STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055916	A. Building B. Wing	06/04/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sequoia Vista	3710 West Tulare Avenue Visalia, CA 93277

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to follow its policy and procedure (P&P) titled, Resident Personal Belongings for two of 51 sampled residents (Resident 26 and Resident 41) when Resident 26 and Resident 41's personal belonging were lost. This failure had the potential to negatively affect residents' dignity and quality of life.Findings:1. During an interview on 6/1/26 at 11:32 a.m. with Resident 41, Resident 41 stated, When I got here, my clothing went missing. This shirt [that I have on] isn't mine, but I wear it because it fit.During a review of Resident 41's Minimum Data Set (MDS-a resident assessment tool), dated 4/23/26, the MDS indicated, Resident 41 had a BIMS (Brief Interview for Mental Status-cognitive assessment) score of 14 (13-15 indicates normal thinking and memory).During a concurrent observation, interview, and record review on 6/3/26 at 2:47 p.m. with Licensed Vocational Nurse (LVN) 4 in Resident 41's room, Resident 41's Inventory of Personal Effects (IPE), dated 5/27/25 was reviewed. The IPE indicated, Resident 41 had a total of twenty personal belongings and there was no documentation of missing personal belongings. Resident 41 had 31 personal belongings in his closet. LVN 4 stated Resident 41 had five missing personal belongings that were not documented as missing in his IPE. LVN 4 stated Resident 41 had four belongings with no name and were not listed on the IPE. LVN 4 stated, Resident 41's belongings should have been labeled with his name. LVN 4 stated, The CNA [certified nursing assistant] or whoever is assigned to the resident [Resident 41] is supposed to update it [inventory list] and label clothing [personal belongings] with resident [Resident 41] name.During an interview on 6/4/26 at 8:31 a.m. with Housekeeping/Laundry Supervisor (HLS), HLS stated, Clothing goes to laundry with no name. It's CNA's responsibility to label it. HLS stated every month laundry had unclaimed resident personal belongings.During an interview on 6/4/26 at 8:59 a.m. with Social Service Director (SSD), SSD stated, all of Resident 41's clothing had been donated to him.2. During an interview on 6/2/26 at 3:13 p.m. with Resident 26, Resident 26 stated I am missing clothing. A whole bag of clothing. It [clothing] was never found.During a review of Resident 26's MDS, dated [DATE], the MDS indicated, Resident 26 had a BIMS score of 14.During a review of Resident 26's IPE, dated 9/18/25, the IPE indicated, Resident 26 had four items of clothing and no documented missing personal belongings. During a review of Resident 26's Theft and Loss Form (TLF), dated 4/6/26, the TLF indicated, Description of missing items: 1 red t-shirt with pocket, 1 navy shirt (t-shirt with pocket), 1 grey tank top, 1 grey shirt with collar.During a review of the facility's P&P titled, Resident Personal Belongings, undated, the P&P indicated, 1. All resident possessions, regardless of their apparent value to others, will be treated with respect. 4. Additional possessions brought in during the duration of the individual's stay shall be added to the existing personal belongings inventory listing.7. The facility will exercise reasonable care for the protection of the resident's property from loss or theft.

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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures to prevent abuse, neglect, and theft. Based on interview and record review, the facility failed to ensure annual abuse prevention training was completed for three of nine sampled employees (Certified Nursing Assistant [CNA] 2, Dietary Aide [DA], and Housekeeping/Laundry Supervisor [HLS]). This failure had the potential to result in staff's inability to recognize, report, and respond appropriately to allegations or signs of abuse, placing residents at risk for harm.Findings:During an interview on 6/4/26 at 9:16 a.m. with CNA 2, CNA 2 stated she had not been provided with annual abuse training.During a concurrent interview and record review on 6/4/26 at 11:16 a.m. with Director of Staff Development (DSD), CNA 2's Employee Personnel File (EPF), (undated) was reviewed. The EPF indicated, CNA 2 did not have annual abuse training completed. DSD stated CNA 2 did not have annual abuse training. DSD stated abuse training should be completed upon hire and annually.During a concurrent interview and record review on 6/4/26 at 2:35 p.m. with Human Resources/Payroll Manager (HR/PM), DA's EPF, (undated) was reviewed. The EPF indicated, DA's last abuse training was completed on 4/19/24. HR/PM stated DA did not have an annual abuse training completed.During a concurrent interview and record review on 6/4/26 at 2:42 p.m. with HR/PM, HLS's EPF, (undated) was reviewed . The EPF indicated, HLS last abuse training was completed on 12/29/23. HR/PM stated HLS did not have an annual abuse training completed. HR/PM stated all facility staff should have annual abuse training. During a review of the facility's policy and procedure (P&P) titled, Abuse, Neglect and Exploitation, dated 2025, the P&P indicated, Employee Training. A. New employees will be educated on abuse, neglect, exploitation and misappropriation of resident property during initial orientation. B. Existing staff will receive annual education through planned in-services and as needed.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. Based on observation, interview, and record review, the facility failed to ensure two of nine registered nurses (RN 2 and Director of Nursing [DON]) received education on use of an intravenous (IV- in the vein) pump (an electronic device that allows the nurse to program the rate and volume of the infusion), prior to the IV pumps being used. This failure had the potential for residents to have a delay in receiving their prescribed medications.Findings:During an observation on 6/3/26 at 9:15 a.m. in Resident 94's room, RN 2 was preparing to administer an IV antibiotic to Resident 94. Resident 94 asked RN 2, Do you know how to use the pump? The other day one of the nurses did not know how to use the pump.During an interview on 6/3/26 at 9:25 a.m. with DON, DON stated the pharmacy the facility recently contracted with uses a different model of IV pump than the prior pharmacy. DON stated she was not sure how to use the new pump and had to ask another nurse for assistance when she was going to administer IV antibiotics to Resident 94. DON stated when a resident had an IV medication order, the pharmacy would send an IV pump to the facility to be used to administer the medication. DON stated the pharmacy had not in-serviced RNs on the use of the new IV pumps. DON stated the pharmacist would provide an in-service, but no date had been set.During an interview on 6/3/26 at 10:55 a.m. with Administrator, Administrator stated her expectation would be for the nursing staff to be in-serviced on the use of the equipment before the equipment is used.During a concurrent interview and record review on 6/3/26 at 11:00 a.m. with DON and ADON, DON stated the facility began using the new pharmacy on 5/1/26. DON stated the new pharmacy provided an in-service on IV pumps that are now being used in the facility on 5/12/26. ADON provided a list of RNs employed by the facility, which showed nine RNs. The IV pump in-service sign-in sheet, dated 5/12/26, listed only three RNs who were in-serviced on use of the new IV pump. RN 2 was not listed on the IV pump in-service sign-in sheet.During a review of the IV pump manufacturers guidelines Service Manual (SM), (undated), the SM indicated, Parameter programming requires trained health care professional confirmation of limits and drug therapy to physician directive.During a review of the facility's policy and procedure (P&P) titled, Training Requirements dated 2025, the P&P indicated, It is the policy of this facility to develop, implement, and maintain an effective training program for all new and existing staff, individuals providing services under a contractual arrangement, and volunteers, consistent with their expected roles. 5. Training requirements should be met prior to staff and volunteers independently providing services to residents annually, and as necessary based on facility assessment.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. Based on interview and record review, the facility failed to ensure competency evaluations were completed upon hire and annually for six of seven sampled employees (Certified Nursing Assistant [CNA] 2, CNA 3, CNA 1, Licensed Vocational Nurse [LVN] 1. LVN 2, and LVN 3). This failure resulted in the facility not being able to ensure staff possessed competency to provide care and services to meet resident needs. Findings:During an interview on 6/4/26 at 9:16 a.m. with CNA 2, CNA 2 stated she had been working at the facility since 2024. CNA 2 stated she had a competency evaluation upon hire but had not had another competency evaluation competed within the last year.During a concurrent interview and record review on 6/4/26 at 11:16 a.m. with Director of Staff Development (DSD), CNA 2's Employee Personnel File (EPF), (undated) was reviewed. The EPF indicated, CNA 2 had an orientation competency evaluation completed on 11/12/24. DSD stated CNA 2 did not have an annual competency evaluation since 11/12/24. DSD stated competency evaluations should be completed annually based off the hire date. DSD stated CNA 2 should have had an annual competency completed in November 2025.During a concurrent interview and record review on 6/4/26 at 11:35 a.m. with DSD, CNA 3's EPF, (undated) was reviewed. The EPF indicated, CNA 3 had an orientation competency evaluation completed on 11/1/24. DSD stated CNA 3 did not have an annual competency evaluation completed since 11/1/24. DSD stated CNA 3 should have had an annual competency completed in November 2025.During a concurrent interview and record review on 6/4/26 at 11:52 a.m. with DSD, CNA 1's EPF, (undated) was reviewed. The EPF indicated, CNA 1 had a hire date of 1/27/25 and there were no competency evaluations completed upon hire or annually. DSD stated CNA 1's orientation competency was blank and not completed. DSD stated CNA 1 should have had annual competency completed in January 2026.During a concurrent interview and record review on 6/4/26 at 2:12 p.m. with Director of Nursing (DON), LVN 1's EPF, (undated) was reviewed. The EPF indicated, LVN 1 had a hire date of 1/30/23 and there were no annual competency evaluations completed. DON stated there were no competencies completed for LVN 1 since 1/30/23. During a concurrent interview and record review on 6/4/26 at 2:21 p.m. with Human Recourses/ Payroll Manager (HR/PM), LVN 2's EPF, (undated) was reviewed. The EPF indicated, LVN 2 had a hire date of 10/20/25 and there were no orientation competency evaluations completed upon hire. HR/PM stated LVN 2 should have had an orientation competency completed.During an interview on 6/4/26 at 2:29 p.m. with DON, DON stated LVN 2 should have had an orientation competency completed upon hire. DON stated because LVN 2 did not have an orientation competency evaluation, she did not know LVN 2's skill set to provide care to residents.During a concurrent interview and record review on 6/4/26 at 2:30 p.m. with DSD, LVN 3's EPF, (undated) was reviewed. The EPF indicated, LVN 3 had a hire date of 5/11/26 and there were no competency evaluations completed upon hire. DSD stated LVN 3's orientation competency was not completed. DSD stated LVN 3 should have had an orientation competency completed prior to her completing the orientation process.During a review of the facility's policy and procedure (P&P) titled, Competency Evaluation, dated 2025, the P&P indicated, It is the policy of this facility to evaluate each employee to assure they meet appropriate competencies and skills for performing their job.Initial competency is evaluated during the orientation process. An employee remains on orientation until all competencies are verified.Subsequent and/or annual competency is evaluated at a frequency determined by the facility assessment, evaluation of the training program, and/or job performance evaluations.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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, and record review, the facility failed to store over-the-counter medications (medication that does not require a prescription) in a clean and sanitary area. This failure had the potential for medications to become contaminated. Findings: During a concurrent observation and interview on [DATE] at 2:03 p.m. with Maintenance and Central Supply Personnel (MCSP), in the dirty utility area (a dedicated space used to store contaminated items and medical waste), there were four vital signs machines (an electronic assessment device) without covering. A sign by the wall indicated, Dirty Side. Two cabinets filled with over-the-counter medications in the dirty area. MCSP stated those are new medications and not expired. MCSP stated they have nowhere else to store the over-the-counter medications.During a review of the facility's policy and procedure (P&P) titled, Medication Storage, dated 2026, the P&P indicated, It is the policy of this facility to ensure all medications housed on our premises will be stored in the pharmacy and/or medications rooms according to the manufacturer's recommendations and sufficient to ensure proper sanitation, temperature, light, ventilation, moisture control, segregation, and security.

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F 0800 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs. Based on observation, interview, and record review, the facility failed to ensure a recipe was followed when preparing a pureed (food blended to a pudding like consistency) diet. This failure had the potential for pureed food to not conserve its nutritive value, flavor, or the proper consistency for a pureed diet. Findings: During a concurrent observation and interview on 6/2/26 at 9:30 a.m. with [NAME] 1 in the kitchen, [NAME] 1 prepared to puree food for nine residents on pureed diets. [NAME] 1 stated the day's lunch menu was herb and spice roast beef with gravy, mashed potatoes, spinach au gratin, Caesar salad, fruit mix, and crumble cake. [NAME] 1 pureed the spinach and did not follow a recipe. [NAME] 1 pureed the roast beef and did not follow a recipe. [NAME] 1 was asked if he followed a pureed recipe. [NAME] 1 stated he had never seen a recipe book or binder for pureed diets and had not followed a recipe.During a concurrent interview and record review on 6/2/26 at 10:39 a.m. with Certified Dietary Manager (CDM), the recipe for pureed meats, dated 2025, was reviewed. The recipe indicated, Directions:1. Complete regular recipe. Measure out the total number of portions needed for pureed diet. 2. Puree on low speed to a paste consistency before adding any liquid. 3. Gradually add warm liquid (low sodium broth or gravy). See above for recommended amounts of liquid, starting with the smaller amount and adding in more as needed to achieve the desired consistency. 5. The finished pureed item should be smooth and free of lumps, hold its shape, while not being too firm or sticky, and should not weep. CDM stated [NAME] 1 did not follow a pureed recipe and he should have.During a review of the facility's policy and procedure (P&P) titled, Food Preparation, dated 2023, the P&P indicated, Food shall be prepared by methods that conserve nutritive value, flavor, and appearance. The facility will use approved recipes, standardized to meet the resident census. 2. Recipes are specific as to portion yield, method or preparation.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to label and date three open boxes of food items in one of one freezer (Freezer 1) in the kitchen. This failure had the potential for residents to consume expired food. Findings: During a concurrent observation and interview on 6/1/26 at 9:32 a.m. in the facility kitchen with Certified Dietary Manager (CDM), Freezer 1 contained open, undated and unlabeled boxes of zucchini, french toast, and sausage. CDM stated all stored food items need to be labeled with a received by date and and open date. During a review of the facility's policy and procedure (P&P) titled, Labeling and dating of Foods, dated 2023, the P&P indicated, All food items in the storeroom, refrigerator, and freezer need to be labeled and dated. newly opened food items will need to be closed and labeled with an open date and used by date. produce is to be dated with received date.

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F 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Inform resident or representatives choice to enter into binding arbitration agreement and right to refuse. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to follow its policy and procedure (P&P) titled, Binding Arbitration Agreement (BAA - a way to resolve disputes between healthcare providers and residents) for three of three sampled residents (Resident 32, Resident 41, and Resident 80) when admission staff did not provide documentation and explanation in the residents' primary language. This failure had the potential for Resident 32, Resident 41, and Resident 80 to not be aware or fully understand the legal document they signed. Findings: 1. During a concurrent interview and record review on 6/3/26 at 9:37 a.m. with admission Coordinator (AC), Resident 32's BAA form, dated 9/9/25, was reviewed. AC stated the form was in English and it was not documented if the BAA was explained to Resident 32 in Spanish.During a concurrent interview and record review on 6/3/26 at 10:53 a.m. with Resident 32, Resident 32's BAA form, dated 9/9/25, was reviewed. Resident 32's BAA indicated, the form was written in English. Resident 32 stated he signed the BAA form written in English but does not know what he signed. Resident 32 stated his primary language was SpanishDuring a review of Resident 32's admission Record (AR), dated 6/3/26, the AR indicated, Resident 32's primary language was Spanish.During a review of Resident 32's Minimum Data Set (MDS-comprehensive assessment tool) dated 3/11/26, the MDS indicated, Resident 32 had a Brief Interview for Mental Status (BIMS-cognitive assessment tool) score of 8 (scores of 8-12 indicated moderately impaired cognition). 2. During a concurrent interview and record review on 6/3/26 at 9:39 a.m. with AC, Resident 41's BAA form, dated 3/12/25, was reviewed. AC stated the BAA form was in English and there was no documentation that indicated the BAA was explained to Resident 41 in Spanish.During a concurrent interview and record review on 6/3/26 at 10:44 a.m. with Resident 41, Resident 41's BAA form, dated 3/12/25, was reviewed. Resident 41's BAA indicated, the form was written in English. Resident 41 stated he signed the BAA form written in English but does not recall if the staff explained to him what he signed. Resident 41 stated the staff just asked him to sign it. Resident 41 stated his primary language was Spanish.During a review of Resident 41's AR, dated 6/3/26, the AR indicated, Resident 41's primary language was Spanish.During a review of Resident 41's MDS, dated [DATE], the MDS indicated, Resident 41 had a BIMS score of 14 (scores of 13-15 indicate intact cognition). 3. During a concurrent interview and record review on 6/3/26 at 9:41 a.m. with AC, Resident 80's BAA form, dated 8/18/25, was reviewed. AC stated the BAA form was in English and there was no documentation that indicated the BAA was explained to Resident 80 in Spanish.During a concurrent interview and record review on 6/3/26 at 11:03 a.m. with Resident 80, Resident 80's BAA form was reviewed. The BAA indicated, the form was written in English. Resident 80 stated the signature on the English form was his. Resident 80 stated no one from the facility had explained what was on the BAA form. Resident 80 stated that he just signed it. Resident 80 stated his primary language was Spanish.During a review of Resident 80's AR, dated 6/3/26, the AR indicated, Resident 80's primary language was Spanish.During a review of Resident 80's MDS dated [DATE], the MDS indicated, Resident 80 had a BIMS score of 14.During a review of the facility's policy and procedure (P&P) titled, Binding Arbitration Agreements, dated 2025, the P&P indicated, 1. When explaining the arbitration agreement, the facility shall. b. Explain to the resident and his or her representative in a form and manner that he or she understands, including in a language the resident and his or her representative understands. c. Ensure the resident or his or her representative acknowledges that he or she understands the agreement.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observation, interview, and record review, the facility failed to implement infection control practices when: The laundry room had two large plastic containers with colored liquid that were stored on the floor.The laundry room had an uncovered trash bin between two washing machines.Two of four sampled clean linen closets (CLC 2 and CLC 3) had dirty equipment stored and touching clean linen. Two of four sampled staff (Minimum Data Set Coordinator [MDSC] and Treatment Nurse [TN]) entered a contact isolation room (rooms where anyone entering must wear a protective gown and gloves, and wash their hands when entering and exiting the room to prevent the spread of infection) without wearing Personal Protective Equipment (PPE- wearable devices, clothing, or equipment to protect from infections.)The TN did not disinfect the surface before placing wound dressing supplies. The TN did not perform hand hygiene (cleaning hands by using soap and water or an alcohol based sanitizer) during wound dressing change for one of one sampled residents (Resident 41).The facility failed to implement effective infection control surveillance for 15 of 15 sampled residents (Resident 3, Resident 96, Resident 97, Resident 98, Resident 14, Resident 6, Resident 89, Resident 22, Resident 51, Resident 46, Resident 9, Resident 68, Resident 26, Resident 99, and Resident 62).Two of two sampled utility rooms (UR) were not separated into clean and dirty areas.Two of two sampled occupied isolation rooms contained residents on different types of isolation precautions (infection control measures used in healthcare settings to prevent the spread of germs). These failures had the potential to spread infectious diseases to residents, staff, and visitors. Findings: 1. During a concurrent observation and interview on 6/3/26 at 8:29 a.m. with Plant Operation Supervisor (POS), in the laundry room, there were two large plastic containers stored on the floor. One container contained a green colored liquid and the other contained a blue colored liquid. POS stated the two plastic containers on the floor were a kitchen degreaser and a cleaner. POS stated he did not know why the two plastic containers were on the laundry room floor and they should not have been there.During an interview on 6/4/26 at 8:42 a.m. with Housekeeping/Laundry Supervisor (HLS), HLS stated the degreaser should not have been on the floor, and it should have been stored on a shelf.2. During an observation on 6/3/26 at 8:30 a.m. in the laundry room, there was a large, uncovered trash bin that contained trash between two washing machines.During an interview on 6/4/26 at 8:42 a.m. with HLS, HLS stated the trash bin should have a lid at all times.During a review of the facility's policy and procedure (P&P) titled, Environmental Services Safety Procedures,(undated), the P&P indicated, It is the policy of this facility to ensure general safety procedures are followed in the course of performing housekeeping and/or laundry duties. Policy Explanation and compliance guidelines. 3. Staff will ensure equipment (e.g., cords, ladders, or chemicals) is properly stored and not left unattended in areas that are accessible to residents. When not in use, equipment will be stored in a locking closet, cabinet or storage area for safety.3. During an observation on 6/3/26 at 8:32 a.m. in CLC 2, there was a folded chair stored and leaning on the clean linens. During an observation on 6/3/26 at 8:32 a.m. in CLC 3, two wheelchair footrests were stored. During an interview on 6/4/26 at 8:42 a.m. with HLS, HLS stated the clean linen closets should not be used as a storage area for equipment. During a review of the facility's P&P titled, Handling Clean Linen, undated, the P&P indicated, It is the policy of the facility to handle, store, process, and transport clean linen in a safe and sanitary method to prevent contamination of the linen, which can lead to infection.4. During an observation on 6/3/26 at 9:17 a.m. in Resident 3's and Resident 41's room, a sign by the door indicated, Contact Precautions. MDSC and TN entered the room without wearing a PPE. During an observation on 6/3/26 at 9:19 a.m. outside of Resident 41 and Resident 3's room, there were two signs by the door that indicated Contact Precautions (CP-measures used to stop the spread of germs that are passed by physical touch) and Enhanced Barrier Precautions (EBP-measures used to prevent the spread of resistant germs). CP sign indicated, Everyone must clean their hands including before entering and when leaving the room. Provider and staff must also put on gloves before room entry and (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	discard gloves before room exit. Put on gown before room entry. Discard gown before exit. Do not wear the same gown and gloves for the care of more than one person. During a review of Resident 3's Order Details (OD), dated 6/1/26, the OD indicated, Contact precautions related to MRSA (Methicillin-resistant Staphylococcus aureus - a type of germ that is resistant to many common antibiotics [medicine to treat infections]) wound infection.During an interview on 6/3/26 at 9:25 a.m. with Infection Preventionist (IP), IP stated for contact precautions, PPE must be worn when entering the room. During a review of the facility's P&P titled, Transmission-Based (Isolation) Precautions, (undated), the P&P indicated, 10. Contact Precautions. c. Healthcare personnel caring for residents on Contact Precautions wear a gown and gloves for all interactions that may involve contact with the resident or potentially contaminated areas in the resident's environment. d. Donning personal protective equipment (PPE) upon room entry and discarding before exiting the room.5. During a concurrent observation and interview on 6/3/26 at 9:40 a.m. with TN, in Resident 41's room, TN placed her wound dressing supplies on a barrier sheet (a protective layer of material). TN carried the barrier sheet and placed it on Resident 41's bedside table. Resident 41's bedside table was not cleaned or sanitized before the barrier sheet was placed. TN stated, I know I should have [sanitized the bedside table].During a review of the facility's P&P titled, Clean Dressing Change, (undated), the P&P indicated, 5. Set up clean field on the overbed table with needed supplies for wound cleansing and dressing application. a. If the table is soiled, wipe clean. 6. During a concurrent observation and interview on 6/3/26 at 9:40 a.m. with TN, in Resident 41's room, TN removed Resident 41's wound dressing, TN removed her gloves and put on a new pair of gloves without performing hand hygiene. TN cleansed the wound with wet gauze, removed her gloves, and applied a new pair of gloves and did not perform hand hygiene. TN applied a cream to Resident 41's wound then changed her gloves and did not perform hand hygiene prior to clean gloves being applied. TN stated she did not perform hand hygiene. During a review of the facility's P&P titled, Clean Dressing Change, (undated), the P&P indicated, 7. Wash hands and put on clean gloves.10. Remove gloves pulling inside out over the dressing. Discard into appropriate receptacle.11. Wash hands and put on clean gloves.During a review of the facility's P&P titled, Hand Hygiene, (undated), the P&P indicated, 1. Staff will perform hand hygiene when indicated, using proper technique consistent with accepted standards of practice. 6. a. The use of gloves does not replace hand hygiene. if your task requires gloves, perform hand hygiene prior to donning gloves, and immediately after removing gloves. 7. During a review of the facility's Infection Surveillance Report (ISR-the systematic collection and analysis of infection data, typically focusing on healthcare-associated infections (HAIs) and communicable diseases), dated January 2026, February 2026, March 2026, and April 2026, the ISR indicated, the following infections did not have documentation of signs and symptoms:a) On 1/19/26, Resident 3 had a diagnosis of sepsis (life threatening infection in the body).b) On 1/24/26, Resident 96 had a diagnosis of Bacteremia (bacteria in the blood stream).c) On 1/28/26, Resident 97 had a diagnosis of Bacteremia. d) On 1/22/26, Resident 98 had a diagnosis of Osteomyelitis (infection of the bone).e) On 1/16/26, Resident 14 had a diagnosis of Periodontitis (gum infection) and Otitis Media (ear infection).f) On 2/16/26, Resident 6 had a diagnosis of skin infection.g) On 2/16/26, Resident 3 had a diagnosis of skin infection. h) On 2/25/26, Resident 89 had a diagnosis of skin infection. i) On 2/26/26, Resident 22 had a diagnosis of Urinary Tract Infection (UTI-bladder infection).j) On 3/26/26, Resident 51 had a diagnosis of Pneumonia (lung infection).k) On 3/31/26, Resident 46 had a diagnosis of UTI.l) On 4/2/26, Resident 9 had a diagnosis of Bacteremia.m) On 4/20/26, Resident 68 had a diagnosis of Pneumonia.n) On 4/22/26, Resident 26 had a diagnosis of UTI.o) On 4/16/26, Resident 99 had a diagnosis of Cystitis (bladder infection).p) On 4/16/26, Resident 62 had a diagnosis of UTI.During an interview on 6/3/26 at 11:02 a.m. with Director of Staff Development (DSD), DSD stated she was the IP from January to April 2026. DSD stated she should have documented the signs and symptoms because it (documentation of signs and symptoms) was part of the ISR. During a review of the facility's P&P titled, Infection Surveillance, dated August 2024, the P&P indicated, The facility will collect data to (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	properly identify possible communicable diseases or infections among residents and staff before they spread by identifying: a. Data to be collected, including how often and the type of data to be documented, including. i. The infection site, pathogen (if available), signs and symptoms, and resident locations.8. During a concurrent observation and interview on 6/3/26 at 2:32 p.m. with IP, in UR1, there was line of red tape on the floor separating a portion of the room. UR 1 had a sign on the left side of the room that indicated, Dirty Side and a sign on the right side of the room that indicated, Clean Side. There was clean equipment on the left side of the red tape identified as the Dirty Side. IP stated the facility's clean and dirty utility area are combined in one room, with red tape dividing the clean and dirty sides. During a concurrent observation and interview on 6/3/26 at 2:34 p.m. with IP, in UR 2, there was a combination of clean and dirty equipment stored with no separation. IP stated the clean and dirty equipment should have been separated.9. During an observation on 6/1/26 at 9:51 a.m. outside of Resident 58's and Resident 89's room, a sign by the door indicated, Neutropenic Precaution (NP-infection prevention rules for people with severely low level of white blood cells [body's main defense against germs.]). The NP sign indicated, Everyone must: Perform hand hygiene before entering room and when leaving room. Put on gown before entering room and remove before leaving room. Put on gloves before entering room and remove before leaving room. Put on mask before entering room. Resident 58 was in the room with Resident 89 who was on neutropenic precautions. Resident 58 was not wearing a mask, gown, or gloves.During a review of Resident 89's OD, dated 6/1/26, the OD indicated, Neutropenic precautions related to neutropenia (low white blood cells).During an interview on 6/1/26 at 9:59 a.m. with IP, IP stated Resident 58 and Resident 89 should be in separate rooms.During an observation on 6/3/26 at 9:19 a.m. outside of Resident 41's and Resident 3's room, there were two signs posted on the wall indicated, Contact Precautions and Enhanced Barrier Precautions. During a review of Resident 41's Order Summary Report (OSR), dated 1/2/26, the OSR indicated, enhanced barrier precautions in place related to chronic [recurs over a long time] wounds.During a review of Resident 3's OD, dated 6/1/26, the OD indicated, Contact precautions related to MRSA wound infection.During an interview on 6/3/26 at 3:16 p.m. with IP, IP stated residents on contact isolation should be separated.During a review of the facility's P&P titled, Neutropenic Precautions, (undated), the P&P indicated, Policy Explanation: People that receive or have received chemotherapy or have other medical conditions that result in the decrease of the number of white blood cells are at risk for developing neutropenia. This places the person at greater risk of developing an infection. Neutropenic precautions are a mechanism to help protect the neutropenic person from the increased risk of infection. Compliance guidelines. 2. Staff, visitors, and other residents will adhere to guidance of the precautions to help protect the affected resident.During a review of the facility's P&P titled, Infection Prevention and Control Program, dated February 2025, the P&P indicated, This facility has established and maintains an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections as per accepted national standards and guidelines. 5. Isolation Protocol (Transmission-Based Precautions). b. Residents on transmission-based precautions should be placed into a private/single room if available/appropriate, or are cohorted with residents with the same pathogen, or share a room with a roommate with limited risk factors, in accordance with national standards.During a review of the facility's P&P titled, Transmission-Based (Isolation) Precautions, (undated), the P&P indicated, It is our policy to take appropriate precautions to prevent transmission of pathogens, based on the pathogens' modes of transmission. Policy explanation and compliance guidelines.3. When implementing transmission-based precautions, the facility will consider the following. c. Cohorting residents with the same pathogen.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. Based on interview and record review, the facility failed to notify the responsible party (RP) for one of 51 sampled residents (Resident 5) when a referral to a specialist (a medical doctor who has training in a specific field of medicine) was made . This failure had the potential for RP not being aware of Resident 5's treatment plan. Findings: During an interview on 6/3/26 at 3:45 p.m. with RP, RP stated she was not informed of Resident 5's referral to a urologist (a medical doctor who specializes in diagnosing and treating diseases of the kidneys). During a review of Resident 5's Order Details (PO-Physician's Orders), dated 4/1/26 the PO indicated, Urology consult ASAP [As soon as possible] per NP [Nurse practitioner - a registered nurse with advanced education and training] . During a review of Resident 5's Minimum Data Set (MDS - Comprehensive assessment tool), dated 4/8/26, the MDS indicated, Resident 5 had a Brief Interview for Mental Status (BIMS- cognitive assessment) score of 4 (score of 0-7 means cognitively impaired). During a concurrent interview and record review on 6/4/26 at 9:20 a.m. with Social Services Director (SSD), Resident 5's clinical record and was reviewed. SSD was unable to find documentation of notification to the RP. SSD stated she did not notify the RP of the referral to the Urologist. During a concurrent interview and record review on 6/4/26 at 10:57 a.m. with Director of Nursing (DON), Resident 5's clinical record was reviewed. DON stated she was unable to find documentation of notification to Resident 5's RP. DON stated the RP notification of Resident 5's referral to the urologist was the responsibility of the licensed nurses. During a review of the facility's policy and procedure (P&P) titled, Care Planning - Resident Participation, (undated), the P&P indicated, 3. The facility will notify the resident and/or resident representative, in advance, of the care to be furnished and the type of caregiver or professional that will furnish care, as well as changes to the plan of care. During a review of the facility's P&P titled, Notification of Changes, (undated), the P&P indicated, Compliance Guidelines: The facility must inform the resident, consult with the resident's physician and/or notify the resident's family member or legal representative when there is a change requiring such notification. Circumstances requiring notification include.3. Circumstances that require a need to alter treatment. This may include: a. New treatment.

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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. Based on interview and record review, the facility failed to ensure care conferences were conducted at least quarterly for one of four sampled residents (Resident 6). This failure had the potential for care needs to go unmet.Findings:During a concurrent interview and record review on 6/3/26 at 11:24 a.m. with Assistant Director of Nursing (ADON) and Social Services Director (SSD), Resident 6's documented care conferences were reviewed. ADON stated Resident 6's last two care conferences were conducted on 3/8/24 and 10/22/25. SSD stated care conferences should be conducted quarterly and for Resident 6 they were not.A care conference policy was requested, and not was provided.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on observation, interview, and record review the facility failed to ensure medication was available to administer for one of four sampled residents (Resident 8). This failure had the potential for Resident 8 to experience symptoms of anxiety (a feeling of worry).Findings:During a review of Resident 8's physician orders (PO), the PO, dated 5/13/26, indicated, BusPIRone HCl [medication used to relieve the symptoms of anxiety and anxiety disorders] Tablet 5 MG [milligram]. Give 2 tablet [sic] by mouth two times a day for m/b [manifested by] inability to relax related to ADJUSTMENT DISORDER WITH MIXED ANXIETY AND DEPRESSED MOOD 2 tablets = 10 mg.During a concurrent observation and interview on 6/3/26 at 9:42 a.m. with Licensed Vocational Nurse (LVN) 5, outside of Resident 8's room, LVN 5 prepared to give Resident 8 his morning medications. LVN 5 stated she was unable to find Resident 8's BusPIRone HCl in the medication cart.During a concurrent observation and interview on 6/3/26 at 9:44 a.m. outside of Resident 8's room, LVN 5 called the facility's pharmacy to re-order Resident 8's BusPIRone HCl. LVN 5 stated the pharmacy told her the medication would be delivered at noon on that day.During an interview on 6/3/26 at 10:38 a.m. with Director of Nursing (DON), DON stated medication refills can be requested using the facility's electronic medical record or by faxing a paper order form to pharmacy. DON stated the expectation is for nurses to re-order medication when there is still one to two days' worth of the resident's medication left and not wait until the medication is depleted.During a review of the facility's policy and procedure (P&P) titled, Medication Reordering dated, 2026, the P&P indicated, It is the policy of this facility to accurately and safely provide or obtain pharmaceutical services including the provision of routine and emergency medications and biologicals in a timely manner to meet the needs of each resident. 1. The facility will utilize a systematic approach to provide or obtain routine and emergency medications and biologicals in order to meet the needs of each resident. 2. Acquisition of medications should be completed in a timely manner to ensure medications are administered in a timely manner. 3. Each time a nurse is administering medications and observes (6) or less doses left of one kind, that nurse will reorder the medication, time permitting.

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure therapeutic diets are prescribed by the attending physician and may be delegated to a registered or licensed dietitian, to the extent allowed by State law. Based on observation, interview, and record review, the facility failed to ensure one of 15 sampled residents (Resident 20) received a diet as ordered by the physician. This failure had the potential to result in choking, difficulty chewing and swallowing, and inadequate nutritional intake.Findings:During a review of Resident 20's Order Summary Report (OSR), dated 6/3/26, the OSR indicated, on 5/8/26 Resident 20's physician ordered a no added salt, soft and bite sized diet. During a review of Resident 20's Care Plan Report (CPR), dated 3/23/26, the CPR indicated, [Resident 20] has nutritional problem or potential nutritional problem r/t [related to]. poor PO [by mouth] intake. Interventions. Licensed nurse to check trays for accuracy every meal. Provide and serve diet as ordered.During an observation on 6/1/26 at 12:28 p.m. in the dining room, Resident 20 was served a lunch plate that had a quesadilla (melted cheese in a toasted flour tortilla) cut into approximately 3-inch triangles. Resident 20 was not eating the quesadilla.During a concurrent observation and interview on 6/1/26 at 12:46 p.m. with Certified Dietary Manager (CDM) in the dining room, Resident 20's lunch plate had a quesadilla that was cut into approximately 3-inch triangles. CDM stated Resident 20 had received the quesadilla for lunch because she did not like beef and this was the alternative. CDM stated Resident 20's quesadilla should have been cut into smaller pieces than what she was served. CDM stated the quesadilla portions were too big of portions to be considered bite sized. CDM stated Resident 20 should not have been served a quesadilla as part of her soft diet.During an observation on 6/1/26 at 12:52 p.m. in the dining room, Resident 20 finished eating her lunch meal. Resident 20 had not eaten any of her quesadilla. During a review of the facility's policy and procedure (P&P) titled, Therapeutic Diet Orders, dated 2026, the P&P indicated, The facility provides all residents with foods in the appropriate form and/or the appropriate nutritive content as prescribed by a physician. 5. Dietary and nursing staff are responsible for providing therapeutic diets in the appropriate form and/or the appropriate nutritive content as prescribed.During a review of the International Dysphagia Diet Standardization Initiative Framework (IDDSIF), dated 2019, the IDDSIF indicated, Soft & [and] Bite-Sized. Bite-sized pieces as appropriate for size and oral processing skills. Adults, 15 mm [millimeter] = [equals] 1.5 cm [centimeter] pieces (no larger than). Biting is not required.When a sample the size of a thumb nail (1.5 cm x 1.5 cm) is pressed with the base of a spoon, the sample squashes and breaks apart, changes shape, and does not return to it original shape when the spoon is removed. No regular dry bread, sandwiches or toast of any kind. prepared bread that meets Level 6 Soft & Bite sized requirements. Pre-gelled soaked breads that are very moist and gelled through the entire thickness.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. Based on interview and record review, the facility failed to implement an effective antibiotic stewardship program (a coordinated healthcare initiative that ensures antibiotics are prescribed only when necessary and used correctly) for one of five sampled residents (Resident 35). This failure had the potential for Resident 35 to receive inappropriate antibiotics and had the potential for untreated infections.Findings: During a review of the facility's Infection Prevention and Control Surveillance Log (IPCSL), dated 4/18/26, the IPCSL indicated, Resident 35 had signs and symptoms. Dysuria [pain, burning, or discomfort during urination] .the organism on culture. not completed. treatment.Bactrim DS [antibiotic] twice a day for seven days. During a review of Resident 35's Lab [laboratory] Results Report (LRR), dated 4/17/26, the LRR indicated, 1) Please specify the test that was not performed: urine culture [a laboratory test that grows bacteria or yeast from a urine sample to diagnose urinary tract infections (UTIs). It identifies the exact type of germ causing the infection and determines which antibiotics will work best to treat]. 2) Please specify the reason the test was not performed: Improper Specimen Storage/Transportation issue. During a review of Resident 35's Medication Administration Record (MAR), dated April 2026, the MAR indicated, Resident 35 received Bactrim DS from 4/19/26 to 4/25/26 (for seven days). During an interview on 6/3/26 at 10:25 a.m. with Infection Preventionist (IP), IP stated there was no documentation the urine culture was re-done. IP stated, The urine specimen should have been re-collected and sent to lab. IP stated re-collection of urine specimen and monitoring lab results was the responsibility of the IP and licensed nurses to follow up. During a review of the facility's policy and procedure (P&P) titled, Antibiotic Stewardship Program, dated February 2025, the P&P indicated, b. Monitoring antibiotic use. i. Monitor response to antibiotics, and laboratory results when available, to determine the antibiotic is still indicated or adjustments should be made (e.g., antibiotic time-out).

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. Based on interview and record review, the facility failed to develop a plan of care for the refusal of immunizations (the process by which a person's immune system becomes fortified against an infectious disease through vaccination) for one of five sampled residents (Resident 18). This failure had the potential for staff to be unaware of monitoring the risks for the Resident 18, who did not receive immunizations.Findings: During a review of Resident 18's Resident Vaccine Consent Form (RVCF), dated 3/25/26, the RVCF indicated, Resident 18 refused immunization for Pneumococcal (bacterial infection of the lungs), RSV (Respiratory Syncytial Virus-serious lung disease), and TDAP (Tetanus- a life-threatening bacterial disease that affects the nervous system, causing painful muscle contractions and spasms, and Diphtheria - a highly contagious, serious bacterial infection and Pertussis-contagious respiratory infection). During a concurrent interview and record review on 6/3/26 at 10:43 a.m. with Infection Preventionist (IP), Resident 18's Clinical Record (CR) was reviewed. IP stated she could not find a care plan for Resident 18's refusal of immunization. During a review of the facility's policy and procedure (P&P) titled, Pneumococcal Vaccine (Series), dated February 2025, the P&P indicated, The resident/representative retains the right to refuse the immunization. The facility will document in the clinical record the reason for refusal or the medical contraindication of the immunization.

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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 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure one of 51 sampled residents (Resident 7) call light system was functioning properly. This failure had the potential to place Resident 7 at risk for delayed staff response to urgent needs and medical emergencies.Findings:During a review of Resident 7's Minimum Data Set (MDS, a standardized assessment tool), dated [DATE]. The MDS, section GG functional abilities indicated, Resident 7 needed staff assistance with activities of daily living, including transfers and toileting.During a concurrent observation and interview on [DATE] at 11:23 a.m. with Resident 7 in Resident 7's room, Resident 7 stated that the call light system had not been working for months. Resident 7 stated that she had informed multiple staff of this issue. Resident 7 stated that she had to go out to the hallway to call for help. Resident 7 pushed the call light that was on her bed to call for assistance. The call light did not light up in the hallway and did not register any noise.During a concurrent observation and interview on [DATE] at 11:24 a.m. with Certified Nursing Assistant (CNA) 1 in Resident 7's room, CNA 1 stated Resident 7 does not use her call light. CNA 1 stated Resident 7 rolls herself out to hallway to ask for assistance. CNA 1 pushed Resident 7's call light and stated Resident 7's call light was not working.During an interview on [DATE] at 11:26 a.m. with Activities Director (AD), AD stated Resident 7's call light was not lighting up in the hallway to indicate Resident 7 needed assistance.During a review of the facility's policy and procedure (P&P) titled, Call Lights: Accessibility and Timely Response, dated 2025, the P&P indicated, The purpose of this policy is to assure the facility is adequately equipped with a call light at each resident bedside, toilet and bathing facility to allow residents to call for assistance. 8. Staff will report problems with a call light or the call system immediately to the supervisor and/or maintenance director and will provide immediate or alternative solutions until the problem can be remedied. (Examples include: replace call light, provide a bell or whistle, increase frequency of rounding, etc.) 9. Ensure the call light system alerts staff members directly or goes to a centralized staff work area.