

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

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No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055917	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/12/2026
NAME OF PROVIDER OR SUPPLIER Harvest Crossing Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 469 East North Street Manteca, CA 95336	
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 0922 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have enough backup water supply for essential areas of the nursing home. Based on observation and interview, the facility failed to ensure an adequate available emergency water supply for a census of 89 residents. This failure had the potential to result in residents not having access to sufficient water for hydration, sanitation, and essential care needs in the event of an emergency. Findings: During a concurrent observation and interview on 3/9/26 at 9:10 AM with the Maintenance Director (MAT), five blue water barrels were observed outdoors along the facility fence. According to the MAT, each of those five water barrels held approximately 55 gallons, totaling 275 gallons. The MAT stated that the barrels were emptied and removed from the maintenance shed in preparation for renovation, as they were heavy to move when filled. The MAT further stated that the barrels were placed outside and would be refilled the following week. Additionally, the MAT stated that the water barrels would remain stored outdoors during the duration of the shed renovation. During an interview on 3/9/26 at 9:30 AM with the Certified Dietary Manager (CDM), the CDM stated that in the event of an emergency, the facility would obtain water from the faucet. The CDM also stated that if the water lines were not functional, they would use water from the boiler, but she was unable to state the volume available. During a concurrent observation and interview on 3/10/26 at 8:04 AM with the MAT, five water barrels were observed inside the maintenance shed and filled with water. The MAT stated that the water barrels were refilled on 3/9/26. During an interview on 3/10/26 at 8:42 AM with the Administrator In Training (AIT), the AIT stated that the emergency water barrels had been emptied on 3/8/26 and acknowledged he was not aware of this until the following day (3/9/26). The AIT stated, in the event of an emergency during that time, the facility would have used boiler water, estimated at approximately 10 gallons, and would have purchased water externally. During an interview on 3/12/26 AT 8:42 AM with the Director of Nursing (DON), the DON stated that if an emergency had occurred after the barrels were emptied, the facility would have insufficient water available. During a review of the facility's policy titled Emergency Supplies Planning, revised on 8/18, indicated, .The facility maintains a minimum of 1 gallon of sealed emergency water per person for three days.		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - 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 maintain sanitary conditions in food handling, storage, and preparation areas for 84 residents whom received meals from the kitchen when:1. A black ice container was stored underneath a soap dispenser;2. A damaged strainer was available for use in food preparation;3. A plastic container used to store food-contact utensils was dirty;4. Water pitchers and lids were stored with visible water droplets and were stacked and stored while still wet;5. A dented canned food item was stored in the canned goods storage area for use;6. A refrigerator located in the nurses' break room that stored resident food items had a temperature reading of 50 degrees Fahrenheit (F; a unit of temperature measurement); and7. A food delivery service driver was in the kitchen without a hair net.These failures have the potential to result in cross-contamination and foodborne illness for 84 residents. Findings:1. During a concurrent observation and interview on 3/9/26 at 8:15 AM with the Certified Dietary Manager (CDM), a black ice container was observed stored underneath a soap dispenser. The CDM stated they did not have another place to store the ice container and repositioned it slightly to prevent water and/or soap from dripping directly onto the ice bucket during handwashing.During a concurrent observation and interview on 3/10/26 at 9:58 AM with the CDM, the CDM stated that their Maintenance Director adjusted the soap dispenser closer to the sink to prevent water and/or soap from dripping onto the ice bucket.During an interview on 3/12/26 at 8:47 AM with the Registered Dietician (RD), the RD stated that placing the ice bucket underneath a soap dispenser poses a risk of contamination.During a review of the facility's policy titled, Ice Machines and Ice Storage Chest, revised on 1/2012, indicated, .ice-storage/distribution containers. can all become contaminated by.unsanitary manipulation.improper storage or handling of ice. 2. During a concurrent observation and interview on 3/9/26 at 8:15 AM with the CDM, a damaged food strainer was observed in the facility kitchen. The CDM stated that the damaged strainer was used in food preparation.During an interview on 3/10/26 at 7:50 AM, the CDM stated that the damaged strainer had been discarded and that equipment should be kept in good repair.During an interview on 3/12/26 at 8:47 AM, the RD stated that worn out items should not be used for food prep as fragments may get into food.3. During a concurrent observation and interview on 3/9/26 at 8:15 AM with the CDM, it was observed that a plastic box container used to store food-contact utensils was not clean to sight and touch, and the CDM acknowledged that the container needed to be cleaned.According to the FDA Food Code (2022), Chapter 4, 4-601.11, Equipment food-contact surfaces and utensils shall be clean to sight and touch, and non-food contact surfaces shall be kept free of accumulation of dust, dirt, food residue, and other debris. (https://www.fda.gov/media/164194/download?attachment)4. During a concurrent observation and interview on 3/9/26 at 8:15 AM with the CDM, water pitchers and lids were observed stored on a tray with a webbed drying surface on a mounted shelf to the left upon entering the kitchen. The items had visible water droplets and were stacked and stored while still wet. The tray beneath the webbing contained pooled water. The water pitchers were observed inverted and placed closely together on the tray.During an interview on 3/9/26 at 2:03 PM with Dietary Aide (DA) 2, DA 2 stated that the water pitchers stored on the mounted shelf were ready for use for residents and should be dry.During a follow up interview on 3/9/26 at 4:40 PM with the CDM, the CDM stated that items should not be stacked or used while wet. During an interview on 3/12/26 at 8:47 AM, with the Registered Dietician (RD), the RD stated that items should be dry prior to storage and use because moisture may lead to bacterial growth.During a review of the facility's policy and procedure titled, 3-COMPARTMENT (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	PROCEDURE FOR MANUAL DISHWASING, dated 2023, indicated, . Step 6. All items are air-dried, which means no water droplets are present. According to the FDA Food Code (2022), Chapter 4, 4-901.11, .After cleaning and sanitizing, equipment and utensils. shall be air dried or used after adequate draining. (https://www.fda.gov/media/164194/download?attachment) 5. During a concurrent observation and interview on 3/9/26 at 8:15 AM with the CDM, a dented canned food item was observed stored in the canned goods area. The CDM stated that the item would be returned to the supplier. During a follow up interview on 3/9/26 at 4:40 PM, with the CDM, the CDM stated that dented canned goods should not be used due to risk of contamination. During an interview on 3/12/26 at 8:47 AM, the RD stated that dented canned goods should not be used due to the risk of bacterial growth. During a review of the facility's policy and procedure titled, STORAGE OF FOOD AND SUPPLIES, dated 2023, indicated, .Food in.cans with side seam dents, rim dents, or swells shall not be retained or used. 6. During a concurrent interview and observation, on 3/10/26 at 10:59 AM, with the Infection Preventionist (IP), it was observed that the refrigerator located in the nurses' break room had a temperature reading of 50F. An inspection of the contents revealed two bottles of milk labeled with resident names and room numbers. Additionally, items observed included juice cartons, cheeses, and puddings. The IP stated that 50F is not within the expected temperature range and that food stored at this temperature may spoil. During an interview on 3/12/26 at 8:47 AM the RD stated that a refrigerator temperature of 50F was not appropriate as food may spoil and cause illness. During a review of the facility's policy and procedure titled, PROCEDURE FOR REFRIGERATED STORAGE, dated 2023, indicated, . Refrigerator - 41F or lower. 7. During a concurrent observation and interview on 3/9/26 at 8:15 AM, a food delivery service driver was observed in the kitchen without a hair restraint. The diver stated that he had not been instructed to wear a hair restraint. The CDM then instructed the driver to wear a hairnet and stated that she would notify the delivery company to ensure compliance. During an interview on 3/12/26 at 8:47 AM, the RD stated that individuals in the kitchen without a hair restraint posed a risk of physical contamination of food from hair. According to the FDA Food code (2022), chapter 2, 2-402.11(A), food employees, shall wear hair restraints such as hats, hair coverings or nets, beard restraints, and clothing that covers body hair, designed and worn to effectively keep hair from contacting exposed food; clean equipment, utensils, and linens; and unwrapped single-service and single-use articles. (https://www.fda.gov/media/164194/download?attachment)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observation, interview, and record review, the facility failed to practice appropriate infection prevention and control measures for a census of 89 residents when:1. A staff member was observed delivering a meal tray inside a contact precaution (used to prevent the spread of germs through touch by requiring gloves and gown) room without wearing gown and gloves despite precaution signage posted outside the room;2. Hand hygiene (washing hands or using hand sanitizer) was not performed in-between resident care for Resident 105, Resident 9, Resident 106, and Resident 89;3. The glucometer (a portable device that measured blood sugar levels by analyzing a small drop of blood on a test strip) cleaning and sanitization process was not completed; and 4. Dirty coffee cups were stored on the coffee cart with clean pitchers of coffee, water, and juice. These failures had the potential to spread infection and cause health problems to the residents in the facility.Findings: 1.During an observation on 3/11/26 at 1:27 PM, during meal tray pass, Licensed Nurse (LN) 6 was observed entering a resident room with signage indicating Contact Precautions without donning a gown or gloves. LN 6 entered the room and delivered a meal tray before exiting the room. During a concurrent observation and interview on 3/11/26 at 1:27 PM with the Infection Preventionist (IP), the IP confirmed the presence of Contact Precaution signage posted at the resident's door. The IP stated that, per facility protocol, staff are required to wear a gown and gloves upon entering a room under contact precautions, including during meal tray delivery. The IP further stated that staff must put on a gown and gloves prior to entry, even when delivering a meal tray, as staff must be prepared to provided resident assistance, if needed, during tray delivery. During an interview on 3/11/26 at 2:19 PM, LN 6 stated she entered the room without wearing a gown and gloves. LN 6 stated she was aware that gown and gloves are required prior to entering a Contact Precautions room. During a review of the facility's policy titled Isolation & Initiating Transmission Based Precautions revised on 8/2019, indicated, .When Transmission-Based Precautions are implemented, the Infection Preventionist.determines the appropriate notification on the room entrance door.so that personnel and visitors are aware of the need for the type of precautions. The signage informs the staff of the type of CDC precaution(s), instructions for use of PPE, and/or instructions to see a nurse before entering a room.protective equipment (i.e., gloves, gowns, masks, etc.) is maintained outside the resident's room so that anyone entering the room can apply the appropriate equipment. 2a. During a medication administration observation, on 3/9/26, at 11:29 AM, with Licensed Nurse (LN) 4, outside of Resident 105's room, LN 4, with ungloved hands, prepared Resident 105's medications. LN 4 entered Resident 105's room without performing hand hygiene and exited Resident 105's room without washing or sanitizing her hands. 2b. During a medication administration observation, on 3/9/26, at 11:35 AM, LN 4 entered Resident 9's room to measure the blood sugar. LN 4 exited the room and did not perform hand hygiene before and after resident care and medication administration. (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3a. During medication administration observation, on 3/9/26, at 11:35 AM, with LN 4 at Resident 9's room. LN 4 gathered the blood sugar measurement supplies which included a glucometer (portable machine to measure blood sugar levels), a test strip (inserted into the glucometer to collect a small blood sample) bottle, one lancet (single use small sharp needle-like device used to poke the finger to get drops of blood for sugar measurement), and alcohol pads into Resident 9's room. LN 4 poked the left second finger of Resident 9 with the lancet device to get a blood sample and soaked the test strip with blood to measure the blood sugar. LN 4 exited Resident 9's room and then with bare hands used a single sanitizing wipe for a short period of time (less than 10 seconds) to clean the outer surface of the glucometer and set it on top of the medication cart. 3b. During a medication administration observation, on 3/9/26, at 11:55 AM, with LN 4, in Resident 89's room, LN 4 was observed placing the glucometer on top of Resident 89's bed when she poked the right thumb of Resident 89 to get a blood sample to collect on the test strip for measuring blood sugar. LN 4 exited the room and with bare hands cleaned the glucometer's outer surface quickly using one sanitizing wipe and left the glucometer on top of the medication cart. During an interview on 3/10/26, at 2:05 PM, with LN 4, LN 4 stated she should have worn gloves when cleaning the glucometer. LN 4 stated she should not have taken the test strip bottle inside the resident's room, as it could potentially get contaminated. LN 4 stated that everything she brings inside the resident's room should have been cleaned and sanitized. LN 4 confirmed she only used one wipe when cleaning the glucometer after use with Resident 89 and Resident 9 on 3/9/26. LN 4 stated she was unaware that she was supposed to use two sanitizing wipes to clean the glucometer. LN 4 stated that she may have missed the glucometer cleaning training in-services due to working part-time. During an interview on 3/10/26, at 3:35 PM, the DON stated that when cleaning the glucometer, the nurse was supposed to use two wipes, one for cleaning and the second wipe for sanitizing and keeping it wet or wrapped to stay wet long enough. The DON stated if the nurse took the test strip bottle inside the resident's room and did not sanitize it afterward, it could lead to the spread of germs. During an interview on 3/11/26, at 12:26 PM, the IP stated that the nursing staff were in-serviced on various infection control topics monthly. The IP stated the test strip bottle should not be taken inside a resident's room and it required cleaning and sanitization if it was taken inside the room. The IP stated the glucometer cleaning required the 2-step process of cleaning and sanitizing including the required wet time based on the manufacturer's recommendations. A review of the facility's approved disinfectant wipe, labeled as Sani-Cloth GERMICIDAL DISPOSABLE WIPE, with a purple color top, the label indicated, .use a wipe to remove visible soil prior to disinfecting.Allow surface to remain wet for two (2) minutes. Let air dry.When using this product, wear disposable protective gloves.All blood and other body fluids must be thoroughly cleaned from surfaces and objects before disinfection by the germicidal wipe . A review of the facility's P&P titled, Isolation &ndash; Categories of Transmission-Based Precautions, revised 9/22, the P&P indicated, .Transmission-based precautions are initiated when a resident develops signs and symptoms of a transmissible infection; arrives for admission with symptoms of an infection; or has a laboratory confirmed infection; and is at risk of transmitting the infection to other (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	residents.Standard precautions are used when caring for residents at all times regardless of their suspected or confirmed infection status.Contact precautions are implemented for residents known or suspected to be infected with microorganisms that can be transmitted by direct contact with the resident or indirect contact with environmental surfaces or resident-care items in the resident's environment. A review of the facility's P&P titled, Obtaining a Fingerstick Glucose Level, revised 10/11, the P&P indicated, .Always ensure that blood glucose meters intended for reuse are cleaned and disinfected between resident uses.Clean and disinfect reusable equipment between uses according to the manufacturer's instructions and current infection control standards of practice. 4.During an observation and concurrent interview with LN 3 on 3/11/26 at 12:50 p.m. in the hallway near a conference room, a coffee cart was in the hallway with two used coffee cups next to the clean coffee pitcher, water pitcher, and juice pitcher. LN 3 confirmed that there were two dirty coffee cups on the cart with the clean coffee, water, and juice pitchers. LN 3 stated that the risk of putting dirty coffee cups on the cart next to the clean coffee, juice, and water pitchers was cross-contamination (physical movement or transfer of harmful bacteria from one person, object, or place to another). During an interview on 3/12/26 at 9:24 a.m., the IP stated that her expectation was that clean and dirty items on the coffee carts were separated. The IP stated that there is a bin on the bottom shelf of the coffee cart for dirty cups. The IP stated that the risk of storing clean coffee, water, and juice pitchers with dirty cups on the same shelf of the coffee cart is infection control (contamination with germs). During an interview on 3/12/26 at 11:05 a.m., the DON stated that her expectation with the coffee cart was that clean items were stored on the cart with clean items and dirty items with dirty items. The DON stated that the risk of storing clean and dirty items together was infection control. The DON acknowledged that facility policy was not followed. A review of a facility P&P titled, Policies and Practices &ndash; Infection Control, revised 10/18, the P&P indicated, .Policy Statement.This facility's infection control policies and practices are intended to facilitate maintaining a safe, sanitary and comfortable environment and to help prevent and manage transmission of diseases and infections.Policy Interpretation and Implementation.2. The objectives of our infection control policies and practices are to.b. Maintain a safe, sanitary, and comfortable environment for personnel, residents, visitors, and the general public.		

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observation, interview, and record review, the facility failed to ensure residents right to privacy and dignity was maintained for 2 of 28 sampled residents (Resident 89 and Resident 94) when: 1. Resident 89's indwelling urinary catheter (a thin, hollow tube inserted through the urethra into the bladder to collect and drain urine) bag (a clear bag that collects urine from the catheter) lacked a dignity bag cover (a discreet, protective sleeve or pouch designed to hold and hide urinary drainage bags allowing for more confidence when moving in public); and, 2. A staff member entered Resident 94's room without knocking and requesting permission prior to entry. These failures placed Resident 89 and Resident 94 at risk of compromised privacy, dignity, feelings of embarrassment, loss of privacy and psychosocial harm. Findings: 1. Review of Resident 89's admission RECORD, indicated Resident 89 was admitted to the facility with multiple diagnoses including but not limited to acute kidney disease, and depression (a serious mood disorder involving persistent feelings of sadness). During a concurrent observation and interview on 3/9/26, at 11:52 AM, with Certified Nursing Assistant (CNA) 2 and CNA 3, in front of Resident 89's room, CNA 2 and CNA 3 both confirmed that Resident 89's urinary catheter bag did not have a dignity bag cover. CNA 3 stated Resident 89's urinary catheter bag had been without a cover since he came from the hospital. CNA 2 stated the dignity bag cover was important for privacy and infection control. A review of Resident 89's Care Plan Report, dated 3/9/26, indicated .Focus: Resident has indwelling catheter. Interventions: Ensure Foley [urinary catheter] bag is covered with a dignity bag. During an interview on 3/12/26, at 8:42 AM, with the Director of Nursing (DON), the DON stated staff always had to keep a resident's urinary catheter bag covered with a dignity cover to maintain the resident's dignity. A review of the facility's policy and procedure (P&P) titled, Dignity, revised on 2/2021, indicated, .Demeaning practices and standards of care that compromise dignity are prohibited, Staff are expected to promote dignity and assist residents.a. helping the resident to keep urinary catheter bags covered. 2. During an observation on 3/9/26, at 10:20 AM, Licensed Nurse (LN) 2 was observed entering Resident 94's room without knocking on the door and did not ask permission before entering the resident's room. During an interview on 3/9/26, at 10:25 AM, with LN 2, LN 2 stated the facility's process required staff to knock on the door, introduce themselves, and ask permission before entering a resident's room. LN 2 further stated that this process was important to show respect for Resident 94's privacy and for the privacy of the other residents in the room. LN 2 stated that even if she already knew the residents, she still needed to follow this process. (continued on next page)		

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/9/26, at 10:32 AM, with Resident 94, in Resident 94's room, Resident 94 confirmed LN 2 did not knock on the door or ask permission before entering the room. Resident 94 stated that it was important for anyone entering the room to knock on the door and introduce themselves so the residents would know who was coming in. Resident 94 further stated that it should be the same as being at home, where a person should knock on the door before entering. Resident 94 stated that knocking before entering was a sign of respecting her privacy and promoting her dignity. During an interview on 3/11/26, at 10:47 AM, with the Director of Nursing (DON), the DON stated that it was the facility's policy for staff to knock on the door and ask permission before entering any resident's room. The DON further stated that this practice was important as a sign of respect and dignity for all residents served by the facility. The DON stated that it was not acceptable for any staff to enter a resident's room without knocking and needed to ask permission before entering. The DON further stated that it was her expectation that all staff follow this process and knock and request permission before entering a resident's room. A review of the facility's P&P titled, Resident Rights, revised 2/21, indicated, .Employees shall treat all residents with kindness, respect, and dignity. Policy Interpretation and Implementation: 1. Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to: a. a dignified existence, b. be treated with respect, kindness, and dignity.t. privacy and confidentiality. A review of the facility's P&P titled, Dignity, revised 2/21, indicated, .Each resident shall be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life, and feeling of self-worth and self-esteem. Policy Interpretation and Implementation.Residents are treated with dignity and respect at all times.Staff are expected to knock and request permission before entering residents' rooms.Staff promote, maintain and protect resident privacy. Demeaning practices and standards of care that compromise dignity are prohibited. Staff are expected to promote dignity.		

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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. Based on observation, interview and record review, the facility failed to ensure self-administration of medication was appropriate for 1 of 28 sampled residents (Resident 14), when two bottles labeled Refresh Tears Lubricant Eye Drops were observed on Resident 14's bedside table and Resident 14 was using it without a doctor's order, without self-medication administration assessment and was not incorporated into Resident 14's care plan. This deficient practice had the potential to result in inappropriate medication use, contamination of the medication, and lack of clinical oversight of Resident 14's treatment. Findings: Review of Resident 14's admission RECORD, indicated Resident 14 was admitted to the facility with a diagnosis of, but not limited to generalized muscle weakness, difficulty in walking, unspecified pain, and anxiety disorder (a mental condition where a person experiences excessive, persistent worry, fear or nervousness that doesn't go away and interferes with daily life), psychosis (a mental health syndrome characterized by a loss of contact with reality, featuring symptoms like seeing/hearing things not there and false, firm beliefs). During a concurrent observation and interview on 3/9/26, at 10:02 AM, in Resident 14's room, Resident 14 had two bottles labeled Refresh Tears Lubricant Eye Drops on top of her bedside table. Resident 14 stated that she purchased the eye drops herself with the help of a friend who visits her at the facility. Resident 14 stated that she was diagnosed with dry eyes in the 1990's and had seen an eye doctor in the past. Resident 14 stated that her friend buys the eye drops for her. Resident 14 further stated that she started using and bringing the eye drops since she was admitted to the facility. Resident 14 explained that it was very hard for her to see without using the Refresh Tears eye drops. Resident 14 stated that the eye drops had been on top of her bedside table, but no staff member talked to her about them. Resident 14 stated that she remembered showing the eye drops to a staff member about two or three times since she was admitted to the facility. Resident 14 stated she did not receive any updates or instructions from the staff about the eye drops, so she continued using them herself. Resident 14 stated that no staff member provided her education about the process for self-medication or about notifying the doctor regarding the eye drops. During a concurrent interview and record review on 3/9/26, at 2:01 PM, with Licensed Nurse (LN) 1, LN 1 confirmed that two bottles labeled Refresh Tears Lubricant Eye Drops were present on top of Resident 14's bedside table. LN 1 reviewed Resident 14's electronic health record (EHR) and confirmed that there was no doctor's order for the Refresh Tears Lubricant Eye Drops. LN 1 stated that it was not acceptable for Resident 14 to keep the eye drops at her bedside without a doctor's order. LN1 explained that if Resident 14 wanted to self-administer the eye drops, the facility must first complete an assessment to determine whether the resident can safely self-administer medications. LN 1 further stated that the interdisciplinary team (IDT- a group of people from different professional backgrounds who work closely together, sharing knowledge and making joint decisions to achieve a common goal) would then review the assessment and present the findings to the doctor to obtain an order for self-administration of the eye drops. LN 1 explained that after obtaining the order, the facility would need to add the intervention to the resident's care plan and monitor resident's use of the medication. LN 1 stated that this process had not been followed and that it was not safe for Resident 14 to have the eye drops at her bedside without the required assessment, doctor's order, care plan, and monitoring. During an interview on 3/11/26 at 10:40 AM, with the Director of Nursing (DON), the DON stated that her expectation for nursing staff was that if Resident 14 had the capacity and requested to self-administer medication, staff should follow the facility's process. The DON stated that staff should first assess Resident 14 to determine if she could safely self-administer medications, obtain a doctor's order, and include the (continued on next page)		

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	intervention in the resident's care plan. The DON further stated that without a doctor's order, Resident 14 should not keep the eye drops at her bedside. The DON stated it would be safer to keep the medication in the medication cart until the proper process was completed. The DON further stated that she needed to provide education to the nursing staff to be more observant of their surroundings when they were inside residents' rooms, whether they were passing medications or making room rounds. The DON further stated that department heads could also help by checking residents' rooms during their rounds from Monday to Friday to ensure that no over the counter (OTC - medicine you can buy without a doctor's prescription) medications were kept at the bedside without staff knowledge or approval. Review of facility policy and procedure titled, Self-Administration of Medications, revised 2/21, indicated, Policy heading: 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. Policy Interpretation and Implementation: As part of the evaluation comprehensive assessment, the interdisciplinary team assesses each resident's cognitive and physical abilities to determine whether self-administering medications is safe and clinically appropriate for the resident . if it is deemed safe and appropriate . this is documented in the medical record and the care plan. Residents who are identified as being able to self-administer medications are asked whether they wish to do so. Any medications found at the bedside that are not authorized for self-administration are turned over to the nurse in charge for return to the family or responsible party.		

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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 observation, interview and record review, the facility failed to ensure that one of two sampled residents (Resident 55) Minimum Data Set (MDS -a federally mandated resident assessment tool) was accurately coded when Resident 55's MDS indicated that Resident 55 had no dental issues when Resident 55 was in fact missing all upper teeth, had no upper denture and the bottom teeth were in various stages of decay. This failure had the potential to affect Resident 55's plan of care due to inaccurate coding of the MDS. Findings: During a review of Resident 55's admission RECORD, the record indicated that Resident 55 was admitted to the facility with pertinent diagnoses that included dementia. During a concurrent observation and interview on 3/9/26 at 11:11 A.M. with Resident 55 in the hallway outside of room [ROOM NUMBER], Resident 55 was observed to be missing her upper teeth and had what appeared to be decaying teeth on the bottom. Resident 55 stated that she had no upper denture and that she completed her own oral care. During a review of Resident 55's clinical document titled Dental Notes, dated 10/22/24, 11/5/25, and 2/4/26, the dental notes indicated that Resident 55 had no upper denture, poor oral hygiene, moderate calculus build up, and severe extrinsic staining (surface-level discoloration of tooth enamel caused by dark pigments from food, beverages, or tobacco). During a review of Resident 55's MDS, dated [DATE], in section L - Oral/Dental Status, indicated that Resident 55 had no dental issues. During a concurrent interview and record review on 3/12/26 at 8:29 AM with the MDS nurse, Resident 55's MDS dated [DATE] and Dental Notes dated 10/22/24, 11/5/25 and 2/4/26 were reviewed. The MDS nurse stated based on the review of the Dental Notes, section L of the MDS dated [DATE] had been coded incorrectly. The MDS stated that Section L should not have been coded as Z None of the above were present but should have had the following checked as dental issues .L0200B No natural teeth or tooth fragments(s) (edentulous (lacking teeth)) .L0200D Obvious or likely cavity or broken natural teeth . The MDS nurse stated that coding this area incorrectly meant that the area did not trigger for further review, which placed Resident 55 at risk for missing needed oral and dental interventions. During a concurrent interview and record review on 3/11/26 at 11:37 AM with the Director of Nurses (DON), the Dental Notes and MDS for Resident 55 were reviewed. The DON confirmed that the clinical records Resident 55 had not been accurately documented and the errors placed Resident 55 at risk for not receiving the appropriate care interventions. During a review of the facility's policy and procedure titled, Certifying Accuracy of the Resident Assessment, dated 11/19, the P&P indicated, .Any person completing a portion of the Minimum Data Set/MDS (Resident Assessment Instrument) must sign and certify the accuracy of that portion of the assessment. Any person who completes any portion of the MDS assessment is required to sign the assessment certifying the accuracy of that portion of the assessment.		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on interview, and record review, the facility failed to develop and implement a comprehensive care plan for 1 of 28 sampled residents (Resident 34), when a comprehensive care plan was not developed for Resident 34's cardiovascular (relating to or affecting the heart and blood vessels) medical condition requiring 5 blood pressure medications. This failure had the potential to place Resident 34 at risk for not receiving effective and person-centered care. Findings: A review of Resident 34's admission RECORD, indicated Resident 34 was admitted to the facility with diagnoses including chronic atrial fibrillation (long term irregular rapid heartbeat), hypertension (high blood pressure without identifiable cause), and heart failure (condition where the heart muscle cannot pump enough blood). A review of Resident 34's medication orders indicated that Resident 34 was taking five different blood pressure medications including: Clonidine HCl (hydrochloride) Oral Tablet 0.2 MG (milligram- unit of measurement), Furosemide Tablet 20 MG, Hydralazine HCl Tablet 50 MG, Losartan Potassium Oral Tablet 50 MG and Metoprolol Succinate ER (Extended Release) Tablet 50 MG. During a concurrent interview and record review on 3/12/26, at 10:30 AM, with License Nurse (LN) 1, Resident 34's electronic health record (EHR) was reviewed. LN 1 confirmed that there was no care plan for Resident 34's blood pressure medications or managing Resident 34's cardiovascular medical conditions. LN 1 stated when a new medication was ordered for a resident, they would initiate the care plan, and the interdisciplinary team (IDT- group of healthcare professionals working together to accomplish a common goal) would review it. LN 1 further stated a care plan was needed to have a goal and that staff would carryout the interventions for the residents. LN 1 stated the IDT reviewed residents' care plans quarterly. LN 1 further stated that cardiovascular medications were care planned. LN 1 stated that cardiovascular medications should not only be in the orders listed in the resident's EHR, but should also be monitored with a resident specific care plan. LN 1 stated that if there was no care plan, there would be no goals, and the staff might not complete the right interventions for the resident's medical condition. During an interview on 3/12/26, at 10:58 AM, with the Director of Nursing (DON), the DON stated the expectation was that the Minimum Data Set (an assessment tool) nurse/ coordinator (responsible for assessing residents' health, functional abilities, cognitive status, and psychosocial status) would check if the care plan was initiated and would complete the comprehensive care plan. The DON further stated that a care plan served as a guide for managing the resident's overall care. A review of the facility's policy and procedure titled, Care Plans, Comprehensive Person-Centered, revised March 2022, indicated, .A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. The comprehensive, person-centered care plan is developed within seven (7) days of the completion of the required MDS assessment (Admission, Annual or Significant Change in Status), and no more than 21 days after admission. The comprehensive, person-centered care plan: a. includes measurable objectives and timeframes; b. describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. e. reflects currently recognized standards of practice for problem areas and conditions.		

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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 and record review the facility failed to revise and review the person-centered comprehensive care plans (a detailed document outlining a person's healthcare needs, goals, and the specific care and support they will receive, including how, when and by whom) for two of 28 sampled residents (Resident 10 and Resident 55) when, 1. Resident 10's comprehensive care plan continued to reflect hospice services were active in providing care after Resident 10 had been discharged from services on 8/27/25, 2. Resident 55's comprehensive care plan concerning the need for dentures and the pending authorization from the [Dental Service Provider] had not been revised since 11/4/24. These failures placed Resident 10 and Resident 55 at risk of not receiving the individualized and person-centered care that they required. Findings: 1. During a review of Resident 10's admission RECORD, the admission RECORD indicated that Resident 10 was admitted to the facility in December 2018 with pertinent diagnoses of senile degeneration of brain (the progressive breakdown and death of brain cells in older adults, causing a significant decline in memory, thinking, and daily functioning), dementia (a progressive state of decline in mental abilities) and schizophrenia (a mental disorder that causes disruptions in thought process, perceptions, emotional responses, and social interactions). During an interview on 3/11/26 at 11:00 AM with Certified Nursing Assistant (CNA) 5, CNA 5 stated that Resident 10 was still on hospice and was receiving care from hospice aides during their visits. During a record review of Resident 10's active physician orders for March 2026, there were no orders that indicated Resident 10 was receiving hospice services. A review of Resident 10's clinical record titled [Hospice Service provider] PHYSICIAN ORDER, dated 8/25/25, indicated that Resident 10 was discharged from [Hospice Service Provider] due to extended prognosis on 8/27/25. During a concurrent interview and record review on 3/11/26 at 11:00 AM with the Social Services Director (SSD), Resident 10's [Hospice Service Provider] physician order dated 8/25/25 and care plans were reviewed. The SSD confirmed that the order indicated that Resident 10 had been discharged from hospice services on 8/27/25. The SSD reviewed Resident 10's care plans (a personalized, written roadmap that outlines an individual's health needs, goals, and the specific daily actions or services required to support them, often managed by healthcare professionals) for dehydration, falls, unplanned/unexpected weight loss and confirmed that these care plans included hospice either in the focus statement of the identified risk or problem and/or as an intervention to help treat the identified risk. The SSD stated that the interventions for hospice were incorrect since Resident 10 was no longer receiving hospice services and should have been reviewed and revised when hospice services were discontinued on 8/25/25. During a concurrent interview and record review on 3/12/26 at 8:36 AM with the Minimum Data Set Nurse (MDS), Resident 10's care plans were reviewed. The MDS confirmed that Resident 10's comprehensive care plan continued to reflect that hospice services were in place when they were not. The MDS stated that the care plan should have been revised when the Interdisciplinary Team (IDT - a group of different health professionals (like doctors, nurses, therapists, and social workers) who work together, sharing information and decisions to provide comprehensive care for a patient) completed a Significant Change in Status MDS (Minimum Data Set - a federally mandated resident assessment tool) on 9/3/25. 2. During a review of Resident 55's admission RECORD, the admission RECORD indicated Resident 55 was admitted to the facility in May 2005 with pertinent diagnosis that included dementia. During a concurrent observation and interview on 3/9/26 at 11:11 A.M. with Resident 55 in the hallway outside of room [ROOM NUMBER], Resident (continued on next page)		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	55 was observed to be missing her upper teeth and had what appeared to be decaying teeth on the bottom. Resident 55 stated she does her own mouth care. Resident 55 stated that she does not have dentures but that she had been waiting for them for a long time but was unable to recall how long. When Resident 55 was asked if she liked the food that was served at the facility, Resident 55 stated that she didn't like how it was chopped up and wished she just got regular food. Resident 55 stated they told her the food was chopped because she had no dentures and what teeth she had left were in bad shape. Resident 55 was unable to identify who told her that. During an interview on 3/10/26 at 9:43 AM with CNA 5, Resident 55's oral care routine was reviewed. CNA 5 confirmed that Resident 55 did not have any upper teeth, that the bottom teeth were in poor condition, and that Resident 55 had no dentures. CNA 5 stated that Resident 55 usually completed her own oral care and would often refuse assistance other than setting out the toothbrush and toothpaste. During a review of Resident 55's undated clinical document titled Care Plan Report, the report indicated that on 5/28/21 a care plan had been initiated with a focus statement (the specific, primary concern or problem that the care team is addressing for the patient at that exact moment) that indicated Following for Full Upper and Partial Lower Dentures per [Dental Service Provider] recommendations. 6/10/24 resident was seen by dental w/X-Rays. 9/26/24 - Per [Dental Service Provider] tx is still under review by insurance. Under the goal (a specific, actionable target you want to reach to improve a person's health or daily life) portion of same care plan, two goals that were initiated on 5/28/21 had been revised on 1/14/26, and indicated, Facility staff will follow for proper diet and food texture for safety precaution while getting the resident new appropriate dentures. SSD will follow with [Dental Service Provider] for new dentures/resident is seen every quarter or as needed. Under the interventions (a specific action or step taken by a caregiver or healthcare professional to help a person reach a health goal) portion of the care plan the following intervention that had been initiated on 8/8/24 had been revised on 9/26/24 indicated SS called [Dental Service Provider] in August 2024 regarding [Resident 55's] dentures. Another intervention on the same care plan had been initiated on 9/30/24 with no further revision date indicated, Will continue follow up with [Dental Service Provider] regularly. During a concurrent interview and record review on 3/12/26 at 8:29 AM with the MDS, Resident 55's dental care plan was reviewed. The MDS stated that Resident 55's care plan for dental needs should have been reviewed and revised by Social Services with each update received from the [Dental Service Provider]. During a concurrent interview and record review on 3/11/26 at 10:47 AM with the SSD, Resident 55's care plan initiated on 5/28/21 for dental services was reviewed. The SSD stated that the care plan should have been updated at least with every dental visit and as needed. The SSD stated that the social service department was responsible for following up on needed adaptive equipment like dentures and glasses. The follow up included contacting the ancillary service provider regarding pending insurance authorizations for dentures. The SSD stated that the follow up for Resident 55's pending authorization for dentures by the social service department had fallen through the cracks and placed Resident 55 at risk for decreased oral intake, oral pain or discomfort and psychosocial issues related to the lack of upper teeth and poor condition of the lower teeth. During a concurrent interview and record review on 3/11/26 at 11:37 AM with the Director of Nurses (DON), the DON reviewed Resident 10's care plans that included interventions for hospice and Resident 55's care plan for dental services and stated that the care plans were not an accurate reflection of the care and services that Resident 10 or Resident 55 currently required. The DON stated that the care plan should reflect the resident's status at the time it was written and then revised and updated as the Residents status or needs changed. During a review of the facility's policy and procedure titled, Care Plans, Comprehensive Person-Centered, dated March 2022, the P&P indicated, .A comprehensive, (continued on next page)		

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident .The comprehensive, person-centered care plan: . Describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being .reflects currently recognized standards of practice for problem areas and conditions .Services provided for or arranged by the facility .are revised as information about the residents and the residents' condition change .The interdisciplinary team reviews and updates the care plan: .when there has been a significant change in the resident's condition .when the desired outcome is not met .at least quarterly, in conjunction with the required quarterly MDS assessment .		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. Based on interview and record review, the facility failed to ensure two of twenty-eight sampled residents (Resident 5 and Resident 6) received care in accordance with professional standards of practice (guidelines and criteria established by professional organizations designed to ensure safe competent and ethical care for residents in all practice settings) when: Intake and output was not documented daily in the medical record per physician order in February 2026 for Resident 5, The indwelling urinary catheter (a tube inserted into the bladder to drain urine) placement, functioning and care was not documented daily in February 2026 per physician orders for Resident 5, and Intake and output was not documented daily in the medical record per physician orders in January 2026 and February 2026 for Resident 6. These failures had the potential to lead to late detection of fluid status abnormalities which could adversely affect the health status of Resident 5 and Resident 6, and a risk of catheter-associated urinary tract infection (CAUTI, occurs when germs enter the urinary tract through a urinary catheter and cause infection) for Resident 5. Findings: 1. A review of Resident 5's admission Record, indicated that Resident 5 was admitted to the facility in 2026 with diagnoses which included Necrotizing Fasciitis (A rare but very severe type of bacterial infection [contaminated with disease-producing germs] of the soft tissue. It can destroy the muscles, skin, and underlying tissue), Type II Diabetes Mellitus (a chronic condition that affects the way the body processes blood sugar), and Heart Failure (Occurs when the heart doesn't pump blood as it should. Also known as congestive heart failure). A review of Resident 5's Physician Order Summary, on 3/10/26 at 7:49 a.m. indicated, .Monitor Intake & Output Q Shift (every shift) . *Add total cc's (unit of measure) consumed in each shift* *Add total cc's or times voided each shift*. Order Status.Active. Order Date.01/07/2026. Start Date.01/07/2026. A review of Resident 5's February 2026 Medication Administration Record (MAR, a document listing medications and monitoring parameters), on 3/10/26 at 7:49 a.m. indicated that Resident 5's intake and output was not documented every shift per physician order in February 2026. During an interview on 3/10/26 at 11:30 a.m. with Licensed Nurse 4 (LN) 4, LN 4 stated that residents with physician orders for intake and output (I&O) had the I&Os recorded on the MAR. LN 4 stated that if there were concerns that the I&Os were outside of parameters, the physician was notified and the LNs documented that the physician was notified in the progress notes. During an interview on 3/10/26 at 11:36 a.m. with LN 6, LN 6 stated that the LNs documented I&Os ordered by the physician every shift each day on the MAR. During an interview on 3/10/26 at 12:24 p.m. with the Director of Nursing (DON), the DON stated that it was her expectation that I&Os were documented every shift per the physician's orders. The DON stated that if there were discrepancies in the resident's I&Os, the LNs would notify the resident's physician, and document the notification in the resident's progress notes. The DON stated that the risk of not documenting a resident's intake and output was that the resident could be overhydrated or underhydrated and it would be missed. During an interview and concurrent record review of Resident 5's February 2026 MAR, on 3/11/26 at 9:45 a.m. with the DON, the DON confirmed that Resident 5's intake and output was not documented per physician's orders in February 2026. The DON acknowledged that the facility policy was not followed. 2. A review of Resident 5's admission Record, indicated that Resident 5 was admitted to the facility in 2026 with diagnoses which included Necrotizing Fasciitis (A rare but very severe type of bacterial infection [contaminated with disease-producing germs] of the soft tissue. It can destroy the muscles, skin, and underlying tissue), Type II Diabetes Mellitus (a chronic condition that affects the way the body processes blood sugar), and Heart Failure (Occurs when the heart doesn't pump blood as it should. Also known as congestive heart failure). A review of Resident 5's February 2026 Treatment (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Administration Record (TAR, list of prescribed treatments), on 3/10/26 at 7:49 a.m. indicated, .Indwelling catheter (a tube inserted into the bladder to drain urine): Monitor for change in urine character (color, odor, consistency).urine output.Notify MD for potential UTI (urinary tract infection, germs in urine) every shift.Order Date.01/02/2026. The February 2026 TAR, further indicated that Resident 5's urine output character was not documented every shift per physician order in February 2026.A review of Resident 5's February 2026 TAR, on 3/10/26 at 7:49 a.m. indicated, .[urinary] Catheter - [urinary] catheter care (hand hygiene [washing hands with soap and water or alcohol hand gel before providing care], use of gloves, provide gentle cleansing of the catheter insertion site, checking for redness, pain or irritation of the skin at the catheter site) QS every shift.Order Date.01/02/2026. The February 2026 TAR, further indicated that Resident 5's urinary catheter care was not documented every shift per physician order in February 2026.A review of Resident 5's February 2026 TAR, on 3/10/26 at 7:49 a.m. indicated, .[Urinary] Catheter #16Fr (catheter size) with 10cc balloon (anchor device to hold catheter in place in urinary bladder) to drainage bag for diagnosis of Wound Vac (a device that pulls moisture and germs out of a wound to help it heal) Placement.Monitor for proper placement of the [Urinary] Catheter, no kinking or compression that could obstruct the urine flow every shift.Order Date.01/02/2026. The February 2026 TAR, further indicated that urinary catheter placement was not documented as checked every shift per physician order in February 2026.During an interview on 3/10/26 at 11:30 a.m. with Licensed Nurse 4 (LN) 4, LN 4 stated that there were orders on the TAR for residents with an indwelling catheter to check for placement and functioning of the catheter, to change the collection bag and/or catheter as needed, and to check the resident for signs and symptoms of infection (include fever, tiredness, chills and sweats) and document on the TAR. LN 4 stated that if there were signs and symptoms of infection or obstruction of urine output, the physician was notified and the LNs documented in the resident's progress note that the physician was notified.During an interview on 3/10/26 at 11:36 a.m. with LN 6, LN 6 stated that for residents with an indwelling catheter, LNs documented the catheter type, and size in the resident's TAR. LN 6 stated that there were standing orders for residents with an indwelling catheter for flushing, collection bag changing, and changing the catheter. LN 6 stated that if the previously mentioned interventions were not effective, the LNs notified the physician and documented that the physician was notified in the progress notes.During an interview on 3/10/26 at 12:24 p.m. with the Director of Nursing (DON), the DON stated that her expectation was that if a resident had an order for an indwelling urinary catheter, the LNs updated the care plan, placed the catheter collection bag below the bladder and not touching the floor, that the drainage bag was covered with a dignity shield (a covering placed over the collection bag to conceal urine collecting in the bag), and that the LNs changed the urinary catheter as needed for signs and symptoms of catheter associated infection, checked the functioning of the catheter each shift, performed catheter care each shift and documented all interventions in the resident's TAR. The DON stated that the risk of not providing the care mentioned and documenting the care was that the staff could miss monitoring, and residents could get a urinary tract infection or other complication.During an interview and concurrent record review of Resident 5's February 2026 TAR, on 3/11/26 at 9:45 a.m. with the DON, the DON confirmed that Resident 5's indwelling catheter placement checks, functioning and care was not documented consistently in February 2026 per physician orders. The DON acknowledged that the facility policy was not followed.3. A review of Resident 6's admission Record, indicated that Resident 6 was admitted to the facility in 2025 with diagnoses which included multiple fractures (broken bones) to thoracic vertebra (spinal bones located in the mid-back connecting the neck to the lower back), left and right tibia (the inner larger bone in the leg between the knee and the ankle), and (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	ribs (multiple slender bones protecting the organs in the chest); and Perforated Colon (a life-threatening condition that occurs when a hole in the bowel causes the contents to leak into the abdomen causing peritonitis [inflammation of the peritoneum, the thin tissue lining the inner abdominal wall and covering the abdominal organs, usually caused by bacterial or fungal infection]).A review of Resident 6's January 2026 Medication Administration Record (MAR, a document listing medications and monitoring parameters), on 3/10/26 at 9:40 a.m. indicated, .Total Parenteral Nutrition (TPN, complete nutrition that provides all the calories, proteins, fats, carbohydrates, vitamins and minerals that a resident needs when they cannot digest food) .use.intravenously (a flexible tube placed in a vein and attached to an apparatus used to administer a fluid such as medication, blood, or nutrients) .one time a day for Perforation of Colon.Order Date.12/28/2025.A review of Resident 6's January 2026 MAR, on 3/10/26 at 9:40 a.m. indicated, .Monitor Intake & Output Q Shift.every shift for TPN.Order Date.12/20/2025. The January 2026 MAR, indicated that intake and output for Resident 6 was not monitored every shift in January 2026.A review of Resident 6's January 2026 MAR, on 3/10/26 at 9:40 a.m. indicated, .Monitor Total Intake & Output QD every evening shift.*Add total cc's consumed in previous 24 hours*.Add total cc's or times voided in previous 24 hours*.Order Date.12/20/2025. The January 2026 MAR, further indicated that intake and output for Resident 6 was not monitored every evening shift in January 2025.A review of Resident 6's January 2026 MAR, on 3/10/26 at 9:40 a.m. indicated, .Total Intake & Output q Week every evening shift every Fri (Friday) for TPN.*Add total cc's consumed for previous 7 days and divide by 7 for weekly average intake*.Add total cc's or times voided for previous 7 days and divide by 7 for weekly average output.Order Date.12/20/2025. The January 2026 MAR, indicated that intake and output totals were not monitored every week on Friday evening shifts for Resident 6.A review of Resident 6's February 2026 MAR, on 3/10/26 at 9:40 a.m. indicated, .Monitor Intake & Output Q Shift.every shift.*Add total cc's consumed in each shift*.Add total cc's or times voided each shift*.Order Date.02/02/2026. The February 2026 MAR, indicated that intake and output was not monitored every shift for Resident 6 in February 2026.During an interview on 3/10/26 at 11:30 a.m. with Licensed Nurse 4 (LN) 4, LN 4 stated that residents with physician orders for intake and output (I&O) had the I&Os recorded on the MAR. LN 4 stated that if there were concerns that the I&Os were outside of parameters the physician was notified and the LNs documented that the physician was notified in the progress notes.During an interview on 3/10/26 at 11:36 a.m. with LN 6, LN 6 stated that the LNs documented I&Os ordered by the physician every shift each day on the MAR.During an interview on 3/10/26 at 12:24 p.m. with the Director of Nursing (DON), the DON stated that it was her expectation that I&Os were documented every shift per the physician's orders. The DON stated that if there were discrepancies in the resident's I&Os, the LNs would notify the resident's physician, and document the notification in the resident's progress notes. The DON stated that the risk of not documenting a resident's intake and output was that the resident could be overhydrated or underhydrated and it would be missed.During an interview and concurrent record review of Resident 6's January 2026 and February 2026 MARs, with the facility Director of Nursing (DON) on 3/11/26 at 9:45 a.m., the DON confirmed that Resident 6's intake and output was not documented consistently in January 2026 and in February 2026 while on TPN per physician's orders. The DON acknowledged that the facility policy was not followed.A review of a facility policy and procedure (P&P) titled, Intake and Output, revised 12/2024, the P&P indicated, .Purpose.To provide an accurate record of the resident's fluid intake and output.Policy.It is the policy of this facility to maintain an intake and output record when needed to monitor residents for adequate fluid balance.Indication.Intake and output monitoring is indicated for residents with.Parenteral fluids or nutrition (TPN).For the entire duration of the order.Order for intake and output monitoring.For the (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	entire duration of the order.General Guidelines.3. Fluids taken intravenously are recorded by the licensed nurse.Procedures.Measuring Intake.1. The nursing assistant shall measure and record oral fluids taken by the resident during meals and during care.4. The licensed nurse shall total the oral fluids recorded by the nursing assistant, consumed during medication pass, and intravenous fluids received during the shift and record total volume on intake and output.Measuring Output.4. Pour or drain urine.into the measuring container.11. If the resident is incontinent (has involuntary loss of urine or feces), the nurse shall record the number of incontinent episodes every shift.Documentation.1. Licensed nurse shall document resident's intake and output at the end of each shift on the intake and output record.A review of a facility P&P titled, Parenteral Nutrition, revised January 2026, The P&P indicated, .Purpose.The purpose of parenteral nutrition (PN, TPN) is to provide guidelines for the safe and aseptic administration of partial or total nutrition to residents who have a need for supplemental nutrition.Monitoring.2. Include the following clinical monitoring at regular intervals (per physician or pharmacy order) .a. intake/output.A review of a facility P&P titled, Perineal (the area between the anus and genital organs) Care, revised February 2018, the P&P indicated, .Purpose.The purpose of this procedure are [sp] to provide cleanliness and comfort to the resident, to prevent infection and skin irritation, and to observe the resident's skin condition.Documentation.1. The date and time that perineal care was given.3. Any.odor.bleeding, skin care problems or irritation, complaints of pain or discomfort.4. Any problems noted at the catheter-urethral junction (the point at which the urinary catheter is inserted into the resident's body for urine collection) .such as drainage, redness, bleeding, irritation.or pain.Reporting.2. Report.information in accordance with facility policy and professional standards of practice.		

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure that there was sufficient, qualified nursing staff available to at all times to provide nursing and related services to meet the residents' needs safely and in a manner that promotes the residents' rights, as well as physical, mental and psychosocial well-being when three of twenty-eight sampled residents (Resident 77, Resident 35, and Resident 8) call lights (a button or cord in a hospital or nursing home room that allows a patient to call for help) were not answered in a timely manner to provide requested care. This failure had the potential to place Resident 77, Resident 35 and Resident 8 at risk for injury and psychosocial distress due to extended wait periods. Findings: During a review of Resident 77's admission RECORD, the admission RECORD indicated that Resident 77 was admitted to the facility in April 2022 with pertinent diagnosis of difficulty in walking, transient ischemic attack (TIA - a temporary blockage of blood flow to the brain that causes stroke-like symptoms lasting from a few minutes to 24 hours), osteoporosis (a disease that makes bones thin, weak, and brittle, often causing them to break from minor falls or daily activities), age related cognitive decline and dysphagia (difficulty swallowing, causing pain or trouble moving food/liquids from the mouth to the stomach). During a review of Resident 77's clinical document titled KHG - Brief Interview for Mental Status (BIMS), (BIMS - a quick, 0-15 point test used in nursing homes to measure a person's memory, ability to learn new information, and awareness of time/place. A higher score (13-15) suggests normal, intact thinking, while lower scores indicate moderate (8-12) or severe (0-7) memory/cognitive impairment) dated 2/9/26, indicated Resident 77's had a BIMS score of 15 which indicated Resident 77's cognitive function was intact. During a concurrent observation and interview on 3/9/26 at 9:27 AM with Resident 77, Resident 77 was in bed watching TV. Resident 77 stated that the facility does not have enough staff. Resident 77 stated they are overloaded and that the response to call lights depends on staffing and stated that once she waited three hours for someone to respond to the call light. Resident 77 stated that the response time is worse on the night shift then the day shift. During a review of Resident 35's admission RECORD, the admission RECORD indicated that Resident 35 was admitted to the facility in October 2025 with pertinent diagnoses that included cerebral infarction (a type of stroke, which occurs when a blood vessel in the brain is blocked, cutting off oxygen and nutrients to brain tissue), hemiplegia affecting right dominant side (paralysis or severe weakness affecting the entire right side of the body-face, arm, and leg-due to damage to the brain's left side), epilepsy (a sudden, uncontrolled surge of electricity in the brain that disrupts normal function), tremor (an unintentional, rhythmic, and involuntary shaking movement of a body part, such as the hands, head, or legs), fusing of spine cervical region (a surgery that permanently joins two or more neck bones together into one solid bone to stabilize the neck, reduce pain, and prevent nerve damage), muscle weakness, difficulty in walking, and hypertension (HTN -elevated blood pressure). During a review of Resident 35's clinical document titled KHG - Brief Interview for Mental Status (BIMS), dated 1/2/26, indicated Resident 35's had a BIMS score of 15 which indicated Resident 35's cognitive function was intact. During a concurrent observation and interview on 3/9/26 at 10:03 AM with Resident 35, Resident 35 was lying down in bed and stated that he had just returned following a session with his physical therapist. Resident 35 stated that he could walk with a front wheeled walker (FWW - A standard medical walker that has two wheels on the front legs to help people move more easily) but required someone to stand next to him due to poor balance since having a stroke. (continued on next page)		

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident 35 stated that at times, it took a while to have his needs met, especially at night. Resident 35 stated it caused him frustration and anxiety, especially if he needed to use the restroom. Resident 35 turned on the call light during the interview at 10:05 AM to request assistance to go to the bathroom. Resident 35's call light was answered at 10:20 AM by a Certified Nursing Assistant (CNA) 7. During an interview on 3/9/26 at 10:37 AM with CNA 7, CNA 7 was asked about the call light response time for Resident 35. CNA 7 stated she was busy helping another resident and answered the call light as quickly as she could. CNA 7 stated that it was difficult answering the lights when there were so many residents to care for. CNA 7 stated that she was assigned 9 residents that day, which was normal for the morning shift. CNA 7 stated sometimes they will have 10 residents, which made call light responses harder to manage. During a review of Resident 8's admission RECORD, the admission RECORD indicated Resident 8 was admitted to the facility in September 2022 with pertinent diagnoses that included diabetes type 2 (a condition where your body struggles to use insulin properly, causing sugar (glucose) to build up in your blood and making it harder for your body to get energy from food), schizoaffective disorder (a chronic mental health condition combining symptoms of schizophrenia (hallucinations, delusions, disorganized thinking) with a mood disorder, such as depression), muscle weakness, neuropathy (damage to the nerves outside the brain and spinal cord, commonly causing numbness, tingling, burning pain, or weakness, usually in the hands and feet), difficulty in walking, and HTN. During a record review of Resident 8's clinical document titled KHG - Brief Interview for Mental Status (BIMS), dated 1/16/26, the BIMS indicated that Resident 8 had a BIMS score of 15, which indicated Resident 8's cognitive function was intact. During a concurrent observation and interview on 3/9/26 at 11:17 AM with Resident 8, Resident 8 was observed to be sitting up in a wheelchair next to the bed in room [ROOM NUMBER]. Resident 8 stated that the staff are very busy, and it is hard for them to stop what they are doing to help her do something or even just talk to her. Resident 8 stated they are too busy to just talk to us for a few minutes. Resident 8 stated sometimes it took 35 minutes to get someone to answer the call light, especially during lunch and dinner when everyone is busy helping other residents eat. During an interview on 3/10/26 at 10:00 AM with residents during the survey related Resident Council Meeting, several residents confirmed that response times to call lights remained an issue. Resident 77, who attended the Resident Council Meeting, stated they have too many residents assigned to them at once. The surveyor made call light observation for response time on the following dates and times: 3/10/26 9:33 AM call light on in room [ROOM NUMBER] - 3/10/26 9:51 AM call light answered 3/11/26 11:45 AM call light on in room [ROOM NUMBER] - 3/11/26 11:51 AM call light answered 3/11/26 12:50 PM call light on in room [ROOM NUMBER] - 3/11/26 12:54 PM call light answered 3/12/26 8:30 AM call light on in room [ROOM NUMBER] - 3/12/26 8:55 AM call light answered. During a concurrent interview and record review on 3/12/26 at 10:35 AM with the Director of Nurses (DON), call light response time expectations were discussed. The DON stated she was aware that the residents had ongoing complaints regarding call light response time and that there was a call light audit that was being completed randomly by the Director of Staff Development. The DON stated that the audit was to be done randomly and had no set schedule. Review of the call light audit form, with the DON, indicated the last time it was completed was on 12/22/25. The DON stated that there should have been audits completed for 2026 but was unable to locate them. The DON stated that the expectation of the facility was for call lights to be answered within 15 minutes. The DON stated that the topic of call light response time had been discussed in the Quality Assurance (QA) meeting, but it had not been identified as a problem that needed a formal Project Improvement Program (PIP). The DON stated that the ongoing concerns from resident's regarding call light response time was a (continued on next page)		

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	concern and if resident's call lights were not being answered timely, it placed residents at risk for injury trying to do tasks like get out of bed on their own and for psychosocial harm if they were worrying about how long it could for someone to come help them. During a review of the facility's policy and procedure titled, CALL LIGHT ANSWERING, dated 8/12/25, the P&P indicated, .It is the policy of this facility to provide the resident a means of communication with nursing staff as indicated based on resident assessment. Answer the call light/bell within a reasonable time. Acknowledge the resident's call light/bell. The nursing staff will ensure that the resident's call for assistance is acknowledged.		

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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 safe pharmaceutical services for a census of 89 residents when:1. The emergency kit (or Ekit, an emergency supply of prescription medications) content was not resupplied in timely manner for an injectable medication called Zyprexa (or olanzapine, a mood stabilizer or mental health drug) for over 5 days in the facility's Automated Dispensing Machine (or ADM, electronic control of drug use and dispensing);2. Resident 18's TPN (Total Parenteral Nutrition, intravenous (IV) form of nutrition given through the vein) product was labeled by the provider pharmacy with two different beyond use dates (or BUD, expiration date, the date after which not to be used) on each side of the bags; and3. Resident 105's hazardous medications (drugs known to be harmful to healthcare workers if handled without proper protective measures) called methimazole (or Tapazole, drug used to treat overactive thyroid disease) was not labeled as hazardous in the electronic medical records and the product label when the pills were crushed and handled unsafely by nursing staff during medication administration. These failed practices had the potential to result in a delay for emergency use of drugs and/or unsafe drug handling for both staff and residents.Findings:1. During a concurrent interview and inspection of facility's Automated Dispensing Machine (ADM), on 3/9/26, at 2:25 PM, accompanied by the Consultant Pharmacist (CP), the contents of the emergency medications were inspected and reviewed. The paper copy of Ekit medication list did not include the quantity of each item. When the CP logged into the ADM, he printed the list of medications inside the machine under Emergency kit, the list included a zero existing quantity for olanzapine injection (or Zyprexa, drug to treat urgent psychiatric treatment). The CP stated the drug was removed on 3/4/26 as documented on the ADM and had not been replaced for over 5 days. When asked if there was any communication with the facility staff on non-replacement, the CP stated when nurses logged into the ADM, they could see it was not available.During an interview with Director of Nursing (DON), on 3/10/26, at 3:45 PM, the DON stated the pharmacy provider had access to the ADM for inspection and they relied on the pharmacy to keep the supplies up to date with quantity and expiration dates. The DON stated she could not recall using this drug. The DON stated the nurses needed more training on use of the ADM machine and how to use the resources available to them.During an interview with Licensed Nurse 1 (LN 1), on 3/12/26, at 10:29 AM, LN 1 was asked to access the Ekit medications. LN 1 stated she did not know how much of each medication were stocked in the ADM and the printed list only gave the name of drugs. LN 1 tried to access the drug olanzapine, went thru the removal process and was encountered with a pending note on the screen. LN 1 stated she was not able to print the drug lists or see what items were available in the ADM.Review of the facility's policy, titled Automated Drug Delivery System, updated on 4/6/22, the policy on section under Missing/Low Medications, indicated .in the event there are missing medications or the quantity is not sufficient . the licensed healthcare professional retrieving the medications will be notified by the system prior to initiating the dispense . If the missing/low medications have not delivered to the remote dispense site, the pharmacy's support team will make appropriate arrangement to have the canisters delivered to the remote site. The policy under Emergency (eKIT) Dispensing, indicated .In the event of an emergency pursuant to a prescriber's order or prescription, an authorized licensed healthcare professional can retrieve unit dose medications from the system prior to a pharmacist's review . The pharmacy will monitor the emergency dispensing audit log within 48 hours of the dispense and a pharmacist will review those orders. The policy under inventory indicated .The pharmacy monitors inventory levels remotely and (continued on next page)		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	will send replacement when quantity or remaining day's supply is running low. The policy on Staff Education indicated .a pharmacy service technician will be responsible for ongoing training for new and existing staff at the Remote Dispensing Site.2. During an inspection of the [NAME] station medication refrigerator, on 3/9/26, at 2:30 PM, the TPN bags labeled for Resident 18 were inspected. The TPN bags had two different labels on each side with two different beyond use date (or BUD, date after which should not be used). The label on one side of the TPN bag indicated date compounded 3/3/26 and Do Not Use After 3/2/27. The TPN label on the opposite side had a BUD of 3/13/26.During a second inspection of the [NAME] station medication refrigerator, on 3/12/26, at 10:18 AM, the TPN bags for Resident 18, from the provider pharmacy, was noted with two labels with BUD of Do Not Use After 3/10/2027 on one side and Discard After 3/21/2026 on the opposite side, with the list of ingredients on both sides.During an interview with Licensed Nurse 1 (LN 1), in the [NAME] station medication room, on 3/12/26, at 10:15 AM, LN 1 stated two different BUD labels were confusing, and the nurses should follow the most recent BUD or call the pharmacy for clarification.During a telephone interview with the facility's Consultant Pharmacist (CP), on 3/12/26, at 12:49 PM, the CP stated the TPN was prepared (mixed) by a contractor pharmacy for the facility. The CP stated he did not notice the discrepancy between the two labels from two different pharmacies on each bag. The CP stated the nurses should follow the earliest expiration date.During an interview with DON, on 3/10/26, at 3:45 PM, the DON stated the provider pharmacy should have had a clear direction for the nurses to safely administer and care for the residents without confusing directions.Review of the facility's policy titled Administering Medications, dated 4/19, the policy indicated, .The expiration/beyond use date on the medication label is checked prior to administering.3. During a medication administration observation, with Licensed Nurse 4 (LN 4), on 3/9/26, at 11:28 AM, LN 4 without gloved hand crushed 4 pills of a medication called Methimazole (a drug for treatment of an overactive thyroid and known to be a hazardous drug) for administration to Resident 105. LN 4 then mixed the crushed pills with apple sauce and gave it to Resident 105 with a spoon.During a concurrent interview and record review of Resident 105 medical record, on 2/10/26, at 2:08 PM, LN 4 stated she was not aware that methimazole required extra precaution in handling during administration. LN 4 stated the clinical record did not have any comments on safe handling under the Additional Direction for the medication methimazole.During an interview with DON, on 3/10/26, at 3:45 PM, the DON stated there should have been a note on safe handling of hazardous drugs in the computer system.During a telephone interview with the facility's Consultant Pharmacist (CP), on 3/12/26, at 12:49 PM, the CP stated the individual unit dose packets produced by the facility's Automated Dispensing Machine (ADM) may not have the space for hazardous labeling. The CP stated the medication administration record should instruct the nursing staff on safe medication handling.Review of the facility's policy titled Hazardous Drugs, dated 4/19, the policy indicated .Hazardous pharmaceutical drugs are handled according to practice standards so as to minimize staff and resident exposure and environmental damage. Hazardous drugs handled in this facility are identified according to criteria published by National Institute for Occupational Safety and Health (NIOSH, federal agency responsible for researching, recommending, and preventing work-related injuries). The policy further indicated .All hazard drugs handled or administered in the facility, including any drug that is not published on the current NIOSH list but that meets the criteria for hazardous drug, is included in facility specific list.Hazardous drugs are labeled, stored, and transported in accordance to current USP (United States Pharmacopeia is an independent, non-profit organization that sets public, science-based quality standards for handling medicines) standards. Staffs are trained on and required to wear personal protective equipment specific to the risk of (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER Harvest Crossing Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 469 East North Street Manteca, CA 95336	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	exposure and activities perform .Review of the facility's policy titled Storage of Medications, dated 11/20, the policy indicated .Hazardous drugs are clearly marked and stored separately from other medications .		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure safe medication storage practices in the medication carts, medication refrigerators, and medication rooms for a census of 89 residents when:1. The east station medication room stored unlabeled IV (intravenous; medication given through a vein) fluid bags, un-retained resident medication stored in an unclean cabinet, and injectable drugs were stored in a wet, soiled plastic zip lock bag inside the refrigerator;2. The east station medication cart 2 contained unopened eye drop marked to be refrigerated when not opened;3. The west medication room IV cart had opened, undated vials of injectable medication called lidocaine (a numbing agent) along with unlabeled IV fluid bags;4. The west station medication cart 3 stored medications that required refrigeration, had undated inhalation medications, and co-mingled oral medications with suppositories (medications designed for insertion into the rectum); and 5. The refrigerator inside the electronic emergency kit (e-kit) was found to be heavily frosted and the facility did not have access to monitor the frost buildup. These failures could contribute to unsafe medication use, medication error, and risk of residents receiving medications that were contaminated, spoiled, expired, or had reduced potency. Findings:1. During a concurrent observation and interview on [DATE], at 9 AM, with Licensed Nurse (LN) 4, in the east nurse's station medication room, the refrigerator stored a soiled plastic bag with an injectable drug called semaglutide (drug used for blood sugar disease) was found to be wet with water spilling from it. LN 4 stated that the semaglutide injectable drug was discontinued. Further observation indicated 2 unlabeled IV fluid bags in the drawer of the east medication room. Upon inspection of another unlocked cabinet, unreturned resident's own medication was found in an untidy cabinet on the east station medication room. LN 4 acknowledged the findings. 2. During an observation on [DATE], at 9:28 AM, at the east station, with LN 4, the medication cart 2 had unopened eye drops called latanoprost (eye drops for eye disease) marked to be refrigerated when not opened. LN 4 acknowledged the finding and was not sure why it was not kept in the refrigerator. 3. During a concurrent observation and interview on [DATE], at 10:08 AM, with LN 1, in the west nurse's station medication room, the IV medication cart had an unlabeled lidocaine injection vial. LN 1 stated that the lidocaine vial should not be there, it should have been discarded. Upon further observation, the IV cart stored 1 bag of IV fluids with a partially peeled resident label on it. LN 1 stated that the IV fluids should have been in the discharge medication box. 4. During a concurrent observation and interview on [DATE], at 10:24 AM, with LN 1, at the west nurse's station, the medication cart 3 had an opened bottle of acidophilus with pectin (drug used for digestive health). The acidophilus label on the bottle indicated Refrigerate after opening. LN 1 confirmed that she did not know that acidophilus bottle was supposed to be refrigerated. Further observation indicated that an opened inhalation medication called Budesonide (drug used for asthma; a condition that causes your airways to swell, narrow and fill with mucus) out of its foil wrap was not dated when first opened. The Budesonide label on the box indicated, Once the foil pouch is opened, use the ampules within 2 weeks. LN 1 confirmed that it was not dated. LN 1 stated that the Budesonide foil pouch was supposed to be dated upon opening. Upon further inspection, medication cart 3 stored suppositories mixed with oral medication. LN 1 stated suppositories should not be mixed with oral medications in the same bin.5. During a concurrent observation and interview on [DATE], at 2:49 PM, with the consultant pharmacist (CP), the refrigerator inside the electronic e-kit was found to (continued on next page)		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	be heavily frosted and the box of insulin (injectable drug for blood sugar disease) medications was attached to the frosted area. The CP stated that the pharmacy provider oversaw and monitored the temperature of the refrigerator. The CP stated that the pharmacy provider inspected the machine regularly. During an interview on [DATE], at 3:35 PM, with the Director of Nursing (DON), the DON stated that she was not aware that the acidophilous medication needed to be refrigerated. The DON stated that the discontinued medications of discharged residents should have been given to the resident or the resident's family. The DON stated that the nurse should have discarded the wet injectable Ozempic drug and placed it in the discontinued cabinet storage. The DON further stated that the discontinued cabinet storage should have been locked inside the medication room. The DON stated that the eye drops that were not opened should have been refrigerated. The DON further stated that she expected the nurses to follow the medication label and storage instruction. The DON stated the nursing staff do not have access to the refrigerator in the electronic e-kit to defrost it. The DON stated that the pharmacy staff that comes should have reported and defrosted the refrigerator. The DON stated she expected the nurses to discard one-time use drugs after each use and not to be kept in the cart after use. The DON stated that the oral medications should have been separated from the suppositories and placed in another bin. During a phone interview on [DATE], at 12:49 PM, the CP stated he visited the facility and inspected the medication storage area including the refrigerator and medication carts every month. The CP stated that he checked the fridge if it was frosted periodically or as needed. The CP stated that the temperature of the electronic e-kit fridge was being monitored remotely. The CP further stated that if the temperature was out of range, it could affect the medications. The CP stated that the resident's own medications should be separated from the pharmacy supply and the staff should be following the facility's policy on that. The CP stated that the discontinued medications should be destroyed following the facility's policy. A review of the facility's policy and procedure titled, Storage of Medications, revised 11/20, indicated, .The facility stores all drugs and biologicals in a safe, secure, and orderly manner. Drugs and biologicals used in the facility are stored in locked compartments under proper temperature, light and humidity controls. The nursing staff is responsible for maintaining medication storage and preparation areas in a clean, safe, and sanitary manner. Drug containers that have missing, incomplete, improper, or incorrect labels are returned to the pharmacy for proper labeling before storing. Discontinued, outdated, or deteriorated drugs or biologicals are returned to the dispensing pharmacy or destroyed. Medications requiring refrigeration are stored in refrigerator located in the drug room at the nurses' station or other secured location. A review of the facility's policy and procedure titled, Medication Storage in the Facility Storage of Medications, revised 8/14, indicated, .Medications and biologicals are stored safely, securely, and properly, following manufacturer's recommendations or those of the supplier. Orally administered medications are kept separate from externally used medications and treatments such as suppositories, ointments, creams, vaginal products, etc. Outdated, contaminated, or deteriorated medications and those in containers that are cracked, soiled, or without secure closures are immediately removed from inventory, disposed of according to procedures for medication disposal. Medication storage areas are kept clean, well-lit, and free of clutter and extreme temperatures and humidity. Medications and biologicals are stored at their appropriate temperatures and humidity. Expiration dates (beyond-use date) of dispensed medications shall be determined by the pharmacist at the time of dispensing. Drugs dispensed in the manufacturer's original container will be labeled with the manufacturer's expiration date. Certain medications or package types, such as IV solutions, multiple dose injectable vials, ophthalmic [eye drops], once opened, require an expiration date shorter than the manufacturer's expiration date to insure medication purity and potency.		

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. Based on observation, interview, and record review, the facility failed to ensure routine dental care was followed up on for one of twenty-eight sampled residents (Resident 55) when, dental services for Resident 55's dentures were not followed up on since 8/25/24. This failure placed Resident 55 at risk for decreased meal intake, continued decay of remaining teeth, and psychosocial distress over the lack of dentures and poor oral health. Findings: During a review of Resident 55's admission RECORD, the record indicated that Resident 55 was admitted to the facility with diagnoses that included dementia (a decline in mental abilities-like memory, thinking, and reasoning-severe enough to interfere with daily life) and hepatic failure (liver is so damaged-either suddenly or over time-that it cannot perform its essential jobs, such as filtering toxins, aiding digestion, and storing energy). During a review of Resident 55's clinical document titled Order Summary Report, dated 3/11/26, the Order Summary Report indicated that Resident 55 had an active physician's order dated 10/1/25 for the following diet texture .Soft and Bit Sized (mechanical soft) texture. (Small Portion) for Bread OKAY .During a concurrent observation and interview on 3/9/26 at 11:11 AM with Resident 55, Resident 55 was observed to have no upper teeth and lower teeth that were in various stages of decay. Resident 55 stated that she did not have any dentures but had been waiting for one for a long time. Resident 55 was unable to recall how long she had been waiting for a set of dentures. Resident 55 also stated that the food tasted ok, but sometimes she did not like how it was chopped up and wished she got just regular food. Resident 55 stated that they told her she was getting her food chopped up so that she could chew better since she had no dentures and her teeth were bad. Resident 55 could not identify who they were. During an interview on 3/10/26 at 9:43 AM with Certified Nursing Assistant (CNA) 5, CNA 5 stated that Resident 55 refused to complete oral care at times, with or without the help of a CNA. CNA 5 stated that Resident 5 complains of oral pain at times when her teeth were brushed. During a review of Resident 55's undated clinical document titled Care Plan Report, the Care Plan Report indicated Resident 55 had a care plan (a personalized, written roadmap that outlines an individual's health needs, goals, and the specific daily actions or services required to support them, often managed by healthcare professionals) with a focus statement (a concise summary of the main health issue, concern, or need that the healthcare team is currently addressing for a patient) that had been initiated on 5/28/21 which indicated .Following for Full Upper and Partial Lower Dentures per [Dental Service Providers Name] recommendations.9/26/24-Per [Dental Service Provider Name] tx [treatment] is still under review by insurance. Resident 55's care plan indicated that the focus statement was last revised on 11/4/24. During review of this same care plan's interventions (the specific, actionable steps, treatments, or actions taken by healthcare providers to help a patient reach their health goals), an intervention initiated on 8/8/24, indicated the SS (Social Services) called the Dental Service Provider in August 2024 regarding Resident 55's dentures. The intervention indicated a last revision date of 9/26/24. During a concurrent interview and record review on 3/11/26 at 10:47 AM with the Social Service Director (SSD), Resident 55's care plan for dental issues and Dental Notes, dated 10/22/24, 11/5/25, and 2/4/26 were reviewed. The SSD stated that it appeared that Resident 55 had fallen through the cracks for denture follow up and the SSD would look through Resident 55's progress notes to see if SSD could determine what happened. The SSD stated that the facility should have been notified in 2024 by the Dental Service Provider if the request for dentures had been approved by the insurance. The SSD stated that Resident 55's care plan for dental concerns should have been reviewed at least quarterly and updated as new information regarding the pending denture approval was received. The SSD confirmed that the social service department was (continued on next page)		

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	responsible for setting up dental appointments and they are to follow up on recommendations for dentures needed. The SSD stated that this oversight placed Resident 55 at risk for decreased oral intake, oral pain, discomfort, and psychosocial issues related to lack of an upper denture. During a follow up interview on 3/12/26 at 9:33 AM with the SSD, the SSD stated that she was unable to determine why Resident 55 did not receive new dentures in 2024. The SSD confirmed that the Resident had not received upper or lower dentures between 2024-2026. During a concurrent interview and record review on 3/12/26 at 11:12 AM with Social Service Assistant (SSA), the SSA stated that an email had been received from [Dental Service Provider] that included Resident 55's treatment authorization documents. Reviewed with the SSA Resident 55's document titled NOTICE OF AUTHORIZATION, dated 10/1/24, which indicated authorization had been approved for the period of 9/30/24 to 3/29/25 for an upper complete denture and a lower partial cast. Reviewed with the SSA Resident 55's document titled NOTICE OF AUTHORIZATION, dated 3/4/26, which indicated authorization had been approved for the period of 3/2/26 to 3/3/27 for an upper complete denture and a lower partial cast. The SSA confirmed that each of these authorization letters indicated that Resident 55 had been approved for a full upper denture and a lower partial. The SSA was unable to explain or provide any documentation as to why the authorization had not been followed up on during the period of 9/0/24 to 3/29/25 or provide any documentation that the current authorization period had been followed up on by the social service department. During a review of the facility's policy and procedure titled, Availability of Services, Dental, dated 8/07, the P&P indicated .Social Service will be responsible for making necessary dental appointments .During a review of the facility's job description titled, JOB DESCRIPTION Social Services Director, dated 3/1/14, the job description indicated .The Social Service Director assumes administrative authority, responsibility and accountability to provide medically related social services which assist resident in maintain or improving their ability to manage their everyday physical, mental and psychosocial needs.		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on observation, interview, and record review, the facility failed to maintain a complete and accurate medical record for 3 of 28 sampled residents (Resident 10, Resident 5, and Resident 66) when:1. Resident 10's Interdisciplinary (IDT - a group of different health professionals (like doctors, nurses, therapists, and social workers) who work together, sharing information and decisions to provide comprehensive care for a patient) Care Conference Notes and care plan (a structured, individualized document that outlines the medical and supportive services a patient needs to address their specific health conditions and goals) indicated Resident 10 was receiving hospice services (specialized, holistic care for individuals with terminal illnesses (typically 6 months or less to live) who have stopped curative treatment) even though Resident 10 had been discharged from hospice on 8/27/25.2. Resident 5's low air loss alternating pressure mattress (medical air mattress designed to reduce pressure on the skin) was not consistently documented for its placement and function each shift daily per physician orders for February 2026; and,3. Resident 66's task for being repositioned every 2 hours was not consistently documented in Resident 66's electronic health record (EHR) on 2/25/26 and 2/26/26.This failure had the potential to affect medical and psychosocial decisions for Resident 10's plan of care due to inaccurate information found in the medical record. These failures placed Resident 5 at risk for a pressure injury, increased the risk for a worsening pressure injury for Resident 66, and had the potential for decreased well-being for Resident 5 and Resident 66.Findings:1. During a review Resident 10's admission RECORD, the record indicated Resident 10 was admitted to the facility with pertinent diagnoses of senile degeneration of brain (the progressive breakdown and death of brain cells in older adults, causing a significant decline in memory, thinking, and daily functioning), dementia (a progressive state of decline in mental abilities) and schizophrenia (a mental disorder that causes disruptions in thought process, perceptions, emotional responses, and social interactions). During an interview on 3/11/26 at 10:14 AM with Certified Nursing Assistant (CNA) 5, CNA 5 stated that Resident 10 was still on hospice and was receiving care from hospice aides during their visits.During a record review of Resident 10's active physician orders for March of 2026, there were no orders that indicated Resident 10 was receiving hospice services. Review of Resident 10's clinical document titled [Name of Hospice Service Provider] PHYSICIAN ORDER, dated 8/25/25, indicated .Discharge from [Name of Hospice Service Provider] due to extended prognosis on 8/27/25 .During a concurrent interview and record review on 3/11/26 at 11 AM with the Social Services Director (SSD), Resident 10's [Name of Hospice Service Provider] physician order, dated 8/25/25, was reviewed. The SSD confirmed that the order indicated that Resident 10 had been discharged from hospice services on 8/27/25. The SSD reviewed Resident 10's IDT notes dated 11/28/25 and 2/19/26 and confirmed that the IDT notes indicated that Resident 10 was still receiving hospice services. The SSD reviewed Resident 10's care plan and confirmed that Resident 10 had active care plans that included hospice in the problem statement and as an intervention. The SSD stated that the care plans that included hospice were incorrect as were the IDT care conference notes that indicated Resident 10 continued to receive hospice services after he had been discharged . The SSD stated it all should have been updated when Resident 10 was discharged from hospice services on 8/25/25.During a concurrent interview and record review on 3/12/26 at 8:36 AM with the MDS nurse, Resident 10's IDT Care Conference Notes dated 9/12/25, 11/28/25, and 2/19/26 were reviewed. The MDS nurse confirmed that the information regarding hospice services was inaccurate and should have reflected that Resident 10 was no longer receiving hospice services from (name of Hospice Service (continued on next page)		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provider). The MDS nurse also confirmed that Resident 10's care plans had not been updated after Resident 10 was discharged from hospice services. The MDS stated that these inaccuracies in Resident 10's record had the potential to lead to miscommunication regarding Resident 10's care needs and long-term goals. During a concurrent interview and record review on 3/11/26 at 11:37 AM with the Director of Nurses (DON), the IDT Care Conference Notes and Care Plan for Resident 10 were reviewed. The DON stated that a resident's clinical record should reflect the resident's status at the time it is written. The DON confirmed that the clinical records for Resident 10 had not been accurately documented and the errors placed Resident 10 at risk for not receiving the appropriate care interventions. 2. A review of Resident 5's admission RECORD, indicated that Resident 5 was admitted to the facility with diagnoses including necrotizing fasciitis (a rare but very severe type of bacterial infection [contaminated with disease-producing germs] of the soft tissue. It can destroy the muscles, skin, and underlying tissue), type II diabetes mellitus (a chronic condition that affects the way the body processes blood sugar), and heart failure (occurs when the heart does not pump blood as it should. Also known as congestive heart failure). A review of Resident 5's Physician Order Summary, indicated, .May have Low Air Loss Mattress on bed at all times for pressure relieving. Monitor Placement and functionality Q shift [every shift]. Order Date. 01/13/2026. Start Date. 01/13/2026. A review of Resident 5's Treatment Administration Record [TAR, list of prescribed treatments] February 2026, indicated, .May Have Low Air Loss Mattress on bed at all times for pressure relieving. Monitor placement and functionality Q [every] shift. Further review of the document indicated that the placement and functionality of Resident 5's low air loss mattress was not checked every shift in February 2026. During an interview on 3/10/26, at 11:30 a.m., with Licensed Nurse (LN) 4, LN 4 stated that the LNs documented the functioning of low air loss mattresses every shift every day in the resident's TAR. LN 4 further stated that if the low air loss mattress was not working properly, the LNs would report to the Treatment LN. LN 4 explained that the Treatment LN checked the mattress for functioning and if needed, would order a replacement mattress. During an interview on 3/10/26, at 11:36 a.m., with LN 6, LN 6 stated residents with low air loss mattresses were at risk for skin breakdown (occurs when skin integrity is compromised, leading to damage of the skin and underlying tissue). LN 6 further stated the LNs checked for an order for the low air loss mattress and documented the functioning of the low air loss mattress every shift each day on the Medication Administration Record (MAR, a document listing medications and monitoring parameters) or the TAR. During an interview on 3/10/26, at 12:24 p.m., with the DON, the DON stated it was her expectation that residents with orders for low air loss mattresses had their functioning documented in the EHR daily. The DON further stated the LNs documented the functioning of the low air loss mattress daily in the TAR. The DON stated the risk was that if the mattress was not functioning the mattress could flatten and put the resident at increased risk for skin breakdown. During a concurrent interview and record review on 3/11/26, at 9:45 a.m., with the DON, Resident 5's February 2026 TAR was reviewed. The DON confirmed that the low air loss mattress checks were not consistently documented in February 2026 for Resident 5. The DON acknowledged that the facility policy was not followed. 3. A review of Resident 66's admission RECORD, indicated that Resident 66 was admitted to the facility with diagnoses including type II diabetes mellitus, heart disease (also known as cardiac disease, is a general term for a variety of conditions that affect the heart and blood vessels), and dementia (a decline in memory or other thinking skills severe enough to reduce a person's ability to perform everyday activities). A review of Resident 66's Minimum Data Set (MDS, a comprehensive care assessment tool) Section M - Skin Conditions, dated 1/23/26, indicated, .M0100: Determination of Pressure Ulcer/Injury Risk. Check all that apply. B. Formal assessment instrument/tool (e.g., (continued on next page)		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Braden.).C. Clinical assessment.M0150.Risk of Pressure Ulcers/Injury.Is this resident at risk of developing pressure ulcers/injuries? 1. Yes.M0210 Unhealed Pressure Ulcers/Injuries.Does this resident have one or more unhealed pressure ulcers/injuries? 0. No.M1200.Skin and Ulcer/Injury Treatments. Check all that apply.B. Pressure reducing device for bed.C. Turning/repositioning program.H. Application of ointments/medications.A review of Resident 66's Progress Notes, dated 3/7/26, indicated, .stage II pressure injury [a shallow, open wound caused by unrelieved pressure, resulting in partial-thickness skin loss] to coccyx [small bone at the bottom of the spine; tailbone] and RP [responsible party] notified.A review of Resident 66's Care Plan Report, indicated, .Focus.Resident has open area to coccyx.Date Initiated.03/07/2026.Goal.Pressure ulcer will show signs of healing and remain free from infection (contamination with germs) by the review date.Target Date.04/23/2026.Interventions.Relieve pressure- Reposition the resident per protocol.A review of Resident 66's Task: Turning and Repositioning, on 3/11/26, indicated that Resident 66 was not turned and repositioned per protocol on 2/25/26 and on 2/26/26.During a concurrent interview and record review on 3/11/26, at 9:45 a.m., with the DON, Resident 66's EHR was reviewed. The DON acknowledged that Resident 66 had a stage II pressure injury. The DON stated that her expectation was that if a resident developed a stage II pressure injury the staff implemented frequent turning and repositioning, frequent incontinent care, the physician was notified, the care plan was updated, and the RP was notified. The DON reviewed Resident 66's Task: Turning and Repositioning, documentation for turning and repositioning for February 2026 and March 2026. The DON confirmed that the documentation on the Task: Turning and Repositioning, indicated that Resident 66 was not turned and repositioned every two hours on 2/25/26 and on 2/26/26.		

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Some	Post nurse staffing information every day. Based on observation, interview, and record review, the facility failed to ensure that complete and accurate nurse staffing information was posted in a readily accessible location for residents and visitors. This deficient practice had the potential to prevent residents, families, and the public from accessing accurate information regarding daily nurse staffing levels, which is required to promote transparency and awareness of the staffing resources available to meet resident care needs. Findings: During an observation on 3/10/26, at 10:30 AM, the daily Nurse Staffing Information (PPD; hours per patient per day) posting could not be located throughout the facility. During an interview on 3/10/26, at 10:44 AM, with the Staffing Coordinator (SC), the SC stated that the PPD had not been posted since the previous week due to electrical repairs in the area where the information was normally posted. The SC explained that her usual process was to prepare the PPD information the day before and post it on a clipboard on the wall facing the nurse station. The SC stated that the PPD represented the projected staffing for the day and confirmed that the PPD should be posted daily. The SC explained that posting the information was important so the public, including visitors, the ombudsman, and state representatives, would be aware of the facility's nursing staffing levels related to resident care. During an interview with record review on 3/11/26 at 11:01 AM, with the Director of Nursing (DON), the DON stated that the Staffing Coordinator was responsible for the daily posting of the PPD. The DON explained that the PPD form was important because it showed the nursing staffing information for each shift, including the staff responsible for providing direct care to residents. The DON stated that this information was important for residents, families, visitors, and staff, so everyone would know the nursing staff responsible for resident care. During an interview on 3/11/26, at 3:05 PM, with the Administrator in Training (AIT), the AIT stated that it was his expectation that the PPD information should be posted daily. The AIT explained that posting the PPD was important to ensure the facility had adequate nursing staff to provide the necessary care for all residents. The AIT also stated that it was important for residents, families, visitors, and other members of the public to have access to the facility's nursing staffing information, so they could understand how the facility was meeting the care needs of the residents. Review of facility policy and procedure titled, Posting Direct Care Daily Staffing Numbers, revised 8/22, indicated, .Policy Statement: Our facility will post on a daily basis for each shift nurse staffing data, including the number of nursing personnel responsible for providing direct care to residents .		