STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055888	A. Building B. Wing	05/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Huntington Valley Healthcare Center	8382 Newman Avenue Huntington Beach, CA 92647

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, and facility P&P review, the facility failed to provide the necessary respiratory care and services for six of 27 final sampled residents (Residents 2, 5, 29, 74, 92, and 137) reviewed for oxygen therapy. * The facility failed to ensure Resident 2's oxygen tubing was labeled and dated. * The facility failed to ensure Resident 5's oxygen tubing was labeled and dated and inside a bag when not in use. * The facility failed to ensure a physician's order was obtained for Resident 29's use of the continuous oxygen therapy via the nasal cannula. * The facility failed to follow the physician's order for the administration of continuous oxygen for Resident 74. Resident 74 had a physician's order to receive continuous oxygen at a rate of two LPM; however, Resident 74 received continuous oxygen at a rate of three LPM. * The facility failed to ensure the signage for oxygen use was placed in Resident 92's room and to ensure Resident 92's nasal cannula tubing was labeled and dated. * Resident 137 received continuous oxygen therapy at two LPM via nasal cannula and CPAP at night. The facility failed to ensure the signage for oxygen use was placed outside of Resident 137's room. Additionally, the facility failed to clean the CPAP water chamber as per the user's guide and failed to ensure a care plan was developed for Resident 137's use of the CPAP machine and for the continuous oxygen therapy via the nasal cannula. These failures had the potential for the residents to not receive the appropriate care and may negatively impact the residents' medical conditions.Findings: Review of the facility's P&P titled Oxygen Administration dated 2001 showed to verify there is a physician's order for this procedure and to review the physician's orders or facility protocol for oxygen administration. Assemble the equipment and supplies as needed. Place an Oxygen in Use sign on the outside of the room entrance door. 1. On 5/18/26 at 0826 hours, during the initial tour of the facility, Resident 92 was observed lying in bed with the oxygen on via nasal cannula, which was attached to the oxygen concentrator machine and set at two LPM. In addition, during the observation, the oxygen tubing was not on Resident 92's nares, unlabeled, undated, and there was no oxygen signage posted on the door. On 5/18/26 at 0826 hours, an observation and concurrent interview was conducted with CNA 1. CNA 1 verified the nasal cannula was not on Resident 92's nares, CNA 1 donned gloves and applied the nasal cannula to Resident 92's nares. In addition, CNA 1 verified there was no label and date on the oxygen tubing and there was no oxygen signage on the resident's room. On 5/19/26 at 0900 hours, Resident 92 was observed lying in bed with the oxygen on via nasal cannula, which was attached to the oxygen concentrator machine and set at two LPM. Medical record review for Resident 92 was initiated on 5/18/26. Resident 92 was admitted to the facility on [DATE], and readmitted on [DATE]. (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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 92's Order Summary Report dated 5/2026 showed a physician's order dated 5/6/26, to administer oxygen at two LPM via nasal cannula continuously per concentrator or tank every shift. In addition, a physician's order dated 5/11/26 showed, to change oxygen tubing every day shift on Friday. Review of Resident 92's Care Plan Report dated 5/19/26, showed a care plan focus addressing the resident required the use of continuous oxygen. The interventions included to change the humidification and oxygen tubing as indicated. On 5/19/26 at 1603 hours, an interview and concurrent medical record review for Resident 92 was conducted with RN 4. RN 4 verified the above findings and stated CNA 1 should have informed the licensed nurse of the nasal cannula not on Resident 92's nares and the nasal cannula should have been labeled and dated, and the oxygen signage should have been posted in Resident 92's room. On 5/21/26 at 1536 hours, the DON and ADON were informed and acknowledged the above findings. 2. On 5/18/26 at 0700 hours, during the initial tour of the facility, Resident 29 was observed in bed receiving continuous oxygen therapy at two LPM via nasal cannula. Medical record review for Resident 29 was initiated on 5/18/26. Resident 29 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 29's H&P examination dated 4/28/26, showed Resident 29 had the capacity to understand and make decisions. Review of Resident 29's Order Summary Report dated 5/18/26, failed to show a physician's order for the administration of continuous oxygen therapy at two LPM via nasal cannula. On 5/18/26 at 0917 hours, an interview and concurrent observation and medical record review for Resident 29 was conducted with LVN 7. LVN 7 verified Resident 29 was receiving continuous oxygen at two LPM via nasal canula. LVN 7 stated there should be a physician's order for the administration of continuous oxygen therapy. LVN 7 reviewed Resident 29's medical record and verified the above findings. 3. Review of the facility's P&P title CPAP/BiPAP Support revised 1/2026 showed to review the physician's order to determine the oxygen concentration and flow, and the PEEP pressure (CPAP, IPAP, and EPAP) for the machine. Specific cleaning instruction guidelines are obtained from the manufacturer of the PAP device. To obtain a NO SMOKING sign for the resident's room. Review of the User Manual for the [NAME] G3 CPAP dated 2/29/24, showed cleaning the device and its accessories as recommended in the following sections is essential to prevent respiratory infections. Under the section Cleaning the Water Chamber showed to dilute Alconox to 1% with water 113 to 140 degrees F. To soak the water chamber in the detergent for five minutes. Clean the water chamber with a soft bristled brush for one minute. Then rinse the water chamber with running water for five minutes. Wipe it dry with a soft cloth or air dry it away from direct sunlight. WARNING- emptying and cleaning the water chamber daily will help prevent mold and bacteria growth. On 5/18/26 at 0702 hours, during the initial tour of the facility, Resident 137 was observed sleeping in bed and connected to the CPAP machine ([NAME] G3) on her bedside drawer. Resident 137 was also (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	observed receiving continuous oxygen at two LPM via the nasal cannula. An oxygen in-use sign was not observed outside of Resident 137's room door. On 5/18/26 at 0920 hours, Resident 137 was observed resting in bed and receiving continuous oxygen at two LPM via the nasal canula. On 5/18/26 at 0925 hours, an interview and concurrent observation and medical record review for Resident 137 was conducted with LVN 7. LVN 7 stated Resident 137 received continuous oxygen at two LPM via nasal cannula. LVN 7 stated for the resident receiving continuous oxygen there should be a sign outside the door to notify others to prevent any hazards. LVN 7 verified the oxygen signage was not outside of Resident 137's room door. Medical record review for Resident 137 was initiated on 5/18/26. Resident 137 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 137's Order Summary Report dated 5/20/26, showed the following physician's orders: - dated 5/12/26, to administer continuous oxygen at two LPM via nasal cannula, every shift for shortness of breath. - dated 5/12/26, to change the CPAP water chamber every six months during the day shift, starting on the 12th for day one. (However, the physician's orders failed to show how often the water chamber should be cleaned). Review of Resident 137's plan of care with a print date of 5/20/26, failed to show documented evidence a care plan was developed to address Resident 137's use of the CPAP machine or the continuous oxygen therapy at two LPM via nasal cannula. On 5/21/26 at 1123 hours, a follow-up interview and concurrent medical record review for Resident 137 was conducted with LVN 7. LVN 7 stated Resident 137 was placed on the CPAP during the evening shift. LVN 7 reviewed Resident 137's medical record and verified a care plan was not developed to address Resident 137's use of the CPAP machine or her continuous oxygen therapy via NC. On 5/21/26 at 1420 hours, an interview and concurrent medical record review for Resident 137 was conducted with the DON. The DON stated there should be a physician's order for the administration of continuous oxygen therapy and there should be signage outside of the resident's door to prevent any accident hazards. The DON stated there should be a care plan developed for the use of the CPAP machine. The DON stated the care and maintenance for the CPAP machine should be done per the CPAP machine's user guide from the manufacturer. The DON verified the CPAP machine's user guide showed to clean the water chamber daily and verified there were no orders on the cleaning of the water chamber. On 5/21/26 at 1515 hours, an interview was conducted with the Administrator, ADON, and DON. The Administrator, ADON, and DON were informed and acknowledged the above findings. 4. On 5/18/26 at 0718 hours, during the initial tour of the facility, an interview and concurrent observation for Resident 2 was conducted with the ADON. Resident 2 was observed lying in bed, (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	receiving oxygen at two LPM and that the nasal cannula tubing was observed unlabeled and undated. The ADON verified the findings and stated the oxygen tubing needed to be labeled and dated when it was changed; and needed to change every seven days to prevent infection. Medical record review for Resident 2 was initiated on 5/18/26. Resident 2 was admitted to the facility on [DATE], and readmitted to the facility on [DATE]. Review of Resident 2's H&P examination dated 5/10/26, showed Resident 2 had the capacity to understand and make medical decisions. Review of Resident 2's Order Summary Report dated 5/20/26, showed the following physician's order: - dated 5/18/26, to administer oxygen at two LPM via nasal cannula as needed. - dated 5/18/26, to change oxygen tubing every Friday day shift. 5. On 5/20/26 at 0834 hours, during an observation of Resident 5 in his room, Resident 5 was observed lying in bed, with a portable oxygen machine beside Resident 5's bed. The resident's oxygen tubing was unlabeled and undated, coiled, and was hanging on the oxygen machine. On 5/20/26 at 0849 hours, an observation and concurrent interview for Resident 5 was conducted with LVN 3. LVN 3 verified the findings and stated the oxygen tubing needed to be labeled and dated when it was changed; and needed to be inside a bag when not in use to prevent infection. Medical record review for Resident 5 was initiated on 5/18/26. Resident 5 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 5's Order Summary Report, showed the following physician's order: -dated 3/17/26, to administer oxygen at two liters per minute via nasal cannula as needed. -dated 3/17/26, to change oxygen tubing every Monday day shift. Review of Resident 5's MDS admission assessment dated [DATE], showed Resident 5 had a BIMS score of 4 (meaning severe cognitive impairment). On 5/21/26 at 1334 hours, an interview and concurrent medical record review for Residents 2 and 5 was conducted with the DON. The DON verified Residents 2 and 5 had oxygen orders, and the licensed nurses needed to label the oxygen tubing with the date it was changed; and if not being used to make (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	sure it was inside the bag to prevent infection. On 5/21/26 at 1403 hours, an interview was conducted with the Administrator, ADON, and DON. The Administrator, ADON, and DON were informed and acknowledged the above findings. 6. Review of the facility's P&P titled Oxygen Administration dated 2001 showed in preparation for the administration of oxygen, review the physician's order. Medical record review for Resident 74 was initiated on 5/18/26. Resident 74 was admitted to the facility on [DATE]. Review of Resident 74's Care Plan Report revised 4/10/26, showed a care plan focus titled Oxygen Therapy related to pulmonary edema. Review of Resident 74's Order Summary Report showed a physician's order dated 4/9/26, to administer oxygen continuously at a rate of two LPM via nasal cannula. On 5/18/26 at 1010 hours, an observation and concurrent interview was conducted with Resident 74. Resident 74 was observed lying in his bed and was receiving continuous oxygen via an oxygen concentrator and nasal cannula, at a rate of three LPM. Resident 74 stated he required continuous oxygen therapy otherwise he felt short of breath. Resident 74 stated he received oxygen therapy at a rate of three LPM. Resident 74 stated the nurses at the facility adjusted the rate of the oxygen he received. On 5/18/26 at 1015 hours, an observation and concurrent interview for Resident 74 was conducted with LVN 3. LVN 3 verified Resident 74 was receiving continuous oxygen via an oxygen concentrator and nasal cannula at a rate of three LPM throughout the day shift; however, the physician's order showed continuous oxygen was to be administered via nasal cannula at a rate of two LPM. LVN 3 stated she would contact Resident 74's physician to clarify the order. Cross reference F656

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure the appropriate hemodialysis care was provided for two of four final sampled residents (Residents 29 and 60) reviewed for dialysis services. * The facility failed to ensure Resident 29's hemodialysis communication records were complete and accurate; and failed to ensure the accurate documentation of bruit (a turbulent whooshing sound heard with a stethoscope over a blood vessel) and thrill (the palpable vibration felt with your fingers in the same location). * The facility failed to ensure Resident 60's fluid intake was monitored per physician's order, and the dialysis access site was consistently and accurately assessed as ordered by the physician. These failures had the potential for the residents to not receive the appropriate hemodialysis care and treatment and could negatively affect the residents' well-being. Findings: Review of the facility's P&P titled Dialysis Services revised 11/2017 showed it is the policy of the facility that each resident receives care and services for the provision of hemodialysis consistent with professional standards of practice including: - the ongoing assessment of the residents condition and monitoring for complications before and after dialysis treatments received at a certified dialysis facility; - ongoing assessment and oversight of the resident before, and after dialysis treatments, including monitoring the resident's condition during treatments, monitoring for complications, implementing appropriate interventions, and using appropriate infection control practices; and - ongoing communication and collaboration with the dialysis facility regarding dialysis care and services. 1. On 5/18/26 at 1250 hours, Resident 29 was observed sitting in the wheelchair with an AV shunt noted in Resident 29's left arm. Resident 29 stated he received hemodialysis treatment every Tuesdays, Thursdays, and Saturdays. Medical record review for Resident 29 was initiated on 5/18/26. Resident 29 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 29's H&P examination dated 4/28/26, showed Resident 29 had the diagnosis of End Stage Renal Disease (ESRD, when the kidneys no longer function well enough to meet a body's needs, treatment involves kidney dialysis or kidney transplant), was on dialysis, and Resident 29 had the capacity to understand and make decisions. Review of Resident 29's Order Summary Report showed the following physician's orders: - dated 4/27/26, for Resident 29's AV fistula shunt (surgically created connection between and artery and vein for hemodialysis) on the left upper arm, to monitor for the presence of bruit (auscultation) and thrill (palpation of vibration) every shift. To document if bruit and thrill is present (+) or absent (-); and to notify the physician if unable to auscultate or palpate, (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- dated 4/29/26, for Resident 29's hemodialysis treatments every Tuesday, Thursdays, and Saturdays with Dialysis Center A. The chair time: 0900 to 1230 hours, and - dated 5/6/26, for Resident 29's pre and post dialysis weights to be obtained while at the dialysis center. a. Review of Resident 29's Hemodialysis Communication Records showed the following missing and/or inaccurate documentation: - dated 4/8/26, the dialysis access was in the right arm, and the assessment of the dialysis access site was blank; - dated 4/9/26, the post-dialysis weight was not documented; - dated 4/11/26, the post-dialysis weight was not documented, the dialysis access was in the right arm, and the assessment of the dialysis access site was blank; - dated 4/14/26, the assessment for the dialysis access site and for the presence of bruit and thrill were blank; - dated 4/16/26, the thrill was documented as absent; - dated 4/28/26, the assessment for the dialysis access site was blank; - dated 5/9/26, the assessment for the dialysis access site and for the presence of bruit and thrill were blank; - dated 5/14/26, the resident's name was not documented, and the dialysis access- type, location, site assessment, presence of bruit and thrill were blank; - dated 5/16/26, the post dialysis weight and vital signs: temperature, pulse, respirations, BP, and pain, were not documented, and the assessment of the dialysis access site and the dialysis nurse's signature were blank. b. Review of Resident 29's MAR for May 2026 showed the following documentation for the assessment of Resident 29's AV fistula. - on 5/4, 5/5, and 5/11/26, for the day shift, the licensed nurse documented - for the presence of thrill, - on 5/11/26, for the evening shift, the licensed nurse documented - for the presence of thrill, and - on 5/18/26, during the night shift, the licensed nurse documented - for the presence of bruit and thrill. Review of Resident 29's medical record failed to show any documentation the physician was notified of the absence of bruit and thrill for the above dates. On 5/19/26 at 1539 hours, an interview and concurrent medical record review for Resident 29 was (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 60's care plan report showed a care plan focus dated 6/14/25, addressing Resident 60's hemodialysis treatment and access site location to right upper extremity AVF. Interventions showed to check AVF dressing upon return from dialysis. Monitor AVF for bleeding, drainage, excessive warmth, pain, redness, numbness in fingers, tenderness, or swelling every shift. Report abnormalities to the physician. Monitor for the presence of bruit and thrill every shift. Further review of Resident 60's care plan report showed a care plan focus addressing Resident 60's fluid restriction, dated 11/5/24; however, interventions failed to show to monitor Resident 60's intake and output. Further review of Resident 60's medical record failed to show the fluid intake for Resident 60 was monitored and documented. Review of the Hemodialysis Communication Records for March, April, and May 2026 showed the following: - On 3/7/26, the dialysis access site assessment/ observation was left blank, it was assessed for bruit marked as both present and absent and thrill was left blank. - On 3/21/26, the dialysis access site assessment/ observation was left blank, it was assessed for bruit marked as both present and absent and thrill was left blank. - On 4/4/26, the dialysis access site assessment/ observation was left blank, it was assessed for bruit marked as both present and absent and thrill was left blank. - On 4/11/26, the dialysis access site assessment/ observation was left blank and bruit was left blank. - On 4/18/26, the dialysis access site location was documented as the left arm and the dialysis access site assessment/ observation was left blank, bruit was left blank and it was assessed for thrill marked as both present and absent. - On 4/25/26, the dialysis access site assessment/ observation was left blank and marked as N/A. - On 5/2/26, the dialysis access site assessment/ observation was left blank. - On 5/9/26, the thrill was assessed and marked as both present and absent. - On 5/14/26, the thrill was left blank. On 5/20/26 at 1402 hours, an interview and concurrent medical record review for Resident 60 was conducted with RN 4. RN 4 verified the above findings and stated the purpose of the dialysis communication records was to provide updates on the resident's condition, pre and post dialysis, therefore the dialysis communication form should have been completed accurately. In addition, RN 4 verified the fluid intakes for Resident 60 were not recorded and stated it was informational for staff to (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, medical record review, facility document review, and facility's P&P review, the facility failed to ensure the Consultant Pharmacist's recommendation were acted upon for four of five residents (Residents 3, 4, 7, and 60) reviewed for unnecessary medications. * The facility failed to ensure the Consultant Pharmacist's recommendations for March 2026 were followed up for Resident 3's use of the metoclopramide (anti-nausea), pantoprazole, and sucralfate (medication to treat and prevent gastrointestinal ulcers) medications. * The facility failed to ensure the Consultant Pharmacist's recommendations for March 2026 were followed up for Resident 4's use of Lovenox (anticoagulant) and Prednisone (medication used to rapidly reduce inflammation and suppress an overactive immune system) medications. * The facility failed to ensure Resident 7's pantoprazole (medication that reduces the amount of acid produced in the stomach) medication recommendation to lower the frequency from twice a day to everyday was followed up with the physician. * The facility failed to ensure the Consultant Pharmacist's recommendations for February 2026 for phenobarbital (medication to control certain types of seizures, anxiety, and manage withdrawal symptoms from other sedative medications) level was acted upon promptly for Resident 60. These failures had the potential to put residents at risk for adverse consequences related to the medications. Findings: Review of the facility's P&P titled Medication Regimen Reviews (undated) showed a licensed pharmacist reviews the medication regimen of each resident at least monthly. The purpose of the medication regimen review is to promote positive outcomes while minimizing adverse consequences and potential risks associated with medication. The medication regimen review includes a review of medical records to prevent, identify, report, and resolve medication-related problems, medication errors, or other irregularities, for example, the use of medication. a. inconsistent with accepted pharmaceutical services, standard of practice; b. not supported by medical evidence; c. that impeded or interfere with achieving the intended outcomes of pharmaceutical services; d. ordered without clinical indication or in excessive dose e. administered without adequate monitoring or in the presence of adverse consequences; and/or f. that appears to be inconsistent with the resident stated preference 1. Medical record review for Resident 7 was initiated on 5/18/26. Resident 7 was admitted to the facility on [DATE], and readmitted to the facility on [DATE]. Review of Resident 7's MDS quarterly assessment dated [DATE], showed a BIMS score of 13 (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	(meaning cognitively intact). Review of Resident 7's Order Summary Report showed the following physician's order dated 12/27/25, to give pantoprazole 40 mg one tablet by mouth two times a day (30 to 60 minutes before meals) for gastrointestinal protection. Review of the Consultant Pharmacist's Medication Regimen Review between 2/2 to 2/5 and 3/13 to 3/15/26, showed a documentation Resident 7 was taking pantoprazole 40 mg twice a day, typically a proton-pump inhibitor is given once -daily. There was a recommendation for a possible duration of therapy for the twice a day dose and to consider a reduction for once daily. On 5/20/26 at 1415 hours, an interview and concurrent medical record review for Resident 7 was conducted with the ADON. The ADON verified the 2/2026 and 3/2026 Consultant Pharmacist's Medication Regimen Review for Resident 7 was not followed up with the resident's physician. The ADON further stated that when they received the Medication Regimen Review from the Consultant Pharmacist, they needed to follow up with the physician as soon as possible before the next Medication Regimen Review. On 5/21/26 at 1334 hours, an interview and concurrent medical record review for Resident 7 was conducted with the DON. The DON verified Resident 7's Medication Regimen Review recommendation was not follow up with the resident's physician. On 5/21/26 at 1403 hours, an interview was conducted with the Administrator, ADON, and DON. The Administrator, ADON, and DON were informed and acknowledged the above findings. 2. Medical record review for Resident 3 was initiated on 5/18/26. Resident 3 was admitted to the facility on [DATE]. Review of Resident 3's MDS assessment dated [DATE], showed Resident 3 had moderately impaired cognition. Review of Resident 3's Order Summary Report dated 5/21/26, showed the following physician's orders: - dated 1/23/26, to administer metoclopramide 5 mg one tablet by mouth before meals for gastroesophageal reflux disease (GERD, a condition where stomach contents frequently flow back into the esophagus, causing irritation and symptoms like heartburn), - dated 1/23/26, to administer pantoprazole delayed release 40 mg one tablet by mouth two times a day for GERD, and - dated 1/23/26, to administer sucralfate 1 gm/10 ml give 10 ml before meals and at bedtime for GERD. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Consultant Pharmacist's Medication Regimen Review between 3/13 to 3/15/26, showed the following recommendations for Resident 3: - The usual maintenance does of Carafate (brand name for sucralfate) was 1 gm two times a day. Resident 3 was currently on Carafate 1 gm four times a day. Is a dose reduction to 1 gm two times a day clinically warranted? - Resident 3 has orders for both pantoprazole and metoclopramide for GERD. Would it be possible to discontinue one of these orders, as the combination may be considered duplicate therapy? On 5/21/26 at 0954 hours, an interview and concurrent medical record review for Resident 3 was conducted with RN 4. RN 4 stated the Consultant Pharmacist reviewed each resident's medication regimen monthly and made recommendations. RN 4 stated the desk nurses or the RN Supervisors were responsible for following up with the recommendations as soon as possible. RN 4 stated if there were no response from the physician, the desk nurse or RN Supervisors should continue to contact the physician until a response was obtained and should document the attempts. RN 4 reviewed Resident 3's medical record and verified the above findings. RN 4 stated he was unable to find the documentation to show the recommendations were followed up or the physician's response to the recommendations. On 5/21/26 at 1420 hours, an interview was conducted with the DON. The DON stated the recommendations from the Consultant Pharmacist should be communicated to the physician and followed-up on as soon as possible. The DON further stated if there was no response from the physician, the facility should continue to follow-up with the physician and document the physician was made aware and any response from the physician. On 5/21/26 at 1515 hours, an interview was conducted with the Administrator, ADON, and DON. The Administrator, ADON, and DON were informed and acknowledged the above findings. 3. Review of Resident 4's medical record was initiated on 5/18/26. Resident 4 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 4's untitled MDS assessment dated [DATE], showed Resident 4 had a BIMS of 5 (0-7 severely impaired cognition). Review of Resident 4's Order Summary Report for 5/2026 showed the following physician's order dated 3/6/26, for enoxaparin sodium (generic name for Lovenox) injection prefilled syringe kit 40 mg/ 0.4 ml, inject 0.4 ml subcutaneously daily for DVT prophylaxis, rotate site of injection; and prednisone oral tablet 10 mg give one tablet by mouth daily for inflammation. Review of the Consultant Pharmacist's Medication Regimen Review between 3/13 to 3/15/26, showed the following recommendations for Resident 4: - Can we obtain a duration of therapy for Lovenox. This class of medication only has FDA-approved (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	indications for DVT prophylaxis from 7-35 days, or until the risk of DVT has been significantly reduced. - Please clarify the indication for the prednisone as inflammation may be considered too vague. On 5/21/26 at 0954 hours, an interview and concurrent medical record review for Resident 4 was conducted with RN 4. RN 4 stated the Consultant Pharmacist reviewed each resident's medication regimen monthly and made recommendations. RN 4 stated the desk nurses or the RN Supervisors were responsible for following up with the recommendations as soon as possible. RN 4 stated if there were no response from the physician, the desk nurse or RN Supervisors should continue to contact the physician until a response was obtained and should document the attempts. RN 4 reviewed Resident 4's medical records and verified the above findings. RN 4 stated he was unable to find the documentation to show the recommendations were followed up or the physician's response to the recommendations. On 5/21/26 at 1124 hours, an interview and concurrent medical record review for Resident 4 was conducted with the ADON. The ADON verified the above findings and stated the pharmacist came to the facility once a month and pharmacy recommendations were acted upon as soon as possible. The ADON verified Resident 4's medical record failed to show any documentation to show the pharmacy recommendations were addressed. On 5/21/26 at 1536 hours, an interview was conducted with the DON. The DON was informed and acknowledged the above findings. 4. Medical record review for Resident 60 was initiated on 5/18/26. Resident 60 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 60's Quarterly MDS assessment dated [DATE], showed Resident 60 had a BIMS of 13 (8-12 moderately impaired cognition). Review of Resident 60's Order Summary Report dated 5/2026 showed a physician's order dated 10/9/22, for phenobarbital tablet 64.8 mg, give one tablet by mouth two times a day for seizures. Review of the Consultant Pharmacist's Medication Regimen Review between 2/2 to 2/5/26, showed the following recommendation for Resident 60: - To comply with CMS regulations which require monitoring of drug-related lab work, please ask the doctor if we can obtain an order for the following lab work for monitoring purposes: phenobarbital recheck. Under recommendation status showed, pending and sent to NP/ MD on 5/17/26 at 1048 hours. On 5/21/26 at 0954 hours, an interview and concurrent medical record review for Resident 60 was conducted with RN 4. RN 4 stated the Consultant Pharmacist reviewed each resident's medication regimen monthly and made recommendations. RN 4 stated the desk nurses or the RN Supervisors were responsible for following up with the recommendations as soon as possible. RN 4 stated if there were no response from the physician, the desk nurse or RN Supervisors should continue to contact the physician until a response was obtained and should document the attempts. RN 4 reviewed Resident 60's medical records and verified the above findings. RN 4 stated he was unable to find the documentation to show the recommendation was followed up or the physician's response to the (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	recommendation sooner. On 5/21/26 at 1108 hours, an interview and concurrent medical record review for Resident 60 was conducted with the ADON. The ADON verified the above findings and stated the pharmacist came once a month and pharmacy recommendations were acted upon as soon as possible. The ADON verified Resident 60's medical records failed to show any documentation to show the pharmacy recommendation was addressed sooner and stated if the lab was not monitored, it can potentially lead for Resident 60 to have a seizure. On 5/21/26 at 1536 hours, and interview was conducted with the DON. The DON was informed and acknowledged the above findings.

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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, facility document review, and facility P&P review, the facility failed to ensure the sanitary requirements were met in the kitchen. * The facility failed to maintain the hood over the stove in a clean and sanitary condition. * The facility failed to ensure the kitchen utensils had smooth, cleanable surfaces and were maintained in good repair. * The facility failed to ensure the kitchenware and kitchen utensils were clean and free of food particles or residue. * The facility failed to ensure the cutting boards were maintained in sanitary condition and had smooth, cleanable surfaces. * The facility failed to ensure the heavy-duty blender, and the clear plastic rectangular food-storage containers were air dried prior to storage. These failures had the potential to cause cross contamination and foodborne illness to the residents consuming the food prepared in the kitchen.Findings: Review of the facility's Diet Type Report dated 5/18/26, showed 115 of 121 residents consumed the food prepared in the kitchen. 1. Review of the facility's P&P titled Hood, Vents and Filters dated 2018 showed the hoods must be cleaned every two weeks and must be free of dust and grease. According to the USDA Food Code 2022 Section 4-204.11 Ventilation Hood Systems, Drip Prevention the dripping of grease or condensation onto food constitutes adulteration and may involve contamination of the food with pathogenic organisms. Equipment, utensils, linens, and single service and single use articles that are subjected to such drippage are no longer clean. On 5/18/26 at 0619 hours, during the initial kitchen tour, an observation and concurrent interview was conducted with the DSS. The kitchen hood over the stove had black, dirty, grease residue. The DSS acknowledged the findings and stated the dietary staff cleaned the hood once a week on Thursdays and the hood was also cleaned by an outside company every six months. The sticker on the hood showed it was last serviced on 2/19/26. 2. Review of the facility's P&P titled Sanitization revised date 11/2022 showed all utensils, counters, shelves, and equipment are kept clean, maintained in good repair and are free from breaks, corrosions, open seams, cracks, and chipped areas that may affect their use or proper cleaning. Plastic ware, China, and glassware that cannot be sanitized or are hazardous because of chips, cracks or loss of glaze are discarded. Damaged or broken equipment that cannot be repaired is discarded. According to the USDA Food Code 2022 Section 4-502.11 Good Repair and Calibration, (A) Utensils shall be maintained in a state of repair and condition that complies with the requirements specified under Parts 4-1 and 4-2 or shall be discarded. According to the USDA Food Code 2022, Section 4-101.11, Multiuse, Characteristics, materials that are used in the construction of utensils and food contact surfaces of equipment may not allow the migration of deleterious substances or impart colors, odors, or tastes to food and under normal use conditions shall be durable, corrosion-resistant, nonabsorbent, finished to have a smooth, easily cleanable surface, and resistant to pitting, chipping, crazing, scratching, scoring, distortion, and decomposition. On 5/18/26 at 0619 hours, during the initial kitchen tour, an observation and concurrent interview was conducted with the DSS. The following was observed: - One stainless steel slotted spatula with black handle was partially melted. - One stainless steel scoop with blue handle partially chipped and broken. - One rubber spatula with red handle had chipped and cracked edges. - One stainless steel dough cutter with black handle partially melted. The DSS verified the above findings and stated all kitchen utensils and equipment should have been discarded and replaced. 3. Review of the facility's P&P titled Dishwashing dated 2018 showed all the dishes will be properly sanitized through the dishwasher. Gross food particles shall be removed by careful scraping and pre-rinsing in running water. Dishes are to be racked loosely without overlapping. According to the USDA Food Code 2022, 4-601.11 Equipment, Food - Contact Surfaces, Nonfood Contact Surface, and Utensils, the equipment food-contact surfaces and utensils shall be clean to sight and touch, the food-contact surfaces of cooking equipment and pans shall be kept free of encrusted grease deposits and other soil accumulations; and the nonfood- contact surface of equipment shall be kept free of an accumulation (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	of dust, dirt, food residue, and other debris. According to the USDA Food Code 2022, 4-602.13, Nonfood- Contact Surfaces, nonfood-contact surfaces of equipment shall be cleaned at a frequency necessary to preclude accumulation of soil residues. On 5/18/26 at 0619 hours, during the initial kitchen tour, an observation and concurrent interview was conducted with the DSS. The following was observed: - Three stainless steel spatulas with white handles had fuzzy films and watermarks. - One stainless steel scoop with white handle had fuzzy films. - Three stainless steel scoops had dry, crusted residue and fuzzy films. - One stainless steel slotted spatula with black handle had dry crusted residue and fuzzy films. - One stainless steel slotted spoon with black handle had watermarks and fuzzy films. - Three stainless steel scoops with blue handles had dry, crusted residue and fuzzy films. - Three stainless steel scoops with gray handles had dry crusted residue and fuzzy films. - Three stainless steel scoops with white handles had dry crusted residue and fuzzy films. - One stainless steel scoop with black handle had dry crusted residue and fuzzy films. The DSS verified the above findings and stated all kitchen utensils and equipment should have been washed properly for infection control purposes. 4. Review of the facility's P&P titled Sanitization date revised 11/2022 showed cutting boards are washed and sanitized between uses. Damaged or broken equipment that cannot be repaired is discarded. According to the USDA Food Code 2022 Section 4-501.12, Cutting Surfaces, for surfaces such as cutting boards and blocks that become scratched and scored may be difficult to clean and sanitize. As a result, pathogenic microorganisms transmissible through food may build up or accumulate. These microorganisms may be transferred to the foods that are prepared on such surfaces. On 5/18/26 at 0619 hours, during the initial kitchen tour, an observation and concurrent interview was conducted with the DSS. Green, yellow, blue, red, brown and white cutting boards were observed fuzzy, heavily marred and had deep groves. The DSS verified the findings and stated cutting boards were replaced every three months. 5. Review of the facility's P&P titled Sanitization date revised 11/2022 showed the food preparation equipment and utensils that are manually washed are allowed to air dry whenever practical. Drying food preparation equipment and utensils with a towel or cloth may increase risks for cross contamination. According to the USDA Food Code 2022, 4-901.11, Equipment and Utensils, Air-Drying Required, that after cleaning and sanitizing, equipment, and utensils shall be air-dried or used after adequate draining before getting in contact with food. According to the USDA Food Code 2022, 4-903.11 Equipment, Utensils, Linens, and Single-Service and Single-Use Articles, cleaned equipment and utensils shall be stored in a self-draining position that allows air drying. On 5/18/26 at 0619 hours, during the initial kitchen tour, an observation and concurrent interview was conducted with the DSS. The following was observed: - One heavy-duty blender stored on the metal rack shelf was observed still wet with visible water inside. - Five rectangular clear bucket containers used for food storage were observed wet with visible water inside and stacked on top of each other. The DSS verified the above findings and stated all kitchen utensils and equipment should have been air dried to prevent bacteria growth. On 5/21/26 at 1536 hours, an interview was conducted with the DON and ADON. The DON and ADON were informed and acknowledged the above findings.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure the medical record for five of 27 final sampled residents (Resident 4, 7, 29, 60, and 73) were complete and accurately documented. * Resident 4's POLST showed she had no advance directive; however, Resident 4's medical record showed she had an advance directive and a copy of the advance directive was in her medical record. * The facility failed to ensure Resident 7's blood pressure access site was accurately documented in the resident's medical record with right upper arm AV site. * The facility failed to ensure accurate documentation in the medical record for Resident 29. Resident 29 had the hemodialysis access on the left arm; however the documentation showed Resident 29's blood pressures were obtained in the left arm. * The facility failed to ensure Resident 60's blood pressure access site was accurately documented in the resident's medical record with right upper arm AVF site. * The facility failed to ensure Resident 73 's blood pressure access site was accurately documented in the medical record with left upper arm AV site. These failures had the potential for the residents' care needs not being met as their medical information were inaccurate and incomplete. Findings: Review of the facility's P&P titled End-Stage Renal Disease, Care of a Resident with, revised 1/2026 showed residents with end stage renal disease (ESRD) will be cared for according to currently recognized standards of care. Education and training of staff include, specifically: g. the care of grafts and fistula 1. Medical record review for Resident 7 was initiated on 5/18/26. Resident 7 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 7's MDS quarterly assessment dated [DATE], showed Resident 7 had a BIMS score of 13 (meaning cognitively intact). Review of Resident 7's Order Summary Report showed a physician's order dated 4/13/25, to avoid taking blood pressure, performing venipuncture, giving injections, strenuous activity, or applying restrictive clothing or restraint on the right upper extremity AV site. Review of Resident 7's Weights and Vitals Summary documentation of blood pressure for April and May 2026 showed the following: - On 4/30/26 at 0530 hours, a BP reading of 126/80 mmHg on the right arm; - On 4/30/26 at 0737 hours, a BP reading of 126/80 mmHg on the right arm; - On 5/5/26 at 1240 hours, a BP reading of 137/78 mmHg on the right arm; - On 5/10/26 at 0904 hours, a BP reading of 120/66 mmHg on the right arm; - On 5/10/26 at 0906 hours, a BP reading of 120/66 mmHg on the right arm; and (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- On 5/18/26 at 1613 hours, a BP reading of 137/71 mmHg on the right arm; On 5/18/26 at 0717 hours, during the initial tour of the facility, Resident 7 was observed awake, lying on the bed with a right upper arm AV shunt. Resident 7 stated he went to dialysis every Tuesday, Thursday, and Saturday. On 5/20/26 at 0816 hours, an interview was conducted with Resident 7. Resident 7 stated he never allowed the licensed nurses to take his BP on the right upper arm. On 5/20/26 at 1426 hours, an interview and concurrent medical record review for Resident 7 was conducted with LVN 1. LVN 1 verified the documentation for the blood pressure reading was on the right upper arm. LVN 1 further stated taking blood pressure on the access site increased the resident risk for infection and blood clot to the left AV shunt. 2. Medical record review for Resident 73 was initiated on 5/18/26. Resident 73 was admitted to the facility on [DATE]. Review of Resident 73's H&P examination dated 4/1/26, showed Resident 73 had the capacity to understand and make medical decisions. Review of Resident 73's Order Summary Report showed a physician's order dated 5/1/26, to avoid taking blood pressure, performing venipuncture, giving injections, strenuous activity, or applying restrictive clothing or restraint on the left upper extremity AV site. Review of Resident 73's Weights and Vitals Summary documentation of blood pressure for May 2026 showed the following: - On 5/5/26 at 1637 hours, a BP reading of 140/76 mmHg on the left arm; - On 5/6/26 at 0950 hours, a BP reading of 131/67 mmHg on the left arm; - On 5/8/26 at 1431 hours, a BP reading of 103/61 mmHg on the left arm; - On 5/13/26 at 0135 hours, a BP reading of 133/73 mmHg on the left arm; - On 5/15/26 at 1430 hours, a BP reading of 143/65 mmHg on the left arm; - On 5/16/26 at 0939 hours, a BP reading of 152/74 mmHg on the left arm;; - On 5/17/26 at 1441 hours, a BP reading of 147/70 mmHg on the left arm; and - On 5/18/26 at 0931 hours, a BP reading of 137/61 mmHg on the left arm; On 5/18/26 at 0659 hours, during the initial tour of the facility, Resident 73 was observed awake, lying on the bed, with Nepro (a specialized, high-calorie, and protein-dense enteral feeding designed specifically for residents with chronic kidney disease on dialysis) at 50 ml/hr running via enteral pump. Resident 73 stated he went to dialysis every Monday, Wednesday, and Friday, with AV site to (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the left upper arm. On 5/19/26 at 1437 hours, an interview and concurrent medical record review for Resident 73 was conducted with LVN 1. LVN 1 verified the documentation for the blood pressure reading was on the left upper arm. LVN 1 further stated taking blood pressure on the access site increased the resident risk for infection and blood clot to the left AV shunt. On 5/20/26 at 0828 hours, an interview was conducted with Resident 73. Resident 73 stated he never allowed the licensed nurses to take his BP on the left upper arm. On 5/21/26 at 1334 hours, an interview was conducted with the DON. The DON verified the above findings and stated she expected the licensed nurses to follow the MD orders to avoid taking blood pressure on the AV site of the residents who went to dialysis. The DON further stated the pressure from the blood pressure cuff will cause the AV site to clot and burst. On 5/21/26 at 1403 hours, an interview was conducted with the Administrator, ADON, and DON. The Administrator, ADON, and DON were informed and acknowledged the above findings. 3. Review of the facility's P&P titled Charting and Documentation revised 1/2026 showed all services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional or psychosocial condition, shall be documented in the resident's medical record. The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care. Documentation in the medical record may be electronic, manual, or a combination. Documentation in the medical record will be objective (not opinionated or speculative), complete, and accurate. Medical record review for Resident 60 was initiated on 5/18/26. Resident 60 was admitted to the facility on [DATE], and readmitted on [DATE]. Resident 60 had a diagnosis of ESRD which required hemodialysis. Review of Resident 60's Quarterly MDS assessment dated [DATE], showed Resident 60 had a BIMS score of 13 (8-12 moderately impaired cognition). Review of Resident 60's Order Summary Report dated 5/2026 showed a physician's order dated 10/10/22, to not take blood pressure, venipuncture, give injections, apply restraints, or restrictive clothing to right upper extremity AV site. Review of the care plan report showed a care plan focus dated 6/14/25, addressing Resident 60's hemodialysis treatment and access site location to right upper extremity AVF. The care plan interventions showed to avoid taking blood pressure, performing venipuncture, giving injections, strenuous activity, or applying restrictive clothing, or restraints on the right upper extremity AV site. Review of Resident 60's Weights and Vitals Summary documentation of blood pressure for March, April, and May 2026 showed the following: - On 3/13/26 at 0829 hours, a BP reading of 112/51 mmHg on the right arm; (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- On 3/16/26 at 0846 hours, a BP reading of 140/66 mmHg on the right arm; - On 3/22/26 at 1557 hours, a BP reading of 137/71 mmHg on the right arm; - On 3/31/26 at 0838 hours, a BP reading of 144/70 mmHg on the right arm; - On 4/29/26 at 1606 hours, a BP reading of 137/65 mmHg on the right arm; - On 4/30/26 at 1632 hours, a BP reading of 127/63 mmHg on the right arm; - On 5/3/26 at 2019 hours, a BP reading of 141/72 mmHg on the right arm; - On 5/3/26 at 0843 hours, a BP reading of 137/72 mmHg on the right arm; - On 5/5/26 at 1642 hours, a BP reading of 139/78 mmHg on the right arm; - On 5/8/26 at 0824 hours, a BP reading of 123/60 mmHg on the right arm; - On 5/12/26 at 1616 hours, a BP reading of 145/73 mmHg on the right arm; and - On 5/17/26 at 1611 hours, a BP reading of 130/57 mmHg on the right arm On 5/21/26 at 0945 hours, an interview and concurrent medical record review for Resident 60 was conducted with RN 4. RN 4 verified the above findings and stated the staff should not check Resident 60's blood pressure on his right upper extremity and should have been documented accurately for the correct arm used for blood pressure check. On 5/21/26 at 1536 hours, an interview was conducted with the DON and ADON. The DON and ADON were informed and acknowledged the above findings. 4. Review of the facility's P&P titled Advance Directives revised 1/2026 showed prior to or upon admission of a resident, the social services director or designee inquires of the resident, their family members and/or their legal representative, about existence of any written advance directives. If the resident or the resident's representative has executed one or more advance directive(s), or executes one upon admission, copies of these documents are obtained and maintained in the same section of the resident's medical record and are readily retrievable by any facility staff. Review of Resident 4's medical record was initiated on 5/18/26. Resident 4 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 4's untitled MDS assessment dated [DATE], showed Resident 4 had a BIMS score of 5 (0-7 severely impaired cognition). Review of Resident 4's POLST dated 4/27/26, showed under Section D, Resident 4 had no advance directive. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Further review of Resident 4's medical record showed Resident 4 had formulated an advance directive and a copy of an advance directive was in Resident 4's medical record dated 5/8/25. On 5/21/26 at 1355 hours, an interview and concurrent medical record review for Resident 4 was conducted with the SSD. The SSD acknowledged the above findings and stated the POLST will be revised to reflect Resident 4 had an advance directive to avoid confusion. On 5/21/26 at 1536 hours, an interview was conducted with the DON and ADON. The DON and ADON were informed and acknowledged the above findings. 5. On 5/18/26 at 1250 hours, Resident 29 was observed sitting in the wheelchair and eating his lunch. Resident 29 was observed with a hemodialysis access in the left arm. Resident 29 stated he received hemodialysis treatments every Tuesday, Thursday, and Saturday. When asked, Resident 29 denied the staff taking blood pressures on his left arm. Medical record review for Resident 29 was initiated on 5/18/26. Resident 29 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 29's H&P examination dated 4/28/26, showed Resident 29 had the capacity to understand and make decisions. Review of Resident 29's Order Summary Report dated 5/18/26, showed a physician's order dated 5/6/26, to avoid taking blood pressure, performing venipuncture, giving injections, strenuous activity, or applying restrictive clothing or restraint on the left arm extremity arteriovenous (AV) site. Review of Resident 29's Weights and Vitals Summary from 5/1 to 5/19/26, showed the following documentation for the blood pressure readings: - On 5/1/26 at 0623 hours, a BP reading of 120/76 mmHg on the left arm; - On 5/1/26 at 1456 hours, a BP reading of 93/43 mmHg on the left arm; - On 5/1/26 at 2021 hours, a BP reading of 135/78 mmHg on the left arm; - On 5/2/26 at 0638 hours, a BP reading of 127/74 mmHg on the left arm; - On 5/2/26 at 2045 hours, a BP reading of 115/74 mmHg on the left arm; - On 5/3/26 at 2101 hours, a BP reading of 101/82 mmHg on the left arm; - On 5/4/26 at 0556 hours, a BP reading of 120/66 mmHg on the left arm; - On 5/4/26 at 1300 hours, a BP reading of 122/64 mmHg on the left arm; - On 5/5/26 at 0641 hours, a BP reading of 136/70 mmHg on the left arm; - On 5/5/26 at 2143 hours, a BP reading of 123/77 mmHg on the left arm; (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- On 5/7/26 at 2304 hours, a BP reading of 101/71 mmHg on the left arm; - On 5/8/26 at 0641 hours, a BP reading of 120/62 mmHg on the left arm; - On 5/9/26 at 2112 hours, a BP reading of 106/73 mmHg on the left arm; - On 5/10/26 at 1145 hours, a BP reading of 101/75 mmHg on the left arm; - On 5/10/26 at 1845 hours, a BP reading of 115/79 mmHg on the left arm; - On 5/10/26 at 2100 hours, a BP reading of 112/76 mmHg on the left arm; - On 5/11/26 at 0555 hours, a BP reading of 122/65 mmHg on the left arm; - On 5/11/26 at 2113 hours, a BP reading of 116/72 mmHg on the left arm; - On 5/12/26 at 2044 hours, a BP reading of 102/71 mmHg on the left arm; - On 5/12/26 at 2259 hours, a BP reading of 120/75 mmHg on the left arm; - On 5/13/26 at 1437 hours, a BP reading of 108/75 mmHg on the left arm; - On 5/13/26 at 2242 hours, a BP reading of 140/117 mmHg on the left arm; - On 5/14/26 at 2138 hours, a BP reading of 116/79 mmHg on the left arm; - On 5/15/26 at 0613 hours, a BP reading of 120/70 mmHg on the left arm; - On 5/18/26 at 0539 hours, a BP reading of 110/66 mmHg on the left arm; and - On 5/19/26 at 0621 hours, a BP reading of 137/97 mmHg on the left arm. On 5/19/26 at 1539 hours, an interview and concurrent medical record review for Resident 29 was conducted with LVN 6. LVN 6 stated Resident 29 had a hemodialysis access in the left arm and the left arm was not used to obtain BP readings. LVN 6 reviewed Resident 29's medical record and verified the above findings. On 5/21/26 at 1515 hours, an interview was conducted with the Administrator, ADON, and DON. The Administrator, ADON, and DON were informed and acknowledged the above findings.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on interview, facility document review, and facility P&P review, the facility failed to implement their infection control surveillance program in accordance with the facility's P&P. * The facility failed to implement their infection control surveillance program for May 2025 through March 2026. The facility conducted surveillance of resident infections based on whether residents were prescribed antimicrobial medications. The facility failed to determine whether the residents who exhibited signs and/or symptoms of infections, and were not prescribed antimicrobial medications, met the facility's criteria for infection (McGeer's Criteria) and thus, failed to include these residents in the facility's infection control surveillance program. These failures posed the risk for not identifying resident infections and controlling the potential transmission of communicable diseases to other residents, staff, and visitors throughout the facility.Findings: Review of the facility's P&P titled Infection Prevention and Control Program (IPCP) dated 1/2026 showed an infection prevention and control program is established and maintained to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. Outcome surveillance (incidence and prevalence of HAIs) is used as a measure of the IPCPs effectiveness. Surveillance tools are used for recognizing the occurrence of infections, recording their number and frequency, detecting outbreaks and epidemics, monitoring adherence to infection prevention and control practices, and detecting unusual pathogens with infection control implications. The information obtained from infection control surveillance activities is compared with that from other facilities with acknowledged standards and used to assess the effectiveness of established infection prevention and control practices. Standard criteria are used to distinguish CAIs from HAIs. On 5/20/26 at 1005 hours, an interview, facility P&P review, and concurrent facility document review was conducted with the IP. The IP was asked to explain the facility's infection surveillance program. The IP stated when a resident exhibited signs and/or symptoms of infection and was prescribed an antimicrobial medication, the facility would then determine if the resident had met the McGeer's Criteria. The IP stated this information was documented on the facility's monthly Infection Prevention and Control Surveillance Log from 5/2025 to 3/2026. The IP stated in accordance with the facility's Infection Prevention and Control Program P&P, the facility's Infection Surveillance program outcome surveillance included the incidence and prevalence of HAIs, and infection surveillance was used as a measurement of the IPCP's effectiveness. The surveillance tools were utilized by the facility to recognize the occurrence of infections, record their number and frequency, detect outbreaks and epidemics, monitor adherence to infection prevention and control practices, and detect unusual pathogens with infection control implications. Review of the facility's monthly Infection Prevention and Control Surveillance Logs from May 2025 through March 2026 showed the following resident infection surveillance data for HAIs, CAIs, and residents who did not meet McGeer's Criteria (DNMC):- 5/2025: HAI - 54, CAI - 27, and DNMC - 14- 6/2025: HAI - 45, CAI - 17, and DNMC - 19- 7/2025: HAI - 42 , CAI - 26 , and DNMC - 40- 8/2025: HAI - 22, CAI - 10, and DNMC - 25- 9/2025: HAI - 31, CAI - 16, and DNMC - 15- 10/2025: HAI - 18, CAI - 16, and DNMC - 16- 11/2025: HAI -35, CAI -7, and DNMC -12- 12/2025: HAI - 28, CAI - 11, and DNMC - 16- 1/2026: HAI - 30, CAI -26, and DNMC - 22- 2/2026: HAI - 30, CAI - 14, and DNMC - 18- 3/2026: HAI - 33, CAI -17, and DNMC - 14 Further review of the facility's monthly Infection Prevention and Control Surveillance Logs from May 2025 through March 2026 showed documentation all the residents categorized as having an HAI, CAI, or not having met McGeer's Criteria were prescribed antimicrobial medications. There was no documentation showing whether residents who exhibited signs and/or symptoms of infection and were not prescribed an antimicrobial medication, had met McGeer's Criteria. The IP was asked when residents exhibited signs and/or symptoms of an infection and were not prescribed antimicrobial medications, if she determined whether these residents had met the McGeer's Criteria. The IP stated when a resident exhibited signs and/or symptoms of an infection, however was not prescribed antimicrobial (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	medications, the facility did not determine if these residents met McGeer's Criteria. The IP was asked how many residents in the facility from May 2025 through March 2026 who exhibited signs and/or symptoms of infection and were not prescribed antimicrobial medications, met McGeer's Criteria. The IP stated she was uncertain, as the facility did not determine if a resident with signs and/or symptoms of infection met the McGeer's Criteria, unless they were prescribed an antimicrobial medication.

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, document review, and medical record review, the facility failed to ensure the residents or their representatives were informed in advance of the proposed treatment regarding the use of psychotropic medications (medications affecting brain activity) for one of five residents reviewed for unnecessary medications (Resident 3). * The facility failed to ensure the informed consent for the valproic acid (anticonvulsant) medication included the manifested behaviors for Resident 3. This failure had the potential to compromise the resident's right, or the right of the designated representative, to be fully informed regarding the psychotropic medication in order to make an informed decision. Findings: Review of the AFL 25-38.1 titled Notice of Release of Psychotherapeutic Drug Informed Consent Form dated 2/3/26, showed the facilities may use the CDPH (California Department of Public Health) Psychotherapeutic Drug Informed Consent Form or use their own in-house form as long as the in-house form contains all the data elements on the CDPH form. The form must be in use by January 1, 2026, for new residents, residents being prescribed a new psychotherapeutic drug, and residents having a psychotherapeutic drug dosage change. Review of the CDPH 9168 document titled Psychotherapeutic Drug Informed Consent Form dated 12/2025 showed to include the following psychotherapeutic drug information: drug category, drug name, dosage prescribed, frequency, duration, administration method, caution and earning summary, reason for use of the psychotherapeutic drug and benefits, the probable side effects and significant risks associated with the use of the psychotherapeutic drug, and the reasonable alternative mode(s) of treatment or possible non-pharmacological approaches that could address the resident's needs. Medical record review for Resident 3 was initiated on 5/18/26. Resident 3 was admitted to the facility on [DATE]. Review of Resident 3's MDS assessment dated [DATE], showed Resident 3 had moderately impaired cognition. Review of Resident 3's Order Summary Report dated 5/21/26, showed a physician's order dated 1/24/26, to administer valproic acid 250 mg/5 ml, to give 5 ml by mouth two times a day for unspecified mood disorder manifested by sudden mood swings from calm/pleasant to angry/frustrated and for seizure disorder. Review of Resident 3's Psychotherapeutic Drug Informed Consent Form showed for the valproic acid 250 mg/5 ml medication, Resident 3's responsible party was informed on 1/24/26. However, further review of the form failed to show the behavior manifestations for the use of the valproic acid medication. On 5/21/26 at 1000 hours, an interview and concurrent medical record review for Resident 3 was conducted with RN 4. RN 4 verified Resident 3's informed consent for the valproic acid medication did not include the specific manifested behaviors for the use of the medication. On 5/21/26 at 1420 hours, an interview was conducted with the DON. The DON stated for the residents prescribed the psychotropic medications, the informed consent should include the type of medication, name, dose, route, frequency, indications, and manifested behaviors. On 5/21/26 at 1515 hours, an interview was conducted with the Administrator, ADON, and DON. The Administrator, ADON, and DON were informed and acknowledged the above findings.

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure one of one nonsampled resident (Resident 54) was assessed for safe self-administration of medications. * Resident 54 was observed with an Equate nasal spray (medication to relieve allergies) medication at the bedside. This failure had the potential for Resident 54 to administer the medication inaccurately and may negatively impact the health and safety of the resident.Findings: 1. Review of the facility's P&P titled Self-Administration of Medication revised 1/2026 showed the residents have the right to self-administer medications if the interdisciplinary team has determined that it is clinically appropriate and safe for the resident to do so. Self-administered medications are stored in a safe and secure place, which is not accessible by other residents. Review of the facility's P&P titled Administering Medication revised 1/2026 showed the medications are administered in a safe and timely manner and as prescribed. Resident may self-administer their own medications only if the attending physician, in conjunction with the interdisciplinary care planning team, has determined that they have the decision - making capacity to do so safely. Medical record review for Resident 54 was initiated on 5/18/26. Resident 54 was admitted to the facility on [DATE]. On 5/19/26 at 0825 hours, an observation, interview, and concurrent medical record review for Resident 54 was conducted with LVN 3. Resident 54 was observed sitting in a wheelchair, and an Equate nasal spray medication was observed on the resident's overbed table. Resident 54 stated the nasal spray was his medication and he used the medication to be sprayed in his nose. LVN 3 stated Resident 54 should have no medication at the bedside, and other residents can get the medication and can use the medication. LVN 3 verified there was no physician order for the nasal spray and to self-administer medication, no self-administration assessment, and no care plan for the use of nasal spray. Review of Resident 54's H&P examination dated 4/2/26, showed Resident 54 had the capacity to understand and make decisions. Review of Resident 54's Order Summary Report for 5/2026 did not show a physician's order for nasal spray medications. Review of Resident 54's Plan of Care with the printed date of 5/20/26, did not show a care plan problem to address Resident 54's safe self-administration of medications. Further review of Resident 54's medical record failed to show a physician's order to self-administer medications, and there was no documentation of an assessment completed for Resident 54 to safely self-administer medications. On 5/21/26 at 1334 hours, an interview and concurrent medical record review for Resident 54 was conducted with DON. The DON verified Resident 54 had no physician's order, assessment, and care plan for the self-administration of any medications. On 5/21/26 at 1403 hours, an interview was conducted with the Administrator, ADON, and DON. The Administrator, ADON, and DON were informed and acknowledged the above findings.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, medical record review, and facility P&P review, the facility failed to inquire about the existence of an advance directives and failed to inform, provide, and document the written information regarding the rights to formulate the advance directives to one of three final sampled residents (Resident 23) reviewed for Advance Directives. * The facility failed to show evidence that an Advance Directive Acknowledgement was available in Resident 23's medical record. This failure had the potential for the facility to provide treatment and services against the resident's wishes.Findings: Review of the facility's P&P titled Advance Directives date revised 1/2026 showed the resident has the right to formulate an advance directive, including the right to accept or refuse medical or surgical treatment. Advance directives are honored in accordance with state law and facility policy. Prior to or upon admission of a resident, the social services director or designee inquires of the resident, their family members and/or their legal representative, about the existence of any written advance directives. Upon admission, the resident or representative is provided with written information concerning their rights under state law to make decisions concerning medical care, including the right to refuse or accept medical or surgical treatment and to formulate an advance directive if they choose to do so. Written information is provided in a manner easily understood by the resident or representative. Medical record review for Resident 23 was initiated on 5/18/26. Resident 23 was admitted to the facility on [DATE]. Review of Resident 23's Physician Orders for Life Sustaining Treatment (POLST) dated 4/18/26, showed under Section D, Resident 23 had capacity and had no Advance Directive. Review of Resident 23's Resident Centered Social History and Discharge Planning assessment dated [DATE], failed to show documentation if advance directive formulation was offered to Resident 23 and her responsible party. Review of Resident 23's admission MDS assessment dated [DATE], showed Resident 23 had a BIMS (Brief Interview for Mental Status) score of 12 (8-12 suggests moderate cognitive impairment). Further review of Resident 23's medical record failed to show the existence of an Advance Directive Acknowledgment form. On 5/21/26 at 1341 hours, an interview and concurrent medical record review for Resident 23 was conducted with the SSD. The SSD acknowledged the findings and stated POLST was initiated upon admission by the admitting nurse and the SSD followed through the next business day. When the resident had an advance directive in place, the SSD asked for a copy to be placed in the resident's medical record. If the resident did not have an advance directive, an information on advance directive formulation was provided to the resident. In addition, the SSD verified there was no Advance Directive Acknowledgment form for Resident 23 and stated the advance directive formulation should have been offered to the resident sooner. On 5/21/26 at 1536 hours, an interview was conducted with the ADON and DON. The ADON and DON were informed and acknowledged the above findings.

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, medical record review, and facility P&P review, the facility failed to ensure one of five final sampled residents (Resident 3) reviewed for unnecessary medications was free from unnecessary psychotropic medications. * The facility failed to ensure Resident 3's orthostatic blood pressure was accurately monitored, as ordered by the physician, for the use of the quetiapine (antipsychotic) medication. This failure had the potential for adverse effects from the psychotropic medication for Resident 3.Findings: Review of the facility's P&P titled Psychoactive/Psychotropic Medication Use dated 4/2025 showed psychotropic medication management for the residents will involve the interdisciplinary [NAME] consideration of the following: indication and clinical need for medication, dose, duration, and adequate monitoring for efficacy and adverse consequences. Management will also include preventing (where possible), identifying, and responding to adverse consequences. Staff will monitor for potential adverse consequences, such as: ii. Cardiovascular: . orthostatic hypotension. Medical record review for Resident 3 was initiated on 5/18/26. Resident 3 was admitted to the facility on [DATE]. Review of Resident 3's MDS assessment dated [DATE], showed Resident 3 had moderately impaired cognition. Review of Resident 3's Order Summary Report dated 5/21/26, showed the following physician's orders:- dated 1/28/26, for the use of the quetiapine medication to monitor Resident 3's orthostatic (measure the blood pressure while laying down or sitting and again upon standing up) blood pressure (BP) in the lying position every Sunday during the day shift,- dated 1/28/26, for the use of the quetiapine medication to monitor Resident 3's orthostatic blood pressure in the sitting position every Sunday during the day shift, and- dated 2/28/26, to administer quetiapine 25 mg by mouth three times a day for unspecified mood disorder manifested by angry outbursts. Review of Resident 3's MARs for April and May 2026 showed the following documentation for the orthostatic BP readings:- on 4/5/26 and 4/12/26, the BP reading was documented as not applicable NA for the lying and sitting positions.- on 4/19/26, the BP reading was documented as 138/84 mmHg for the lying and the sitting positions.- on 4/26/26, the BP reading was documented as 119/76 mmHg for the lying and the sitting positions.- on 5/10/26, the BP reading was documented as 118/67 mmHg for the lying and the sitting positions. On 5/21/26 at 1000 hours, an interview and concurrent medical record review for Resident 3 was conducted with RN 4. RN 4 stated the orthostatic hypotension was a common side effect of the antipsychotic medication. RN 4 stated for the residents on the antipsychotic medications, the orthostatic blood pressure should be checked weekly and the BP readings compared determine if there was a drop. RN 4 reviewed Resident 3's MARs for April and May 2026 and verified the above findings. RN 4 stated the BP readings for the different positions should not be the same. RN 4 further stated NA should not be documented and the licensed nurse should reattempt to obtain the BP readings and/or document in the nurse's progress notes. RN 4 reviewed Resident 3's medical record and verified there were no documentation in the nurse's progress notes for the above dates where the licensed nurse documented NA. On 5/21/26 at 1420 hours, an interview was conducted with the DON. The DON stated the residents prescribed the antipsychotic medications were monitored weekly for orthostatic hypotension. The DON stated the BP readings should not be NA or the same for the different positions. On 5/21/26 at 1515 hours, an interview was conducted with the Administrator, ADON, and DON. The Administrator, ADON, and DON were informed and acknowledged the above findings.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, medical record review, facility document review, and facility P&P review, the facility failed to follow their protocol for written notification of transfer or discharge for two of three residents (Residents 29 and 138) reviewed for hospitalizations. * The facility failed to provide written information to Resident 29 about the facility's bed-hold information and failed to ensure a copy of the transfer discharge notification was sent to the Ombudsman when Resident 29 was transferred to the acute care hospital on 4/19/26. * The facility failed to ensure a copy of the transfer discharge notification was sent to the Ombudsman when Resident 138 was transferred to the acute care hospital. These failures had the potential for Residents 29 and 138 to not receive additional protection when the residents were being inappropriately transferred or discharged from the facility. Findings: Review of the facility's P&P titled Transfer or Discharge Notices revised 3/2025 showed residents (or resident representatives) are notified of an impending discharge and the reasons for the move in writing and in a language and manner they understand. Under the section Notice of Transfer or Discharge (Emergency) showed the Notice of Transfer is provided to the resident and representative as soon as practicable before the transfer and to the long-term care (LTC) ombudsman when practicable. The Notice of Facility Bed-Hold and return policies are provided to the resident and representative within 24 hours of emergency transfer. A copy of the notice is sent to the Office of the State Long-Term Ombudsman at the same time the notice of transfer or discharge is provided to the resident and representative. Review of the facility's document titled Bed Hold Policy and Notification (undated) showed it is the policy of the facility to provide any resident that is transferred to a general acute hospital the right to exercise the bed hold provision. 1. Medical record review for Resident 29 was initiated on 5/18/26. Resident 29 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 29's Bed Hold Policy and Notification dated 4/1/26, showed the section to be completed upon Resident 29's transfer was blank. Review of Resident 29's H&P examination dated 4/28/26, showed Resident 29 had the capacity to understand and make decisions. Review of Resident 29's Order Summary Report dated 5/20/26, showed the a physician's order dated 4/19/26, to transfer Resident 29 to Acute Hospital A emergency room for evaluation: weakness, diaphoretic (excessive sweating), shaking, and malaise (feeling of discomfort or being off). Bed hold for seven days if admitted . Emergency contact notified. Review of Resident 29's medical record failed to show documented evidence the Ombudsman was notified of Resident 29's transfer to the acute-care hospital on 4/19/26. Further review of Resident 29's medical record failed to show documentation Resident 29 was provided with the information on the bed-hold options. (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/19/26 at 1430 hours, an interview was conducted with the Ombudsman. The Ombudsman stated he wanted the facility to send the notification of the transfer discharge as soon as possible so he could review the notification and determine if the transfer was warranted. On 5/20/26 at 1027 hours, an interview and concurrent medical record review for Resident 29 was conducted with the SSD. The SSD verified Resident 29's bed hold notification was not completed upon Resident 29's transfer to the acute hospital on 4/19/26. When asked for the confirmation the notification of transfer was faxed to the Ombudsman, the SSD stated he was unable to find any documentation. On 5/21/26 at 1420 hours, an interview was conducted with the DON. The DON stated the notification of transfer discharge should be sent weekly to the Ombudsman via email or fax communication. The DON stated the residents were informed of the facility's bed hold policy upon admission to the facility and at the time of the resident's transfer to the acute care hospital. On 5/21/26 at 1515 hours, an interview was conducted with the Administrator, ADON, and DON. The Administrator, ADON, and DON were informed and acknowledged the above findings. 2. Review of the facility's P&P titled Transfer or Discharge Notices revised March 2025 showed in part, the residents (or resident representatives) are notified of an impending transfer or discharge and the reasons for the move in writing and in a language and manner they understand. A copy of the notice is sent to the Office of the State Long-Term Care Ombudsman. When a resident is sent emergently to an acute care setting, this is considered a transfer, not discharge, because the resident's return is generally expected. Notice of Transfer is provided to the residents and representative as soon as practicable before the transfer and to the long-term care (LTC) Ombudsman when practicable (e.g., in a monthly list of residents that includes all notice content requirement). Notice of Facility Bed-Hold and return policies are provided to the residents and representative within 24 hours of emergency transfer. Notices are provided in a form and manner the resident can understand, taking into account the resident's educational level, language, communication barriers, and physical or mental impairments. Nursing notes will include documentation of appropriate orientation and preparation of the resident prior to transfer or discharge. Closed medial record review for Resident 138 was initiated on 5/19/26. Resident 138 was admitted to the facility on [DATE], and was transferred to an acute care hospital on 5/15/26. Review of Resident 138's Physician Order summary showed a physician's order dated 5/15/26, to transfer Resident 138 to an acute care hospital ER for further evaluation due to episode of blackish stool. Bed hold for 7 days if admitted . Review of Resident 138's medical record failed to show proof that the Ombudsman was notified of Resident 138's transfer to an acute care hospital. (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/20/26 at 1443 hours, an interview and concurrent closed record review for Resident 138 was conducted with DON. The DON verified there was no notification to the Ombudsman regarding the transfer to an acute care hospital. The DON stated it was missed and It should have been done upon transfer.

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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 medical record review, the facility failed to ensure the MDS assessment was accurate for two of 27 final sampled residents (Residents 15 and 50) reviewed for MDS. * Resident 15's MDS assessment dated [DATE], showed Resident 15 had a diagnosis of schizophrenia (a chronic and severe brain disorder that affects how a person interprets reality); however, Resident 15 did not have schizophrenia. * Resident 50 was administered lamotrigine (anticonvulsant/mood stabilizer) medication for bipolar (a mental health condition that causes extreme mood swings) disorder. The facility failed to code the diagnosis of bipolar disorder in Resident 50's quarterly MDS assessment dated [DATE]. These failures posed the residents at risk of not receiving an individualized plan of care based on their specific needs. Findings: 1. Medical record review for Resident 15 was initiated on 5/18/26. Resident 15 was admitted to the facility on [DATE]. Review of Resident 15's Psychiatric Initial Evaluation dated 3/9/26, showed documentation Resident 15 was not diagnosed with schizophrenia while having resided in the facility, and Resident 15 stated he had no prior diagnosis of schizophrenia. On 5/19/26 at 1123 hours, an interview and concurrent medical record review for Resident 15 was conducted with the MDS Coordinator. Review of Resident 15's MDS dated [DATE], showed Resident 15 had an active diagnosis of schizophrenia. The MDS Coordinator stated having coded Resident 15 with an active diagnosis of schizophrenia was an error. The MDS Coordinator stated Resident 15's physician had assessed Resident 15 at the facility, and Resident 15 did not have a diagnosis of schizophrenia. The MDS Coordinator stated she was familiar with Resident 15 and the resident had not exhibited any signs and/or symptoms of schizophrenia while having resided in the facility. 2. Medical record review for Resident 50 was initiated on 5/18/26. Resident 50 was admitted to the facility on [DATE], and had the diagnosis of Bipolar disorder on 1/9/26. Review of Resident 50's Order Summary Report 4/21/26, showed a physicians order dated 4/16/26, to administer lamotrigine 200 mg one tablet by mouth at bedtime for Bipolar disorder manifested by verbalization of helplessness (bipolar depression). Review of Resident 50's MDS assessment dated [DATE], showed Resident 50 was coded for taking the anticonvulsant medication. However, Resident 50 was not coded for the diagnosis of Bipolar disorder. On 5/21/26 at 1055 hours, an interview and concurrent medical record review for Resident 50 was conducted with LVN 5. LVN 5 stated Resident 50 was administered the lamotrigine medication for Bipolar disorder. LVN 5 reviewed Resident 50's MDS assessment and verified the above findings. On 5/21/26 at 1515 hours, an interview was conducted with the Administrator, ADON, and DON. The Administrator, ADON, and DON were informed and acknowledged the above findings.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and medical record review, the facility failed to ensure the PASRR (Preadmission Screening and Resident Review) Level 1 screening (identifies if a resident has a suspected mental illness or intellectual/developmental disability or related condition) contained accurate information specific to mental illness, for one of one resident (Resident 11) reviewed for PASRR. * Resident 11 had a diagnosis of Bipolar (a mental health condition that causes extreme mood swings) disorder and was prescribed divalproex sodium (mood stabilizing medication); however, the level 1 PASRR showed Resident 11 had no diagnosed mental illness and was not prescribed a psychotropic medication. This failure had the potential for Resident 11 not receiving a PASRR Level II Mental Health Evaluation (determines if the resident can benefit from specialized mental health services), which posed the risk for Resident 11 not receiving recommendations for specialized services that supplement nursing facility care to address resident mental health needs.Findings: Medical record review for Resident 11 was initiated on 5/18/26. Resident 11 was admitted to the facility on [DATE]. Review of Resident 11's May 2026 MAR showed a physician's order dated 5/1/26, for divalproex sodium 1500 mg orally at bedtime for Bipolar disorder. Review of Resident 11's PASRR Level I Screening results dated 5/4/26, showed Resident 11 had no diagnosed serious mental illness and was not prescribed psychotropic medications. On 5/19/26 at 1103 hours, an interview and concurrent medical record review for Resident 11 was conducted with the MDS Coordinator. The MDS Coordinator was asked to describe the purpose of a PASRR Level 1 Screening. The MDS Coordinator stated the PASRR Level 1 screening functioned to screen and evaluate residents for serious mental illness. Additionally, the results of the PASRR Level 1 screening may necessitate a level II mental health evaluation to be conducted, to determine if a resident could benefit from specialized mental health services. The MDS Coordinator reviewed Resident 11's medical record and verified Resident 11's PASRR Level I Screening dated 5/4/26, showed Resident 11 had no diagnosed serious mental illness and was not prescribed psychotropic medications. The MDS Coordinator stated this information was incorrect as Resident 11 had a diagnosis of Bipolar disorder and was prescribed divalproex odium medication. The MDS Coordinator stated she would complete a new PASRR Level 1 Screening to show Resident 11 had a diagnosis of schizophrenia and was prescribed a psychotropic medication.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and medical record review, the facility failed to ensure the comprehensive care plan was implemented for one of 27 final sampled residents (Resident 74). * The facility failed to implement Resident 74's care plan specific to oxygen administration. This failure placed the resident at risk for not being provided appropriate, consistent, and individualized care.Findings: Medical record review for Resident 74 was initiated on 5/18/26. Resident 74 was admitted to the facility on [DATE]. Review of Resident 74's Care Plan Report showed a care plan focus initiated on 2/10/26, titled At Risk for Ineffective Breathing Pattern related to chronic pulmonary edema (a condition defined by excess fluid in the lungs, which collects in the air sacks and impairs oxygen exchange). The care plan interventions included the administration of oxygen as ordered. Review of Resident 74's Order Summary Report showed a physician's order dated 4/9/26, to administer oxygen continuously at a rate of two LPM (liters per minute) via nasal cannula (a flexible tube to deliver oxygen into the nose). On 5/18/26 at 1010 hours, an observation and concurrent interview was conducted with Resident 74. Resident 74 was observed lying in his bed and was receiving continuous oxygen via an oxygen concentrator and nasal cannula, at a rate of three LPM. Resident 74 stated he required continuous oxygen therapy, otherwise he felt short of breath. Resident 74 stated he received oxygen therapy at a rate of three LPM. On 5/18/26 at 1015 hours, an observation and concurrent interview was conducted with LVN 3. LVN 3 verified Resident 74 was receiving continuous oxygen via an oxygen concentrator and nasal cannula, at a rate of three LPM throughout the day shift; however, the physician's order showed continuous oxygen was to be administered via nasal cannula at a rate of two LPM. LVN 3 verified Resident 74's oxygen was not administered in accordance with his care plan.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure the comprehensive plan of care were revised to reflect the residents' current care needs and interventions for four of 27 final sampled residents (Residents 31, 50, 63, and 84) reviewed for care plans. * The facility failed to revise Resident 31's care plan for impaired skin integrity and coccyx (tailbone) pressure injury (localized areas of skin and tissue damage from prolonged pressure) to include the Wound Consultant's recommendations to avoid sitting for longer than two-hour periods at a time. * The facility failed to revise Resident 50's care plan for anticoagulant (blood thinners) therapy to reflect the resident's current Eliquis (anticoagulant) medication use. * The facility failed to revise Resident 63's care plan for dehydration to reflect the resident's current enteral feeding (delivers liquid nutrients directly into the stomach or small intestine for individuals unable to meet nutritional needs orally) rate and water flushes. * The facility failed to revise Resident 84's enteral nutrition/medication care plan to reflect the resident ?s current condition and needs when Resident's 84 was no longer receiving the enteral feeding. These failures posed the risk of not providing the residents with individualized and person-centered care. Findings: Review of the facility's P&P titled Care Plans, Comprehensive Person – Centered revised 1/2026 showed a comprehensive, person-centered care plan that include measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. Assessments of residents are ongoing, and care plans are revised as information about the residents and the resident's conditions change. The interdisciplinary team reviews and updates the care plan: when there has been a significant change in the residents' condition. 1. On 5/18/26 at 0644 hours, during the initial tour of the facility, Resident 63 was observed sleeping in bed. Resident 63 was observed with the Jevity 1.5 (enteral feeding formula) infusing at a rate of 75 ml/hr via the GT (gastrostomy tube). Medical record review for Resident 63 was initiated on 5/18/26. Resident 63 was admitted to the facility on [DATE]. Review of Resident 63's Care Plan Report showed a care plan problem dated 11/5/24, addressing Resident 63's risk for dehydration or electrolyte imbalance related to the enteral nutrition. The interventions included the following: - every shift, to administer Promote with Fiber (enteral feeding formula) at 72 ml/hr for 20 hours to provide 1,440 ml/1,440 calories via the GT/enteral feeding pump, and - every shift, to automatically flush the GT with water at 18 ml/hr via the feeding pump for 20 hours per day for a total volume of 360 ml per day. Review of Resident 63's Order Summary Report for May 2026 showed the following physician's orders: (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- dated 12/27/25, to flush the GT with water at 40 ml/hr for 20 hours via the feeding pump for a total volume of 800 ml if water per day, and - dated 1/8/26, to administer Jevity 1.2 at 75 ml/hr for 20 hours via the feeding pump. On 5/20/26 at 0929 hours, an interview and concurrent medical record review for Resident 63 was conducted with LVN 9. LVN 9 reviewed Resident 63's medical record and verified the above findings. LVN 9 stated the care plan interventions should be revised when the interventions have changed. 2. Medical record review for Resident 31 was initiated on 5/18/26. Resident 31 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 31's Care Plan Report, showed the following care plan problems: - dated 3/28/25, addressing Resident 31's impaired skin integrity as evidenced by the pressure ulcer to the coccyx. - dated 2/23/26, addressing Resident 31's pressure ulcer to the coccyx and risk for further skin breakdown and/or slow , delayed healing. Review of Resident 31's MDS assessment dated [DATE], showed Resident 31 was at risk for developing pressure ulcers/injuries and had one unhealed, Stage 4 pressure ulcer (full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling). Review of Resident 31's Preliminary Wound Reports showed the following documentation by the Wound Consultant: - dated 4/22/26, to avoid sitting for longer than two-hour periods at a time. Family requests for patient to be up for activities and meals. - dated 4/29/256, to continue to avoid sitting for longer than two-hour periods at a time. However, further review of the above care plans failed to show the care plans were revised to include the recommendations by the Wound Consultant. On 5/20/26 at 1418 hours, an interview and concurrent medical record review for Resident 31 was conducted with LVN 8. LVN 8 stated Resident 8 had a Stage 4 pressure ulcer in the coccyx. LVN 8 stated Resident 31 was under the care of the Wound Consultant who assessed the wound weekly and completed the Preliminary Wound Reports. LVN 8 stated the report was then given to the treatment nurse to review and updated the treatment plan as per the order or recommendations. LVN 8 stated the care plan should be revised to reflect the orders and recommendations. LVN 8 stated the Wound Consultant recommended Resident 31 should not be in the wheelchair for more than two hours at a time. LVN 8 stated she had communicated the recommendations to the CNAs. LVN 8 reviewed Resident 31's medical record and verified the above findings. 3. Medical record review for Resident 50 was initiated on 5/18/26. Resident 50 was admitted to the facility on [DATE]. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 50's Care Plan Report showed a care plan problem was developed dated 12/8/25, to address Resident 50's anticoagulant therapy and black box warning for the enoxaparin (anticoagulant) medication. Review of Resident 50's Order Summary Report dated 5/21/26, showed a physician's order dated 12/10/25, to administer Eliquis 2.5 mg one tablet by mouth two times a day for DVT (deep vein thrombosis- blood clots in the deep veins, usually legs) prophylaxis. Further review of Resident 50's Order Summary Report failed to show the resident was on the enoxaparin medication). On 5/21/26 at 1055 hours, an interview and concurrent medical record review for Resident 50 was conducted with LVN 5. LVN 5 stated Resident 50 had left-sided paralysis (loss of muscle function in part or all of body) and was taking the Eliquis medication. LVN 5 reviewed Resident 50's medical records and verified the above findings. On 5/21/26 at 1420 hours, an interview was conducted with the DON. The DON stated the revisions were coordinated through MDS depending on the change in condition, any new medications, or updated interventions. On 5/21/26 at 1515 hours, an interview was conducted with the Administrator, ADON, and DON. The Administrator, ADON, and DON were informed and acknowledged the above findings. 4. On 5/18/26 at 0803 hours, during the initial tour of the facility, Resident 84 was observed lying in bed, and eating breakfast. Medical record review for Resident 84 was initiated on 5/18/26. Resident 84 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 84's H&P examination dated 5/10/25, showed the resident had no capacity to make medical decisions. Review of Resident 84's Care Plan Report showed a care plan problem dated 5/10/25, for Enteral feeding/medication: Resident has a PEG (Percutaneous Endoscopic Gastrostomy- a flexible feeding tube placed directly through the abdominal wall into the stomach) tube and is at risk for enteral nutrition complication. The care plan interventions included the following: - on Jevity 1.2 at 35 ml/hr via feeding pump for 12 hours to provide 635 ml/756 kcal; - check for residual as ordered; - check tube placement as ordered; - provide enteral tube care as ordered: - provide flushes as ordered; and - head of the elevated at least 30 degrees. Review of Resident 84's Order Summary Report dated 5/21/26, failed to show resident was receiving (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	enteral feeding. On 5/20/26 at 0946 hours, an interview and concurrent medical record review for Resident 84 was conducted with the MDS Assistant. The MDS Assistant verified the care plan failed to show Resident 84's current condition. Resident 84 no longer receiving enteral feeding through PEG tube. On 5/21/26 at 1403 hours, an interview was conducted with the Administrator, ADON and DON. The Administrator, ADON and DON were informed and acknowledged the above findings.

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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 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, medical record review, and facility P&P review, the facility failed to ensure the quality of care and services were provided for one of 27 final sampled residents (Resident 3) reviewed for quality of care. * The facility failed to ensure the injection sites for the insulin (medication to control blood glucose levels) administration were rotated for Resident 3. This failure had the risk for lipodystrophy (buildup of fatty lumps) and decreased with insulin absorption.Findings: Review of the facility's P&P titled Insulin Administration revised 3/2025 showed insulin may be injected into the subcutaneous tissue of the upper arm and the anterior or lateral areas of the thighs and abdomen. Injection sites should be rotated, preferably within the same general area. Medical record review for Resident 3 was initiated on 5/18/26. Resident 3 was admitted to the facility on [DATE], and had the diagnosis of Type 2 diabetes mellitus with hyperglycemia (high blood sugar). Review of Resident 3's Order Summary Report dated 5/21/26, showed a physician's order dated 1/23/26, to administer the regular insulin (a short-acting human insulin, used to manage blood sugar) as per the sliding scale, if the blood sugar was:- 0 to 149 mg/dl: administer zero (0) units;- 150 to 199 mg/dl: administer one unit;- 200 to 249 mg/dl: administer two units;- 250 to 299 mg/dl: administer three units;- 300 to 349 mg/dl: administer four units;- 350 to 399 mg/dl: administer five units; and- >400 mg/dl: administer six units and call the physician.- to administer subcutaneously before meals and at bedtime for diabetes mellitus and to rotate the injection sites. Review of Resident 3's MARs for April and May 2026 showed the injection site to administer the insulin medications injection were not rotated. For example:* Resident 3 received the insulin medication at the right upper quadrant of the abdomen on the following dates and times: - on 4/4/26 at 1130 hours, and on 4/5/26 at 11230, 1630, 2100 hours; and- on 4/15/26 at 1630 and 2100 hours.* Resident 3 received the insulin medication at the left lower quadrant of the abdomen on the following dates and times: - on 4/9/26 at 0630 and 1130 hours;- on 4/24/26 at 1630 and 2100 hours;- on 4/27/26 at 1130, 1630, and 2100 hours- on 5/2/26 at 1630 and 2100 hours;- on 5/9/26 at 1630 and 2100 hours;- on 5/14/26 at 1130 and 2100 hours;- on 5/15/26 at 2100 hours and 5/16/26 at 0630 hours;- on 5/17/26 at 2100 hours, on 5/18/26 at 1130 and 2100 hours, and on 5/19/26 at 0630 hours; and- on 5/19/26 at 1630 and 2100 hours and on 5/20/26 at 0630 hours. On 5/21/26 at 1000 hours, an interview and concurrent medical record review for Resident 3 was conducted with RN 4. RN 4 stated for the administration of insulin injections, the injections site should be rotated to prevent complication of the skin if injected at the same site repeatedly. RN 4 reviewed Resident 3's MARs for April and May 2026 and verified the above findings. On 5/21/26 at 1515 hours, an interview was conducted with the Administrator, ADON, and DON. The Administrator, ADON, and DON were informed and acknowledged the above findings.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, and facility P&P review, the facility failed to ensure to provide the necessary care and services to maintain skin integrity for one of three sampled residents (Resident 17) reviewed for pressure injuries. * The facility failed to ensure Resident 17's LAL (low air loss mattress) setting was consistent with the resident's weight. This failure had the potential for the resident not to benefit from the therapy provided by the LAL mattress.Findings: Review of the facility's P&P titled Support Surface Guidelines revised 4/2026 showed support surfaces are used for pressure redistribution, shear reduction, and in some cases temperature or moisture control for the resident at risk of pressure injury. Select appropriate pressure redistribution support surfaces based on current recommended practices for device selection, as well as the resident's risk factors, clinical and functional needs, and preferences. Following the manufacturer's recommendation for use, ensure the support surface accommodates the weight, height, size, and body mass index (BMI) of the resident. When a powered device is in use, regularly check it is plugged in, turned on, and functioning. When an air-inflated device is in use, ensure it remains inflated to a pressure appropriate to the resident's body weight. Check for bottoming out. On 5/18/26 at 0806 hours, during the initial tour of the facility, Resident 17 was observed positioned on her back and lying on a LAL mattress - Select Air MAX plus pump with the comfort pressure level set at six. Review of the LAL mattress device showed level six setting was for a 200-lbs. weight. On 5/18/26 at 1219 hours, during an observation, Resident 17 was observed positioned on her back and lying on a LAL mattress - Select Air MAX plus pump with the comfort pressure level set at 12. Review of the LAL mattress device showed level 12 setting was for a 700-lbs.weight. Medical record review for Resident 17 was initiated on 5/18/26. Resident 17 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 17's Care Plan Report dated 11/1/24, showed a care plan focus addressing the resident is at risk for skin breakdown. The interventions included pressure reduction mattress. Review of Resident 17's H&P examination dated 3/26/25, showed Resident 17 had no capacity to make medical decisions. Review of Resident 17's Annual MDS assessment dated [DATE], showed the resident had a BIMS (Brief Interview of Mental Status) of 2 (0-7 suggests severely impaired cognition and functional challenges). Review of Resident 17's Order Summary Report for 5/2026 showed a physician's order dated 4/12/25, for air mattress for skin management, set according to resident's weight. Review of Resident 17's weight record dated 5/1/26, showed 111.4 lbs. On 5/21/26 at 1422 hours, an interview was conducted with LVN 8. LVN 8 was informed of the findings and stated LAL mattress was monitored by the treatment nurse, the setting was checked daily, and adjusted weekly based on the resident's weight. LVN 8 stated it was crucial to have the correct setting on the LAL mattress to prevent falls and the development of pressure injury. On 5/21/26 at 1536 hours, the DON and ADON were informed and acknowledged the above findings.

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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 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** Based on interview, medical record review, and facility P&P review, the facility failed to ensure the nutritional recommendations from the RD were followed for one of three final sampled residents (Resident 29) reviewed for nutrition. * The facility failed to ensure the physician was notified of the RD/IDT team's recommendations for the liquid protein supplement and therapeutic diet change to address Resident 29's weight loss. Resident 29 did not receive the supplement as recommended by the RD. This failure had the risk of not providing the nutritional needs and poor health outcome for Resident 29.Findings: Review of the facility's P&P titled Nutritional Assessment revised 10/2017 showed the dietician, in conjunction with the nursing staff and healthcare practitioners, will conduct a nutritional assessment for each resident upon admission (within current baseline assessment timeframes) and as indicated by a change in condition that places the resident at risk for impaired nutrition. As part of the comprehensive assessment, the nutritional assessment will be systematic, multidisciplinary process that includes gathering and interpreting data and using that data to help define meaningful interventions for the resident at risk for or with impaired nutrition. Review of the facility's P&P titled Weight Assessment and Intervention revised 1/2026, showed resident weights are monitored for undesirable or unintended weight loss or gain. Interventions for undesirable weight loss are based on careful consideration of the following:a. resident choice and preferencesb. nutrition and hydrations needs of the residente. chewing and swallowing abnormalities and the need for diet modifications;g. the use of supplementation and/or feeding tubes. Medical record review for Resident 29 was initiated on 5/18/26. Resident 29 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 29's H&P examination dated 4/28/26, showed Resident 29 had the capacity to understand and make decisions. Review of Resident 29's Weights and Vitals Summary showed the following weights recorded for the resident:- dated 4/2/26, weight of 179.6 lbs.;- dated 4/18/26, weight of 176.6 lbs.;- dated 4/28/26, weight of 170.6 lbs. (- 5% change, -9 lbs. from 4/2/26);- dated 5/1/26, weight of 169.8 lbs. (- 5% change, -9.8 lbs. from 4/2/26). Review of Resident 29's Nutritional Risk assessment dated [DATE], showed the following RD documentation: Resident currently on a regular CCHO diet, weight loss of 6# in one week on readmit, risk of further weight changes with ESRD/HD and continued antibiotic. The RD recommended 30 cc sugar-free liquid protein (supplement) and to change the diet to Renal-CCHO. Review of Resident 29's IDT-Weight Variance Assessments showed the following documentations:- dated 4/28/26, showed the documentation Resident 29 had a 6 lbs. weight loss in one week. The interventions showed to change the diet to Renal-CCHO and administer 30 ml sugar-free liquid protein two times a day.- dated 5/5/26, showed the documentation Resident 29 had 10 lbs. weight loss in four weeks. The interventions showed to obtain weekly weights for four weeks, and 30 ml sugar-free liquid protein two times a day. However, review of Resident 29's Order Summary Report dated 4/20/26, failed to show documented evidence Resident 2's diet was changed to Renal-CCHO, or a physician's order for the liquid protein supplement. On 5/20/26 at 0942 hours, an interview and concurrent medical record review for Resident 29 was conducted with RN 3. RN 3 verified the RD and IDT's recommendations to change Resident 29's diet and for the protein supplement; however, there was no documentation the physician was notified of the RD/IDT's recommendations, or a physician's order was obtained for the protein supplement. On 5/20/26 at 1509 hours, an interview was conducted with the DON. The DON stated the recommendations/interventions from the IDT-Weight Variance should be carried out by informing the physician of the recommendations and carrying out or following up the orders as needed. On 5/20/26 at 1549 hours, a follow-up interview was conducted with the DON. The DON stated she was unable to find the documentation the RD and IDT recommendations were followed up. The DON verified Resident 29 was still on the CCHO diet, and the resident currently did not have a physician's order for protein supplements. The DON further stated the recommendations should have been follow-up and (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	documented. On 5/21/26 at 1515 hours, an interview was conducted with the Administrator, ADON, and DON. The Administrator, ADON, and DON were informed and acknowledged the above findings.

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, medical record review, and facility P&P review, the facility failed to provide the necessary care and services to maintain the intravenous access for one sampled resident (Resident 23) and two nonsampled residents (Residents 9 and 123) reviewed for intravenous fluids. * The facility failed to ensure Resident 9's IV medication was correctly labeled. * The facility failed to ensure Resident 23's PICC line external catheter and arm circumference measurements were completed and documented upon admission in the resident's medical record. * The facility failed to ensure Resident 123's IV tubing was labeled. These failures had the potential to delay the identification of catheter related complications for the residents. Findings: 1. Review of the facility's P&P titled Care of Peripheral Inserted Central Lines (PICC) – Dressing Change and Site Care (undated) showed the purpose of this procedure is to assure safety and aseptic technique in the performance of this procedure and to minimize the possibility of local and systemic infection. The pressure dressing applied at time of PICC line insertion should be changed 24 hours later preferably by the nurse who inserted the PICC. Transparent PICC line dressings are routinely changed every seven days or when the dressing becomes loose, wet or soiled, unless otherwise ordered. Assess the insertion site, areas and the course of the vein for redness, tenderness, edema, and drainage. In addition, further review of facility's P&P titled Central Venous Catheter Care and Dressing Changes date revised 6/2025 showed the purpose of this procedure is to prevent complications associated with intravenous therapy, including catheter-related infections associated with contaminated, loosened, soiled, or wet dressings. Measure the length of the external central vascular access device with each dressing change or if catheter dislodgement is suspected. Compare with the length documented at insertion. For PICCs, measure arm circumference and compare to baseline when clinically indicated to assess for edema and possible deep-vein thrombosis. Medical record review for Resident 23 was initiated on 5/18/26. Resident 23 was admitted to the facility on [DATE]. Review of Resident 23's admission MDS assessment dated [DATE], showed Resident 23 had a BIMS of 12 (8-12 suggests moderate cognitive impairment). Review of Resident 23's Order Summary Report for 5/2026 showed a physician's order dated 4/18/26, to measure external catheter length of the PICC and Midlines upon admission and with each dressing change, include arm circumference for midline device every seven days and as needed. However, the review of the Nursing Admission/readmission Evaluation/assessment dated [DATE], failed to show the information of the measurement and assessment of the right upper arm single lumen PICC line was documented when the resident was admitted to the facility. Further review of Resident 23's medical record failed to show a documented evidence for the measurements of the length of the right upper arm PICC line catheter above the insertion site and arm circumference were obtained upon admission. On 5/21/26 at 1433 hours, an interview and concurrent medical record review for Resident 23 was conducted with the ADON. The ADON verified Resident 23's medical record did not show the right upper arm PICC line external catheter and arm circumference measurements upon admission to the (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	facility. The ADON stated there should have been a measurement of the length of the catheter and arm circumference upon admission of the resident to monitor patency and placement, swelling, signs and symptoms of infections, and should have been documented in the resident's medical records. On 5/21/26 at 1536 hours, an interview was conducted with the DON and ADON. The DON and ADON were informed and acknowledged the above findings. 2. On 5/18/26 at 0629 hours, during the initial tour of the facility, Resident 123 was observed with a peripheral IV (PIV) in the left hand. A one-liter bag of 0.9 % Sodium Chloride (normal saline, a sterile solution usually given by injection into a vein for IV hydration) was observed hanging on the IV pole and infusing at a rate of 75 ml per hour. The IV tubing was not observed labeled with the date, time, and nurse's initials. Medical record review for Resident 123 was initiated on 5/18/26. Resident 123 was admitted to the facility on [DATE], and readmitted on [DATE]. Review of Resident 123's Order Summary Report for May 2026 showed a physician's order dated 5/18/26, to change the IV tubing every 24 hours for intermittent IV infusion and TPN and every 72 hours for continuous IV infusion. On 5/18/26 at 0638 hours, an interview and concurrent observation for Resident 123 was conducted with RN 1. RN 1 stated the IV tubing used for hydration should be labeled with the date and time and discarded after 96 hours. RN 1 verified the above findings. On 5/21/26 at 1515 hours, an interview was conducted with the Administrator, ADON, and DON. The Administrator, ADON, and DON were informed and acknowledged the above findings. 3. Review of the facility's P&P titled IV Solution (undated) showed the nurse hanging the IV solutions will label the bag with the date, time and initials. During the medication administration observation on 5/19/26 at 1412 hours, Resident 9 was observed in bed awake, with the right upper arm three lumen PICC line and was dated 5/18/26. RN 2 prepared the meropenem (a broad-spectrum carbapenem antibiotic used to treat severe bacterial infection) one gram, RN 2 labeled the IV tubing with the date, time and initial, and administered the meropenem medication in Resident 9's right upper arm PICC line. Medical record review for Resident 9 was initiated on 5/18/26. Resident 9 was admitted to the facility on [DATE], and readmitted to the facility on [DATE]. Review of Resident 9's Order Summary Report showed a physician's order dated 5/18/26, for meropenem one gram, to give intravenously every eight hours for cystitis (an inflammation of the bladder most frequently caused by a bacterial infection) until 5/23/26. (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/19/26 at 1504 hours, an observation and concurrent interview for Resident 9 was conducted with RN 4. RN 4 verified that the meropenem medication bag was not labeled with the date, time, and initial of the RN who administered the medication. On 5/21/26 at 1403 hours, an interview was conducted with the Administrator, ADON and DON. The Administrator, ADON and DON were informed and acknowledged the above findings.

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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, medical record review, facility document review, and facility P&P review, the facility failed to ensure the medication error rate was below 5%. The facility's medication error rate was 8%. Two of five licensed nurses (LVNs 2 and 4) who were observed during medication administration were found to have errors. * LVN 2 failed to administer Resident 85's metformin (medication to lower the blood sugar) as ordered by the physician. * LVN 4 failed to administer Resident 92's diltiazem (medication used to treat high blood pressure) as ordered by the physician. These failures created the risk for the residents to have potential side effects or complications related to the medications.Findings: Review of the facility's P&P titled Administering Medication revised 1/2026 showed the medications are administered in a safe and timely manner and as prescribed. Medications are administered in accordance with the prescriber's orders, including any required time frame. 1. On 5/19/26 at 1115 hours, a medication administration observation for Resident 92 was conducted with LVN 4. LVN 4 was observed taking Resident 92's blood pressure on his left upper arm with a reading of 112/66 mmHg. LVN 4 prepared and administered the following medications to Resident 92:- one tablet of midodrine (medication for low blood pressure) 5 mg via GT with instructions to hold medication for systolic blood pressure above 130 mmHg. Medical record review for Resident 92 was initiated on 5/18/26. Resident 92 was readmitted to the facility on [DATE]. Review of Resident 92's Order Summary Report showed the following physician's orders dated 5/6/26:- to administer diltiazem 30 mg one tablet via GT four times a day for hypertension (high blood pressure) and to hold the medication if the systolic blood pressure was below 100 mmHg or heart rate below 60 beats per minute; and- to administer midodrine 5 mg one tablet via GT before meals for hypotension (low blood pressure) and to hold the medication if the systolic blood pressure was above 130 mmHg. Further review of the Medication Administration Note, dated 5/19/26, showed documentation the diltiazem medication was held due to Resident 92's blood pressure was outside the parameter. On 5/19/26 at 1446 hours, an interview was conducted with LVN 4. LVN 4 verified the above findings. When asked about the diltiazem medications that was not given during the medication administration observation for Resident 92, LVN 4 stated she did not give the medication to Resident 92 because the blood pressure was low. LVN 4 further stated she should have given the diltiazem medication. Resident 92's blood pressure of 112/66 mmHg obtained by LVN 4 was within the parameters as ordered by the physician. 2. Medical record review for Resident 85 was initiated on 5/18/26. Resident 85 was admitted to the facility on [DATE] and readmitted to the facility on [DATE]. Review of Residents 85's H&P examination dated 10/14/25, showed Resident 85's does not have the capacity to understand and make decisions. On 5/19/26 at 1614 hours, a medication administration observation for Resident 85 was conducted with LVN 2. There was no dinner tray observed on Resident 85's overbed table. LVN 2 took Resident 85's blood sugar then prepared and administered the following medications to Resident 85:- one tablet of Eliquis (blood thinner) 2.5 mg;- one tablet of metformin 1000 mg takes with meals; and- 12 units of insulin lispro (diabetes medication). Review of Resident 85's MAR for May 2026 showed the following physician's order: - dated 5/31/25, for insulin lispro 100 unit/ml subcutaneously as per sliding scale before meals and at bedtime for diabetes mellitus;- dated 6/1/25, to administer Eliquis 2.5 mg one tablet by mouth two times a day for atrial fibrillation (irregular rapid heart rate); and- dated 6/1/25, to administer metformin 500 mg, one tablet by mouth two times a day for diabetes mellitus and to take with meals. On 5/19/26 at 1635 hours, an interview was conducted with LVN 2. LVN 2 verified the metformin medication was not given with meals nor food. On 5/21/26 at 1334 hours, an interview was conducted with the DON. The DON verified the above findings and stated the licensed nurse needs to follow the rights in medication administration to prevent medication error. On 5/21/26 at 1403 hours, an interview was conducted with the Administrator, ADON and DON. The Administrator, ADON and DON were informed and acknowledged the above findings.

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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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, facility document review, and facility P&P review, the facility failed to ensure the drugs and biologicals were stored, labeled, and/or disposed properly. * The facility failed to ensure discontinued or expired medications and supplies were removed from Medication room [ROOM NUMBER] and Medication Cart A. * The facility failed to ensure the orally administered medications were stored separately from the externally used medications in Medication Cart A. These failures posed the risk for the administration of potentially contaminated or deteriorated medications, and posed the risk for the medications to be used or improperly administered to the residents.Findings: Review of the facility's P&P titled Medication Labeling and Storage revised 1/2026 showed the nursing staff was responsible for maintaining medication storage and preparation areas in a clean, safe, and sanitary manner. Multi-dose vials that have been opened or accessed are dated and discarded within 28 days unless the manufacturer specifies a shorter or longer date for the open vial. Medications for external use, as well as hazardous drugs and biologicals, are clearly marked as such, and are stored separately from the other medications 1. On 5/19/26 at 1116 hours, an inspection of Medication room [ROOM NUMBER] and concurrent interview was conducted with LVN 10. The following were observed:- one bottle of nystatin suspension (antifungal medication) 100,000 units for Resident 37. The bottle was labeled with the opened date of 3/24/26. The label on the bottle showed to administer 5 ml by mouth four times a day for five days. LVN 10 reviewed Resident 37's record and stated Resident 37 was no longer on the medication.- one Humalog Kwik pen (rapid-acting insulin (medication to control blood glucose levels), a pre-filled, disposable insulin injection device) 100 units/ml for Resident 29, opened and stored inside the refrigerator. The insulin pen was labeled with the opened date of 4/2/26 and the expiration date of 4/30/26.- 12 culture swabs with the expiration date of 4/23/26. LVN 10 verified the above findings. LVN 10 stated the insulin pen should not be kept in the refrigerator once removed and opened. LVN 10 further stated the IP nurse and the RN during the night shift was responsible for checking the medication rooms and removing the expired medications and supplies. 2. On 5/19/26 at 1412 hours, a medication cart inspection for Medication Cart A and concurrent interview was conducted with LVN 10. The following was observed:- one opened box of levalbuterol (breathing treatment medication) 0.63 mg/3 ml for Resident 10. The box was labeled with the opened date of 2/26/26, and the expiration date of 3/26/26.- one bottle of furosemide (diuretic medication) 80 mg, two boxes of alendronate (bisphosphonate medication, to treat osteoporosis) 70 mg, one naloxone (opioid antagonist) nasal spray, one bottle of glucosamine sulfate (supplement) 750 mg, were stored with the bisacodyl (laxative) 10 mg suppositories. LVN 10 verified the above findings and stated the internal and external medications should be stored separately to prevent medication administration errors. On 5/21/26 at 1420 hours, an interview was conducted with the DON. The DON stated the licensed nurses assigned to the medication carts were responsible for ensuring the medications inside the carts were dated, labeled, and separated by route, and discarding of the expired medications. The DON stated the IP nurse and night shift nurses were responsible for the removal of the expired medications and supplies in the medications rooms. On 5/21/26 at 1515 hours, an interview was conducted with the Administrator, ADON, and DON. The Administrator, ADON, and DON were informed and acknowledged the above findings.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, facility document review, and facility P&P review, the facility failed to ensure the menu was followed for one of one nonsampled resident (Resident 120) reviewed for therapeutic diet. * The facility failed to ensure Resident 120 was served with the boiled potatoes as per the therapeutic spreadsheet for the lunch meal on 5/18/26. This failure had the potential to not meet Resident 120's nutritional needs and negatively impact the resident's nutritional health.Findings: Review of the facility's document titled Diet Type Report dated 5/18/26, showed 115 of 121 residents in the facility received food prepared in the kitchen. Review of the facility's P&P titled Menus revised 1/2026 showed menus meet the nutritional needs of residents in accordance with the recommended diet allowances of the Food and Nutrition Board. Menus for regular and therapeutic diets are written at least two weeks in advance and are dated and posted in the kitchen at least one week in advance. If a food group is missing from a resident's daily diet, the resident is provided an alternate means of meeting his or her nutritional needs. Review of the facility's P&P titled Therapeutic Diets revised 1/2026 showed therapeutic diets are prescribed by the attending physician to support the resident's treatment and plan of care and in accordance with his or her goals and references. A therapeutic diet is considered a diet ordered by a physician, practitioner, or dietician as part of treatment for a disease or clinical condition, to modify specific nutrients in the diet, or to alter the texture of a diet. If a mechanically altered diet is ordered, the provider will specify the texture modification. Review of the facility's document titled Good For Your Health Menus (undated) showed the lunch menu for Monday 5/18/26, was baked hamburger with brown sauce, diced fried potatoes, capri blend vegetables, wheat roll, and spring fruit crisp. Medical record review for Resident 120 was initiated on 5/18/26. Resident 120 was admitted to the facility on [DATE]. Review of Resident 120's MDS assessment dated [DATE], showed Resident 120 had severely impaired cognition and was coded for receiving the mechanically altered and therapeutic diet. Review of Resident 120's Order Summary Report for May 2026 showed a physician's order dated 1/22/26, to provide Resident 120 with a fortified IDDSI (International Dysphagia Diet Standardization Initiative) 6: Soft and Bite Sized texture, thin liquids consistency, soft bread was okay for feeding assistance. Review of the facility document titled Spring Cycle Menus (undated) Week 4- Monday 5/18/26, under soft & bite size- IDDSI Level 6, showed the following items: tender, chopped baked hamburger with puree brown sauce, boiled potatoes, chopped capri-blend vegetables, and chopped, moist spring fruit crisp. On 5/18/26 at 1203 hours, during the meal observation in the dining room, the facility staff was observed assisting Resident 120 with her lunch. On Resident 120's lunch plate, the following items were observed: chopped baked hamburger with brown sauce, chopped vegetable blend, rice, a wheat roll, and a cup of fruit crisp dessert. Resident 120 was not observed served with the boiled potatoes. On 5/18/26 at 1314 hours, an interview and concurrent observation was conducted with the DSS. The DSS verified the above findings. The DSS stated the residents on the soft and bite sized diet should have had the boiled potatoes as per the menu. On 5/18/26 at 1400 hours, a follow-up interview was conducted with the DSS. The DSS stated the Notes and Standing Orders on the meal tickets were the resident's preferences for certain items for the meal. The DSS further stated if the item was listed on the meal ticket, the resident should have that item in addition to the items on the menu. On 5/21/26 at 1515 hours, an interview was conducted with the Administrator, ADON, and DON. The Administrator, ADON, and DON were informed and acknowledged the above findings.

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, facility document review, and facility P&P review, the facility failed to ensure one of 27 final sampled residents (Resident 31) received food that accommodated the resident's preferences. * Resident 31 was not served with the fresh fruit cup as per the lunch meal ticket on 5/18/26. This failure posed the risk of Resident 31 not enjoying her meal and for her food preferences not being honored.Findings: Review of the facility's document titled Diet Type Report dated 5/18/26, showed 115 of 121 residents in the facility received food prepared in the kitchen. Review of the facility's P&P titled Resident Food Preferences revised 1/2026 showed when possible, staff will interview the resident directly to determine current food preferences based on history and life patterns related to food and mealtimes. The food services department will offer a variety of foods at each scheduled meal, as well as access to nourishing snacks throughout the day and night. Medical record review for Resident 31 was initiated on 5/18/26. Resident 31 was admitted to the facility on [DATE], and readmitted on [DATE]. On 5/18/26 at 1310 hours, during the lunch observation, Resident 31 was observed eating lunch in her room. Resident 31's lunch tray was observed with the baked hamburger with brown sauce, capri blend vegetables, fried diced potatoes, a wheat roll, and a fruit crisp dessert. Review of Resident 31's lunch meal ticket, under Notes, showed to add fresh fruit cup. However, Resident 31 was not observed with the fresh fruit cup. When asked, Resident 31 stated she would like to have her fruit cup for her lunch meal. On 5/18/26 at 1315 hours, an interview and concurrent observation was conducted with LVN 7. LVN 7 reviewed Resident 31's meal ticket and verified the above findings. Resident 31 was observed informing LVN 7 she wanted her fruit cup. On 5/18/26 at 1400 hours, an interview was conducted with the DSS. The DSS stated the Notes section on the meal tickets were the resident's preferences for certain items for the meal. The DSS further stated if the item was listed on the meal ticket, the resident should have that item in addition to the items on the menu. On 5/21/26 at 1515 hours, an interview was conducted with the Administrator, ADON, and DON. The Administrator, ADON, and DON were informed and acknowledged the above findings.

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Dispose of garbage and refuse properly. Based on observation, interview, and facility P&P review, the facility failed to ensure the garbage was properly stored in two of four garbage dumpsters. * Two garbage dumpsters were observed with the lids partially propped open by the garbage bags, preventing the lids from fully closing. This failure had the potential to attract pest/rodents that carried diseases.Findings: Review of the facility's P&P titled Dumpster Management undated showed, dumpsters must be covered and secured at all times, free of visible leaks or damage, and washed and deodorized as needed (minimum quarterly). Dumpster enclosures must be maintained with lids closed to reduce odor. In addition, further review of the facility's P&P titled Miscellaneous Areas: Garbage and Trash dated 2018 showed, adequate, clean, vermin-proof areas must be provided for storage of garbage and rubbish. Furthermore, the facility's P&P titled Sanitization date revised 11/2022 showed, garbage and refuse containers are in good condition, without leaks, and waste is properly contained in dumpsters or compactors with lids (or otherwise covered). According to the USDA Food Code 2022, Section 5-501.11 Storing Refuse, Recyclables, and Returnables showed refuse, recyclable, and returnable shall be stored in receptacles or waste handing units so that they are inaccessible to insects and rodents. According to the USDA Food Code 2022, Section 5-501.15 Covering receptacles: Receptacles and waste handling units for refuse, recyclables, and returnables used with materials containing food residue and used outside the food establishment shall be deigned and constructed to have tight-fitting lids, doors, or cover. On 5/18/26 at 0709 hours, an observation of the facility's four of four outside garbage dumpsters was conducted with the DSS. Two of the garbage dumpsters were observed with the lids partially propped open by the garbage bags, preventing the lids from fully closing. On 5/19/26 at 1048 hours, an interview was conducted with the Maintenance Director. The Maintenance Director was informed of the above observation with a photograph of the garbage dumpsters taken on 5/18/26 at 0709 hours. The Maintenance Director verified the above findings and stated the dumpster lids should be fully closed for pest control and infection control purposes. On 5/21/26 at 1536 hours, an interview was conducted with the DON and ADON. The DON and ADON were informed and acknowledged the above findings.

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, medical record review, facility document review, and facility P&P review, the facility failed to provide the necessary care and services for one of two final sampled residents (Resident 63) reviewed for hospice services. * The facility failed to ensure the hospice staff were included in Resident 63's interdisciplinary team meetings to discuss Resident 63's plan of care; and failed to ensure the hospice plan of care was integrated into the facility's care plan to include the frequency of visits of each hospice staff and the provisions of care. These failures posed the risk for delay in communication and/or uncoordinated medical care between the facility and hospice provider which may affect Resident 63's care.Findings: Review of the facility's P&P titled Hospice Program dated 2001 showed it is the responsibility of the facility to meet the residents' personal care and nursing needs in coordination with the hospice representative, and ensure that the level of care provided is appropriately based on the individual resident's needs. The facility's designated individual is responsible for coordinating care provided to the resident by the facility and the hospice staff. The designated individual is responsible for the following: a. Collaborating with hospice representatives and coordinating facility staff participation in the hospice care planning process for residents receiving these services. The coordinated care plans for residents receiving hospice services will include the most recent hospice plan of care as well as the care and services provided by out facility (including the responsible provider and discipline assigned to specific tasks) in order to maintain the resident's highest practicable physical, mental and psychosocial well-being. Review of the facility's contract with Hospice Provider A dated 11/1/24, showed hospice shall be responsible for determining and modifying, as necessary, the appropriate hospice care plan as specified in 42 C.F.R. 418.112(d). Such a hospice plan of care shall encompass all issues related to the terminal illness and related conditions. Hospice shall communicate with the Resident, family members, Facility staff, and the attending physician to develop and update the content of the hospice care plan. The facility shall ensure that each resident's written plan of care includes both the most recent hospice plan of care, if applicable, and a description of the services furnished by the facility to attain or maintain the residents highest practicable physical, mental, and psycho-social well-being. Hospice and Facility shall permit each other to attend the care planning meetings involving any resident under hospice's care. Medical record review for Resident 63 was initiated on 5/18/26. Resident 63 was admitted to the facility on [DATE]. Review of Resident 63's Order Summary Report for May 2026, showed a physician's order dated 10/4/25, to admit Resident 63 to Hospice Provider A under routine care with the primary diagnosis of CVA (stroke). Review of Resident 63's Hospice Plan of Care/IDG Review, dated 10/8/25, showed the following visit frequencies for the hospice staff:- Hospice Aide (HA): two times a week- Skilled Nurse: one to three times per week- Spiritual Counselor (SC): one initial assessment evaluation. Review of Resident 63's care plan dated 10/8/25, for end of life and admission to Hospice Provider A failed to show the frequency of visits by each hospice staff member and the services provided by each hospice staff member. Review of the document titled Hospice Provider A- Integrated Hospice and Facility Plan of Care (located in Resident 63's hospice binder) showed the document was not completed to include the frequency of hospice nurse and hospice aide visits, and was not signed by the hospice RN and the facility's RN. Review of Resident 63's IDT Conference Notes dated 1/1/26, showed to continue with Hospice Provider A and to integrate care with the hospice team. Further review of the IDT Conference Notes failed to show the documentation the Hospice Provider A staff were part of the IDT Meeting. Review of Resident 63's IDT Conference Notes dated 4/3/26, showed Resident 63 continued with hospice services. Further review of the IDT Conference Notes failed to show documentation the Hospice Provider A staff were part of the IDT Meeting. On 5/19/26 at 0933 hours, an interview and concurrent medical record review for Resident (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	63 was conducted with the SSD. The SSD stated he was one of facility's hospice coordinators and was responsible for coordinating the hospice resident's care between the hospice provider and the facility. The SSD stated the IDT care conferences were conducted quarterly with the facility's IDT members, the resident, family members, and hospice staff. The SSD verified the IDT meetings conducted for Resident 63 did not include participation from Hospice Provider A staff and stated he was unable to find the documentation Hospice Provider A was informed or contacted to attend the facility's IDT meetings for Resident 63. The SSD stated an IDT meeting should be conducted to discuss the resident's hospice plan of care and the integration of the hospice plan of care into the facility's care plan. The SSD reviewed Resident 63's medical record and verified an IDT meeting was not conducted to discuss the Resident 63's hospice plan of care and the facility's care plan was not updated to incorporate the hospice plan of care. On 5/21/26 at 1420 hours, an interview was conducted with the DON. The DON stated the hospice staff should be part of the IDT meetings to ensure the care was appropriate for the hospice resident. On 5/21/26 at 1515 hours, an interview was conducted with the Administrator, ADON, and DON. The Administrator, ADON, and DON were informed and acknowledged the above findings.

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep all essential equipment working safely. Based on observation, interview, facility document review, and manufacturer's guidelines review, the facility failed to ensure the facility equipment was maintained in a safe operating condition for one of two medication carts (Medication Cart A) inspected. * The facility failed to ensure Medication Cart A's glucometer's (a device that measures the amount of sugar in the blood) serial number was documented on the quality control record and failed to ensure the lot number for the glucometer test strips in Medication Cart A matched the lot number on the quality control record for the cart. Additionally, the documented control test results were not observed on the glucometer result history. These failures had the potential risk of inaccuracy for the blood glucose test resultsFindings: Review of the Assure Platinum (Blood Glucose Monitoring System), Quality Assurance and Quality Control Reference Manual revised 8/2023 showed to check the glucometer and test strips using the Assure Dose Control Solutions to confirm the meter and test strips are working properly. To conduct a control solution test before using a new glucometer or a new bottle of test strips. Further review of the manual showed if you do not set the glucometer in the control solution mode, the control solution result will NOT be valid. Using the control solution mode will also flag the result in memory. On 5/19/26 at 1412 hours, an inspection of Medication Cart A and concurrent interview was conducted with LVN 3. LVN 3 stated the licensed nurses during the NOC shift (the shift from 2300 to 0700 hours) were responsible for performing the quality control tests for the glucometers. In addition, a concurrent review of the facility's document titled Quality Control Record for May 2026 (for Medication Cart A) was conducted with LVN 3. LVN 3 verified the serial number for the glucometer currently in use in Medication Cart A was not documented in the Quality Control Record. LVN 3 verified the test strip bottle currently in use for the glucometer in Medication Cart A was dated 5/18/26, and the lot number on the test strip bottle did not match the lot number documented on the Quality Control Record. Further review of the Quality Control Record showed the following documented Quality Control Results:- on 5/16/26, the normal (level 1) control result was 107 mg/dl and the high (level 2) control result was 243 mg/dl,- on 5/17/26, the normal (level 1) control result was 97 mg/dl and the high (level 2) control result was 254 mg/dl,- on 5/18/26, the normal (level 1) control result was 99 mg/dl and the high (level 2) control result was 262 mg/dl, and- on 5/19/26, the normal (level 1) control result was 102 mg/dl and the high (level 2) control result was 249 mg/dl.However, concurrent review of the results stored in the glucometer's memory storage failed to show the above documented control results. LVN 3 verified the above findings. On 5/21/26 at 1420 hours, an interview was conducted with the DON. The DON stated the purpose of performing the quality control test for the glucometers was to ensure the glucometers were working properly and ensure accurate measurements of blood glucoses. The DON stated the quality control tests were performed daily during the NOC shift, and the licensed nurses during the day shift were instructed to check at the beginning of the shift that the quality control tests were performed. On 5/21/26 at 1515 hours, an interview was conducted with the Administrator, ADON, and DON. The Administrator, ADON, and DON were informed and acknowledged the above findings.