explained that Resident 19 was able to move independently while sitting in his wheelchair. LN 1 further stated there was an increased risk of dust accumulation and cross-contamination because of the boxes which were placed directly on the floor, particularly when Resident 19 independently opened the boxes and/or retrieved cans from them. 2b. During an observation on 4/28/26 at 12 PM in Resident 19's room, the floor was noted to be unclean with multiple dark brown stains presented around the bedside table area, located on the left side of Resident 19's bed between the privacy curtain (a curtain that can be pulled around the bed to provide privacy) and the bed. During an interview on 4/30/26 at 8:45 AM with LN 1, LN 1 stated residents' rooms should be kept clean and free from clutter daily and as needed when visibly unclean. LN 1 stated Resident 19 did not want anyone to move the boxes that were stored directly on the floor, which could potentially make it difficult to properly clean the room and contribute to infection control concerns. During an interview on 4/30/26 at 9:55 AM with the Housekeeping Lead (HKL), the HKL explained that residents' rooms, including Resident 19's room, were scheduled for cleaning every day to ensure cleanliness and prevent infections. The HKL stated that she worked four days per week and, when she was assigned to clean Resident 19's room, Resident 19 allowed her to clean and mop his room. The HKL further stated that she was unsure whether Resident 19 allowed other staff members to move the boxes stored directly on the floor to clean underneath them that might lead to infection control concerns. (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 on 5/1/26 at 10:04 AM, the Infection Preventionist (IP) stated that it was Resident 19's preference to store all boxes of soda in his room, and he was encouraged to allow the facility to move them; however, he refused. The IP stated it was difficult to clean underneath the boxes stored directly on the floor, and housekeeping staff were unable to properly clean the area because Resident 19 did not want or allow staff to move them. The IP further stated that floors should be kept clean, and Resident 19 was particular about staff touching the boxes on the floor. The IP further added that there was a risk of pests' (mice or insects) activity when Resident 19's room was not properly cleaned, with an increased risk for cross-contamination and infection prevention concerns. During an interview on 5/1/26 at 10:43 AM with the Director of Nursing (DON), the DON stated Resident 19 had respiratory issues such as COPD, and there was a possibility that boxes stored directly on the floor in his room could accumulate dust, potentially worsening his respiratory condition. The DON added that pests, including cockroaches, could potentially nest between the boxes, particularly when the floor was visibly dirty. The DON further stated that Resident 19 was prone to infection due to his medical conditions and that the floor should be kept clean to help prevent infections. The DON further added that staff were expected to educate Resident 19 regarding those concerns and document the education provided. Review of the facility's policy and procedure (P&P) titled, INFECTION AND PREVENTION AND CONTROL, revised on January 2026, indicated, . The facility has an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. DEFINITION. Cleaning: The removal of visible soil (e.g., organic, and inorganic material) from objects and surfaces and it normally accomplished manually or mechanically using water with detergents.

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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 record review, the facility failed to protect resident privacy when three tray tickets were thrown into the trash for a census of 103 residents who were receiving facility-prepared meals.^ This failure had the potential for the residents' personal and health information to be viewed and utilized by unauthorized individuals. Findings:During the initial kitchen tour on 4/28/26 at 9:52 AM, the Diet Aide (DA) 1 was washing the breakfast dishes.^ DA 1 removed the trays from the cart, dumped leftover food and paper products, including at least three residents' tray tickets, into the garbage can before separating like items for washing.^ When questioned, DA 1 stated dirty and/or wet tray tickets were put into the garbage without any other destruction occurring. During a concurrent review of the residents' tray tickets (from 4/29/26) and interview with the Director of Nursing (DON) on 4/30/26 at 2:39 PM, the DON agreed that the tray tickets included the following resident information: names, unit/room/bed, date, diet orders, food allergies, food and beverage texture requirements, and notes such as the need for assistive devices, portion sizes, and dislikes. The DON stated that the tray tickets contained resident identifiers and diet-related health information that should be protected. The DON continued that the expectation was that tray tickets were shredded before disposal, and that they should not be placed in regular garbage where unauthorized individuals could access them. The DON further stated this was not in compliance with privacy and confidentiality requirements under the Health Insurance Portability and Accountability Act Privacy Rule (HIPAA - established national standards to protect individuals' medical records and other individually identifiable health information, collectively defined as protected health information). During a subsequent interview on 4/30/26 at 3:39 PM with the Dietary Supervisor (DS) and Registered Dietitian (RD), the DS and RD acknowledged that residents' tray tickets contained confidential information and that placing them in the garbage was not appropriate. Review of facility's policy and procedure (P&P) titled, PRIVACY AND CONFIDENTIALITY, revised in 3/2023, the P&P indicated, .The resident has a right to personal privacy and confidentiality of his or her personal and medical records, including all provisions of the HIPAA Privacy Rule.Safeguarding the content of information.from unauthorized disclosure. The facility supports each resident's right.to privacy and confidentiality for all aspects of care and services. Resident medical information.shall not be in public view.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on observation, interview, and record review, the facility failed to develop and update comprehensive care plans (a dynamic, individualized, and multidisciplinary document outlining a resident's medical, functional, and psychosocial needs) for 2 of 29 sampled residents when: 1. A care plan for shortness of breath was not updated to include new oxygen therapy interventions for Resident 74; and2. A care plan for dialysis care (a specialized medical treatment for patients with chronic kidney failure who receive treatments to filter waste and excess fluids from their blood) was not developed for Resident 124. These failures had the potential to place Resident 74 and Resident 124 at risk for not receiving effective, individualized care. As a result, these failed practices could negatively impact the health, safety, and well-being of Residents 74 and 124. Findings: 1.During a review of Resident 74's admission RECORD, the record indicated Resident 74's diagnosis included chronic obstructive pulmonary disease (COPD, airway inflammation in a resident with a progressive, incurable lung disease and damage to the airway, making it difficult to breathe), and personal history of pulmonary embolism (a sudden, life threatening blockage in one or more lung arteries, symptoms included sudden shortness of breath, sharp chest pain, and fainting or lightheadedness). During a concurrent observation and interview on 4/28/26 at 11:20 AM with the Licensed Nurse (LN) 6, LN 6 confirmed there was a sign outside of Resident 74's room that indicated oxygen was in use inside Resident 74's room and LN 6 verified Resident 74 was receiving oxygen for shortness of breath. During a concurrent interview and record review on 4/28/26 at 11:44 AM with LN 6, Resident 74's medical record titled, Order Review History Report [a list of the resident's ordered medications], dated 4/1/26 through 4/30/26 and all active care plans were reviewed. LN 6 confirmed the following order for Resident 74: . Administer O2 [oxygen] at 2 liters/min [liters per minute, a unit of measurement] via nasal cannula [a plastic tube with two prongs placed in the nostrils to deliver supplemental oxygen to patients with respiratory conditions] to maintain SaO2 [oxygen saturation] level at 90% [% is a percentage a number or ratio representing a part of a whole expressed as a fraction of 100] . was started on 3/17/26. LN 6 verified the physician's order for oxygen therapy. However, upon review of the care plan, LN 6 acknowledged that oxygen therapy was not included as an intervention for shortness of breath and/or respiratory distress. Additionally, the care plan had not been updated to reflect the initiation of oxygen therapy on 3/17/26. LN 6 acknowledged the findings and stated that care plans served as a framework for nursing care. LN 6 explained that nurses were responsible for developing care plans, implementing and updating interventions as needed, and using them as guiding tools to evaluate effectiveness. LN 6 further stated that the absence of appropriate care plan interventions suggested that necessary measures might not have been implemented to meet Resident 74's respiratory needs. During an interview on 4/29/26 at 12:05 PM with LN 4, LN 4 stated that care plans served as a communication tool to guide nursing staff in providing appropriate care to residents and in establishing goals aimed at improving outcomes and meeting individual needs. LN 4 explained that nursing staff were responsible for developing person-centered care plans and implementing appropriate interventions based on each resident's specific needs and goals. LN 4 further stated that (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	care plans provided guidance and direction to ensure residents' needs were met, and that the absence of an updated and comprehensive care plan could result in a lack of coordination of care. During an interview on 5/1/26 at 10:43 AM with the Director of Nursing (DON), the DON stated care plans served as essential guidelines for nursing staff to ensure appropriate resident care. Additionally, the DON stated that care plans should be individualized and include person-centered goals and interventions aimed at improving residents' health conditions. The DON added nurses were expected to create, update, or resolve care plans as necessary, particularly when existing interventions were ineffective. The DON further stated that those expectations were not met without appropriate care plans and effective interventions for Resident 74 and it appeared that Resident 74 did not receive optimal care. During a review of the facility provided policy and procedure (P&P) titled, DEVELOP-IMPLEMENT COMPREHENSIVE CARE PLANS, revised on January 2026, the review indicated, . POLICY STATEMENT: The facility develops a person-centered comprehensive care plan. developed and implemented to meet. and address the resident's medical, physical. needs. GUIDELINES. 1. a. The services that are to be furnished are to attain or maintain the resident's highest practicable physical. 2. Care plans must be person-centered and reflect the resident's goals. and desired outcomes. 2. During a review of Resident 124's admission RECORD, dated 5/1/26, the record indicated, Resident 124 was admitted to the facility with diagnoses including end stage renal disease (ESRD, the final, irreversible stage of kidney failure where kidneys function at less than 15% [percent - out of 100] of normal capacity) and type 2 diabetes mellitus (DM2, a chronic metabolic condition where the body develops insulin [a hormone produced by the pancreas] resistance or fails to produce enough insulin, resulting in high blood sugar levels). During an initial interview on 4/28/26 at 8:35 AM with Resident 124 while in her room, Resident 124 stated she was getting ready to go to her dialysis appointment. Resident 124 also stated her dialysis days were every Tuesdays, Thursdays, and Saturdays. During a review of Resident 124's Order Summary Report, active orders as of 5/1/26, the order indicated, .Hemodialysis Schedule 3 x [times] per week every T-TH-S [Tuesday, Thursday, and Saturday] at 10:25 AM Dialysis Center.Hemodialysis: Do not restrict fluids.Do not take blood pressure or blood draws on LEFT arm.Monitor access site Left upper AV fistula [a connection surgically created between an artery and a vein designed for long-term hemodialysis] for redness, swelling, drainage & [and] pain. Notify MD [Medical Director] if (+) [positive].Monitor intake and output [the amount of fluid that goes into the body and the amount of fluid that leaves the body] every shift.Monitor for presence of bruit [vascular sound] & thrill [palpable vibration] every shift.Vital signs [measurable body functions used to detect or monitor medical problems] pre [before] and post [after] dialysis in the evening every Tue, Thu, Sat [Tuesday, Thursday, and Saturday] for Post Dialysis.Vital signs pre and post dialysis one time a day every Tue, Thu, Sat for Pre Dialysis. During a review of Resident 124's Care Plan Report, dated 4/22/26, the report revealed that there was no care plan created or initiated for dialysis care to include the physician's orders listed above as measures of meeting Resident 124's dialysis needs. During an interview on 5/1/26 at 8:46 AM with the Assistant Director of Nursing (ADON), the ADON confirmed Resident 124's care plan report did not include a dialysis care plan. The ADON stated there should have been a stand-alone dialysis care plan initiated to include interventions pertaining to (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	dialysis care such as checking for the fistula access site, reviewing the body weight history before and after dialysis, checking for electrolyte (essential minerals the body needs to function) imbalance, and other measures necessary in providing care to Resident 124. The ADON also stated that without the care plan the interventions mentioned above could have been missed and could have affected the care of Resident 124. During an interview on 5/1/26 at 1:07 PM with the Director of Nursing (DON), the DON stated she expected the dialysis care plan to be initiated and implemented to achieve the goals instituted for Resident 124, and so the nursing staff could have used the care plan as a guideline in implementing dialysis care. The DON also stated the risk of not having a dialysis care plan was that the nursing staff would not have had the proper direction in providing care. During a review of the facility's Policy and Procedure (P&P) titled, DIALYSIS MANAGEMENT, revision date January 2025, the P&P indicated, .To provide residents who require dialysis care, services consistent with professional standards of practice, a comprehensive person-centered care plan which meets the residents' goals and preferences. During a review of the facility's Policy and Procedure (P&P) titled, BASELINE CARE PLAN, revision date January 2026, the P&P indicated, .The facility develops and implements a baseline care plan for each resident that includes instructions needed to provide effective, person-centered care of the resident that meet professional standards of quality care.Completion and implementation of the baseline care plan within 48 hours of a resident's admission is intended to promote continuity of care and communication among nursing home staff, increase resident safety, and safeguard against adverse events that are most likely to occur right after admission .The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan is developed within 48 hours of the resident's admission . During a review of the facility's Policy and Procedure (P&P) titled, DEVELOP-IMPLEMENT COMPREHENSIVE CARE PLANS, revision date January 2026, the P&P indicated, .The facility develops a person-centered comprehensive care plan that is culturally competent and trauma-informed, developed and implemented to meet each resident's preferences and goals, and address the resident's medical, physical, mental, and psychosocial needs.

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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 provide adequate care and services to promote healing and for the prevention of a pressure injury (a localized injury to the skin and/or underlying tissue because of prolonged pressure) for 1 of 29 sampled residents (Resident 2), when Resident 2's low-air loss mattress (LAL mattress, a mattress designed to prevent and treat pressure wounds that uses a continuous, gentle flow of air through a surface of tiny holes to reduce pressure helping to prevent and treat skin breakdown and pressure wounds) was not correctly adjusted according to Resident 2's current weight. This deficient practice had the potential to delay wound healing and placed Resident 2 at increased risk for developing pressure injury and/or skin breakdown. Findings:During a review of Resident 2's admission RECORD, the record indicated Resident 2 was admitted to the facility with multiple diagnoses including end stage renal disease (final permanent kidney disease), peripheral vascular diseases (a slow, progressive blood circulation disorder that could slow wound healing process), and anemia in chronic kidney disease (a condition where the blood lacks enough healthy red blood cells, causing reduced oxygen delivery to organs and tissues that could impairs wound healing).During a concurrent observation and interview on 4/28/26 at 3:39 PM with Resident 2, Resident 2 was in bed on a LAL mattress, and the mattress setting was calibrated to 120 pounds (lbs.- a unit of measurement). Resident 2 stated the mattress was in use due to pressure injuries to his buttocks area (consists of two rounded muscles which are essential for walking, running, standing up from a chair, and a primary support for the body while in a seated position), with the purpose of promoting wound healing and preventing further skin breakdown.During a concurrent observation and interview on 4/28/26 at 3:44 PM in Resident 2's room, Licensed Nurse (LN) 8 confirmed Resident 2 was lying in bed on a LAL mattress which was adjusted to 120 lbs. LN 8 stated that nurses were responsible for checking the mattress setting each shift to ensure proper function and that the pump was supposed to be adjusted according to Resident 2's actual weight. LN 8 further stated that Resident 2 had existing wounds on the buttocks.During a subsequent concurrent interview and record review on 4/28/26 at 3:46 PM with LN 8, Resident 2's medical record titled, Weights and Vitals Summary, dated 4/28/26 was reviewed. The record indicated Resident 2's most recent post-dialysis (dialysis-a specialized medical treatment for patients with chronic kidney failure who receive treatments to filter waste and excess fluids from their blood) weight documented on 4/28/26 was 142 lbs. LN 8 acknowledged the findings and explained that the purpose of a LAL mattress was to relieve pressure on the wound, promote wound healing, and prevent further skin breakdown. LN 8 stated the LAL mattress pump should have been set according to Resident 2's actual weight and acknowledged the current mattress setting did not reflect Resident 2's actual weight. LN 8 acknowledged that inadequate pressure setting could contribute to worsening of existing wounds on the buttocks.During a review of Resident 2's medical record titled, Care Plan Report, contained a specific care plan initiated on 4/24/26 and titled, Focus. PREVENTATIVE: Resident [Resident 2] has high risk/or at risk for pressure injury development or skin impairment. contributing factors. fragile skin. easy skin breakdown, exposure to moisture r/t [related to] incontinence [inability to hold urine or stool]. prolong laying in same position. Interventions/Tasks. The resident [Resident 2] needs . pressure relieving/reducing mattress. LAL mattress for skin management. Additionally, the review revealed a care plan titled, Focus. The resident [Resident 2] has actual impairment to skin integrity, PI [Pressure Injury] on readmission to. Stage 2 PI [Pressure Injury that causes a partial loss of skin with an exposed, red-pink wound area]- left buttock. surrounding area of the open wound with non-blanchable, [does not turn white or fade when pressed] redness. contributing factors. impaired in mobility. prolong laying in same position. Interventions/Tasks. The resident [Resident 2] needs. pressure relieving/reducing mattress. LAL mattress.During an interview on 4/30/26 at 8:45 AM with LN 1, LN 1 explained the purpose of LAL mattress for Resident 2 was to promote wound healing and prevent further skin breakdown. LN 1 stated the mattress setting was (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	adjusted from 120 lbs. to 160 lbs. LN 1 stated when the setting was at 120 lbs., the air pressure was too low, resulting in reduced air flow which could have allowed Resident 2's skin to be against the bed's metal frame, potentially worsening the existing wounds.During an interview on 4/30/26 at 9:41 AM with the Treatment Nurse (Tx Nurse), the Tx Nurse explained that upon admission, a LAL mattress was implemented for residents with stage 2 or higher PI, or for those at risk of developing pressure injuries. The Tx Nurse stated the purpose of the LAL mattress was to relieve pressure at the site of injury, to promote wound healing, and to prevent further skin breakdown. The Tx Nurse stated that when the LAL mattress was set at lower scale than the residents' current weights, the air pressure within the mattress was insufficient, as a result, the support provided was inadequate, potentially allowing residents' skin to be against their beds' frames, which could negatively impact the wound healing process.During an interview on 4/30/26 at 3 PM with the Environmental Services Director (ESD), the ESD stated he was notified by the nursing staff when there was an order to be placed for a LAL mattress on a resident's bed. The ESD stated once he was notified, he installed the mattress and set the air pressure according to the resident's current weight. The ESD further stated that when the pump scale did not allow for an exact weight setting, he adjusted the pressure to the next highest setting. The ESD further stated that if a resident's current weight was 142 lbs. and the pump scale included settings of 80 lbs.,120 lbs., and 160 lbs., he would have selected 160 lbs., in accordance with the manufacturer's guidelines.During an interview on 5/1/26 at 10:43 AM with the Director of Nursing (DON), the DON stated she expected nurses to adjust the LAL mattress pressure in accordance with the manufacturer's guidelines and the resident's comfort level. The DON further explained that when Resident 2 was lying on a LAL mattress set at a lower weight than current weight, there was a possibility that the wound healing process could have been delayed and/or the wound condition could have worsened.During a review of the facility provided undated LAL mattress operation manual for [Brand Name], the review indicated, . General. system is designed for prevention, treatment and management of pressure ulcers [localized damage to the skin and underlying soft tissue, usually over a bony areas of the body]. Weigh/Pressure set up. adjust air mattress to a desired firmness according to patient's weight.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident?s drug regimen must be free from unnecessary drugs. Based on interview and record review, the facility failed to ensure the safe use of the medications for one out of five sampled residents (Resident 59) who's medical records were reviewed for the use of unnecessary medications, when Resident 59's physician's order for a lidocaine patch (a numbing agent used as a topical patch placed on the skin) did not follow the doctor's order and/or the manufacture specification for use.This failed practice could contribute to unsafe medication use, ineffective pain relief, and an adverse drug reaction (a harmful, unintended response to a medication occurring at normal doses).Findings:During a review of Resident 59's electronic medical record titled, admission Record, the record indicated Resident 59 was admitted to the facility with a diagnosis that included back and knee pain.During a review of Resident 59's electronic medical record titled, Discharge Summary and Orders, dated 2/2/26, the record from [Hospital A] indicated a Lidocaine 5% (percent, the amount out of 100) pain patch was to be applied once daily and then removed after 12 hours (drug free period). The medication start date was 2/3/26. During a review of Resident 59's electronic medical record titled, Medication Administration Record, (MAR, a document that contains medications ordered, given, and/or held) dated 2/26 through 4/26, the record indicated, Lidocaine External [outside of the body] Patch 4% (Lidocaine) Apply to affected area topically every 12 hours for Pain; Start date 3/26/26. The patch was scheduled for 9 AM and 9 PM without any drug free period time.During a concurrent interview and record review on 4/30/26 at 3:47 PM with Licensed Nurse 7 (LN 7) at the East nursing station, Resident 59's Order Summary Report, dated 1/2026 through 3/2026 was reviewed for a history of Lidocaine orders. The report indicated, - lidocaine 5% patch once daily at 9 AM and removal at 9 PM from 1/21/26 to 2/1/26,- lidocaine 4% patch once daily at 9 AM and removal at 9 PM from 2/2/26 to 3/26/26,- lidocaine 4% patch twice daily at 9 AM and 9 PM from 3/26/26 to 4/30/26LN 7 stated she entered the last order (3/26/26 through 4/30/26) into the computer on 3/26/26. LN 7 could not recall what prompted the order change. LN 7 stated she had not called the doctor to change the order.During a phone interview on 4/30/26 at 3:12 PM with the Medical Doctor (MD 1), MD 1 stated she was the medical director but had not closely monitored Resident 59. MD 1 stated she did not recall if she signed the monthly order review sheet (a monthly review of all physician orders) for the resident.On 4/30/26 at 11 AM, a phone call was made from the Department to Medical Doctor 2 (MD 2). MD 2 did not return the call. During an interview on 4/30/26 at 4:44 PM with Resident 59 in the facility's activity room, Resident 59 stated the pain patch was placed on her right knee and had not been effective or helpful in managing her knee pain.During an interview on 5/1/26 at 12 PM with Director of Nursing (DON) in her office, the DON stated she expected the nursing staff to discuss the need for medication change or the timing of the use of the medication with the care team and medical provider. The DON stated excessive use of lidocaine could cause side effects, change the effectiveness of the medication, and the nursing staff should have followed the standards of practice for safe medication usage.A review of the DailyMed (the official National Library of Medicine website providing up-to-date FDA [Food and Drug Administration]-approved drug labeling and package inserts) drug information based on FDA approved drug labeling and use, last accessed on 5/5/26 via https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=078bc9a3-41b7-26a4-e063-6394a90a200d, the drug information under Direction For Use indicated Remove patch from the skin after at most 8-hour application. A review of the facility's policy titled, Resident Care Supervised by a Physician, dated in March 2018, the policy indicated, . The physician supervises the medical care of residents by participating in residence assessment and care planning, monitoring changes in residence medical status and providing consultation or treatment when contacted by the facility. Supervision by the physician also includes, but is not limited to, prescribing medication and therapy, ordering a residence transfer to the hospital, conducting required routine visits or delegating to and supervising follow-up visits by NPP (Non-Physician Practitioner) .

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Based on observation, interview, and record review, the facility failed to ensure safe medication administration practices when the medication error rate was more than 5% (percentage - number or ratio that expressed as a fraction of 100) with a census of 103 residents. Medication administration observations were conducted over multiple days, at varied times, in random locations throughout the facility. The facility had a total of 3 errors out of 32 opportunities which resulted in a facility wide medication error rate of 9.38 % for 3 out of 9 residents (Resident 19, Resident 27, and Resident 28) during medication administration observation.These failures may result in unsafe use of medications, medication errors, and not following the doctor's orders and manufacturer specifications.Findings: 1. During a medication administration observation with Licensed Nurse (LN) 6, on 4/28/26 at 8:55 AM, LN 6 poured 10 medications for Resident 19 into a cup. The medications included bicalutamide (cancer medication), amlodipine (blood pressure medication), Calcium plus Vitamin D3, doxycycline (antibiotic), hydralazine (blood pressure medication), ferrous sulfate (iron), metoprolol (blood pressure medication), multivitamin with minerals (includes Zinc as a mineral) acetaminophen/ hydrocodone bitartrate (pain medication) and loratadine (allergy medication). LN 6 administered all these medications with a cup of water.A review of the Resident 19's medication label for doxycycline, on the bubble pack (or blister pack, a type of protective packaging where drug is sealed in individual, transparent, plastic bubbles on a card) provided by the pharmacy, indicated, Take this medication at least 2 hours before or 2 hours after magnesium or aluminum containing antacids or other products containing calcium, iron or zinc.A review of Resident 19's Medication Administration Record, (MAR, a document that contains the physician ordered medications that were given or held) dated 4/1/26 through 4/30/26, indicated the administered medications were all timed to be given at 9 AM as follows:-Calcium-Vitamin D tablet scheduled and given at 9 AM-Multiple Vitamins-Minerals Tablet scheduled and given at 9 AM-Iron tablet 325 milligram (mg, unit of measurement) scheduled and given at 9 AM and 5 PM.-Doxycycline oral tablet 100 MG scheduled and given at 9 AM and 5 PM,During a concurrent interview and record review on 4/29 /26 at 10:53 AM with LN 1, Resident 19's MAR, dated 4/1/26 through 4/30/26 was reviewed. LN 1 stated that medications ordered to be given twice a day were usually scheduled for 9 AM and 5 PM. LN 1 confirmed that Resident 19 was taking iron, calcium, and a multivitamin that contained Zinc and that those medications and supplements were scheduled at the same time as Doxycycline. LN 1 stated the Doxycycline should be scheduled at 7 AM or two hours before the other medications. LN 1 stated the nursing staff did not have the medication information instructions when they received the new medication order or when they input the order in the computer system. LN 1 stated the nursing staff should have researched the medication information or changed the medication administration time. Review of DailyMed drug information based on FDA approved drug labeling and use, last accessed on 5/5/26 via https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=3e7cf78f-3b48-4614-9fa4-c6d1e0c05a35, the drug information on doxycycline under Drug Interactions, indicated, Absorption of tetracyclines (class of drugs including Doxycycline) is impaired by antacids containing aluminum, calcium, or magnesium, and iron-containing preparations.2. During a medication administration observation on 4/28/26 at 9:37 AM with LN 4, LN 4 poured seven oral medications into a medication cup for Resident 27. The medications included Linzess (or linaclotide, medication for chronic constipation) with a label that indicated, TAKE ON AN EMPTY STOMACH and another medication called Carvedilol (or Coreg - a blood pressure medication) with a label that indicated, TAKE MEDICATION WITH FOOD. LN 4 administered all these medications with a cup of grape juice.During an interview on 4/28/26 at 9:40 AM with Resident 27, Resident 27 stated he already ate this morning about an hour ago (approximately 8:40 AM) and the staff had just picked up his breakfast tray.A review of Resident 27's Medication Administration Record, (MAR) dated 4/1/26 through 4/30/26, indicated, Linzess oral capsule 72 micrograms [MCG, a unit of measurement]; Give 1 capsule by mouth one time a day (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	related to . CONSTIPATION.hold for loose stools; Start date: 12/3/24. The MAR indicated the medication was scheduled and given at 9 AM. The MAR did not indicate Linzess should be given and timed with an empty stomach.During a concurrent interview and record review on 4/28/26 at 10:04 AM with LN 4, Resident 27's MAR, dated 4/1/26 through 4/30/26 was reviewed. LN 4 stated for the medications with instructions to administer the medication with food, the medication should have been given within an hour of the resident eating. LN 4 stated for the medications that should have been administered on an empty stomach, the medications should have been given earlier, before the resident ate breakfast. LN 4 confirmed that she administered Linzess to Resident 27 after he ate breakfast. LN 4 confirmed that there were no instructions on the MAR to give the medication Linzess on an empty stomach as noted on the medication bubble pack label.Review of DailyMed (the official National Library of Medicine website providing up-to-date FDA [Food and Drug Administration] -approved drug labeling and package inserts) drug information based on FDA approved drug labeling and use, last accessed on 5/5/26 via https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=09beda19-56d6-4a56-afdc-9a77b70b2ef3 , the drug information on Linzess under Preparation and Administration Instructions, indicated, Take LINZESS on an empty stomach, at least 30 minutes prior to a meal, at approximately the same time each day.3. During a medication administration observation on 4/28/26 at 9:50 AM with LN 4, LN 4 poured Resident 28's oral medications that were due for 9 AM into a medication cup. The medications included metoprolol (blood pressure medication), midodrine (a medication to regulate blood pressure), citalopram liquid (depression medication in liquid form), and multivitamins (supplements). A review of Resident 28's Medication Administration Record, dated 4/1/26 through 4/30/26, the MAR indicated all medication orders scheduled at 9 AM were given by LN 4. An order for Vitamin D that was not administered during medication administration observation as follow: Cholecalciferol (vitamin D3, a supplement) Oral Tablet 125 MCG (or 5,000 units, a measure of product strength); Give one tablet by mouth one time a day for supplement. Vitamin D was scheduled for 9 AM.During a concurrent interview and record review on 4/29/26 at 11:42 AM with LN 4, Resident 28's MAR, dated 4/1/26 through 4/30/26 was reviewed. LN 4 stated she gave Vitamin D to Resident 28 on 4/28/26 and 4/29/26. LN 4 showed a bottle of 2000 international unit (IU, unit of measurement) of Vitamin D3 and stated that this was what she gave to Resident 28. LN 4 confirmed there was no 5000 IU of vitamin D3 on the medication cart. LN 4 stated she gave 2 tablets of Vitamin D3 (2000 IU) to Resident 28. LN 4 confirmed that the order was for 5000 IU of vitamin D3. LN 4 went to the medication room to get the 5000 IU Vitamin D3 but there was none. LN 4 then went to the central supply storage room to find the Vitamin D 5000 units and found one bottle.During an interview on 4/29/26 at 3:30 PM with LN 4 in the Director of Nursing (DON) office, LN 4 stated she wanted to clarify that she gave two and a half tablets of Vitamin D3 (2000 IU) to Resident 28 on 4/29/26. LN 4 did not explain why she did not use the vitamin D 5000 units from the supply room.During a concurrent interview and a record review on 4/29/26 at 3:24 PM with the DON in her office, Resident 19's MAR, dated 4/1/26 through 4/30/26 and the doxycycline medication label were reviewed. The DON confirmed the findings that doxycycline was given to Resident 19 together with iron, calcium and vitamins with minerals. The DON confirmed that the medication doxycycline's label indicated the medication should be taken at least two hours before or two hours after magnesium or aluminum containing antacids or other products containing calcium, iron, or zinc. The DON stated that she expected the nurses to communicate to the supervisor, to the DON, or the doctor and have the medication administration times changed. The DON stated the pharmacist should have reviewed it during drug regimen review (a structured, authorized, and ongoing evaluation of a patient's medication therapy conducted by a pharmacist). The DON stated the nursing staff was following the hospital orders, which did not include a warning or an instruction on the medication. The DON stated that she expected nurses to notify her or the supervisor if there was a warning in the medication label and they would make a correction to the administration time. The DON stated the timing of medication administration should have been based on drug information and the (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	best practices for safe medication use. The DON stated she was not aware if the facility's computer system alerted the nurses for drug interaction or drug information. The DON stated she expected the nurses to administer the drugs with the correct dosage and if medication was out of stock, to request a refill. A review of the facility's policy titled, ADMINISTERING MEDICATIONS, revised January 2025, indicated .Medications must be administered in accordance with the orders.Medications must be administered in accordance with state and federal guidelines.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, and record review, the facility failed to ensure safe medication storage practices in the medication cart and treatment cart (a secured cart that contains wound care treatment supplies) for a resident census of 103 when:1. The [NAME] Station treatment cart contained expired wound care supplies, and a one-time use normal saline (a sterile-germ free- mixture of water and salt) for wound care was found to be open and not discarded; and2. The [NAME] Station medication cart stored fleet enema (medications designed for insertion into the rectum) and was co-mingled with oral medications. These failures could result in unsafe and unsanitary medication storage and the risk of residents receiving contaminated or spoiled product or supplies.Findings:1.During a concurrent observation and interview on 4/28/26 at 3:41 PM with Licensed Nurse (LN) 1, an observation of the [NAME] Station treatment cart was conducted. The following supplies stored in the treatment cart were as follows: Sterile normal saline wound care solution was found to be opened and dated when the product label indicated it was for one time use and perineal spray lotion (a product used to clean and protect skin) expired on 2/28/26.LN 1 stated that once the normal saline package was opened, it was good for 24 hours. However, after LN 1 read the product label, LN 1 stated the normal saline was for a one-time use and LN 1 discarded the saline bottle. LN 1 stated expired products should not have been stored in active storage areas in the cart.During an interview on 4/29/26 at 11:50 AM with LN 3, LN 3 stated that the normal saline should have been discarded once it was opened and used for a resident. LN 3 stated if the normal saline was re-used after the one-time use, there would be an infection control concern and possible risk of cross contamination (moving bacteria from one location to another). LN 3 stated expired wound care items should have been checked for expiration dates and discarded if applicable.2.During a concurrent observation and interview on 4/28/26 at 3:58 PM with LN 2 at the [NAME] Station medication cart, the medication cart bottom drawer stored a fleet enema next to oral medications (in the same bin). LN 2 confirmed the findings. LN 2 stated that the enema should have been stored separately from the oral medications.During an interview on 4/29/26 at 3:24 PM with the Director of Nursing (DON), the DON stated one time use drugs should have been discarded after use. The DON stated expired medications and treatment care supplies should have been removed and discarded from the cart. The DON further stated that the enema found in the medication cart should have been separated from the oral medications and there should be a divider in the medication cart that separated the two routes of medications. A review of the facility's policy and procedure titled, LABELING OF BIOLOGICALS AND STORAGE OF BIOLOGICALS, revised January 2025, indicated, .The facility, in coordination with the licensed pharmacist, provides accurate labeling to facilitate precautions and safe administration of medications, and safe and secure storage.A review of the facility's policy and procedure titled, ADMINISTERING MEDICATIONS, revised January 2025, indicated, .Vials labeled as single dose, or single use will not be used on multiple residents. Such vials will be used only for one resident in a single procedure.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. Based on interview and record review, the facility failed to ensure long term antibiotic use was clinically justified for safe use with monitoring and a nursing plan of care for 1 out of 29 sampled residents (Resident 56), when Resident 56 was prescribed doxycycline (an antibiotic, a medication used to treat infection) with full dosing regimen for over one year.This failed practice could contribute to unsafe antibiotic use, risk of developing resistance bugs (when antibiotic no longer can kill or suppress the bug), and ineffective use with side effects.Findings:A review of Resident 56's clinical record titled, admission RECORD, indicated Resident 56's diagnosis included diabetes (blood sugar disease), kidney disease, obesity (excessive body fat), and history of knee surgery with an infection. Review of the Resident 56's medical record titled, Medication Administration Record, (MAR, a record that indicates physician orders, medications administered and/or held) dated 4/26, the record indicated Resident 56 was on an ongoing antibiotic called doxycycline as follows: .Doxycycline . tablet 100 mg [milligram, a unit of measure]; Give 1 tablet by mouth two times a day for streptococcal [a type of bacteria or bug causing skin infection]; Start date 3/21/25 .During a review of Resident 56's clinical record titled, Order Summary for the history of doxycycline use, indicated Resident 56 was on doxycycline in 2024 as follows: 2/27/24 through 5/27/24, 7/23/24 through 8/12/24, 10/26/24 through 11/5/24 and 12/2/24 through 12/12/24.During a review of the Resident 56's medical record titled, Office/Clinic Note, dated 2/2/24, the record indicated Resident 56 visited an orthopedic (bone surgical specialist) doctor for complaint of right knee pain. The note under Assessment/Plan, indicated Resident 56 had Chronic PJI right knee, [PJI, Periprosthetic Joint Infection- infection of hardware inside the knee) mechanical (a physical or structural issue) complication of the right knee, and there was a recommendation for another surgical procedure.During a review of the Resident 56's medical record titled, Office/Clinic Note, dated 3/15/24, the record indicated Resident 56 underwent a surgery on her right knee for chronic PJI on 2/14/24. The note under Assessment/Plan, indicated wound healing was the most critical part of the recovery and there were some concerns about an eschar (a thick, dry, leathery layer of dead [necrotic] tissue, usually black or brown, that forms over deep wounds) around the incision site of the surgery. The note further indicated to continue with local wound care at the facility with a dry dressing.During a concurrent interview and record review on 4/30/26 at 1:40 PM with the facility's Infection Preventionist (IP), a letter found in Resident 56's electronic health record, sent from the facility's IP to the orthopedic doctor, dated 4/22/25 was reviewed. In the letter, the IP inquired from the orthopedist doctor to address and reassess the long-term antibiotic (doxycycline) use. The letter indicated, .As a long term care provider, we aim to ensure antibiotics are used appropriately, reducing antibiotic resistance and improving patient outcomes. We are writing to see if you are willing to reconsider the indefinite order for the above-mentioned antibiotic to adhere to McGeer criteria [McGeer criteria are standardized, evidence-based surveillance definitions used to identify infections in nursing homes. They are designed to differentiate true infections from colonization aiding in appropriate antibiotic use] and reduce resistance. The IP stated there was no response or clinical justification from the orthopedic provider. The IP nurse stated she did not escalate to the medical director when there was no response from orthopedic doctor.A review of the Resident 56's electronic medical record under Notes To Attending Physician, dated 3/14/26, written by the facility's Consultant Pharmacist (CP) to Medical Doctor (MD) 1, the note indicated, .When a resident is on prophylactic [preventive] antibiotic therapy. Risk versus benefit and medical justification statements are required . Please evaluate indication and document on dose/duration of therapy and if resident condition has improved/stabilized or underlying causes of symptoms have resolved and that the sign and symptoms are persistent or clinically significant to warrant medication use . The record had a handwritten note from the surgeon that indicated, Clarified with MD since 4/22/25 with order indefinite r/t [related to] sensitivity of streptococci species to tetracycline [an antibiotic- same class as doxycycline]. The (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055833	A. Building B. Wing	05/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fulton Gardens Post Acute, LLC	537 E. Fulton Street Stockton, CA 95204

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	note was initialed by a nurse and signed by a facility's provider.A review of the facility's nursing plan of care for Resident 56, last review completed on 4/10/26, the nursing plan of care did not address long term antibiotic use and the chronic surgical wound infection or wound care.During a phone interview on 4/30/26 at 3 PM with Medical Doctor (MD) 1, MD 1 stated she did not follow Resident 59 care closely as the Medical Director. MD 1 stated her review of the medical record indicated the antibiotic was used for chronic suppression and was ordered by the orthopedic doctor for the wound on Resident 56's knee. MD 1 acknowledged orders by the outside specialist consultants were reviewed and ordered by the facility's main doctor. MD 1 stated the facility did not contact her to address long term antibiotic use and the facility did not order any lab work or consult with an infection control specialist to re-assess long term antibiotic use.A phone call to Medical Doctor 2 (MD 2) was made on 4/30/26 and the phone call was not returned by the MD 2. During an interview on 5/1/26 at 12:22 PM with facility's Director of Nursing (DON) in her office, the DON stated the long-term antibiotic use should have been escalated to the facility's medical director for further testing or re-assessment.During an interview on 5/1/26 at 1:03 PM with the Administrator (ADM), the ADM confirmed there was no care plan for Resident 56's antibiotics.A review of the facility's policy and procedure titled, PHYSICIAN MEDICATION ORDERS, revised January 2025, indicated, .Physician's orders not specifying the number of doses, or duration of medication, may be subject to automatic stop orders.Medications subject to automatic stop orders shall be reported to the physician for continuation, discontinuation or change orders as needed.A review of the facility's policy titled, Antimicrobial Stewardship, dated 9/2016, the policy indicated, . The World Health Organization has reported that antimicrobial resistance is one of the major threats to human health. Especially because some bacteria have developed resistance to all known classes of antibiotics. According to CDC, improving the use of antibiotics in healthcare to protect patients and reduce the threat of antibiotic resistance is a national priority. The policy further indicated, . It is the policy of . Care Center to implement antibiotic stewardship program (ASP) which will promote appropriate use of antimicrobials while optimizing the treatment of infection, at the same time reducing the possible adverse event . This policy has the potential to limit antimicrobial resistance in the post-acute care setting . The policy further indicated, .the ASP team may track compliance of physician and physician groups with the recommendation of ASP's team. The policy under Action indicated the facility may consider protocols to, optimized use and duration of antimicrobial therapy. The policy under Reporting section indicated, A designee of the ASP team will review and report findings to facility QA (Quality Assessment) committee who will then provide feedback to facility staff. Feedback will be given to physicians by the ASP team regarding prescribing pattern, cultures ordered, and antimicrobial prescribed, as indicated .