

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055887	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/30/2026
NAME OF PROVIDER OR SUPPLIER River Bend Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2215 Oakmont Way West Sacramento, CA 95691	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Provide enough food/fluids to maintain a resident's health. Based on observation, interview, and record review, the facility failed to maintain the weight of five residents (Resident 103, 48, 54, 2, & 89). This failure had the potential of leading to malnutrition, muscles wasting and functional loss, as well as increased susceptibility to infections for the residents. Findings: During an observation of the lunch meal on 7/27/26 at 11:38 a.m. in the dining room, Resident 103 (Res 103) was eating her lunch meal. Res 103 picked at her meal, but stated the food was pretty good though it would be better with some salt. Review of Res 103's electronic medical record indicated that Res 103 was her 60's, and had the following diagnosis: a fracture of the right humerus (arm bone), diabetes type 2 (low response to insulin leading to high blood sugar levels), retinopathy (an eye disease affecting the sensitive tissue at the back of the eye), high blood pressure, and amenia. Weight history: 5/8/26=178 pounds (lbs.), 5/31/26=160 lbs. (a loss of 18 lbs. or 10% of body weight in 23 days which is severe, 6/28/26=150 lbs. (a loss of 10 lbs. or 6% in one month which is severe). Severity was based on facility provided policy titled Weight Assessment and Intervention [Med-Pass Inc, Revised September 2008) which indicated the threshold for significant unplanned and undesired weight loss will be based on the following criteria . 1 month-5% weight loss is significant; greater than 5% is severe 3 months-7.5% weight loss is significant; greater than 7.5% is severe 6 months-10% weight loss is significant; greater than 10% is severe. Review of Nutrition/dietary note from 5/12/26 indicated Nut Dx (nutrition diagnosis): Inadequate oral intake r/t (related to) not meeting nutrition needs AEB (as evidenced by) an average 50% meal intake .Goals: . Comfort care focused . During an interview with the Registered Dietitian (RD) on 7/28/26 at 1:39 p.m., the RD was asked the meaning of comfort care focused and how it was determined to be appropriate for a resident. The RD stated that she reviewed the resident's POLST (Physician Orders for Life-Sustaining Treatment) form and when the resident of responsible party had checked comfort measures, she interpreted it to mean that no weight or food intake goals were desired. During an interview on 7/29/26 at 8:03 a.m. with the Assistant Director of Nursing (ADON), the ADON stated that the POLST form was used for directing care when a resident had a medical change of condition and was unable to state their treatment wishes. The ADON denied that the POLST form would not be used for planning day-to-day care. Review of the website Capolst.org indicated that A California POLST form is a bright pink medical order for seriously ill or frail individuals that details preferences for CPR, medical interventions, and tube feeding. Review of Understanding POLST Form Decisions by the National POLST Collaborative indicated in the Comfort Measures Only section a POLST form does not dictate everyday dietary restrictions or specific food choices. Instead, it guides emergency medical care to focus on pain and symptom relief. The POLST form lets people choose comfort-focused care (often called Comfort Measures Only or Allow Natural Death), which prioritizes symptom relief (pain, shortness of breath, anxiety) and avoids aggressive life-prolonging interventions that can be traumatic. Comfort-focused care explicitly directs clinicians to keep the patient (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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	comfortable and avoid hospital transfers unless comfort can't be maintained. 2. During an observation of the lunch meal on 7/27/26 at 11: 46 a.m., Res 48 was being fed in the dining room and had eaten almost 100% of the meal.During breakfast meal observation on 7/28/26 at 8:03 a.m., Res 48 was asleep in bed, and no breakfast tray was observed on her bedstand. Review of tray cart found outside of the kitchen on 7/28/26 at 8:22 a.m., had Res 48's breakfast tray. The tray was observed to contain all food items and clean utensils without evidence of food intake. During lunch meal observation on 7/28/26 at 12:10 p.m., Res 48's meal tray was on the bedstand. Res 48 exited the restroom and walked to her window and used the curtains to dry the hands. Res 48 did not seem to register the meal tray and instead focused her attention on three empty cups on lying on her nightstand. Res 48 alternately brought the empty cups to her mouth but was confused as to which end to drink from. Once Res 48 was seated, the surveyor attempted to ask Res 48 questions, but Res 48 did not respond in English. Res 48 did not attempt to eat and no staff arrived to assist Res 48 with the lunch meal over the following 20 minutes. During breakfast meal observation on 7/29/26 at 8:37, Res 48 was asleep with a blanket over her head. A meal tray was left on the bedstand and no food had been eaten. During a return to Res 48's room at 8:49 a.m., the resident was still asleep and the breakfast tray was intact.Review of Res 48's electronic medical record indicated resident was in her 80's and had the following diagnosis: type 2 diabetes, chronic kidney disease, muscle wasting, moderate protein/calorie malnutrition, osteoporosis (low bone mass), anemia (lower than normal number of red blood cells or low hemoglobin concentration), dementia (loss of memory, thinking and reasoning skills), and dysphagia (difficulty swallowing).Weight history:8/3/25=124 lbs.,9/7/25=120 lbs.,10/5/25=112 lbs. (a loss of 8 lbs. or 6.7% in one month which is severe),11/7/25=105 lbs. (a loss of 7 lbs. or 6.3% in one month which is severe),7/3/26=92 lbs. (an additional loss of 13 lbs. in 8 months).Review of Nutrition/dietary note from 7/27/25 indicated that The resident feeds self with supervision .Review of Nutrition/dietary note from 11/25/25 indicated .Plan: Recommend Boost Glucose Control (supplemental drink) 5x/day.Review of Nutrition/dietary note from 1/22/26 indicated Unintentional significant weight loss r/t (related to) low PO (by mouth) intake AEB (as evidenced by) losing 18 lbs (14%) x 180 days. Plan: Encourage PO/Fluids.Nutrition/dietary note from 7/14/26 indicated that . Plan: Recommend small portions.Add Magic Cup (supplement ice cream with added protein) at 1000 (10 a.m.) and 1500 (3 p.m.) for supplementation. Encourage PO/Fluids.Review of current care plan indicated comfort care focused.During an interview on 7/29/26 at 8:03 a.m. with the Assistant Director of Nursing (ADON), the ADON stated that the POLST form was used for directing care when a resident had a medical change of condition and was unable to state their treatment wishes. The ADON denied that the POLST form would not be used for planning day-to-day care. During an interview of the RD on 7/28/25 at 2:18 p.m., the RD stated Res 48 had been refusing meals and only drinking the supplemental shakes. The RD further stated she was unsure what language Res 48 spoke. The RD also stated that she could recommend nursing interventions such as providing one-to-one feeding assistance but had not done that for Res 48. During a return visit to the kitchen on 7/29/26 at 9:04 a.m., the Dietary Services Supervisor (DSS) stated that Res 48 was from (Name of country) and she believed staff were able to converse with her in her native language.During a visit to Res 48 with a (Res 48's native language that DSS identified) speaking surveyor on 7/29/26 at 10:36 a.m., Res 48 was unable to converse in the language. Review of chart indicated Res 48 spoke a (Another Language).Review of facility provided policy titled Weight Assessment and Intervention [Med-Pass Inc, Revised September 2008) indicated under the Analysis section in bullet 2 The physician and the multidisciplinary team will identify conditions and medications that may be causing anorexia, weight loss . For example: a. Cognitive or functional decline; .3. During an observation of (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview and record review, the facility failed to meet food service standards for food storage and preparation when: Food labeling was not performed consistently, Worn kitchen equipment was still in use, An air gap was not found on the fruit/vegetable wash sink, and Five dirty and/or wet steam table pans were found stored in the cook's ready to use area. These failures had the potential of leading to food borne illnesses for the residents eating facility prepared meals. Findings: During the initial kitchen tour on 7/27/26 at 8:42 a.m., in the dry storage area, a large plastic container of soft, white powder was observed. The container did not have a label to indicate what it was, when it was opened, or when it would no longer be safe to use. During a subsequent interview on 7/27/26 at 8:46 a.m. with the Dietary Services Supervisor (DSS), the DSS confirmed that there was no label on the flour container which would be safe for 6 to 8 months per their storage guide. During the initial kitchen tour on 7/27/26 at 8:51 a.m., in the reach-in refrigerator was a container of cheese slices that indicated they were opened on 7/4/26 and were to be discarded on 7/21/26 but were still in the refrigerator. During a subsequent interview on 7/27/26 at 9:04 a.m. with the DSS, the DSS confirmed the American cheese slices and reviewed the storage guide. The storage guide indicated that various types of cheeses could be safely kept from anywhere from 1 week to 4 weeks (depending on the type of cheese). American cheese was not listed on the storage guide though the DSS stated she believed that they were still safe to eat. Review of facility provided Food Storage and Retention Guide indicated that Time/temperature Control for Safety Foods (TCS) were Food that requires time/temperature control for safety to limit pathogenic (disease causing) microorganism (tiny living cells) growth or toxin (poisonous substance) formation. Review of facility provided policy Receiving (Healthcare Services Group, Inc. and its subsidiaries, 2/2023) indicated in bullet 5 All food items will be appropriately labeled and dated either through manufacturer packaging or staff notation. Review of the US Food and Drug Administration's (FDA) 2022 Food Code section 3-501.17 on Ready-to-Eat, Time/Temperature Control for Safety Food, Date Marking indicated that Ready-to-eat, time/temperature control for safety food prepared and held in a food establishment for more than 24 hours shall be clearly marked to indicate the date or day by which the food shall be consumed or discarded. 2. During the initial kitchen tour on 7/27/26 at 9:34 a.m., the can opener was observed with a rusted area on the tip as well as a whitish coating. During a concurrent interview with the DSS, the DSS confirmed the rust and asked staff to rewash the can opener. During the initial kitchen tour on 7/27/26 at 9:47 a.m., two cutting boards (a blue board usually used for seafood and a green usually used for fruits, vegetables and herbs) were observed to have deep gouges on the cutting service. During a concurrent interview with the DSS, the DSS confirmed the deep grooves and indicated that the cutting boards should be replaced. Review of the US FDA 2022 Food Code section 4-501.11 on Good Repair and Proper Adjustment indicated that (A) Equipment shall be maintained in a state of repair and condition that meets the requirements specified under Parts 4-1 and 4-2. (C) Cutting or piercing parts of can openers shall be kept sharp to minimize the creation of metal fragments that can contaminate food when the container is opened. The cutting or piercing parts of can openers may accumulate metal fragments that could lead to food containing foreign objects and, possibly, result in consumer injury. No air gap seen on the f/v sink. Review of the US FDA 2022 Food Code section 4-501.12 on Cutting Surfaces indicated that Surfaces such as cutting blocks and boards that are subject to scratching and scoring shall be resurfaced if they can no longer be effectively cleaned and sanitized, or discarded if they are not capable of being resurfaced. Cutting surfaces such as cutting (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	boards and blocks that become scratched and scored may be difficult to clean and sanitize. As a result, pathogenic microorganisms transmissible (capable of being spread) through food may build up or accumulate. These microorganisms may be transferred to foods that are prepared on such surfaces.3. During the initial kitchen tour on 7/27/26 at 10:24 a.m., an air gap (break in pipe leading to the sewage line) was not observed on the fruit and vegetable wash sink. During a concurrent interview with the DSS, the DSS confirmed the observation.During a return to the kitchen on 7/29/2026 at 10:57 a.m. with the Director of Maintenance (DM), the DM also confirmed that an air gap had not been installed.Review of the US FDA 2022 Food Code section 5-202.13 on Backflow Prevention, Air Gap indicated that An air gap between the water supply inlet and the flood level rim of the plumbing fixture, equipment, or nonfood equipment shall be at least twice the diameter of the water supply inlet and may not be less than 25 mm (1 inch) .During periods of extraordinary demand, drinking water systems may develop negative pressure in portions of the system. If a connection exists between the system and a source of contaminated water during times of negative pressure, contaminated water may be drawn into and foul the entire system.4. During the initial kitchen tour on 7/27/26 at 10:37 a.m., steam table pans were stored and ready for use in the cook's station. Two of the small steam table pans were observed with a brown residue on the bottom and sides of the pans. Three of these small steam table pans were observed with a glossy film and drops on the inner surface.During a subsequent interview with the DSS on 7/27/26 at 10:41 a.m., the DSS stated that the pans should not have been put in the clean area due to the food, oil, and/or water residue.Review of facility provided policy titled Warewashing (Health Services Group, Inc. and its subsidiaries, 12/2024) indicated that All dishware, serviceware, and utensils will be cleaned and sanitized after each use. In bullet 4 of the procedures section it indicated that All dishware will be air dried and properly stored.Review of the US FDA 2022 Food Code section 4-901.11 on :Equipment and Utensils, Air-Drying Required indicated that After cleaning and sanitizing, equipment and utensils: (A) Shall be air-dried or used after adequate draining as specified . and (B) May not be cloth dried .Items must be allowed to drain and to air-dry before being stacked or stored. Stacking wet items such as pans prevents them from drying and may allow an environment where microorganisms can begin to grow. Cloth drying of equipment and utensils is prohibited to prevent the possible transfer of microorganisms to equipment or utensils.		

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure one of 24 sampled residents (Resident 13's) pain was managed when the scheduled pain medications were not administered as ordered. This failure resulted in Resident 13 experiencing unmanaged pain. Findings: A review of Resident 13's medical record indicated the resident had diagnoses that included secondary malignant neoplasm of the brain (cancer that had spread to the brain from another part of the body), spondylosis of the lumbosacral region (wear and tear arthritis of the lower back), a right tibia and fibula fracture (broken bones in the lower right leg), and was receiving palliative care services (comfort focused care for a serious illness). A review of Resident 13's Minimum Data Set (MDS), dated [DATE], indicated a Brief Interview for Mental Status (BIMS) score of 10/15, which indicated moderate cognitive impairment. During a concurrent observation and interview on 7/27/26 at 11:09 a.m. with Resident 13, the resident was awake. Resident 13 stated that she had pain in her legs, rated the pain at 15/10; however, no apparent grimacing or shortness of breath was noted. Resident 13 reported to Certified Nursing Assistant (CNA) 1 who responded to her call light that she was experiencing pain. CNA 1 stated she would notify Resident 13's nurse about her pain. A review of Resident 13's Order Summary Report (OSR) and Medication Administration History indicated the following pain medications: a. Methadone 10 mg (milligrams, unit of measurement) /mL (milliliters, unit of measurement), Give 0.5 mL by mouth every eight hours for pain management, scheduled at 8:00 a.m. Methadone was administered on 7/27/26 at 12:21 p.m. b. Morphine Sulfate Oral Solution 20 mg/mL, Give 1 mL by mouth every eight hours for pain or shortness of breath, scheduled at 8:00 a.m. Morphine was administered on 7/27/26 at 12:22 p.m. During an interview on 7/27/26 at 1:55 p.m., with Licensed Nurse (LN) 1, LN 1 stated she administered Resident 13's pain medications around noon and acknowledged the pain medications were scheduled for 8 a.m. LN 1 explained the delay in administering the pain medications was due to another LN calling off that morning, which resulted in an increased workload. A review of Resident 13's Nurse's Note written by LN 1, dated 7/26/26 at 3:56 p.m., indicated: AM [morning] medication administration ran long - MD [Medical Doctor] notified and received an okay to continue administering medications. Resident received her routine pain medications late (around noon). Resident does not appear to be in pain - no noted grimacing, guarding, or calling out. Resident is resting comfortably in bed, respirations are even and unlabored. Continue with current plan of care. During an interview and record review on 7/29/26 at 2:40 p.m., the Director of Nursing (DON) stated their expectation was for nurses to address and manage residents' pain. The DON stated that Resident 13 was on hospice care and had a fracture of the right tibia and fibula. The DON further stated that medications should be administered within one hour before or one hour after the scheduled time. A review of the facility's policy and procedure titled Administering Medications, dated 3/26, indicated: Medications are administered in a safe and timely manner, and as prescribed. Medications are administered within one (1) hour of their prescribed time.		

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that medication error rates remained below 5% when seven medication errors were identified out of 31 opportunities, resulting in a medication error rate of 22.58% for a census of 91. These failures placed Resident 66 and Resident 17 at risk for altered or delayed therapeutic drug responses and reduced medication effectiveness. Findings: 1a. During a concurrent medication administration observation and interview starting on 7/27/26 at 9:22 a.m. with Licensed Nurse (LN 2), LN 2 was observed preparing and administering four medications for Resident 66. LN 2 stated that the medications were scheduled for 8 a.m. but were administered after 10 a.m. A review of Resident 66's Physician's Orders (PO) and Medication Administration Record (MAR) showed the following: a. Hydralazine hydrochloride (blood pressure medication) 50 mg (milligrams, unit of measurement) per tablet, give one tablet via G-tube (gastrostomy tube, a tube placed through the abdomen into the stomach to give food, water, and medicine when a person can't eat or swallow safely) every eight hours for high blood pressure; hold if systolic blood pressure (SBP) is less than 120 mmHg (millimeters of mercury, a unit to measure blood pressure). Medication was scheduled for 8 a.m. and given on 7/27/26 at 10:13 a.m. b. Metoprolol tartrate (heart and blood pressure medication) 25 mg/tablet, give 25 mg via G-tube twice daily for high heart rate (HR); hold if SBP is less than 100 mmHg or HR is less than 60. Medication was scheduled for 8 a.m. and given on 7/27/26 at 10:14 a.m. c. Levetiracetam (seizure medication) 100 mg/mL, give 10 mL (milliliters, unit of measurement) via G-tube twice daily for seizures. Medication was scheduled for 8 a.m. and given on 7/27/26 at 10:13 a.m. d. Humulin R (Regular Insulin, diabetes medication) Injection solution 100 units/mL, inject 8 units subcutaneously three times daily. Medication was scheduled for 8 a.m. and given on 7/27/26 at 10:04 a.m. During an interview on 7/29/26 at 2:40 p.m. with the Director of Nursing (DON), the DON stated that medications should be given within one hour before and one hour after the scheduled time, and staff were expected to follow the administration schedule. A review of the facility's policy and procedure (P&P) titled Administering Medications, dated 3/26, indicated: Medications are administered in a safe and timely manner, and as prescribed. Medications are administered within one (1) hour of their prescribed time. 1b. During a medication administration observation on 7/28/26 beginning at 8:32 a.m. with LN 3, LN 3 was observed combining and crushing three medications together and administered them altogether to Resident 17 via G-tube. The three medications were: a. carvedilol tablet (Heart and blood pressure medication) 12.5 mg per tablet, 1 tablet given through the G-tube. b. empagliflozin (Diabetes medication) 10 mg per tablet, 1 tablet given through the G-tube. c. sacubitril-valsartan (Heart failure medicine) 49-51 mg per tablet, 1 tablet given through the G-tube. During an interview on 7/29/26 at 1 p.m. with the Consultant Pharmacist (RPh), the RPh stated that carvedilol, empagliflozin, and sacubitril-valsartan should not be crushed together because there was no literature supporting that crushing medications and administering them altogether no physical or chemical incompatibilities would occur. The RPh stated that nurses were expected to crush medications individually and administer each medication with flushes in between. According to the Journal of Parenteral and Enteral Nutrition, Volume 41, Issue 1, titled ASPEN [American Society for Parenteral and Enteral Nutrition] Safe Practices for Enteral Nutrition Therapy, <https://aspenjournals.onlinelibrary.[NAME].com/doi/epdf/10.1177/0148607116673053>, retrieved on 7/29/26, indicated, 8. Administer each medication separately through an appropriate access. 9. Avoid mixing together different medications intended for administration through the feeding tube given (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the risk for physical and chemical incompatibilities, tube obstruction, and altered therapeutic drug responses.A review of the facility's Policies and Procedures (P&P), titled Administering Medications through an Enteral Tube, dated 4/2026, indicated, The purpose of this procedure is to provide guidelines for the safe administration of medications through an enteral tube. 3. Administer each medication separately and flush between medications.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview and record review, the facility failed to maintain an effective infection prevention control program for 80 out of 91 residents when; 1. Staff did not follow Infection Control Practices for Resident 15, Resident 58, Resident 61; and 2. The portable and window type air conditioning (AC) unit filters were not cleaned and properly maintained for the 77 residents who resided in the hall. These failures had the potential to increase the risk of transmission and spread of infection for Resident 15, Resident 58, and Resident 61, and increased airborne contaminants for 77 residents who resided in the hall. Findings: 1. Resident 15 was admitted to the facility in early 2023 with diagnoses that included serious breathing problems, history of infections, resistance to multiple antibiotics, and a stage 4 pressure injury (wound caused by pressure that extends into the muscle or bone). During a review of Resident 15's Order Summary Report [OSR], dated 3/30/26, the OSR indicated, CONTACT PRECAUTIONS PER [name of county] R/T [related to] [High-contact resident care activities with colonized or infected MDRO (multidrug-resistant organism, bacteria that do not respond to many common antibiotics), increased risk of MDRO acquisition due to presence of wounds or indwelling medical devices). HAND HYGIENE AND PPE [personal protective equipment: gowns, gloves, mask] ANY TIME every shift for prevention. During a review of Resident 15's Care Plan Report [CP], initiated on 11/4/23, the CP indicated, CONTACT PRECAUTIONS. Follow facility policy and procedure related to contact precautions. Staff will follow PPE protocol per guidelines. Resident 58 was admitted to the facility in early 2023 with diagnoses that included stroke, dependence on a ventilator, and being a carrier of a bacteria that were resistant to strong antibiotics During a review of Resident 58's CP, dated 5/30/24, the CP indicated, INFECTIOUS DISEASE: CONTACT PRECAUTION. Follow facility policy and procedure related to contact precautions. Staff will follow PPE protocol per guidelines. Resident 61 was admitted to the facility early 2023 with diagnoses that included stroke, urinary tract infection, resistance to multiple antibiotics, and being a carrier of a bacteria that were resistant to strong antibiotics. During a review of Resident 61's CP, dated 6/7/24, the CP indicated, INFECTIOUS DISEASE: CONTACT PRECAUTION. Follow facility policy and procedure related to contact precautions. Staff will follow PPE protocol per guidelines. During a concurrent observation and interview on 7/28/26 at 2:24 p.m., Certified Nursing Assistant (CNA2) was observed inside the shared room of Resident 15, Resident 58, and Resident 61. A sign outside the door indicated, STOP: CONTACT PRECAUTIONS EVERYONE MUST: Clean their hands, (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	including before entering and when leaving the room. PROVIDERS AND STAFF MUST ALSO: Put on gloves before room entry. Discard gloves before room exit. Put on gown before room entry. Discard gown before room exit. Do not wear the same gown and gloves for the care of more than one person. CNA 2 was observed inside the room without a gown. CNA 2 wore gloves, picked up three urinals filled with urine in one hand, and exited the room. CNA 2 walked with the three urinals to the shower room, entered the shower room and exited the shower room with three empty urinals, walked back to the room, and re- entered the room without sanitizing hands or putting on a gown. CNA 2 placed the empty urinals at each resident's bedside, emptied the trash, and brought the trash outside the room to the trash area. CNA 2 confirmed the above observations and stated she knew she was supposed to wear a gown but was in a rush. CNA 2 confirmed the sign outside the room indicated the residents were on contact precautions and stated she knew staff was supposed to follow the precautions. During a phone interview on 7/29/26 at 10:59 a.m. with the Infection Preventionist (IP), the IP stated residents on contact precautions required gown and gloves to be worn during care. The IP stated contact precautions were used to prevent MDRO and decrease or prevent the spread of infection and she expected PPE to be worn before entering a room, .it's automatically part of the uniform. The IP stated if urinals were removed from a room, they had to be removed one at a time and covered during transport. The IP indicated that the CNA should not have carried all three full urinals in one hand, uncovered, down the hall and should have put on a gown before entering the room to empty the trash; the IP stated, That is not correct practice. During an interview on 7/30/26 at 9:55 a.m. with the Director of Nursing (DON), the DON stated she expected staff to follow contact precautions to prevent infection and the spread of bacteria. During a review of the facility's policy and procedure (P&P) titled, CONTACT PRECAUTIONS, undated, the P&P indicated, It is the intent of this facility to use contact precautions for resident known or suspected to have serious illnesses easily transmitted by direct patient contact or by contact with items in the patient's environment. Contact precautions shall be used in addition to Standard precautions for resident with infections that can easily be transmitted by direct and indirect contact. Gloves should be removed before leaving the resident's room and hands should be washed immediately. A gown should be worn when entering the room if it is anticipated that clothing will have substantial contact with the resident, environmental surfaces, or items in the resident's roo (sic). 2. During an observation on 7/29/26 beginning at 9:49 a.m., two operating portable AC units located in two residents' rooms were observed with visibly soiled filters on the back of the units. The filters were heavily saturated with dark debris indicating they had not been adequately cleaned or maintained which could compromise the airflow and its cooling efficiency. During a concurrent observation and interview on 7/29/26 at 10:01 a.m. in another resident's room, the family member confirmed that the portable AC's filter was heavily soiled and stated, I've been here almost every day and I never seen it cleaned; they should have been cleaning that. A review of the facility document titled 'Weekly AC Filter Cleaning Schedule' indicated that AC logs were missing and that the last recorded cleanings ranged from 6/12/26 to 6/26/26. (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview on 7/29/26 at 10:17 a.m. with the Director of Maintenance (DM), the DM confirmed that the AC filter in the resident's room was heavily soiled and obstructed, which affected the portable AC's ability to circulate air effectively. The DM stated that the filters needed to be cleaned weekly and explained that he was on vacation for a month and did not have anyone to endorse the task to. The DM confirmed that all the AC units in the area of the facility had not been serviced for a month. Review of the Weekly AC Filter Cleaning Schedule log indicated that 33 residents rooms were affected housing a total of 77 residents. During an interview on 7/29/25 at 10:40 a.m. with the Assistant Director of Nursing (ADON), the ADON confirmed the findings described above and stated, It may be a source of infections for patients that has trach [tracheostomy, a surgical opening in the neck leading into the windpipe that holds a small tube to help a person breathe]. ADON further stated that the AC units were not able to blow cold air efficiently. During an interview on 7/29/26 at 11:46 a.m. with the Infection Preventionist (IP), the IP stated that if the AC units were not checked every month, dust would accumulate, and it could affect the health and condition of residents with tracheostomies because they would be breathing in dust. A review of the facility Policy and Procedures (P&P) titled, Departmental (Maintenance) &ndash; Plumbing, HVAC, and Related Systems revised on 2011 indicated, Inspect air-conditioning unit drains and filters weekly .Clean or discard filters in individual air-conditioning units in the resident rooms at least monthly.		

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to document in the medical record the information and education provided regarding the influenza (respiratory illness that is also known as the flu) and pneumococcal (pathogen that causes respiratory illness) vaccines for two of 24 sampled residents (Resident 27 and Resident 100), when Resident 27 and Resident 100's medical record showed no evidence that education was provided. This failure increased the risk for Resident 27 and Resident 100 to contract and transmit preventable illnesses. Findings: Resident 27 was admitted to the facility in May of 2026 with diagnoses that included type two diabetes (a chronic condition that causes a person to have persistently high blood sugar levels). A review of Resident 27's Minimum Data Set (MDS, a standardized assessment tool used in skilled nursing facilities), dated 7/3/26, indicated Resident 27 had a Brief Interview for Mental Status (BIMS, an assessment used to determine a resident's cognition level) score of 15/15 indicating Resident 27 was cognitively intact. A review of Resident 27's document titled, Immunization Details, dated 5/19/26, indicated Resident 27 refused the PCV 20 (a pneumococcal vaccine) vaccine but there was no documented evidence that, prior to refusal, education on benefits of vaccination or risks of not receiving the vaccination was provided to Resident 27. Resident 100 was admitted to the facility in July of 2026 with diagnoses that included respiratory failure. A review of Resident 100's MDS, dated [DATE], indicated Resident 100 had a BIMS score of 15/15 indicating Resident 100 was cognitively intact. A review of Resident 100's Immunization Details document, dated 7/13/2026, indicated that Resident 100 declined both the influenza and pneumococcal vaccines. The record also indicated that no educational information was provided to Resident 100 about these vaccines. During an interview on 7/29/26 at 8:30 a.m. with Resident 100, Resident 100 indicated that he was never educated on the the influenza and pneumococcal vaccines. During an interview on 7/29/26 at 8:43 a.m. with Resident 27, Resident 27 indicated that he was never offered the pneumococcal vaccine and that he would have taken it had it been offered and education provided to him. During an interview on 7/29/26 at 11:14 a.m. with the Infection Preventionist (IP), the IP indicated that education on vaccination was provided to residents regardless of if they refuse the vaccine. The IP further indicated that it was important for residents to receive the vaccines to prevent the spread of infections. During a concurrent record review and interview on 7/30/26 at 9:48 a.m. with the Director of Nursing (DON), Resident 27 and Resident 100's immunization information was reviewed. The DON confirmed that there was no documentation that education on the influenza and pneumococcal vaccines was provided to either Resident 27 or Resident 100. The DON indicated that she expected staff to educate residents on the vaccines then document it in the residents' record. During a review of the facility's policy and procedures (P&P) titled, Prevention and Management of Covid-19 [pathogen that causes covid infection], Influenza, and Other Respiratory Viral Infections, revised 2/1/24, the PNP indicated, Facility will educate and offer COVID-19, influenza, and pneumococcal vaccines to residents.		