STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055886	A. Building B. Wing	06/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Roseville Care Center	1161 Cirby Way Roseville, CA 95661

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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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. Based on interview and record review the facility failed to ensure that two of 52 sampled residents (Resident 82 and Resident 9) were free from unnecessary drugs including chemical restraints when medications were administered without specific target behaviors and diagnoses to support indication for use of these drugs. This failure resulted in the administration of medications without adequate indication for use. Findings: 1a. During a review of Resident 82's clinical record, the record indicated Resident 82 was admitted in late 2022 with multiple diagnoses including bipolar disorder (a mental condition manifested by extreme mood swings) and anxiety disorder (a mental condition manifested by worry, fear, or nervousness that is excessive, persistent, and interferes with daily life). A review of Resident 82's Minimum Data Set (MDS- a federally mandated assessment tool), Cognitive Patterns, dated 3/21/25, indicated Resident 82 had a Brief Interview for Mental Status (BIMS- tool to assess cognition) score of 10 out of 15 that indicated Resident 82 had moderately impaired cognition. During a review of Resident 82's physician's order dated 2/19/25, the order indicated, . ARIPiprazole Oral Tablet 10 MG (mg- milligram, a unit of measurement) Give 1 tablet by mouth at bedtime for Bipolar disorder M/B [sic. Manifested by] impulsive behaviors . During a review of Resident 82's physician orders dated 2/19/25, the order indicated, . Olanzapine Oral Tablet 5 MG Give 1 tablet by mouth at bedtime for bipolar disorder M/B [sic. manifested by] manic phases . During a review of the facility's Medication Regimen Review (MRR) for Resident 82, the record indicated, . Please clarify the indication for aripiprazole & olanzapine .it was being used for bipolar disorder. Antipsychotics are not typically used for depression, especially when the manifestation is manic phases . (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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 6/27/25 at 3:13 p.m. with Director of Nursing (DON) and Assistant Director of Nursing 1 (ADON 1) of Resident 82's clinical record, the DON and ADON 1 confirmed Resident 82's MRR was reviewed by the physician and facility. ADON 1 reviewed symptoms experienced by Resident 82. ADON 1 and DON further acknowledged the resident order needed specific behaviors to monitor the resident accurately. 1b. During a review of Resident 9's clinical record, the record indicated Resident 9 was admitted in late 2024 with multiple diagnoses including Dementia (a decline in mental ability severe enough to interfere with daily life with symptoms including difficulty thinking and memory loss). A review of Resident 9's Minimum Data Set (MDS- a federally mandated assessment tool), Cognitive Patterns, dated 5/31/25, indicated Resident 9 had a Brief Interview for Mental Status (BIMS- tool to assess cognition) score of 12 out of 15 that indicated Resident 9 had moderately impaired cognition. During a review of Resident 9's physician orders, dated 12/12/2024 the order indicated, . Depakote Tablet Delayed Release 500 MG (milligram- a unit of measurement) . Give 1 tablet by mouth in the evening for behaviors m/b [sic. Manifested by] dementia . During a review of the facility Medication Regimen review (MRR) dated 6/1/25 through 6/9/25 indicated, . The resident has an order for Depakote for behaviors m/b dementia. This is not a sufficient indication of manifestation for use of Depakote . During a review of the facilities (MRR) dated 6/1/2025 and 6/9/2025, the MRR indicated that, .The resident has an order for Depakote for behaviors m/b dementia. This is not a sufficient indication or manifestation for the use of Depakote During a concurrent interview and record review on 6/27/25 at 3:13 p.m. with DON and ADON 1 of Resident 9's clinical record, ADON 1 confirmed the order and MRR was reviewed by the physician and facility clinical staff. ADON 1 further acknowledged the recommendation from the MRR for Resident 9's Depakote order manifested by Dementia and stated the order needed to have specific target behaviors. ADON 1 further stated the recommendation was missed due to Resident 9 being in the hospital. ADON 1 further stated when Resident 9 was out in the hospital, the orders were put on hold. ADON acknowledged that she missed this pharmacy recommendation to update the order with behaviors despite physician having reviewed it. During a review of facility policy and procedure (P&P) titled, Psychotropic Medication Use, dated October 2024, the P&P indicated, . The physician/Nurse Practitioner will identify, evaluate, and document, with input from other disciplines as needed, symptoms that may warrant the use of psychotropic medications .

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure accurate assessments were completed for two of 52 sampled residents (Resident 170 and Resident 176) when: 1. Resident 170's Minimum Data Set (MDS- a federally mandated resident assessment tool) did not indicate the correct number of pressure ulcer or pressure injury (PU or PI) present on admission; and, 2. Resident 176's MDS did not reflect the resident's status at the time of discharge from the facility. These failures increased the potential for Resident 170 not to receive consistent care and for Resident 176 not to receive referral for necessary services in the community. Findings: 1. A review of the admission Record indicated Resident 170 was admitted early part of June 2025 with diagnoses including rhabdomyolysis (breakdown of muscle tissue) and unstageable pressure ulcer (or pressure injury [PI], base of wound covered by a layer of dead tissue that may be yellow, brown or black and stage is unclear) of other site. A review of Resident 170's admission MDS dated [DATE] indicated Resident 170 had five (5) unstageable pressure ulcers and four (4) of these pressure ulcers were present on admission. In an interview on 6/25/25 at 11:54 a.m., the Treatment Nurse 1 (TN 1) stated Resident 170 was admitted with five (5) PI. The TN 1 further stated Resident 170 had no new PI since admission. In an interview on 6/26/25 at 9:16 a.m., the MDS Assistant Coordinator 1 (MDSA 1) stated when she did the admission Assessment for Resident 170, she did not verify the number of PI from the TN 1. A concurrent interview and record review was conducted on 6/26/25 at 9:23 a.m. with the MDS Coordinator (MDSC). The MDCS confirmed Resident 170's MDS assessment dated [DATE] did not indicate the correct number of PI present on admission. The MDSC stated all information in the MDS should be accurate for resident to receive consistent care. In an interview on 6/27/25 at 12:06 p.m., the Director of Nursing (DON) stated her expectation was for the licensed staff doing the assessments to be careful with entering information for the accuracy of MDS Assessments. A review of the facility's policy & procedure revised October 2024 and titled, Resident Assessments indicated, .The resident assessment coordinator is responsible for ensuring that the interdisciplinary team conducts timely and appropriate resident assessments . Assessments are completed by staff members who are knowledgeable about the resident's needs .Persons who have completed any portion of the MDS resident assessment form must sign the document attesting to the accuracy of such information. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. A review of the admission Record indicated Resident 176 was admitted early May 2025 after hospitalization for hip surgery from a fall at home. Resident 176 was admitted for rehabilitation and physical therapy. The goal was to discharge home with Home Health Physical Therapy. Resident 176 was discharged home on 6/1/25. A review of Resident 176's closed record reflected, Nurse's Notes dated 6/1/25 that indicated, Discharge papers reviewed by nurse in charge and resident 176 nurse explained all medication and all discharge summary. Resident 176 agree and all discharge papers signed by resident. Left the facility with improved condition via wheelchair with Resident 176 family member .Discharge to home. Record review of resident 176's MDS section A dated 6/1/25 indicated, a discharge status of 04. Short Term General Hospital (acute hospital). In an interview and concurrent record review with MDSA 1 on 6/25/25 at 3:15 p.m., MDSA 1 reviewed Resident 176's records and confirmed the resident was discharged home on 6/1/25. MDSA 1 further reviewed Resident 176's MDS section 04 and confirmed it was an incorrect discharge status. MDSA 1 stated Resident 176 did not discharge to Acute Care facility. She also stated that inaccurate documentation can affect CMS (Centers for Medicare and Medicaid) documentation and data. A review of the facility's policy & procedure revised October 2024 and titled, Resident Assessments indicated, .The resident assessment coordinator is responsible for ensuring that the interdisciplinary team conducts timely and appropriate resident assessments . Assessments are completed by staff members who are knowledgeable about the resident's needs .Persons who have completed any portion of the MDS resident assessment form must sign the document attesting to the accuracy of such information.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. Based on observation, interview, and record review, the facility failed to ensure services provided met professional standards of quality for two of 52 sampled residents (Resident 170 and Resident 15) when: 1. Resident 170's LAL (low air loss, designed to prevent and treat pressure ulcers by reducing and redistributing pressure on the body) mattress was not followed as ordered; and 2. Resident 15's blood pressure medication was not administered as ordered. These failures increased the potential for Resident 170 to develop new pressure ulcers and for Resident 15 to experience complications. Findings: 1. A review of the admission Record indicated Resident 170 was admitted early part of June 2025 with diagnoses including rhabdomyolysis (breakdown of muscle tissue) and unstageable pressure ulcer (or pressure injury [PI], base of wound covered by a layer of dead tissue that may be yellow, brown or black and stage is unclear) of other site. A review of Resident 170's physician order dated 6/4/25 indicated treatment orders for five (5) PIs and an order for LAL mattress. During an observation on 6/24/25 at 9:24 a.m., Resident 170 was in bed and had a regular mattress. A concurrent observation and interview was conducted on 6/25/25 at 11:54 a.m. with the Treatment Nurse 1 (TN 1). The TN 1 confirmed Resident 170 had no LAL mattress. The TN 1 further confirmed Resident 170 had an order for LAL mattress dated 6/4/25. A concurrent interview and record review was conducted on 6/26/25 at 9:43 a.m., with the Minimum Data Set Assistant Coordinator 2 (MDSA 2). The MDSA 2 confirmed Resident 170's Medication Administration Record (MAR) indicated the LAL mattress was signed as present on 6/24/25 and 6/25/25. In an interview on 6/27/25 at 11:58 a.m., the Director of Nursing (DON) stated Resident 170 was moved to another room on 6/23/25 and unfortunately the staff did not move the LAL mattress with the resident. The DON stated her expectation was for nurses to check the LAL mattress and document in the Medication Administration Record (MAR). The DON further stated if LAL mattress was not available the staff should notify the Housekeeping Manager. The DON added Resident 170 had wounds and the LAL mattress was for offloading. A review of the facility's policy and procedure (P & P) revised October 2024 and titled, Pressure Ulcers indicated, .The licensed nurse will examine the skin of newly admitted residents for evidence of existing pressure ulcers .The physician/NP [nurse practitioner] will order pertinent wound treatments, including pressure reduction surfaces . A review of the facility's P & P revised October 2024 and titled, Physician Orders indicated, .The licensed staff shall carry out physician/nurse practitioner's orders as prescribed. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. During a review of Resident 15's admission records, the records indicated Resident 15 was admitted in May 2025 with diagnoses that included hypertension (high blood pressure) and atrial fibrillation (irregular, often rapid heart rate that causes poor blood flow). During a review of Resident 15's physician order, dated 5/15/25, the order indicated, Metoprolol Tartrate [medication to treat hypertension] .1 tablet by mouth two times a day for HTN [hypertension] Hold for SBP [systolic blood pressure - the pressure in the arteries when the heart beats] <100 or HR [heart rate] <60. During a review of Resident 15's Medication Administration Record (MAR), the MAR indicated the following: - Vital signs (measurements that reflect essential body functions) were not taken before holding or administering Metoprolol on the following dates: 5/23/25, 6/7/25, 6/14/25, 6/15/25, 6/24/25, and 6/25/25; - Metoprolol was given for BP: 96/51 mmHg [millimeters of mercury, a unit of pressure measurement] on 6/22/25; and, - Metoprolol was not given on the following dates with BP within limits: 5/18/25 - 102/56 mmHg 5/27/25 - 104/62 mmHg 5/30/25 - 104/51 mmHg 5/31/25 - 105/57 mmHg 6/1/25 - 106/50 mmHg 6/4/25 - 106/72 mmHg 6/10/25 - 107/66 mmHg 6/17/25 - 103/56 mmHg 6/24/25 - 104/60 mmHg During a concurrent interview and record review on 6/26/25 at 10:44 a.m. with Licensed Nurse 11 (LN 11), LN 11 confirmed Resident 15 had an order of Metoprolol twice a day and to hold dose if systolic blood pressure was less than 100 mmHg and heart rate was less than 60 beats per minute (bpm). LN 11 stated Resident 15's blood pressure will drop if Metoprolol was given outside the hold parameters. The LN 11 stated, It's important to check vital signs first before giving for the same reason. The LN 11 confirmed doses were also held for vital signs that were within the hold parameters and stated, I don't know why they held it . I'm not sure why they documented that .Resident BP can go up if we don't give it. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 6/27/25 at 8:56 a.m. with the DON, the DON confirmed Resident 15 had an order for Metoprolol with hold parameters. The DON confirmed there were no vitals signs taken before administering or holding Resident 15's Metoprolol on 5/23/25, 6/7/25, 6/14/25, 6/15/25, 6/24/25, and 6/25/25, and stated, All the vitals need to be there whether you hold it or not. The DON further confirmed Resident 15's Metoprolol was administered on 6/22/25 for BP of 96/51 mmHg and that there were nine scheduled dates where Resident 15's Metoprolol doses were held even though the vitals signs were within parameters, and stated, This is not following the doctor's hold parameters .they [staff] are holding it even when residents bp is not low, the HR might go faster . During a review of the facility's policy and procedure (P&P) titled Administering Medications, revised 10/2024, the P&P indicated, .Medications are administered in a safe and timely manner, and as prescribed . 2. Medications are administered in accordance with prescriber orders, including any required time frame .8. The following information is checked/verified for each resident prior to administering medications: .b. Vitals signs, if necessary .

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to protect one of 52 sampled residents (Resident 160) from further injury when they did not implement specified interventions from the care plan to prevent skin tears. This failure resulted in Resident 160 sustaining additional skin tears to her left leg. Findings: A review of Resident 160's admission record indicated she was admitted on [DATE] after a syncopal episode with a ground level fall resulting in a left femur (thigh bone) and left humerus (upper arm bone) fractures. A review of Resident 160's change of condition (COC) note, dated 6/7/25, indicated Resident 160 had sustained a new skin tear to left lower leg during a wheelchair transfer with a Certified Nursing Assistant (CNA). A review of Resident 160's Potential for Skin Tears care plan, initiated on 6/7/25, indicated interventions to prevent skin tears were to keep her nails trimmed and short, pad the wheelchair arms and legs, wear protective sleeves, use a pressure relief mattress, bunny boots, and caution during transfers. A review of Resident 160's COC note, dated 6/22/25, indicated a new skin tear to left knee when transferring from bed to wheelchair. During an observation on 6/24/25 with Resident 160 at 4:15 p.m, a large skin tear was noted to her left knee and there was another healing skin tear to her left lower leg. During an observation on 6/26/25 with Resident 160 at 1:45pm, Resident 160 was seen lying in bed, with no sleeves on, nails were very long and unkept, and her wheelchair arms and legs were not padded. During a concurrent observation and interview on 6/26/25 at 3:35 p.m with Licensed Nurse 2 (LN2), LN 2 stated, No, I do not see any padding on the wheelchair, she does not have sleeves on, and her nails are very long and need attention. During an interview on 6/27/25 with the Assistant Director of Nursing 2 (ADON 2) at 1:24 p.m, the ADON 2 stated, If there are interventions on the care plan it is the responsibility of both the CNA's and the LN's to ensure they are being completed. If the resident had orders for short, trimmed nails, sleeves and padding to wheelchair arms and legs to prevent skin tears then it should have been implemented. A review of the facility's policy and procedure titled Care Plans, Comprehensive dated 10/2024 at number (5) section (a) indicated that, the comprehensive care plan will describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. Based on observation, interview, and record review, the facility failed to provide services that met professional standards of quality for one of 52 sampled residents (Resident 731), when the facility did not follow a physician order for straight catheterization (a thin, flexible tube is inserted into the urethra to drain urine and removed immediately) when the resident complained of inability to urinate and inserted a Foley catheter (a flexible plastic tube inserted into the bladder) to provide continuous urinary drainage. This failure had the potential to result in urinary tract infection. Findings: A review of the admission Record indicated Resident 731 was admitted to the facility in June 2025 with multiple diagnoses which included aftercare following joint replacement surgery and retention of urine (inability to urinate). A review of the physician order for Resident 731, dated 6/21/25, indicated,If patient is unable to urinate after 6 hours, bladder scan [a portable medical device to measure how much urine the bladder has]. If bladder scan and RV [residual volume] greater than 450 [milliliters, ml, a unit of measurement], straight cath [catheterize] as needed. During an observation and interview with Resident 731 on 6/24/25, at 12:48 p.m., the resident was sitting upright in his bed dressed in hospital gown. An indwelling catheter in dark privacy bag was attached to the frame of the bed. The resident was awake, alert and oriented. Resident 731 explained that he was admitted to facility without Foley catheter. Resident 731 stated he was not able to urinate for the entire night and added, My bladder was full .hurt like hell. A review of Resident 731's clinical records failed to reveal a physician order for Foley catheter and there was no order for catheter care. There was no documented date and time when the catheter was inserted. Resident 731's record had no care plan initiated to address Foley catheter. A review of nursing progress notes dated 6/24/25, at 3:28 p.m., indicated, .daughter came and complain [sic] about Foley catheter she stated she did not want Foley if my dad is retaining do straight cath [catheterization] this writer explain [sic] patient retained a lot last night and complain [sic] for pain and tenderness .this writer handed a communication note to PA [physician assistant] about family concern and waiting for orders. During a concurrent interview and record review with Licensed Nurse (LN 6) on 6/26/25, at 9:40 a.m., LN 6 acknowledged that there was no physician order for Foley catheter insertion. During an interview on 6/26/25, at 2:35 p.m., the Director of Nursing (DON) stated the nursing staff did not follow physician's order for straight catheterization and inserted Foley catheter instead. The DON confirmed that Resident 731 did not have a physician order for Foley catheter insertion. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of facility's 'Physician Orders' policy dated 10/24, indicated, Prescribed medication and treatment orders will be carried out in accordance with the physician/nurse practitioner order .Phone or written orders must be recorded in the resident's chart by the person receiving the order and must include the prescriber's last name, credentials, the date, and the time of the order.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Findings: A review of Resident 732's admission Record indicated the facility admitted the resident recently after hospitalization for lung infection. Resident 732's multiple diagnoses included muscle weakness and unsteadiness on feet. A review of the 'Order Summary Report' contained a physician's order dated 6/8/25 indicating that Resident 732 had capacity to make healthcare decisions. A review of Resident 732's care plan titled Malnutrition: Resident is at risk for malnutritioninitiated on 6/8/25, indicated resident's goal was to maintain adequate nutritional status as evidenced by stable weight. The care plan interventions indicated, Assist with meals/fluids as needed, encourage adequate nutrition and hydration, encourage position [sic] of choice of meals. The care plan did not contain resident's food preferences, weight monitoring, and was not updated with new interventions addressing Resident 732's weight loss. A review of Resident 732's clinical records contained a Nutritional Risk Assessment dated 6/13/25. The assessment included resident's height and weight and laboratory results, and did not indicate the resident's weight goal and if the resident desired to loose weight. During an observation and interview on 6/25/25, at 11:36 a.m., Resident 732 was observed laying in her bed. Resident 732 was alert and answered all questions appropriately. When the resident was asked if she had any concerns, the resident replied, Food sucks, not appetizing, not tasteful, I eat because I need to eat. During continued interview Resident 732 stated nobody asked her about her food preferences, likes and dislikes and nobody explained about menus choices and the alternatives. The resident added, Alternatives - no varieties, only peanut butter jelly sandwiches. Whenever I ask, they offer peanut butter jelly sandwich. Resident 732 stated she had lost some weight since admission to facility and had not have anyone from dietary to come and discuss her weight loss. A review of the clinical record indicated Resident 732 weighed 171 pounds upon admission and currently weighed 164 pounds, a 7 pounds weight loss in 17 days. Resident 732's 'Weights and Vitals Summary' indicated the resident was progressively loosing weight. A review of Resident 732's clinical record contained no documented evidence the facility addressed the resident's weight loss and communicated the weight loss to RD or physician. During an observation on 6/25/25, at approximately 12:20 p.m., Resident 732 was sitting in bed with lunch meal tray in front of her. Resident 732 consumed less than 50% of her meal and stated she did not like the food. Resident 732 stated she did not ask for alternate food and added, No point, they will offer peanut butter jelly sandwich. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/26/25, at 1:54 p.m., Certified Nursing Assistant (CNA 3) stated Resident 732 was eating independently. CNA 3 was asked what was the process if the resident did not like their food. CNA 3 explained, Resident can check the menu and if something that they don't like, they can ask to substitute. CNA 3 stated that kitchen staff distributed menus upon resident's admission and the facility had menus posted in each nursing stations where residents could see what food will be served. CNA 3 added that if resident was unable to see the menu at the nursing station, they could ask and the staff will bring the menu to them. CNA 3 stated she could not recall if she offered Resident 732 menu or alternate meals and if Resident 732 asked for menu. During a concurrent interview and records review with RD on 6/27/25, at 9:38 a.m., the RD stated she reviewed residents' clinical records and if noted any concerns with weight loss or if resident was not eating adequately to meet their nutritional needs, she would re-assess the resident, identify the reason for weight loss, and if needed update food preferences. Upon a review of Resident 732's records, the RD acknowledged that resident's record did not contain food preferences, likes and dislikes. The RD confirmed that Resident 732 had lost 7 pounds in less than 3 weeks. The RD acknowledged that on 6/13/25 and 6/17/25 Resident 732 experienced 3 pounds weight loss within 24 hours, and had lost 2 pounds within 24 hours on other occasions. The RD stated she was not aware of the resident's weight loss and was not able to find any documentation that the facility addressed Resident 732's weight loss. The RD stated the facility conducted weekly weight variance Interdisciplinary Team Meetings (IDT - a group of professionals all working collaboratively toward a common goal), where they discussed resident's weight loss and recommended interventions. The RD stated Resident 732's weight loss was not addressed at any of the IDT meetings. A review of the facility policy titled, Weight Assessment and Intervention, dated 2023, indicated, The multidisciplinary team will strive to decrease the risk, monitor, and intervene for undesirable weight loss for our residents .Care planning for weight loss or impaired nutrition will be a multidisciplinary effort . Interventions for undesirable weight loss shall be based on careful consideration of .resident choice and preferences .Interventions for undesired weight .loss should be considered preferences and rights. During and interview and record review with Director of Nursing (DON) on 6/27/25, 10:35 a.m., the DON reviewed Resident 732's clinical record and acknowledged that the resident had a weight loss of 7 pounds since admission to the facility. The DON explained, Normally the physician gives us a guidance to notify him/her if weight loss out of parameters. The DON was unable to find any physician notes addressing Resident 732's weight loss. The DON added, We bring resident's weight loss in weekly IDT weight meetings. When we see a trend of continuous weight loss, we bring to IDT. The DON validated that Resident 732's weight loss was not addressed during 6/25/25 IDT meeting. Based on observation, interview, and record review, the facility failed to recognize, evaluate, and address nutritional needs for two of 52 sampled residents (Resident 147 and Resident 732) who had progressive weight loss. This failure resulted in Resident 732 losing seven (7) pounds (lbs) in less than three weeks and Resident 147 losing 17 lbs since admission (approximately 8 weeks) jeopardizing the health status of both residents. Findings: (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 147's medical record indicated Resident 147 was admitted to the facility in March of 2025 with diagnoses of Fusion of Spine (a surgical procedure to stabilize the spine), Protein-Calorie Malnutrition and Anemia (a condition of not having enough healthy red blood cells). Resident 147's Minimum Data Set (MDS, a federally mandated resident assessment tool) indicated Resident 147 had moderate cognitive impairment. During a medical record review on 6/25/25, Resident 147's weights were as follows: 3/28/25 weight 132 lbs 3/30/25 weight 131 lbs 4/07/25 weight 128 lbs 4/08/25 weight 127 lbs 5/08/25 weight 113 lbs 5/25/25 weight 115 lbs During a record review of Resident 147's medical record, there were no noted records of weight documented after 5/25/25. The medical records revealed in Resident 147's weight and height record, dated 5/25/25, indicated resident measured 70 inches tall (5 feet and 10 inches) and weighed 115 lbs. Resident 147 had a 14 lb weight loss during the time frame of 4/8/25 to 5/8/25. As of 5/25/25, Resident 147 had a 17 lb weight loss since his admission on [DATE]. During an observation and interview on 6/24/25 at 1:37 p.m. with Resident 147, Resident 147 appeared emaciated (abnormally thin or weak, especially because of illness or lack of food). Resident 147 stated he had concerns with his weight loss. Resident 147 stated, . lost 20 pounds . I was 140 . now 120 pounds . During an interview on 6/26/25 at 12:30 p.m. with the Director of Nursing (DON), the DON stated, [Registered] Dietician (RD) will review all weights monthly or weekly .the dietician will look at all the weights and find out what is significant, that would trigger an IDT [Interdisciplinary Team]. The DON acknowledged that an 11% weight loss is considered a significant weight loss. When the DON was asked about her expectations, the DON stated, . expectation is to follow Title 22 and P&P . in IDT we come up with interventions that we proposed to MD [Medical Doctor]. The DON stated that if the interventions proposed by the IDT were ineffective, the IDT would bring the residents back to IDT to implement new interventions and update the care plan. The DON further stated that a resident with an 11% weight loss in a month would need more frequent weights in a month to ensure that the interventions were working. During an interview on 6/26/25 at 1:00 p.m. with Licensed Nurse 3 (LN 3) when asked about treatment for residents with weight loss, LN 3 stated that, If significant weight loss, it'll pop up on eMAR [electronic medical administration record] like a regular order .it will say notify MD if patient is losing weight, we would write a note to the MD with before and after weight .the MD would order a boost, ensure or MedPass or sometimes both .as a LN we could notify the MD if we see the supplement is not helping to improve weight gain. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent record review and interview on 6/27/25 at 1:17 p.m. with LN 4, LN 4 was unable to locate a nurse's assessment of a change of condition for Resident 147 after the weight measured on 5/25/25. Furthermore, LN 4 was unable to locate a weekly nurses note that addressed Resident 147 having significant weight loss as of 5/25/25. LN 4 was also unable to locate a document that indicated that the doctor was notified of Resident 147's significant weight loss. During a concurrent medical record review and interview on 6/26/25 1:42 p.m. with the RD, the RD noted the IDT documentation dated 5/29/25 at 12:25 p.m. titled, IDT NOTE showed, RD: Weight 5/25 115# [pounds] BMI 16.5 (underweight/cachexic [a general state of health involving great weight loss and muscle loss]). -17# or -12.9% wt loss within 2 months, addressed in weight change note on 5/8 and IDT - weight variance assessment on 4/30 . No dietary issues/interventions at this time. RD to follow up as needed. RD further acknowledged that Resident 147 had a significant weight loss of 11% in one month and stated, . he should have been on weekly weights . RD acknowledged that they failed to place Resident 147 on weekly weights after IDT and that there were no weights recorded after 5/25/25. RD acknowledged that this failure could have resulted in harm to Resident 147. A review of the facility's Policy and Procedure (P&P) titled, Weight Assessment and Intervention revised 2023, the P&P indicated, The multidisciplinary team will strive to decrease the risk, monitor and intervene for undesirable weight loss for our residents.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure safety for one of 52 sampled residents (Resident 100) with gastrostomy tube (G-tube, a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems) when the facility did not follow the physician's order to keep Resident 100's head of bed (HOB) elevated at 30 degrees during tube feeding. This failure increased the risk for Resident 100 to experience aspiration (inhaling liquid, vomit or saliva) and develop pneumonia or lung infection. Findings: A review of the admission Record indicated Resident 100 was readmitted [DATE] with diagnoses including dysphagia (difficulty swallowing) and paralytic syndrome (loss of muscle function). A review of Resident 100's care plan revised 1/13/25 indicated resident requires tube feeding related to swallowing problem. The goal of care was for resident to be free of aspiration. The interventions included, The resident needs HOB elevated 45 degrees during and thirty minutes after tube feeding. A review of Resident 100's physician order dated 4/23/25 indicated Enteral [use of feeding tube]- Elevate HOB 30-45 Degrees At all Times During Feedings & for 30 Minutes Post-Administration Of Feedings. A review of Resident 100's Physician History and Physical (H & P) dated 4/25/25 indicated Resident 100 was treated with a course of antibiotics for aspiration pneumonia and he was discharged with nothing by mouth (NPO) order. A concurrent observation and interview was conducted on 6/26/25 at 12:15 p.m. inside Resident 100's room. Resident was lying in bed with continuous G-tube feeding and HOB was less than 30 degrees. Resident 100 stated the G-tube was inserted in the hospital when he was not able to swallow. In an interview on 6/26/25 at 12:20 p.m., Licensed Nurse 3 (LN 3) stated Resident 100's HOB should be 30 degrees or higher because he had a feeding tube. In a subsequent observation and interview on 6/26/25 at 12:22 p.m. with LN 3, LN 3 stated Resident 100's HOB was not 30 degrees. LN 3 further stated Resident 100's HOB was elevated around 15 to 20 degrees. LN 3 added Resident 100 was not able to adjust the HOB since he was paralyzed from neck down. In a follow up interview on 6/26/25 at 12:26 p.m., LN 3 stated she saw Resident 100 around 9:30 a.m. and HOB was at 45 degrees. LN 3 further stated Resident 100 can aspirate if HOB was not elevated to 45 degrees. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A concurrent interview and record review was conducted on 6/26/25 at 1:42 p.m., with the Director of Nursing (DON) and Assistant Director of Nursing 1 (ADON 1). The DON stated Resident 100 was transferred to the hospital on [DATE] due to a change in condition and he came back on 1/10/25 with a G-tube. The ADON 1 stated Resident 100 was transferred to the hospital on 4/11/25 due to shortness of breath and resident was readmitted with diagnosis of silent aspiration pneumonia. In a follow up interview on 6/27/25 at 12:09 p.m., the DON stated her expectation was for the Certified Nursing Assistant to notify licensed nurse (LN) when a resident refused to be positioned per physician's order, the LN will document the refusal and inform the physician. The DON further stated the order to elevate the HOB from 30 to 45 degrees was to prevent aspiration. A review of the facility's policy & procedure (P & P) revised September 2024 and titled Enteral Feedings-Safety Precautions indicated the purpose of the P & P, To ensure the safe administration of enteral nutrition . Preventing aspiration .Elevate the head of bed (HOB) at least 30 [degrees] during tube feeding and at least 30 minutes after feeding.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on observation, interview, and record review, the facility failed to ensure one of 52 sampled residents (Resident 82) was provided with respiratory care when Resident 82 was not provided with a functioning continuous positive airway pressure (CPAP, a breathing machine designed to increase air pressure, keeping the airway open when the person breaths in) machine. This failure had the potential to result in Resident 82 experiencing respiratory distress. Findings: During a review of Resident 82's clinical record, the record indicated Resident 82 was admitted in late 2022 with multiple diagnoses including sleep apnea (a sleep disorder where the individual stops breathing for short periods when sleeping) and obstructive sleep apnea (a sleep disorder where the throat muscles relax and block the airway). A review of Resident 82's Minimum Data Set (MDS- a federally mandated assessment tool), Cognitive Patterns, dated 3/21/2025, indicated Resident 82 had a Brief Interview for Mental Status (BIMS- tool to assess cognition) score of 10 out of 15 that indicated Resident 82 had moderately impaired cognition. During a concurrent observation and interview on 6/26/25 at 10:31 a.m. with Resident 82, Resident 82 stated she has not had a CPAP machine in her room in over 2 months, no oxygen concentrator was observed in Resident 82's room. Resident 82 stated the facility was aware her CPAP was broken and had not been replaced. Resident 82 stated it was hard for her to breathe at night and without her machine she had trouble sleeping. A review of Resident 82's progress note dated 4/10/25, indicated . order from PA, as follows . Order CPAP (QHS [at bedtime]) for replacement . Facility could not provide copy of original order on 6/27/25 at 4:32 p.m. Emailed facility on 7/1/25 requesting missing documentation and were not received. During a concurrent observation and interview on 6/26/25 at 12:58 p.m. with Certified Nurse Assistant 2 (CNA 2), CNA 2 confirmed there was not a working CPAP machine in Resident 82's room. During a concurrent interview and record review on 6/26/25 at 1 p.m. with Licensed Nurse 5 (LN 5), LN 5 confirmed Resident 82 had no functional CPAP machine for a period greater than 2 months. LN 5 further confirmed a physician order dated 4/10/25 for CPAP replacement. LN 5 reviewed electronic medication administration record and confirmed entries from 4/10/25 through 6/21/25 of CPAP being broken and having missing parts. LN 5 further confirmed it could be harmful for Resident 82 to not have their machine and could experience respiratory distress during sleep hours. LN 5 confirmed there were no specific interventions ordered to monitor Resident 82 during sleep hours while waiting for the CPAP replacement machine to arrive. During an interview on 6/27/25 at 10:18 a.m. with Director of Nursing (DON), the DON confirmed that the facility and provider were aware that Resident 82's CPAP has been broken since April 2025. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's policy and procedure (P&P), titled Assistive Devices and Equipment, dated October 2024, the P&P indicated, . devices and equipment will be maintained . Defective or worn devices will be discarded or repaired .

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. Based on observation, interview, and record review, the facility failed to ensure pain management was provided consistent with professional standards of practice for one of 52 residents (Resident 15) when doses of Resident 15's PRN (as needed) pain medications were given without indication. This failure had the potential to increase Resident 15's risk of exposure to side effects and dependence to pain medication. Findings: During a review of Resident 15's admission records, the records indicated Resident 15 was admitted in May 2025 with diagnoses that included Lumbar Spondylosis (the degeneration of bones in the lower back), rheumatoid arthritis (a chronic inflammatory disorder affecting small joints in the hands and feet), lumbosacral radiculopathy (a condition where a nerve root in the lower back is compressed or irritated), and fibromyalgia (causes pain in muscles and soft tissues all over the body). Resident 15's Minimum Data Set (MDS, a federally mandated resident assessment tool indicated Resident 15 had moderate cognitive impairment. During a review of Resident 15's physician order, dated 5/15/25, the order indicated, Oxycodone [medication to treat moderate to severe pain] . 5 MG [milligrams, a unit of measurement] .1 tablet by mouth every 6 hours as needed for moderate (4-7) to severe (8-10) pain. During a review of Resident 15's physician order, dated 5/15/25, the order indicated, Tylenol [medication to treat mild pain] Tablet 325 MG .Give 2 tablets by mouth every 6 hours as needed for Pain mild (1-3) . During a review of Resident 15's care plan, revised 5/29/25, the care plan indicated, Resident is at risk for discomfort, and disturbance of daily living related to pain .Administer medications as ordered . During a review of Resident 15's Medication Administration Record (MAR) for June 2025, the MAR indicated that on 6/6/25, oxycodone was given for pain level 7/10 and Tylenol was given for pain level 4/10, both at the same time at 8:58 a.m. The MAR further indicated oxycodone was administered on 6/11/25 at 12:49 a.m. with pain level 0/10 (no pain). During a concurrent interview and record review on 6/27/25 with the Director of Nursing (DON), the DON verified Resident 15 had orders for oxycodone for moderate to severe pain, and Tylenol for mild pain. The DON confirmed Tylenol was given for pain level 4/10 on 6/6/25 and was given at the same time as oxycodone. The DON also confirmed oxycodone was given for 0/10 pain on 6/11/25. The DON stated, Expectation is to follow the pain scale order .Maybe the resident didn't need it . During a review of the facility's policy and procedure (P&P) titled Pain Assessment and Management, revised 10/2024, the P&P indicated, The purpose of this procedure is to help the staff identify pain in the resident, and to develop interventions that are consistent with the resident's goals and needs and that address the underlying causes of pain in a practicable manner .4. Implement the medication regimen as ordered .

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. 2. During a review of Resident 579's admission records, the records indicated Resident 579 was admitted in June 2025 with diagnoses that included end stage renal disease and dependence on renal dialysis. Resident 579's MDS indicated Resident 579 had intact cognition. During a review of Resident 579's care plan, initiated 6/7/25, the care plan indicated, Dialysis: Resident Requires Hemodialysis .and has an AV Fistula (shunt) (left arm) .Avoid taking blood pressure .on the AV site extremity . During a review of Resident 579's physician order, dated 6/12/25, the order indicated, Avoid taking BP [blood pressure] on Left Arm . During a review Resident 579's Weights and Vitals Summary, the summary indicated blood pressures were taken on Resident 579's left arm twice on 6/9/25 and once on 6/19/25. During a concurrent interview and review on 6/27/25 at 8:56 a.m. with the Director of Nursing (DON), the DON stated, .They are not supposed to check bp on the arm with fistula .not on that arm . The DON confirmed Resident 579 had an order to avoid taking BP on left arm and confirmed BP was taken on Resident 579's left arm twice on 6/9/25 and once on 6/19/25. The DON stated, The expectation is to make sure that they don't take BP on the arm they are not supposed to .Because you can damage the fistula if you use it . During a review of the facility's policy and procedure (P&P) titled End-Stage Renal Disease, Care of a Resident with, revised 10/2024, the P&P indicated, Residents with end-stage renal disease (ESRD), including residents receiving dialysis care outside the facility, will be cared for according to currently recognized standards of care . Based on observation, interview, and record review, the facility failed to provide care consistent with professional standards of practice for two residents (Resident 107 and Resident 579) of 52 sampled residents when: 1. Resident 107's arm with an atrioventricular fistula (AVF- a connection surgically created between an artery and vein that allows blood flow between the two used for dialysis treatments [a procedure of removing toxins from the body]) was used for blood pressure assessments; the facility did not obtain a physician's order to avoid the use of Resident 107's left arm [the site of her AVF] for blood pressure, and 2. Resident 579's arm with an AVF was used for blood pressure assessments. These deficient practices had the potential to damage Resident 107's and Resident 579's AVF which could delay dialysis treatment and require hospitalization. Findings: 1. A review of Resident 107's admission record indicated she was admitted in May 2024 with a diagnosis of end stage renal disease (the final stage of chronic kidney disease [CKD], where the kidneys have lost most of their ability to function, requiring dialysis for survival). (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 107's Minimum Data Set (MDS- a federally mandated resident assessment tool), dated 6/3/25, indicated Resident 107 had no cognitive impairment. A review of Resident 107's order summary report indicated an active order as of 6/27/25 for, DIALYSIS UPDATED .dialysis schedule is 2 times per week normally on Mondays and Fridays . A review of Resident 107's care plan initiated on 6/18/2024 indicated, Dialysis: [Resident 107] has AV shunt LUA [left upper arm] and is at risk for clotting and infection . [staff were expected to] No B/P [blood pressure] on affected arm/site. A review of Resident 107's weights and vitals summary dated 6/27/25, indicated blood pressure was taken on her left arm once on 6/22/25, 6/17/25, 6/12/25, 6/10/25, 6/7/25, and twice on 6/3/25 and 6/14/25. During an observation on 6/24/25 at 10:20 a.m., in Resident 107's room, a visible sign was posted on the wall behind the resident's head of bed indicating, No BP or blood draw on LEFT arm. During a concurrent interview and record review on 6/27/25 at 10:21 a.m. with Licensed Nurse 9 (LN 9), LN 9 confirmed blood pressure should not be taken on the same arm as an AVF. LN 9 stated the pressure from the cuff could damage the fistula, and dialysis may need to be postponed. LN 9 confirmed Resident 107 had no physician order to not use the left arm for blood pressure. LN 9 stated, The resident [Resident 107] should have one [an order not to use the left arm for blood pressure] so staff know not to use the left arm. During a concurrent interview and record review on 6/27/25 at 11:34 a.m. with the Assistant Director of Nursing 1 (ADON 1), the ADON 1 stated if a resident has an AVF, the expectation is to have an order to avoid the use of that arm. The ADON 1 stated if the AVF was damaged, the resident would need to go to the hospital and they [the resident] would not be able to get dialysis. ADON 1 confirmed the documentation of nine incidents of Resident 107's blood pressure taken on the left arm. ADON 1 confirmed Resident 107 had no physician orders to not take blood pressure on her left arm. During a review of the National Kidney Foundation website, titled, Hemodialysis Access, dated 2025, the website indicated, Here are some tips you should follow to help keep your fistula or graft working longer: do not let anyone use a blood pressure cuff on your access arm, do not carry anything heavy or do anything that would put pressure on the access, and do not let anyone draw blood from your access arm

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to implement pharmaceutical policies and procedures to meet the needs of each resident and ensure that these procedures were consistent with standards of practice, when: 1. A medication for Resident 76 was not administered as prescribed by physician; 2. A prescribed medication was not available at the time of administration for Resident 529; 3. Resident 731 did not receive prescribed ointment treatment for multiple days; 4. Resident 68 received medication beyond the expiration date; 5. A loose unidentified medication was stored in the drawer with controlled substances, and 6. A loose pink pill was observed on the floor in hallway. These failures had the potential for worsening of resident's condition from receiving the smaller dose that was ordered, not receiving important medication and treatment as prescribed, receive medication with unsafe or reduced potency from being used past their expiration date, and diversion or misuse of controlled drugs and substances. Findings: 1. During a medication pass observation on 6/26/25, at 7:24 a.m., with Licensed Nurse 6 (LN 6), LN 6 was observed preparing Resident 76's morning medications, which included Flomax (a medication used to relax bladder muscle), 0.4 milligram (mg, dose of measurements). LN 6 placed one capsule of medication into a small plastic cup containing other medications and administered to Resident 76. The bubble pack label (a sealed package that holds the individual medications securely) indicated, Administer 2 capsule and give 30 minutes after the same meal each day. A review of Resident 76's physician order, dated 6/4/25, indicated, Flomax 0.4 mg, Give 2 capsule by mouth one time a day for benign prostatic hyperplasia (enlargement of prostate gland) 30 minutes after the same meal each day. During a follow up interview on 6/26/25, at 9:40 a.m., LN 6 acknowledged that she administered one capsule to Resident 76, and validated it was a wrong dose. LN 6 stated the the physician instructions directed nursing to administer Flomax medication 30 minutes after the meal and Resident 76 received all of his medications before the breakfast was served. A review of the facility's 'Administering Medications' policy dated 10/24 indicated, Medications are administered in a safe and timely manner, and as prescribed .Medications are administered in accordance with prescriber orders, including any required time frame .The individual administering the medication checks the label THREE (3) times to verify the right resident, right medication, right dosage, right time .before giving the medication. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. During a medication pass observation on 6/26/25, at 7:45 a.m., with LN 7, LN 7 prepared Resident 529's morning medications and informed that one of the resident's medication Valsartan (a medication to control high blood pressure) 320 mg was not available for administration. LN 7 explained that the nurses faxed the refill request for Valsartan, but apparently there was a delay with pharmacy delivering the medication. LN 7 stated she will follow up with pharmacy regarding missing medication. A review of Resident 529's physician orders, dated 6/12/25, indicated that Valsartan 320 mg tablet was to be administered orally one time a day for high blood pressure. A review of Resident 529's Medication Administration Record (MAR) on 6/26/25 at 2:30 p.m., indicated that morning dose of Valsartan 320 mg scheduled for 8 a.m., had not been administered. During an interview on 6/26/25, at 2:35 p.m., the blood pressure medication not available for administration for Resident 529 was discussed with the Director of Nursing (DON). The DON stated the pharmacy delivered medications three times a day and the expectation was that there should be no delays with administering resident's medications. The DON acknowledged that sometimes there were issues with pharmacy delivering medications. A review of the 'Administering Medications' policy dated 10/24 indicated, Medications are administered in a safe and timely manner .in accordance with prescriber orders, including any required time frame. A review of facility's policy titled Medication Re-Ordering, dated 10/24 indicated, Medication refills are ordered by peeling the reorder strip from the label and placing it in the appropriate area on the order form provided by pharmacy. The licensed nurse notifies the pharmacy and provider if a medication is not filled on time and a medication is unavailable. 3. A review of the admission Record indicated the facility admitted Resident 731 in June 2025 with multiple diagnoses which included aftercare following a joint replacement surgery. A review of Resident 731's Order Summary Report (OSR) contained an order for Terbinafine (a cream used to treat fungal infections) 1%, directing nurses to apply to groin and buttocks topically (directly to the surface of the skin) two times a day for fungal infection for 2 weeks. A review of Resident 731's MARs indicated the resident did not receive treatment for fungal infection on 6/21/25, 6/22/25, 6/23/25, 6/24/25, and 6/25/25 dosages scheduled for 8 p.m., and 6/23/25, 6/24/25, and 6/25/25 dosages scheduled for 8 a.m. A review of the nursing progress notes dated 6/21/25 at 9:04 p.m., indicated the Terbinafine was not administered. The nurse documented, awaiting pharmacy to deliver. A review of the nursing progress notes dated 6/22/25, at 7:30 p.m., indicated the Terbinafine was not administered. The nurse documented, Unable to locate OTC [over the counter], ordered from Central Supply. A review of the nursing progress notes dated 6/25/25, at 7:58 a.m., indicated the Terbinafine was not administered. The nurse documented, Waiting for supply. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the nursing progress notes dated 6/25/25, at 7:11 p.m., indicated the Terbinafine was not administered. The nurse documented, Awaiting for supply. During a concurrent interview and record review on 6/26/25, commencing at 10:50 a.m., the DON acknowledged that Resident 731 had not received treatment for fungal infection for multiple days. The DON stated the nursing staff waited for antifungal medication delivery from pharmacy and yesterday the pharmacy informed the facility that the medication should come from house supply. The DON stated the expectation was that the nurses called the pharmacy and followed up on delivery; asked why it was not delivered and requested to deliver as soon as possible. The DON added, If not administered, a physician should be notified and then we go by his recommendation .If the medication is not available, the physician can prescribe another medication. The DON was unable to locate any records indicating that the nurses notified the physician that the resident had not been receiving prescribed untifungal medication for multiple days. A review of 'Administering Medications' policy dated 10/24 indicated, Medications are administered in a safe and timely manner .Medications are administered in accordance with prescriber order .Medication administration times are determined by resident needs and benefit. 4. During an inspection of Med Cart #2 on Station B and interview with LN 8 on 6/26/25, at 10:57 a.m., an inhaler medication Advair Discus (used to treat asthma) 500 microgram (mcg, a unit of measurement)/50 mcg was observed inside of the drawer. The date on the inhaler indicated it was removed and opened from the package on 5/11. LN 8 stated that she administered Advair medication to Resident 68 earlier this morning around 8 a.m. LN 8 stated that per manufacturer instructions, Advair medication should be discarded 30 days after the package was opened. LN 8 stated the nurses were to check the medication expiration date every time they administered medication to the resident and the expired medications should not be kept in medication cart and available for use. During an interview with DON on 6/26/25, commencing at 10:50 a.m., the DON stated nursing staff were expected to check expiration dates of all medications during medication administration and should never administer expired medications. The DON stated the nursing staff should have reordered Advair from pharmacy ahead of time and discarded the expired medication as indicated by manufacturer's instruction. A review of 'Administering Medications' policy dated 10/24 indicated, Medications are administered in a safe . manner .The expiration/beyond use date on the medication label is checked prior to administering. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5. During an inspection of Med Cart #2 on Station A with LN 10 on 6/27/25, at 10:45 a.m., LN 10 opened the drawer containing narcotics medications (strong medications administered for pain with a high potential for abuse and diversion), grabbed a small plastic medication cup with one white long tablet, opened the bottle containing of drug buster (a special container containing liquid for destruction of wasted or refused medications), and attempted to drop the medication into the bottle. The writing on the cup with medication inside indicated 'waste,' however had no medication name on it and did not contain resident's name for whom it was prescribed. LN 10 explained that the medication was Norco (narcotic medication to control pain) and needed to be wasted. LN 10 stated he accidentally popped out a wrong medication for Resident 133 and was waiting for another nurse to witness the medication destruction. A review of Resident 133's 'Controlled Drug Record,' indicated that Norco 5-325 mg was removed 6/27/25 at 9:50 a.m., and the left side of the document next to the date and time indicated 'wasted' and on the right side there were two initials confirming the waste. LN 10 stated the narcotic medication destruction had to be witnessed by another nurse and was unable to explain why the medication was not placed into buster container at the time another nurse initialed the waste and why he attempted to empty the cup with medication earlier without another nurse present. During an interview with DON on 6/26/25, commencing at 10:50 a.m., the DON stated the nurse should have another nurse to witness the medication destruction while it was placed into drug buster container as soon as possible. Discussed with the DON that the unidentified medication sitting in medication cup and a nurse attempting to destroy Norco without other nurse present. The DON explained the process and stated that controlled substances could not be destroyed without another nurse present who needed to co-sign the medication destruction at the same time it was wasted. A review of facility's policy titled, Discarding and Destroying Medications, dated 9/24, indicated, Medications will be disposed of in accordance with federal, state, and local regulations governing management of . controlled substances. 6. During an observation on 6/27/25 at 10:44 a.m. in the facility back hallway, a pink unidentified loose pill was observed on floor in the hallway outside of room [ROOM NUMBER] while a resident was observed passing by in their wheelchair. During a concurrent observation and interview on 6/27/25 at 10:47 a.m. with Licensed Nurse (LN 1), LN 1 confirmed pink unidentified medication on floor in hallway. LN 1 stated that pill should not be on the floor, another resident could take it and it could be harmful to them leading to a drug reaction. During an interview on 6/27/25 at 12:51 p.m. with DON, the DON acknowledged the medication on the facility floor via photograph. The DON stated nursing staff are expected to wait for the resident to swallow the medication and then document it was given. The DON further stated if medication is found in hallway someone may pick it up and take it and this could be harmful to them if they were allergic.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. Based on observation, interview, and record review, the facility failed to ensure the planned menu spreadsheet (a menu excel sheet that indicated what items and portions to be served for each prescribed diet) and recipes (a set of instructions for preparing a particular dish, including a list of the ingredients required) were followed for the therapeutic diets during the lunch meal distribution on 6/25/25 when: 1.Resident 14 with low fat and low cholesterol diet (a diet designed to lower elevated levels of cholesterol and other fats in the blood to reduce the risk of heart disease) received tartar sauce (a cold sauce, typically eaten with fish, consisting of mayonnaise) instead of a lemon slice for the lunch. 2.Four residents (Resident 36, 110, 147 and 152) with a fortified diet (a diet designed for residents who cannot consume adequate amounts of calories or proteins to maintain their weight or nutritional status) did not receive fortified food with their meals. 3.Three residents (Resident 62, 85 and 89) with mechanical soft texture diet (a diet designed with modified texture for residents who experience chewing and/or swallowing limitations) received the fish in dysphagia (difficulty swallowing) mechanical soft texture (food textures that are moist and mechanically altered, such as blended, grinded, chopped or mashed, to limit chewing and easier to swallow). 4.Five residents (Resident 17, 70, 109, 134 and 149) with dysphagia mechanical soft diet received dysphagia mechanical soft texture fish which did not follow the recipe. These deficient practices had the potential to result in 13 out of 172 residents who received meals from the facility kitchen not having meals which would meet their nutritional needs and the food textures for the prescribed diets. Findings: During a concurrent observation of lunch meal distribution and spreadsheet review on 6/25/25 beginning at 11:58 a.m., it was noted as followed: 1.Resident 14 with a low fat and low cholesterol diet received tartar sauce for the fish in the entrée. A concurrent review of the facility spreadsheet titled, Summer Menus, Week 4 Wednesday, indicated low fat and low cholesterol diet should receive a lemon slice for the fish. During an interview with Registered Dietitian (RD) on 6/26/25 at 10:42 a.m., RD stated the staff missed it and confirmed low fat/low cholesterol diet should get a lemon slice instead of tartar sauce. 2.Four residents (Resident 36, 110, 147 and 152) with a fortified food with their diets did not receive an extra one ounce (oz., unit of measurement) of margarine on the vegetables as fortified food with their meals. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with RD on 6/26/25 at 10:42 a.m., RD confirmed the staff need to pay more attention during the meal distribution. She further stated the fortified foods were given for different reasons and usually for the residents who needed extra calories and sometimes as the intervention for weight loss. 3.Three residents (Resident 62, 85 and 89) with mechanical soft texture diet were served the fish that was prepared for dysphagia mechanical soft texture diet. It was noted the fish was grinded with small pieces of tomatoes. A concurrent review of Summer Menus, Week 4 Wednesday, indicated mechanical soft diet should serve flaked/moist fish with soft tomatoes. During an interview with RD on 6/26/25 at 10:42 a.m., RD reviewed the spreadsheet and stated the whole fish fillet was soft enough for mechanical soft texture. She further stated that mechanical soft texture and dysphagia mechanical soft texture should be different. RD stated the staff should follow the menu or spreadsheet. A review of facility document titled, Recipe: Fish Italiano, indicated, Mechanical Soft: Flake each portion of fish prior to serving .Top with cream sauce or broth to be sure fish is moist. Tomatoes should be soft . 4.Five residents (Resident 17, 70, 109, 134 and 149) with dysphagia mechanical soft texture diet who received dysphagia mechanical soft fish, and observed the fish was grinded with small pieces of tomatoes. A concurrent review of the Summer Menus, Week 4 Wednesday, indicated the fish for dysphagia mechanical soft diet should be grinded and moist and added one tablespoon (tbsp) of pureed tomatoes. During a concurrent review of the recipe and interview with RD on 6/26/25 at 10:42 a.m., RD agreed and stated the [NAME] did not prepare the fish for dysphagia mechanical soft diet correctly according to the recipe. The tomato should be pureed but not in pieces. She further stated the [NAME] may be misunderstood the instruction of the recipe. A review of facility document titled, Recipe: Fish Italiano, indicated the fish for dysphagia mechanical soft diet should be grinded with onions and moistened with pureed tomatoes (like tomato sauce) and seasonings. A review of the facility policy and procedure (P&P) titled, Menus revised October 2024, policy statement Menus are developed and prepared to meet the resident .needs .while following the established national guidelines and for nutritional adequacy . A review of facility document titled, Job Description: Cook, dated 2/2024, showed, .Ability to follow prepared menus . and ability to prepare special diets accurately . A review of facility document titled, Job Description: Dietary Supervisor, dated 2/2024, showed, .Check trays for accuracy before they are delivered . A review of facility document titled, Job Description: Registered Dietitian, dated 2/2024, showed, .Monitor food services control systems such as . portion control, preparation methods . in order to ensure that food is prepared and presented in an acceptable manner .Inspect diet trays for conformance to physician's diet orders prior to delivery .

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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 ensure the proper dishwashing process and sanitary conditions were maintained in the dietetic services when: 1. Two serving metal pans with debris particles stacked together were found stored in a clean and ready-to-use storage area. 2. Dietary Aide (DA) 1 was not able to verbalize and/or demonstrate: -The practice of measuring the water temperatures for the automated dishwashing and -The knowledge of the temperatures and sanitation concentrations for the manual dishwashing by 3-compartment sink procedure. 3. The wash and rinse temperatures log and instructions of the dishwashing machine did not match the manufacturer's guidance. These failures had the potential to result in food contamination which could cause illness in 172 out of 172 medically vulnerable residents who received and consumed food from the facility kitchen. Findings: 1. A kitchen initial tour observation and concurrent interview with Dietary Supervisor (DS) on 6/24/25 at 9:08 a.m. was conducted. There were two of the one-third (1/3) sheet metal pans (pans that hold the food for meal distribution) found with brown sticky substances. DS confirmed and stated the substances were food particles. She further stated the metal pans should be cleaned and checked before being stored away. During a follow up interview on 6/26/25 at 10:42 a.m. with Registered Dietitian (RD), RD stated the dishes should be clean and the staff should check them before storing away. A review of facility policy and procedure (P&P) titled, Sanitation, revised October 2024, indicated, .Utensils . shall be kept clean, maintained .Equipment .and utensils shall be washed to remove or loosen soil by using the manual or mechanical means necessary and sanitized using hot water and/or chemical sanitizing solutions . A review of facility P&P titled, Dishwashing, dated 2023, indicated, .Gross food particles shall be removed by careful scraping and pre-rinsing in running water .Dishes are to be air dried in racks before stacking and storing . A review of facility document titled, Job Description: Dietary Supervisor (DS), dated 2/2024, showed, . Maintain Kitchen . in a safe, orderly, clean and sanitary manner. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	2. A concurrent observation of dishwashing process by the dishwashing machine and interview with DA 1 and DS on 6/24/25 at 9:33 a.m. was conducted. DA 1 explained the process but she was not able to verbalize the water temperatures of the dishwasher for the final wash and final rinse cycles. A concurrent review of undated facility document titled, Low Temperature Dish Machine Log, June 2025, showed, the wash water temperature recorded 135 degrees Fahrenheit (F) and the rinse water temperature recorded 110 degrees F on 6/24/25. DA 1 stated the wash and rinse water temperatures recorded on the log were at the correct range. DS confirmed and stated both the wash and rinse temperatures should be at least 120 degrees F. During an interview with DA 1 on 6/24/25 at 10:39 a.m., DA 1 stated she would start to wash dishes manually with the 3-compartment sink if the dishwasher was not working. DA 1 explained the process and stated the first sink was for wash, second sink was for rinse, and there was a big bucket used as third compartment for sanitizer to sanitize. DA 1 was not able to answer the proper water temperatures for the steps of wash and rinse, and the immersion time for the dishes in the sanitizer for the sanitizing step. DA 1 was not able to answer the concentration of the sanitizer (quaternary ammonium (quat), a type of chemical agent for sanitizing). A concurrent interview with DS for immersion time of the sanitizer, she read the posted instruction Steps for 3-Compartment Wash at the station and stated 30 seconds, and the concentration would be 200 ppm (part per million, a unit of measurement). A concurrent review of the quat solution instructions on the bottle label with DS, it indicated the immersion time was 60 seconds and the final concentration should be in the range of 200-400 ppm. During a follow up interview on 6/26/25 at 10:42 a.m. with RD, RD stated the dietary staff, especially the dishwasher, should have a good knowledge of both the automated and manual procedures for dishwashing. A review of a facility document titled, Food and Nutritional Services In-Service, Topic: Cleaning and Sanitizing of Dishes, Utensils, Pots and Pans, completed on 3/29/25 by DS and Assistant Dietary Supervisor (ADS). DS confirmed DA 1 attended the in-service. A review of facility P&P titled, Dishwashing, dated 2023, indicated low temperature machine, .use the machine at a range of 120-140 degrees F . A review of undated facility document titled, Log Temperature Dish Machine Log, it indicated, .Directions . wash & rinse temperatures should be equal to or greater than 120 degrees F, or follow manufacturer's recommendations .if temperature or chlorine levels are incorrect, discontinue use and notify supervisor immediately . A review of facility P&P titled, 3-Compartment Procedure for Manual Dishwashing, revised October 2024, it stated, .The first compartment is for washing .hot water (110-120 degrees F) .Second compartment is for rinsing . clear hot water (110-120 degrees F) .The third compartment is for sanitizing .Test the concentration with the appropriate test strip, which is dipped in the sanitizer solution 10 seconds before reading Must read 200-400 ppm. Immerse all washed items for 60 seconds . 3. During a record review and a concurrent interview on 6/24/25 at 9:33 a.m. with DS, the temperature log of the dishwasher with a recorded entry on 6/24/25 for A.M. (morning) shift, stated a final wash at 138 degrees F and a final rinse at 110 degrees F. DS confirmed and stated both final wash and rinse temperatures should be at least 120 degrees F. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview, and concurrent record review on 6/26/25 at 10:42 a.m. with RD, RD acknowledged dishwasher DA 1 recorded a few times the final rinse temperature of 110 degrees F in the Dishwashing Machine Log for June 2025. RD reviewed the log and stated both the final wash and rinse temperature should be at least 120 F. During a concurrent interview and record review on 6/26/25 at 3:20 p.m. with Maintenance Supervisor (MS), MS confirmed the recommended wash and rinse temperatures visualized and posted on the dishwashing machine. The posted manufacturer's guideline stated for the chemical sanitizing dishwashing procedure, the minimum of 140 degrees F for the wash tank temperature and the minimum of 120 degrees F for the final rinse temperatures. During a concurrent interview and record review on 6/26/25 at 3:40 p.m. with DS and RD, DS and RD agreed they were not aware of the manufacturer's guidelines with the minimum wash temperature of 140 degrees F and rinse temperature of 120 degrees F that was posted on the facility's dishwashing machine. A concurrent review of the dishwasher temperature log for May and June of 2025, DS and RD confirmed most of the wash temperature were below 140 degrees F and some rinse temperatures were below 120 degrees F. RD and DS agreed the documented entries were not at manufacture's recommendations. RD and DS confirmed the directions of the dishwasher temperature log regarding the wash and rinse temperatures should be at least 120 degrees F were not at manufacturer's recommendations. A review of facility document titled, Low Temperature Dish Machine Log dated May 2025, stated, .Directions . 1. Record wash and rinse temperatures and chlorine test before starting dishes. 2. Wash and rinse temperatures should be equal to or greater than 120 degrees F or follow manufacture's recommendations . 4. If temperature or chlorine levels are incorrect discontinue use and notify supervisor immediately . A review of facility P&P titled, Dishwashing, dated 2023, indicated, .Low-Temperature machine: If you do not have the manufacturer's recommendations, use the machine at a range of 120 degrees F to 140 degrees F . A review of facility P&P titled, Sanitization, revised October 2024, stated, .8. Dishwashing machines are operated using Low-Temperature Dishwashers (Chemical Sanitization). Wash temperature (120 degrees F), final rinse with 100-200 ppm .liquid sanitizer . A review of facility document titled, Job Description: Dietary Supervisor (DS), dated 2/2024, showed, . Maintain Kitchen .in a safe, orderly, clean and sanitary manner. A review of facility document titled, Job Description: Registered Dietitian (RD), dated 2/2024, showed, . Monitor food service operations to ensure conformance to .safety, sanitation and quality standards .

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to implement infection prevention and control measures to prevent the introduction and spread of infections to residents, when: 1. The nursing staff did not implement EBP (enhanced barrier precautions) for Resident 731; 2. The housekeeping staff did not wear appropriate PPE (personal protective equipment) while cleaning inside a room on EBP; 3. Resident 25's nebulizer mask (a face mask that fits over the nose and mouth to deliver medication into the lungs) was not stored properly; and 4. Treatment Nurse provided care to an open wound and did not wear adequate PPE per EBP standards. These failures had the potential to spread infections among residents, staff and visitors. Findings: During an observation and interview with Resident 731 on 6/24/25, at 12:48 p.m., the resident was sitting upright in his in bed dressed in hospital gown. The resident was awake, alert and oriented. An indwelling Foley catheter (a flexible plastic tube inserted into the bladder to provide continuous urine drainage) in dark privacy bag was attached to the frame of the bed. Resident 731 stated he also had a drain placed after his surgery for left hip. There was no EBP precaution sign posted next to the entrance to resident's room and there was no PPE's available for use when caring for Resident 731's drain and Foley catheter. A review of Resident 731's 'Enhanced Barrier Precautions' [EBP] care plan initiated 6/22/25 indicated that the resident required enhanced barrier precautions during high-contact care activities due the presence of indwelling wound vacuum (a medical device that helps wound heal by applying suction and drawing out excess fluid). One of the interventions indicated, Utilize PPE [personal protective equipment] gown and gloves; face-shield as indicated) during high-contact resident activities, [including] dressing, bathing .hygiene .device care, wound care. During a follow up observation on 6/24/25, at 4:08 p.m., there was no EBP sign posted on the wall next to Resident 731's room entrance. Upon entering the resident's room, observed a partially closed curtain and the nurse working with drainage canister. The nurse had gloves on but did not utilize a protective gown and/or face protection. During a concurrent observation and interview with Treatment Nurse 2 (TN 2), on 6/24/25, at 4:10 p.m., TN 2 stated he finished providing care to Resident 731's wound vacuum and replaced the drain canister. TN 2 stated he did not utilize any other PPE, except gloves while providing wound vacuum care. TN 2 stated he was not sure if the resident was on EBP. TN 2 pointed to resident's name on the wall and explained, If resident on EBP, there will be a purple dot next to his name and we keep PPEs in a little caddy inside the door. TN 2 stated there was no EBP sign posted and no purple dot next to resident's name. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055886	A. Building B. Wing	06/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Roseville Care Center	1161 Cirby Way Roseville, CA 95661

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with DON on 6/27/25, at 9:50 a.m., the DON explained, Indwelling catheter and wound drain are automatically qualify for EBP. Should have sign EBP by the door, guidance of PPE donning/doffing, and PPE caddy inside the room on the inner side of the door. The DON added, Expect staff wearing PPE every time directly dealing with wounds, Foley care and drain care. 2. During an observation on 6/26/25 at 9:46 a.m. in room [ROOM NUMBER], Housekeeping Staff 1 (HS 1) was observed cleaning and mopping the room. Rooms 325 had a signage posted by the indicating the room is on enhanced barrier precaution (EBP) and HS 1 was observed wearing a mask but no gown. During an interview on 6/26/25 at 9:48 a.m. with HS 1, HS 1 confirmed room [ROOM NUMBER] was on EBP and stated she forgot to wear the gown while cleaning the room. HS further stated wearing proper PPE (Personal Protective Equipment) was important to protect her and the residents. HS 1 stated she will wear the gown but there was no gown available in the room and had to get a pack of gown from the supply room. During an interview on 6/27/25 at 8:56 a.m. with the Director of Nursing (DON), the DON stated, Expectation is to follow the assigned guidance [on EBP] .They [staff] might spread infection if you don't follow the precaution .Everybody that enters the door, even housekeeping . During a review of the facility's policy and procedure (P&P) titled Infection Prevention and Control, revised 8/2024, the P&P indicated, .11. Prevention of Infection .a. Important facets of infection prevention include: . (3) educating staff and ensuring that they adhere to proper techniques and procedures; .(7) implementing appropriate isolation precautions when necessary .d. The facility provides personal protective equipment, checks for its proper use, and provides appropriate means of disposal. 3. Resident 25's nebulizer mask (a face mask that fits over the nose and mouth to deliver medication into the lungs) was not stored properly. During a review of Resident 25's admission Record (AR), the AR indicated, Resident 25 was admitted on [DATE] with diagnoses which included morbid obesity (severe form of having too much body fat) and obstructive sleep apnea (sleep disorder that occurs when the airway becomes blocked while sleeping). During a review of Resident 25's Order Summary Report (OSR), dated 7/1/25, the OSR indicated Resident 25 had Ipratropium-Albuterol Solution (medication used to treat air flow blockage) . inhale orally via nebulizer every 6 hours for increased cough for 1 Week. During a concurrent observation and interview on 6/24/25 at 10:28 a.m. with LN 8 in Resident 25's room, Resident 25's nebulizer mask was observed on the nightstand uncovered next to a blue mesh bag. LN 8 stated Should be in a bag, should have been put in bag after use. LN 8 further stated that it could be a source of infection. During an interview on 6/27/25 at 10:48 a.m. with ADON 2, ADON 2 stated that nebulizer mask, when not in use should be stored in a bag as it is part of their infection control practices to prevent spread of infection and bacteria. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's P&P titled, Departmental (Respiratory Therapy)-Prevention of Infection, revised November 2024, the P&P indicated, Infection Control Considerations Related to Medication Nebulizers: store the circuit in plastic bag, marked with resident's name, between uses . 4. A review of Resident 41's admission record indicated she was admitted on [DATE] with diagnoses of a fracture of her right pubis (a break in the pelvic bone) and a pressure-induced deep tissue damage of sacral region (tailbone). A review of Resident 41's most recent Skin and Wound Evaluation, dated 6/24/25, indicated the pressure injury to sacral/coccyx region now measured, 2.2 cm in length, 1.6 cm in width, no depth is documented, and wound bed was now 30% granulated tissue (healthy beefy red tissue) and 70% slough (dead tissue that is usually yellow, tan, grey, or green in color, usually moist and stringy texture, that may be found in wounds) . A review of Resident 41's EBP Care Plan, last updated on 6/25/25 indicated that she continued to be on EBP for a chronic wound. During a concurrent observation and interview on 6/25/25 at 1:20 p.m. with Treatment Nurse 1(TN 1), TN 1 was observed putting gloves and a mask on before entering Resident 41's room and providing wound care. Outside Resident 41's room was a sign that indicated Resident 41 was on EBP and what personal protective equipment (PPE-clothing and equipment that is worn or used to provide protection against hazardous substances and/or environments) staff should wear when providing direct care. After wound care was completed, TN 1 stated, Yes, she is on EBP, that is the sign to the left of the door. The expectation is that we put on gloves, a gown, and a mask if indicated. TN 1 stated, I did not wear a gown while providing wound care to Resident 41, and confirmed that she should have. During an interview on 6/26/25 with the Assistant Director of Nursing 2 (ADON 2) at 3:45p.m, the ADON 2 stated if a resident was on EBP and had an open wound she would expect the nurse to wear a gown, gloves and a mask. The ADON 2 also stated, If a treatment nurse did not wear a gown while completing wound care this would not meet my expectation. A review of the facility door sign titled, The Six Moments of Enhanced Standard Precautions, shows a picture of steps to follow for these precautions as follows: hand hygiene, gloves, and gowns for morning and evening care, toileting, caring for medical devices, wound care, mobility assistance and cleaning the environment. A review of the facility's policy titled, Multidrug-Resistant Organisms; Infection Precaution and Enhanced Standard Precautions, indicated that effective 4/1/24 in compliance with CMS, that EBP employs targeted gown and glove use during high contact resident care activities including wound care.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. Based on observation, interview, and record review, the facility failed to ensure the laundry was maintained in a sanitary manner and in good repair when the contaminated linen area was found dirty, and a window screen was damaged. This failure had the potential to result in the facility not providing safe and sanitary handling of laundry items used by residents for a census of 175. Findings: During a concurrent observation and interview on 6/26/25 at 9 a.m. with the Housekeeping and Laundry Supervisor (HLS) in the contaminated linen area in the laundry room, dust particles were observed on laundry supplies and racks. The windows in the area were also observed with dust particles on the screens, and one of the window screens was damaged and had a hole in it. The HLS confirmed the observations and stated, .it [laundry room] should be clean all the time because of infection. During an observation and interview on 6/26/25 at 9:26 a.m. with the Maintenance Worker 1 (MW 1) in the contaminated linen area in the laundry room, the MW 1 confirmed the window screen had a hole, there was dust on the windows and the storage rack was dirty. During a follow-up interview on 6/26/25 at 9:31 a.m. with the HLS, the HLS stated the contaminated linen area is cleaned once a week and the clean linen area is cleaned every shift. The HLS was not able to provide cleaning logs for both areas of the laundry room. During an interview on 6/27/25 at 11:33 a.m. with the Assistant Director of Nursing 2 (ADON 2), the ADON 2 stated, Expectation is like what I want with my house, I want everything to be clean .Even the soiled linen area should be cleaned, no dust particles, and should be kept clean . When photos of the hole on the window screen were shown, the ADON 2 stated, .we don't want animals or rodents to come in, that's not good for anybody .It's a way to prevent infection. During an interview on 6/27/25 at 1:53 p.m. with the Administrator (ADM), the ADM stated, Expectation is to fix anything that we are aware of in a timely manner .We want the building and the residents to have things that they need and for the building to function the way it should. During a review of the facility's policy and procedure (P&P) titled Physical Environment and Accommodations Policy, undated, the P&P indicated, .(a) The facility shall be clean, safe, sanitary and in good repair at all times. Maintenance shall include provision of maintenance services and procedures for the safety and well-being of residents, employees, and visitors .(c) All window screens shall be clean and maintained in good repair .