

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

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055922	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/10/2026
NAME OF PROVIDER OR SUPPLIER Courtyard Health Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1850 E. 8th Street Davis, CA 95616	
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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review the facility failed to ensure food was stored, prepared and distributed in accordance with professional standards of food service for a census of 104 Residents when:1.Two ovens were observed with blackened, burnt debris on the bottom and doors;2.Food items in Freezer #1 were opened and undated;3.Food items in the dry storage area were placed in bowls unlabeled and undated; and,4. Meal trays were observed being delivered to residents with uncovered food. These failures had the potential to cause food borne illness among a vulnerable resident population. Findings: 1.During a concurrent observation and interview on 7/7/26 at 8:46 a.m., with the Dietary Manager (DM) and the Registered Dietician (RD), the 2 kitchen ovens were observed to have blackened and burnt debris on the bottom and the oven doors. DM confirmed the above findings and stated she expected the oven to be cleaner. The RD stated that if the oven is not kept clean, it could affect the cooking temperature of the food. Review of the facility's policy and procedure (P&P), titled, Ranges and Ovens, dated 2023, the P&P indicated, Oven's cleaning procedure.clean weekly or as often and necessary.in manufacture directions. Review of the oven owner's manual for Restaurant Series Ranges, dated 2012, the owner's manual indicated for Oven Maintenance-Daily: 1. Wipe the inside of the oven. 2.During a concurrent observation and interview on 7/7/26 at 9 a.m. with the DM and RD, in freezer #1 the following items in gallon containers were opened and undated: Mayonnaise, Sesame dressing and Pickle relish. The DM confirmed the above findings and stated her expectation would be that the dietary staff date the item when they open it. The RD stated that if the food does not have an open date there is no way to tell how long the food has been there. The RD further stated that it could affect the taste of the food and cause food borne illness. Review of the facility's policy and procedure (P&P), titled Procedure for Freezer Storage, dated 2023, the P&P indicated, All frozen foods should be labeled and dated. 3.During a concurrent observation and interview on 7/7/26 at 9:20 a.m. with the DM and RD in the dry storage area, observed eight covered serving bowls of cereal that were unlabeled and undated. DM confirmed the above finding and stated her expectation is that the cereal bowls should have a date (continued on next page)		

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER
REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	that they were prepared. The RD stated that it could affect the taste of the cereal. Review of the facility's policy and procedure (P&P), titled, Storage of food and Supplies, dated 2023, indicated, dry food items which have been opened.such as cereal.will be labeled and dated. 4.During a concurrent observation and interview on 7/7/26 at 12:21 p.m. with Certified Nursing Assistant (CNA) 8 in the hallway outside the dining room, CNA 8 removed a tray containing an uncovered brownie and salad from the dining room food cart and proceeded to bring the tray to the memory care dining room. CNA 8 confirmed that the brownie and salad did not have covers. During a concurrent observation and interview on 7/7/26 at 12:27 p.m. with CNA 8 in the hallway outside the dining room, CNA 8 took a tray containing an uncovered brownie from the dining room food cart and proceeded to walk the tray to the resident's room in the C hallway. CNA 8 confirmed that the brownie was uncovered. During a concurrent observation and interview on 7/7/26 at 12:35 p.m. with CNA 6, CNA 6 was observed with a tray containing an uncovered brownie coming from the kitchen hallway. CNA 6 stated that she took the tray from the food cart in B hallway, went to the kitchen to confirm that the food was okay to be served, and was walking the tray back to the resident's room in B hallway. During a concurrent observation and interview on 7/7/26 at 12:33 p.m. outside the dining room, Resident 65's food tray containing an uncovered brownie was left on top of the dining room food cart. At 12:36 p.m. CNA 1 placed the tray back inside the food cart. At 12:37 p.m., CNA 8 removed the tray from the food cart and walked it back to Resident 65's room in Hallway C. CNA 8 confirmed that the brownie was uncovered. At 12:38 p.m., CNA 1 confirmed that the tray that had been left on top of the cart belonged to Resident 65. During an observation on 7/8/26 at 12:35 p.m., observed lunch trays being passed on B hall with uncovered food. The tray cart was outside of the dining room and a tray was passed by the Director of Staff Development (DSD) to room B17 with an uncovered fruit cup. The tray cart was then moved to B17, and a lunch tray was brought to a resident in room B15 by CNA 6 with an uncovered fruit cup and bean salad. CNA 6 stated that the food should have been covered. During an interview on 7/8/26 at 12:45 p.m. with the DSD, the DSD confirmed these findings and stated that the food should have been covered. The DSD further stated that the tray cart should be directly outside of a resident's room when a food tray is being delivered. During an interview on 7/8/26 at 1:20 p.m. with the RD, the RD stated that if a meal tray is being delivered to a resident's room from a tray cart in the hallway the food on the tray should be covered because there is risk of food contamination. During a review of the facility's P&P titled, Covering Food During Transport, undated, the P&P indicated 1. Meal trays will be delivered in carts. All foods will be covered in trays if not in an enclosed or covered cart.2. If tray leaves the dining room not in a cart and is being delivered to patient rooms, all food on the tray needs to be covered.7. Carts may be parked outside of the residents' doors in (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	hallway as trays are delivered to adjacent rooms; minimizing transport of food through a common area to protect it from contamination while it is uncovered.		

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. Based on interview and record review, the facility failed to ensure five residents (Residents 1, 3, 4, 12, and 91) out of 26 sampled residents were free from unnecessary psychotropic medications (drugs that affects brain activities associated with mental processes and behaviors), when they received psychotropic medications while nursing staff did not implement nonpharmacological (non-drug, behavioral interventions). This failure had the potential to result in the unnecessary use of psychotropic medications and to not utilize the lowest effective dose of medication.1. A review of Resident 12's medical record indicated she was admitted to the facility in September 2023 with diagnoses which included seizures, major depressive disorder (an illness where one experiences persistent feeling of emptiness, hopelessness, and a total loss of interest in activities), and schizoaffective disorder (a chronic mental health condition that combines the symptoms of two distinct illnesses: schizophrenia [losing touch with reality] and a mood disorder such as depression). A review of Resident 12's physician's orders indicated the following orders:- Risperidone (an antipsychotic medication) 0.5 milligram (mg, a unit of measurement) tablet: Give 1 tablet by mouth two times a day for schizoaffective disorder m/b (manifested by) hallucinations, ordered 8/6/25- Sertraline (a medication to treat depression) 100 mg tablet: Give 1 tablet by mouth one time a day for depression m/b SI (suicidal ideation, the thought of killing oneself) & tearfulness. Give with 25 mg tablet to total 125mg, dated 10/7/25- Sertraline 25 mg tablet: Give 1 tablet by mouth one time a day for depression m/b SI & tearfulness. Give with 100 mg tablet to total 125mg, dated 11/11/25- Trazodone (a medication to treat depression and insomnia) 50 mg tablet: Give 50 mg by mouth at bedtime for depression m/b inability to sleep, dated 10/21/25 During a concurrent interview and record review on 7/9/26 at 2:24 p.m. with the Director of Nursing (DON), the DON stated the first response to resident who displayed behaviors was always behavioral interventions. He stated nursing staff were expected to document the intervention that was implemented. He stated behavioral interventions were expected to be routine and implemented every shift. The DON stated once a resident was started on a psychotropic medication, nonpharmacological interventions were implemented if a medication was scheduled to be administered as needed and not routine. The DON reviewed the Resident 12's record and stated he did not see non drug interventions 2. A review of Resident 4's medical record indicated he was admitted to the facility in February 2026 with diagnoses which included major depressive disorder. A review of Resident 4's physician's orders indicated the following orders:- Aripiprazole oral solution 1 mg/milliliter (mg/ml, a unit of measurement): Give 15 mg via PEG-Tube (Percutaneous Endoscopic Gastrostomy, a soft, flexible feeding tube that is placed directly through the skin of the belly into the stomach) one time a day for MDD (major depressive disorder) m/b self isolation, dated 5/6/26- Escitalopram (an antidepressant to treat depression) 10 mg tablet: Give 1 tablet via PEG-Tube at bedtime for MDD m/b verbalization of sadness, dated 5/5/26 During a concurrent interview and record review on 7/9/26 at 2:36 p.m. with the DON, Resident 4's medical record was reviewed. The DON stated social services and activities created care plans that were specific to a resident's likes and dislikes to help direct staff on what nonpharmacological interventions to implement. The DON reviewed Resident 4's medical record and confirmed there was no documentation that behavioral interventions were implemented. 3. A review of Resident 91's medical record indicated she was admitted to the facility in December 2022 with diagnoses which included anxiety disorder and major depressive disorder. A review of Resident 91's physician's orders indicated the following orders:- Fluoxetine (an antidepressant to treat depression) 20 mg/5 ml oral (continued on next page)		

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	solution: Give 2.5 ml by mouth one time a day for anxiety m/b compulsive skin picking, dated 9/10/25- Seroquel (an antipsychotic medication) 25 mg tablet: Give 0.5 tablet by mouth two times a day for behavioral disturbance m/b agitation, dated 6/15/26 During a concurrent interview and record review on 7/9/26 at 2:59 p.m. with the DON, Resident 91's physician's orders and documentation for behavioral interventions were reviewed. The DON confirmed Resident 91's medical record did not indicate that nonpharmacological interventions related to her anxiety and agitation were implemented because her psychotropic medications were administered routinely, not as needed. 4. A review of Resident 3's medical record indicated he was admitted to the facility in April 2022 with diagnoses which included major depressive disorder and anxiety disorder. A review of Resident 3's physician's orders indicated an order for the following:- Ativan (a psychotropic medication to treat anxiety) 0.5 mg tablet: Give 1 tablet by mouth every 8 hours as needed for anxiety/inability to relax for 14 days hold for sedation, RR (respiratory rate) less than 12, SBP (systolic blood pressure, a measurement of the maximum pressure of blood pushing against artery walls when the heart beats and pumps blood out to the body) less than 90, or new confusion or delirium, ordered 7/7/26- Sertraline 25 mg tablet: Give 1 tablet by mouth one time a day for depression m/b social isolation, dated 5/24/26 During a concurrent interview and record review on 7/9/26 at 3:01 p.m. with the DON, Resident 3's psychotropic medication orders and behavioral interventions were reviewed. The DON stated Resident 3's medical record did not indicate nursing staff implemented behavioral interventions for his psychiatric conditions and confirmed the record indicated he was only monitored for behaviors related to the sertraline and Ativan. 5. A review of Resident 1's medical record indicated he was admitted to the facility in November 2023 with diagnoses which included major depressive disorder and anxiety disorder. A review of Resident 1's physician's orders indicated an order for venlafaxine (a medication to treat depression) 37.5 mg tablet, give 2 tablet by mouth in the morning for anxiety disorder m/b worrying about dying, feeling fatigue, dated 5/28/26. During a concurrent interview and record review on 7/9/26 at 3:03 p.m. with the DON, Resident 1's medical record was reviewed for behavioral interventions related to his anxiety disorder. The DON confirmed Resident 1's record did not indicate that any non-drug interventions were implemented for anxiety in an effort to use the lowest effect dose of venlafaxine. During a review of the facility's policy and procedure (P&P) titled Care and Treatment, revised 2/2025, the P&P indicated, Based on a comprehensive assessment of a resident, the facility will ensure that: 1. Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. Procedures. 6. Upon initial comprehensive assessment, SSD [Social Services Director] and/or nursing designee shall review new admissions for any psychiatric, mood or behavior disorders, mental and psychosocial difficulties, and/or physician's orders for psychotropic medications. These residents will be referred to the facility's Psychotropic Drug Review Committee and/or the Psychiatrist to ensure. g. Review of plan of care shows individualized, person-centered care approaches to manage behavior with non-pharmacological interventions.		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. Based on observation, interview, and record review, the facility failed to ensure professional standards were followed for four residents (Residents 1, 3, 4, and 12) out of 26 sampled residents when: 1. Resident 3 did not receive appropriate pain management services during wound care treatment; 2. Resident 12's physician's order to discontinue medication was not carried out; 3. Resident 4's opioid (a potent medication to treat pain) medication was not administered by nursing staff according to the physician's order; and, 4. Nursing staff did not routinely check Resident 1's blood sugar (BS) prior to administration of (brand name for semaglutide) (a medication to treat type 2 diabetes). These failures resulted in Resident 3 to exhibit severe pain and not attain his highest practicable well-being and had the potential to result in Residents 12, 4, and 1 to receive unnecessary medication and exposure to unwanted side effects such as sedation or hypoglycemia (low blood sugar). Findings: 1. During a review of Resident 3's admission Record (AR-front page of the chart that contains a summary of basic information about the resident, part of medical record), the AR indicated Resident 3 was admitted to the facility in April 2022 with multiple diagnoses which included chronic pain syndrome and pain in thoracic (mid-back between neck and lower back) spine (provides structural support for posture, bending, and movement). During a review of Resident 3's Treatment Administration Record (TAR-a daily documentation record used by a licensed nurse to document medications and treatments given to a resident, physician orders), Resident 3 received multiple daily wound treatments for pressure ulcer/injury stage 3 (Full-thickness loss of skin. Dead and black tissue may be visible) located to right lower buttock and deep tissue injury (DTI- a severe type of pressure sore that develops deep within the soft tissue or muscle near a bone, presenting as a localized area of persistent, non-blanchable deep red, maroon, or purple skin) located to left and right heel. During a review of Resident 3's Order Summary Report (OSR, physician orders), dated 7/7/26, indicated, Morphine (pain medication) 15 mg (milligram, unit of measurement) give 1 tablet by mouth every 8 hours for pain management. During a review of Resident 3's OSR, dated 7/7/26, indicated, acetaminophen (pain medication) 325 mg .give 2 tablet by mouth every 6 hours as needed for mild pain (1-3 on the pain scale) . During a review of Resident 3's OSR, dated 7/7/26, indicated, licensed nurse (LN) to document Pain-Record highest level of pain every shift. During a concurrent observation, interview and record review on 7/7/26 at 1:24 p.m. in the hallway in front and outside of Resident 3's room, Resident 3 was observed moaning and yelling, .ow, ow, it hurts! LN 2 confirmed the wound doctor and LN 1 were inside providing treatment for Resident 3. LN 2 stated that Resident 3 was always complaining he was in pain and per review of Resident 3's medical record, was given only morphine at 6 a.m. and not given acetaminophen. LN 2 further stated that (continued on next page)		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident 3's yelling in pain was his baseline. LN 2 acknowledged that administration of pain medication was important to keep Resident 3 comfortable during wound treatment. During a review of Resident 3's Medication Administration Records (MARs, physician orders), the MARs indicated Resident 3 had 21 episodes of pain greater than 2 in June 2026 with 21 missed opportunities to administer acetaminophen. In July 2026, Resident 3 had 5 episodes of pain greater than 2 with 5 missed opportunities to administer acetaminophen. No documented evidence that acetaminophen was offered, refused or given. During a concurrent observation and interview on 7/9/26 at 10 a.m. in Resident 3's room, Certified Nursing Assistant (CNA)1 and CNA 2 assisted Resident 3 with activities of daily living (ADLs- routine tasks/activities such as bathing, dressing and toileting). Resident 3 was observed continuously grimacing, groaning, moaning and yelling ow, ow it hurts. LN 1 did not ask Resident 3 what his pain level was. Resident 3 continued to moan and yell ow! This surveyor prompted LN 1 at 10:20 a.m. to ask Resident 3 what his pain level was and Resident 3 stated 10/10 pain. LN 1 exited room and reported pain level to LN 3. LN 1 came back, and CNA 1 and CNA 2 continued wound treatments without any pain medication administered to Resident 3. Resident 3 continued to moan and yell ow! LN 1, CNA 1 and CNA 2 exited Resident 3's room at 10:55 a.m. Resident 3 was heard moaning inside the room from outside of the hallway. During a concurrent interview and record review on 7/9/26 at 11:13 a.m. with LN 3, LN 3 confirmed Resident 3 had 10/10 (highest) pain scale. LN 3 also confirmed no documented evidence of pain assessment and pain medication administration prior to Resident 3's wound treatment. Resident 3's MAR was reviewed and indicated a new pain medication started on 7/7/26, oxycodone (pain medicine) Give 5mg every 4 hours as needed for moderate pain, then give 10mg every 4 hours as needed for severe pain AND Give 2 tablet by mouth every 4 hours as needed for Severe Pain (7-10/10). Review of Resident 3's Medication Audit Report and MAR indicated, LN 3 administered oxycodone at 11:15 a.m., which indicated pain medication was given not prior to but after the wound treatment. During a review of facility's Class attendance Roster, dated 4/16/26, indicated that CNA 1 attended an in-person in-service for pain and pain management: CNA responsibilities. During a review of facility's Class attendance Roster, dated 6/26/26, indicated that LN 2 and LN 3 attended an in-person in-service for pain management, pain assessment, pain parameters, and PRN pain medication. During a review of Resident 3's care plan intervention for pain, initiated on 9/9/25, indicated, .will not have discomfort.anticipate need for pain relief and respond immediately to any complaint of pain.reassess for pain meds PRN. During an interview on 7/10/26 at 9:30 a.m. with the Director of Nursing (DON), the DON stated it was the expectation of LNs to pre-medicate resident (prior to care provision), and if resident was in pain during wound treatment, to administer as needed pain medication as soon as possible and come back when the pain has alleviated. The DON further stated that a pain scale assessment should be used to (continued on next page)		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	assess pain. During a review of the facility's policy and procedure (P&P), titled, Pain Recognition and Management , revised May 2007, indicated, .recognize when a resident is experiencing pain and identify circumstances when pain can be anticipated .manages or prevents pain, consistent with assessment and plan of care, current professional standards of practice.using a scale of 1-10. During a review of the facility's P&P, titled Wound Care, undated, indicated, Review the resident's care plan to assess for any special needs of the resident.a. For example, the resident may have a PRN order for pain medication to be administered. 2. During a review of Resident 12's medical record indicated she was admitted to the facility in September 2023 with diagnoses which included seizures, depression (an illness where one experiences persistent feeling of emptiness, hopelessness, and a total loss of interest in activities), and schizoaffective disorder (a chronic mental health condition that combines the symptoms of two distinct illnesses: schizophrenia (losing touch with reality) and a mood disorder (like depression or bipolar disorder). A review of Resident 12's medical record indicated a physician's order for melatonin (a lab-made version of a natural hormone produced by the brain that regulates the sleep and wake cycle) 5 milligrams (mg, a unit of measurement), give one tablet at bedtime for inability to sleep, dated 8/3/25. During a concurrent interview and record review on 7/9/26 at 2:18 p.m. with the DON, Resident 12's physician's orders, psychiatry note dated 6/15/26, and physician's note dated 6/15/26 were reviewed. The DON confirmed the psychiatry note indicated, Concern for medical contribution to altered mental status and sedation. Discussed case with nursing staff regarding current presentation including increased sedation. Recommendations: Medication Management: Discontinue melatonin 5 mg. The DON reviewed the physician's note in response to the recommendations made by psychiatry and stated the note indicated the order for melatonin should have been discontinued but had not been. 3. During a review of Resident 4's medical record indicated he was admitted to the facility in February 2026 with diagnoses which included type 1 diabetes (a condition where the body does not make enough insulin, a hormone that allows the body to utilize sugar from ingested food or can't use it properly), muscle weakness, and dysarthria following cerebral infarct (slurred or slowed speech caused by muscle weakness following a stroke [when blood flow to a part of the brain is suddenly cut off or a blood vessel in the brain bursts]). A review of Resident 4's physician's orders indicated an order for oxycodone (an opioid medication to treat pain) 5 mg tablet, give one tablet via PEG tube (percutaneous endoscopic gastrostomy, a flexible medical feeding tube inserted directly through the abdominal wall into the stomach) every 8 hours as needed for severe pain (7-10) (pain scale of 0 to 10, with 10 being the highest level of pain), dated 5/5/26. During a concurrent interview and record review on 7/9/26 at 2:52 p.m. with the DON, Resident 4's oxycodone order and MARs dated June to July 2026 were reviewed. The DON confirmed Resident 4's (continued on next page)		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	oxycodone order indicated to be administered only for a pain score of 7 to 10. The DON reviewed Resident 4's June and July MARs and confirmed nursing staff administered oxycodone for pain scores outside of the physician's parameters for the following dates and pain levels: 6/7/26 pain level 5, 6/10/26 pain level 5, 6/18/26 pain level 6, 6/20/26 pain level 0, and 7/7/26 pain level 5. The DON stated nursing staff were expected to contact the physician to change an order if the needs of a resident were different than what was indicated in the order. He stated otherwise, nursing staff were expected to administer medications according to the order. 4. During a review of Resident 1's medical record indicated he was admitted to the facility in November 2023 with diagnoses which included type 2 diabetes (a condition where the body does not make enough insulin, a hormone that allows the body to utilize sugar from ingested food or can't use it properly). A review of Resident 1's physician's orders indicated an order for (brand name of semaglutide) 14 milligrams (mg, a unit of measurement) tablet, give one tablet by mouth one time a day for diabetes 30 minutes before breakfast, give with no more than four ounces of water, Hold if BS (blood sugar) less than 100 mg/dl (milligrams/deciliter, a unit of measurement), dated 5/16/26. During a concurrent interview and record review on 7/9/26 at 3:03 pm. with the DON, Resident 1's (brand name of semaglutide) order and blood sugar test results dated May to July 2026 were reviewed. The DON reviewed the (brand name of semaglutide) order and stated Resident 1 was administered the medication daily at 5:45 a.m. The DON stated Resident 1 had blood sugar checks before each meal, but his blood sugar was not routinely checked prior to administration of (brand name of semaglutide) to confirm it was not less than 100 mg/dl. During a review of the facility's P&P titled, Medication Administration, revised 1/2020, the P&P indicated, Policy: It is the policy of this facility to accurately prepare, administer and document oral medications. Procedures. Administering Unit Doses and Previously Prepared Drugs. 3. Read resident's medication sheet and select appropriate drugs from unit dose drawer. 4. Take vital signs if required. Hold drugs if indicated.14. If there is any question in regard to dosage, the person in doubt should not give the drug until she has obtained information which clarifies drug dosage.		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure: 1. One of four emergency kits (E-kit, a kit/box containing medications and supplies for immediate use during a medical emergency) was replaced timely after removal of medication; and, 2. One of four E-kits had the contents clearly listed on the exterior in accordance with facility policy and procedure (P&P). These failures had the potential to result in emergency medications not available when needed, and the potential for not meeting the residents' therapeutic needs or worsening of their medical conditions for a census of 103. During a concurrent inspection and interview on [DATE] at 1:14 p.m. of the Station 1 Medication Storage Room with the Director of Nursing (DON), a refrigerated E-kit was identified with a red plastic tie indicating it had been opened by nursing staff. The DON opened the E-kit and the emergency kit log (a document completed by nursing staff whenever a medication is removed from the emergency supply) was dated [DATE], 20 days prior. The DON stated whenever nursing staff opened an E-kit and removed medication, the log was to be filled out and faxed to the supplier pharmacy to notify them. The DON stated it was important to have E-kits replaced timely so medications were available for administration in the event of an emergency or when waiting for a new resident's medications to be delivered from the pharmacy. During a concurrent inspection and interview on [DATE] at 1:38 p.m. of the Station 2 Medication Storage Room with the DON, a large white opaque E-kit was identified without a list of contents affixed to it. The DON confirmed the finding and stated it should have had a list of contents on the outside in order to know what was available for use and when the E-kit expired. During a review of the facility's P&P titled, Emergency Medications, undated, the P&P indicated, Policy Statement: The facility shall maintain a supply of medications typically used in emergencies. Policy Interpretation and Implementation. 4. The contents of each emergency medication kit will be clearly listed. 9. Medications and supplies used from the emergency medication kit must be replaced upon the next routine drug order.		

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. Based on observation, interview, and record review, the facility failed to ensure a medication error rates of less than 5 percent when four medication errors out of 37 opportunities were observed during a medication pass for two of six Residents (Residents 59 and 100) observed for a census of 104. These failures resulted in 10.81% medication error rates, and in medications not given in accordance with the prescriber's order and the potential to negatively affect residents' clinical conditions. During a medication pass observation on 7/7/26 at 8:43 a.m. with Licensed Nurse 8 (LN 8), LN 8 was observed preparing five medications for Resident 100, including levothyroxine (a medication to treat an underactive thyroid gland, to restore metabolism, energy levels, and normal body temperature) 25 micrograms (mcg, a unit of measurement), 1 tablet. A review of Resident 100's medical record indicated a physician's order for levothyroxine 25 mcg, give one tablet by mouth one time a day for hypothyroidism (also known as an underactive thyroid), dated 7/2/26. During a concurrent interview and record review on 7/7/26 at 12:44 p.m. with LN 8, Resident 100's levothyroxine order was reviewed. LN 8 stated the medication was scheduled to be administered at 9 a.m. and that it was to be given with food. During an interview on 7/8/26 at 9:54 a.m. with the Director of Nursing (DON), the DON stated levothyroxine was to be administered on an empty stomach, 30 minutes to one hour before breakfast so it could be absorbed by the body. A review of the manufacturer's labeling for levothyroxine sodium tablets, revised 3/2024, indicated, Important Administration Instructions: Administer levothyroxine sodium tablets as a single daily dose, on an empty stomach, one-half to one hour before breakfast. During a medication pass observation on 7/7/26 at 9:43 a.m. with LN 2, LN 2 was observed preparing nine medications for Resident 59, including calcium 600 milligrams (mg, a unit of measurement) with vitamin D 10 micrograms (mcg, a unit of measurement), 1 tablet, timolol (a medication to lower the pressure in the eye) 0.5% eye drop, and brimonidine (a medication to lower the pressure in the eye) 0.2% eye drop. During an observation on 7/7/26 at 9:55 a.m. with LN 2, LN 2 administered Resident 59's calcium with vitamin D tablet. LN 2 then instilled one drop timolol into Resident 59's right eye, waited approximately 30 seconds, then instilled one drop brimonidine into the same eye. Resident 59 refused brimonidine drops to be administered in his left eye. A review of Resident 59's medical record indicated a physician's order for the following:- Calcium 600 mg with vitamin D 5 mcg tablet: Give one tablet twice daily, ordered 6/30/26- Timolol 0.5% eye drop: Instill one drop in the right eye every 12 hours for glaucoma (a disease where there is increased pressure in the eye), ordered 6/24/26- Brimonidine 0.2% eye drop: Instill one drop in both eyes every 12 hours for glaucoma, ordered 6/24/26 During a concurrent observation, interview, and record review on 7/7/26 at 12:49 p.m. with LN 2, LN 2 reviewed Resident 59's calcium with vitamin D order. LN 2 removed the calcium with vitamin D from the medication cart that she had prepared and administered to Resident 59 and confirmed the strength of vitamin D did not match the physician's order. LN 2 reviewed the labeling on the timolol and brimonidine eye drops and confirmed the labeling indicated to wait five minutes between the eye drops. LN 2 stated she should have waited longer between the administration of the two different eye drops. A review of an article published by the American Academy of Ophthalmology (the world's largest association of eye physicians and surgeons) titled, How to Put in Eye Drops, dated 5/5/23, the article indicated, If you need to take more than one type of eye drop at the same time, wait 3 to 5 minutes between the different kinds of medication. During an interview on 7/8/26 at 9:51 a.m. with the Director of Nursing (DON), the DON stated nursing staff were expected to wait five minutes between the administration of different eye drops for them to be effective. The DON stated supplements administered to residents should match the physician's order. (continued on next page)		

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

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	He stated if the supplement ordered was not available, nursing staff were expected to notify the physician to change the order. During a review of the facility's policy and procedure (P&P) titled, Medication Administration, revised 1/2020, the P&P indicated, Policy: It is the policy of this facility to accurately prepare, administer and document oral medications.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure proper infection prevention and control measures were implemented for a census of 104 when: 1. Nursing Staff did not maintain hand hygiene in accordance with accepted professional standards; 2. Resident 18's, Resident 65's and Resident 104's oxygen tubing were on the floor; 3. Licensed Nurse (LN) 1 did not change gloves between two different wound sites during wound treatment for Resident 106; 4. Resident 106's PICC (Peripherally inserted central catheter- a long tube inserted into a vein in the upper arm for intravenous access for medications) line dressing was not intact; and, 5. Facility staff provided care without wearing all the required personal protective equipment (PPE) for Resident 28 and Resident 59 who were on Enhanced Barrier Precaution (EBP-infection control intervention designed to reduce transmission of multidrug-resistant organisms [MDROs- bacteria that resist treatment with more than one antibiotic] that requires gown and glove use). These failures had the potential to cause the spread of infection among a vulnerable resident population. Findings: 1. During a concurrent observation and interview on 7/8/26 at 10:21 a.m. with Licensed Nurse (LN) 9, LN 9 was observed preparing medications for a resident. LN 9 was observed with ungloved hands and approximately one quarter inch long polished, artificial nails on her fingers. LN 9 stated she had forgotten to remove her artificial nails and that nursing staff were expected to keep nails natural and short. During a concurrent observation and interview on 7/8/26 at 10:30 a.m. with LN 10, LN 10 was preparing to pass medications. LN 10 was observed with approximately one quarter inch long polished, artificial nails on her fingers. She confirmed her responsibilities included passing medications and performing direct resident care. LN 10 stated it was permissible to have artificial nails with some length. She stated it was important for the nails to not be too long so that a resident would not be injured during care. LN 10 stated she would occasionally double glove when she performed direct resident care, such as when inserting a suppository, to avoid injuring a resident. During a concurrent observation and interview on 7/8/26 at 10:38 a.m. with LN 11 at Medication Cart A, LN 11 was observed with approximately one quarter inch long polished, artificial nails on her fingers. LN 11 confirmed her responsibilities included preparing and passing medications to residents and performing direct resident care. LN 11 stated her understanding was that one quarter inch long nails were acceptable for nursing staff but artificial nails were not. During an interview on 7/8/26 at 10:51 a.m. with Infection Preventionist (IP) and Director of Staff Development (DSD), DSD stated nursing staff were expected to keep nails natural and short, so they did not extend past the fingertip. She stated fingernail polish was acceptable so long as it was not chipped. DSD stated short nails prevented the spread of germs and long nails, even if gloved, could poke through and injure a resident. During an interview on 7/8/26 at 10:55 a.m. with the Director of Nursing (DON), the DON stated as a (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	professional standard, nursing staff were expected to keep nails short. During a review of the facility's policy and procedure (P&P) titled, Handwashing/Hand Hygiene, undated, the P&P indicated, Policy Interpretation and Implementation. 2. All personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors. 9. The use of gloves does not replace hand washing/hand hygiene.11. Wearing artificial fingernails is strongly discouraged among staff members with direct resident-care responsibilities, and fingernails must also be kept clean, neatly trimmed, and well-groomed. A review of an article published by the CDC titled, Clinical Safety: Hand Hygiene for Healthcare Workers, dated 2/27/24, the article indicated, Maintain fingernail and jewelry safety: Natural nails should not extend past the fingertip. Do not wear artificial fingernails or extensions when having direct contact with high-risk patients. Germs can live under artificial fingernails both before and after using an alcohol-based hand sanitizer and handwashing. (https://www.cdc.gov/clean-hands/hcp/clinical-safety/index.html; accessed 6/23/26) A review of World Health Organization's (WHO, the specialized agency of the United [NAME] responsible for international public health) Guidelines on Hand Hygiene in Health Care guidelines on hand hygiene in health care, dated 2009, the guidelines indicated, II. CONSENSUS [a general, widespread agreement among a group of people] RECOMMENDATIONS. 7. Other aspects of hand hygiene A. Do not wear artificial fingernails or extenders when having direct contact with patients. B. Keep natural nails short (tips less than 0.5 cm long or approximately 1/4 inch). 2.During a review of Resident 18's admission Record (AR), the AR indicated Resident 18 was admitted to the facility on [DATE] with diagnoses that included chronic respiratory failure (CRF-long term condition where lung cannot properly get enough oxygen into the blood) with hypoxia (body's tissue and organs do not receive enough oxygen to function properly), CRF with hypercapnia (too much carbon dioxide in the bloodstream), and obstructive sleep apnea (OSA-sleep disorder where breathing repeatedly stops and starts while sleeping). During a review of Resident 18's OSR (OSR &ndash; a list of a person's current medical orders or instructions from their healthcare provider), indicated Resident 18 had an order for Oxygen may titrate up to 5L [liters, unit of measurement] . via NC [Nasal cannula- a small, soft plastic tube with two short prongs that sit inside the nostrils to deliver oxygen] continuous every shift for oxygen. During a concurrent observation and interview on 7/7/26 at 9:52 a.m. with LN 5 in Resident 18's room, Resident 18's oxygen tubing was on the floor. LN 5 confirmed that the oxygen tubing was on the floor and stated that it should not have been on the floor. During a review of Resident 65's AR, indicated Resident 65 was admitted to the facility on [DATE] with diagnoses that included CRF with hypercapnia and OSA. During a review of Resident 65's OSR, indicated Resident 65 had an order for Oxygen at 2 LPM [liters per minute &ndash; a measurement] via NC continuous every shift. (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview on 7/7/26 at 10:01 a.m. with LN 5 in Resident 65's room, Resident 65's oxygen tubing was on the floor. LN 5 confirmed that the oxygen tubing was on the floor. During a review of Resident 104's admission Record (AR), indicated the resident was admitted to the facility with diagnosis including Acute and Chronic Respiratory Failure (a medical emergency when the lungs suddenly stop working well enough to help the individual breathe properly.) During a review of Resident 104 OSR, the OSR indicated, May titrate oxygen up to 3 LPM via NC. During an observation on 7/7/2026 at 10:46 a.m. in Resident 104's room, Resident 104 was being administered with oxygen at 2 liters per minute via nasal cannula. A portion of the nasal cannula tubing was observed to be on the floor. During an interview on 7/7/26 at 10:50 a.m., with Certified Nurse Assistant (CNA) 2, CNA 2 was asked to come into Resident 104's room. CNA 2 confirmed that the oxygen tubing was on the floor. CNA 2 stated oxygen tubing should be kept off the floor for infection prevention. During an interview on 7/9/26 at 1:39 p.m. with IP, IP stated that oxygen tubing should not touch the floor for infection control purposes because the floor could contain germs that could cause infection. The facility did not provide a policy and procedure (P&P) addressing oxygen tubing contacting the floor upon request. 3. During a review of Resident 106's AR, indicated Resident 106 was admitted to the facility on [DATE] with diagnoses that included osteomyelitis (inflammation of bone or bone marrow, usually due to infection), cellulitis (common, potentially serious bacterial infection of the skin) of left lower limb, type 2 diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing) with diabetic neuropathy (nerve damage caused by long term high blood sugar) and acquired (not present at birth) absence of left toe(s). During a review of Resident 106's OSR, indicated Resident 106 had an order for .Tx (treatment): L (left) shin trauma wound: clean with NS (normal saline), pat dry, apply xeroform and cover with dry dressing every day shift. and .Tx: TMA (trans metatarsal amputation) site venous ulcer (slow healing open sore): clean with NS, pat dry, apply Medi honey gel, cover with abd (abdominal pad) and wrap in kerlix then ace bandage. During an observation on 7/9/26 at 9:13 a.m. in Resident 106's room during wound treatment, observed with a pair of gloves LN 1 with removed a wet gauze from a medicine cup and cleaned the shin wound. LN 1 discarded the gauze, removed another wet gauze from the same medicine cup, and cleaned the TMA wound (different wound site) without changing gloves between the wound sites. With a new pair of gloves, LN 1 removed a dry gauze from the clean field on the overbed table, patted the shin wound dry, then removed another dry gauze to pat the TMA wound dry without changing gloves. (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 7/9/26 at 9:34 a.m. with LN 1, LN 1 confirmed that she used the same gloves to clean the shin wound and the TMA wound and also used the same gloves to dry both wound sites. LN 1 stated different gloves should be used for each wound site. LN 1 stated that using different gloves helped prevent cross-contamination. During an interview on 7/9/26 at 1:39 p.m. with IP, the IP stated that wound treatment should be completed one wound site at a time. IP stated that if wound treatment was not completed one wound site at a time, a different pair of gloves should be used for each wound site to help prevent infection because bacteria from one wound site could transfer to another site. During a review of the facility's policy and procedure (P&P) titled, Wound Care, undated, the P&P indicated, 10. Wear sterile gloves when physically touching the wound or holding a moist surface over the wound. 4. Review of Resident 106's admission Record (AR), the AR indicated that Resident 106 was admitted to the facility on 8/2025 with diagnoses including osteomyelitis (infection of the bone) and cellulitis of left lower limb (bacterial infection of the skin's deeper layers). Review of Resident 106's OSR dated 7/8/26, indicated, .IV Device Type PICC: Gauge 4 fr (French-a unit of diameter measurement) .Change catheter site RUE (right upper extremity) with transparent dressing.every week and as needed complications; observe site.dressing dislodgement . Review of Resident 106's Care Plan (CP) dated 6/30/26, indicated, .Focus: Is on antibiotic therapy related to osteomyelitis and cellulitis and an intervention that included PICC line per facility policy . During a concurrent observation and interview on 7/8/26 at 9:30 a.m. with LN 6 in Resident 106's room, observed Resident 106 lying in bed with a right upper arm PICC line. The PICC dressing had drops of dried blood underneath, the right corner and left side of the dressing was not intact. LN 6 confirmed the above findings and stated the dressing should be checked each shift. During an interview on 7/8/26 at 9:40 a.m. with LN 7 in Resident 106's room, LN 7 stated that she was concerned that there was dried blood under the dressing and the PICC site looked a little red. LN 7 acknowledged the PICC dressing needed to be changed and if the dressing was not intact the PICC could become dislodged (pulled out of its proper place) and there was an increased risk of infection. During an interview on 7/9/26 at 9:18 a.m. with the IP, the IP stated, it is the facility's policy that the PICC dressing be checked every shift. IP further stated if any part of the dressing is not intact there is an increased risk of infection. Review of the facility's policy and procedure (P&P) titled Midline and Peripherally Inserted Catheter Dressing Changes, undated, the P&P indicated, 1. Change the Midline/PICC line dressing.if not in Inserted tact or compromised in any way. 5.During a review of Resident 28's AR, the AR indicated, Resident 28 was admitted to the facility on 2/2026 with diagnosis including Cerebral Infarction (Loss of blood flow to a part of the brain.), (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Aphasia (a disorder that makes it difficult to speak), and Gastrostomy tube (G-tube/GT- a device to allow feedings to be administered directly to the stomach common people with swallowing problems). During a review of Resident 28's OSR dated 5/22/26, the OSR indicated, .Place Resident on EBP (Enhance Barrier Precaution) . During an observation on 7/10/26 at 9:06 a.m. outside of Resident 28's room, a sign was posted, Enhanced Barrier Precaution. A storage compartment was observed to contain blue gowns, gloves available for the staff to use. Resident 28 was in bed with a G-tube. During a concurrent observation and interview on 7/10/26 at 9:10 a.m., CNA 4 entered Resident 28's room without putting on a gown. CNA 4 assisted Resident 28 for incontinence care. CNA 4 confirmed she forgot to wear the Personal Protective equipment (PPE &ndash; a clothing and equipment that is worn or used to provide protection against hazardous substances and/or environments.) CNA 4 stated, wearing a gown, and gloves must be worn when caring for Resident 28 (who was placed on EBP) to prevent infection and protect the resident. During a review of Resident 59's AR, the AR indicated Resident 59 was admitted to the facility in June 2026 with diagnosis of Endocarditis (inflammation of the heart's inner lining and valves). During an observation on 7/7/26 at 12:30 p.m. outside of Resident 59's room, a sign was posted under Resident name card with an orange sticker which indicated, Enhanced Barrier Precaution. A hanging storage compartment was observed to contain blue gowns and gloves available for the staff to use. Resident 59 was observed laying in bed with a PICC to the right arm. During a concurrent observation and interview on 7/7/26 at 12:55 p.m., CNA 3 entered Resident 59 without putting on a gown. CNA 3 assisted Resident 59 to the bathroom. CNA 3 then began to fix Resident 59's bed linen. CNA 3 confirmed that she did not wear a gown when transferring, assisting and handling bed linens. CNA 3 confirmed that proper PPE for Resident 59 was to wear gown and gloves. CNA 3 further stated that it was important to wear proper PPE for EBP to protect the residents. During a review of Resident 59's care plan (CP), dated 6/25/26, the CP indicated, Resident is on enhanced barrier precautions (EBP) related to PICC line.direct care staff and visitors to follow EBP. During an interview on 7/9/26 at 2:50 pm. with the IP, the IP stated that the expectation for staff was to wear gloves and gown with residents on EBP precautions. Gowns and gloves were to be worn while staff was in close contact with EBP residents. IP further stated that the CNA should have worn proper PPE to not spread infection to other residents. During a review of the facility's P&P titled, IPCP Standard and Transmission-Based Precautions, dated 6/2021, the P&P indicated, .use of gown and gloves during high-contact resident care activities.(e.g. residents with.indwelling medical devices.examples of high contact resident care activities requiring gown and glove use.transferring.changing linens.		

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to promote dignity and respect for two residents (Resident 48 and Resident 104) out of 26 sampled residents, when:1. Certified Nursing Assistant (CNA) 5 remained standing while assisting and feeding Resident 48 with lunch and,2. The privacy curtain between the two residents was not closed during wound treatment for Resident 106. These failures had the potential to impact the two residents' self-esteem and self-worth. Findings:1. During a review of Resident 48's admission Record (AR), the AR indicated Resident 48 was admitted to the facility on [DATE] with diagnoses that included multiple sclerosis (MS- a chronic, progressive disease involving damage to the nerve cells in the brain and spinal cord) and dysphagia (difficulty swallowing). During a review of Resident 48's Care Plan (CP), the CP indicated, EATING: Requires assistance to eat. During an observation on 7/7/26 at 12:26 p.m. in the dining room, Resident 48 was seated in a wheelchair while CNA 5 stood over him while feeding him lunch with a spoon. During an interview on 7/9/26 at 1:43 p.m. with Director of Staff Development (DSD), DSD stated that staff were expected to sit while assisting residents with eating to promote resident dignity. During a review of the facility's policy and procedure (P&P) titled, Dignity, undated, the P&P 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 feelings of self-worth and self-esteem. residents are treated with dignity and respect at all times. when assisting with care, resident are supported exercising their rights. resident are provided with a dignified dining experience. 2. During a review of Resident 106's AR, the AR indicated Resident 106 was admitted to the facility on [DATE] with diagnoses that included type 2 diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing) with diabetic neuropathy (nerve damage caused by long term high blood sugar) and acquired (not present at birth) absence of left toe(s). During a review of Resident 106's Order Summary Report (OSR), the OSR indicated Resident 106 had an order for Tx (treatment): L (left) shin trauma wound. and Tx: TMA (trans metatarsal amputation) site venous ulcer (slow healing open sore) . During an observation on 7/9/26 at 9:13 a.m. with Licensed Nurse (LN) 1 in Resident 106's room, LN 1 performed wound treatment for Resident 106 while the privacy curtain between Resident 106 and the roommate remained open throughout the procedure. During an interview on 7/9/26 at 9:34 a.m. with LN 1, LN 1 stated that during wound treatment, staff provided privacy by closing the privacy curtains around the resident, including the curtain separating the two residents. LN 1 confirmed that she did not close the curtain between Resident 106 and the roommate. LN 1 stated that providing privacy promoted the resident's dignity and respect and helped the resident feel comfortable during wound treatment. During a review of the facility's P&P titled, Dignity, undated, the P&P indicated 12. Staff promote, maintain and protect resident privacy, including bodily privacy during assistance with personal care and during treatment procedures.		

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. Based on observation, interview and record review, the facility failed to ensure communication needs for one resident (Resident 28) of 26 sampled residents was accommodated, when staff did not use communication board for Resident 28 per resident's care plan. Resident 28 speaks mainly Hmong and has limited ability to communicate. This failure limited the resident's ability to express discomfort during care, contributed to frustration and affected the resident's dignity. Findings: During a review of Resident 28's admission Record (AR), the AR indicated, Resident 28 was admitted to the facility on 2/2026 with diagnosis including Cerebral Infarction (stroke, loss of blood flow to a part of the brain), and Hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body.) During a review of Resident 28's Minimum Data Set (MDS- a federally mandated resident assessment tool) dated 5/27/26, the MDS indicated Resident 28 was unable to perform the Brief Interview for Mental status (BIMS- an assessment tool used by facilities to screen and identify memory, orientation, and judgement status of a resident) due to the stroke. The Staff Assessment for Mental status indicated his cognitive skills for daily decision making are moderately impaired. During a review of Resident 28's communication care plan revised 5/22/26, indicated, . Use alternative communication tool. such as communication board, pictures, signs. During an observation on 7/9/26 at 1:55 p.m. in Resident 28's room, Licensed Nurse (LN)1 was observed preparing supplies to change the dressing around Resident 28's gastrostomy tube (GT- a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common to people with swallowing problems). LN 1 began removing Resident 28's old dressing, when Resident 28 began crying. LN 1 continued the dressing change without asking Resident 28 why she was crying. LN 1 did not use a communication board and no communication board was observed at bedside. During a concurrent observation and interview on 7/10/26 at 9:43 a.m. with LN 4 in Resident 28's room, LN 4 confirmed that Resident 28's communication board was not within reach (not used) and was tucked underneath the bedside drawer. During an interview on 7/10/26 at 11:30 a.m. with Director of Nursing (DON), DON stated, communication board must always be within reach (to use). DON further stated, Communication Board should be treated like it was a call light. Always within reach. A review of the facility's policy and procedure titled, Resident's Rights, undated, indicated, . Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to: b. Be treated with respect, kindness and dignity; f. communication with and access to people and services, both inside and outside the facility.		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure three residents (Resident 9, Resident 28 and Resident 102) out of 26 sampled residents, were assisted with their Activities of Daily Living (ADLs- normal daily functions required to meet basic needs) when: Resident 9 was observed with long toenails and dry thickened heels; Resident 28 was observed with long fingernails containing brown debris underneath, an oily face and hair, dried crusting inside both nostrils, long toenails, dry thickened skin surrounding the toenails and thick, dry, cracked heels; and, Resident 102 was observed with long fingernails containing brown debris underneath. These failures had the potential to result in poor personal hygiene, skin breakdown, discomfort, unpleasant odor and diminished dignity and well-being. Findings: 1. During a review of Resident 9's admission record (AR), indicated Resident 9 was admitted to the facility on 5/2026 with diagnoses including sepsis (sepsis- blood infection), bacteremia (bacteria in the blood stream), and generalized muscle weakness. During a review of Resident 9's Minimum Data set (MDS &ndash; a federally mandated resident assessment tool), dated 5/17/26, the MDS indicated, Resident 9 had intact cognition. The MDS also indicated Resident 9 required maximal assistance (maximal assistance -helper [staff] does more than half of the effort) with shower, bed bath and maximal assistance with personal hygiene. During a review of Resident 9's care plan initiated on 5/14/26, there was no evidence of a person-centered care plan related to self-care deficit and ADLs including nail care. During a review of Resident 9's bathing tasks for June 2026 indicated, Sponge bath (SB) on June 3 and June 10; Shower June 6; Resident Refused (RR) June 13, June 20, the rest of the dates in June were noted as Not Applicable (NA). July 2026 bathing tasks indicated, Shower July 1; RR July 4, NA for July 2,3,5,9. No documentation written for July 7, 2026. During the initial tour observation on 7/7/26 at 10:03 a.m. in Resident 9's room, Resident 9 was observed to be in bed, with her feet uncovered. Resident 9's toenails observed to be long, and her heels were thick and dry, the skin at her bilateral lower extremities were scaly dry, with fragments of the dry flaked skin were on the bed. During a concurrent observation and interview on 7/8/26 at 9:50 a.m. with Resident 9, in Resident 9's room, Resident 9 remained to have long toenails and dry skin and dry thickened heels. Resident 9 stated, she'll agree for her nails to be trimmed when the staff have the chance to do it. During a concurrent observation and interview on 7/10/26 at 9:55 a.m. with Licensed Nurse (LN) 4 in Resident 9's room, LN 4 stated, nails must be kept clean and trimmed. Toenails should be checked during sponge bath or showers. CNAs are allowed to clip their nails if needed and can clip toenails if the resident was not diabetic. LN 4 confirmed that Resident 9's toenails were long, her skin in her (continued on next page)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	bilateral lower extremities were dry and scaly, and her heels were cracked and dry. LN 4 confirmed Resident 9 was agreeable for her toenails to be clipped. 2. During a review of Resident 28's AR, indicated, Resident 28 was admitted to the facility on 2/2026 with diagnosis including Cerebral Infarction (Loss of blood flow to a part of the brain), Hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body), Aphasia (a disorder that makes it difficult to speak.) During a review of Resident 28's MDS dated [DATE], the MDS indicated Resident 28 was unable to perform the Brief Interview for Mental status (BIMS- an assessment tool used by facilities to screen and identify memory, orientation, and judgement status of a resident) due to the cerebral infarction and aphasia. The Staff Assessment for Mental status indicated his cognitive skills for daily decision making are moderately impaired. The MDS also indicated Resident 28 required dependent assistance (dependent- helper does all the effort) in shower, in bed bath, and in personal hygiene. During a review of Resident 28's care plan initiated on 2/21/26, there was no evidence of a person-centered care plan related to self-care deficit and ADLs including nail care. During a review of Resident 28's bathing tasks for June 2026 indicated, Sponge Bath (SB) June 15, 18, 22, 29; Full-body bath (FB) June 1, 4,7, 8, 26. The rest of the dates in June were noted as NA. July 2026 bathing tasks indicated, SB July 6, RR July 9, NA for July 1,2,3,4,5,8. No documentation written for July 7, 2026. During an observation on 7/7/26 at 10:14 a.m. in Resident 28's room, Resident 28 was observed lying in bed with greasy hair, and with a greasy face. Dried, crusted nasal mucus were present in both nostrils. Resident 28 was observed scratching his scalp, and behind his left ear. Resident 28's fingernails were long with brown debris underneath. The toenails were long, and the surrounding skin appeared dry and thickened. Both heels were dry, thickened, and had visible cracks. During a concurrent observation and interview on 7/10/26 at 9:10 a.m. with Certified Nurse Assistant (CNA) 4 in Resident 28's room, CNA 4 confirmed Resident 28's nails were long and had brown debris underneath the fingernails. CNA 4 confirmed that Resident 28's toenails were long, with bilateral thick dry heels and visible cracks. During a concurrent observation and interview on 7/10/26 at 9:43 a.m. with LN 4 at Resident 28's room, LN 4 confirmed Resident 28's nails were long and had brown debris underneath, his toenails were long and had thick skin around the nails and bilateral thick dry heels and with visible crack. Resident 28 nodded his head when asked if he wanted his nails trimmed. During a concurrent interview and record review on 10/10/26 at 10:10 a.m. with Director of Staff Development (DSD), the bathing tasks for Resident 9 and Resident 28 were reviewed for the last 30 days. DSD confirmed that the Not Applicable or NA documentation meant that the tasks were not performed. The DSD further stated that every resident should be showered two times every week, full body bath or sponge bath in between shower day as part of the residents' morning care. During the shower, skin check and nails should be checked. DSD stated, fingernails and toenails can be trimmed (continued on next page)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	by the CNA as long as the resident does not have diabetes (a disorder characterized by difficulty in blood sugar control and poor wound healing). During an interview on 7/10/26 at 11:30 a.m. with Director of Nursing (DON), DON stated, his expectations for ADLs were as follows: Showers two times a week, bed bath or full body bath in between shower days. Skin check and nails checked by CNA during shower days. Nail care and toenail care should be done by the CNA unless otherwise contraindicated. 3. Review of Resident 102's admission Record (AR), indicated Resident 102 was admitted to the facility on 7/2026 with diagnoses including nontraumatic intercerebral hemorrhage (a bleeding in the brain tissue that occurs without a head injury or external trauma), hemiplegia and hemiparesis (near complete paralysis of one side of the body and weakness or partial loss of strength on one side of the body) affecting the left dominant side, muscle weakness and need for assistance with personal care. Review of Resident 102's MDS dated [DATE], the MDS indicated that Resident 102 had intact cognition. Review of Resident 102's Care Plan (CP) dated 7/4/26, the CP indicated a focus of Risk for Self-Care Deficit: Bathing, Dressing and Feeding and an intervention included: Provide assistance with ADLs. During a concurrent observation and interview on 7/7/26 at 9:45 a.m. with Resident 102 and CNA 6, Resident 102 was observed lying in bed with long fingernails and a dark brown substance under his fingernails on his right hand. Resident 102 stated that it bothered him because he cannot use his phone when they are long and he is not able to use his left arm because he had a stroke. CNA 6 confirmed that Resident 102's fingernails had a brown substance underneath and stated they needed to be trimmed. During an interview on 7/9/26 at 9:34 a.m. with CNA 7, CNA 7 stated that Resident 102 had some left sided weakness. Resident 102 was dependent on the left upper extremity and required partial assistance using right upper extremity for ADL care. During an interview on 7/9/26 at 9:40 a.m. with the Infection Preventionist (IP), the IP stated that she would expect that residents' fingernails be clean and trimmed. The IP stated that if they are not clean it has the potential to spread germs and is an infection control problem. During a review of the facility's policy and procedure titled, Activities of Daily Living (ADLs), Supporting undated, indicated, appropriate care and services will be provided for residents who are unable to carry out ADLs independently, with consent of the resident including appropriate support and assistance with: a. Hygiene (bathing, dressing, grooming, oral, finger and toe nail care.		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure resident environment remained free of accident hazards for two residents (Resident 18 and Resident 91) out of 26 sampled residents when:1. A portable oxygen cylinder tank in Resident 18's room was not secured in a stand/cart; and,2. Resident 91's floormat (fall mat, a cushioned floor pad designed to help prevent injury should a person fall) was placed underneath the bed not beside the bed. These failures had the potential to result in accident and injury. Findings:1. During an observation on 7/7/26 at 9:49 a.m. in Resident 18's room, a portable oxygen cylinder was positioned on the right side of the bed, in front of the oxygen concentrator, and was not secured in a cylinder stand or carrier. During an interview on 7/10/26 at 10:44 a.m. with Director of Nursing (DON), DON stated that portable oxygen cylinders should be secured in an oxygen carrier to prevent them from falling and causing injury/accident. During a review of the facility's policy and procedure (P&P) titled, Oxygen Safety, dated 8/1/25, the P&P indicated, Oxygen storage. cylinders will be properly chained or supported in racks or other fastenings (i.e. sturdy portable carts, approved stands) to secure all cylinders from falling, whether connected, unconnected, full, or empty. 2. During a review of Resident 91's admission Record (AR), indicated Resident 91 was admitted to the facility on [DATE] with diagnoses that included vascular dementia (a progressive state of decline in mental abilities), Alzheimer's disease (a disease characterized by a progressive decline in mental abilities), and age-related osteoporosis (weak and brittle bones due to lack of calcium and Vitamin D) without current pathological fracture. During a review of Resident 91's Care Plan (CP), the CP indicated Resident 91 was a risk for fall which was identified on 8/3/25. During a review of Resident 91's Long Term Care Eval Progress Note (PN) dated 7/4/26, the PN indicated, the resident's safety interventions included half side rails, a low bed and a bedside (fall) mat. During a review of Resident 91's Physician Progress Note (PPN) dated 6/16/26, the PPN indicated that the plan for Alzheimer's disease included continuing safety measures. The plan for age-related osteoporosis included maintaining fall precautions and providing supportive care to minimize the risk of fractures. During a concurrent observation and interview on 7/7/26 at 10:13 a.m. with Certified Nursing Assistant (CNA) 9 in Resident 91's room, Resident 91 was lying in bed, and the floormat was located underneath the bed. CNA 9 confirmed the floor mat was under the bed and stated the floormat was part of Resident 91's fall precaution and should have been placed beside the bed. During an interview on 7/9/26 at 1:43 p.m. with Director of Staff Development (DSD), DSD stated that floor mats should be placed beside the bed as part of the resident's fall precautions to prevent or lessen injury. During a review of the facility's policy and procedure (P&P) titled, Fall and Fall Risk, Managing, undated, the P&P indicated 1. The staff, with the input of the attending physician, will implement a resident-centered fall prevention plan to reduce the specific risk factor(s) of falls for each resident at risk or with a history of falls. 3. Examples of initial approaches might include fall mats etc.		

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. Based on observation, interview and record review, the facility failed to ensure one resident (Resident 3) out of 26 sampled residents received appropriate pain management services consistent with professional standards of practice and facility's policy and procedure (P&P), when Resident 3's pain was not managed during wound care treatment. This failure resulted in Resident 3 to exhibit severe pain and not attain his highest practicable well-being. Findings: During a review of Resident 3's admission Record (AR-front page of the chart that contains a summary of basic information about the resident, part of medical record), the AR indicated Resident 3 was admitted to the facility April 2022 with multiple diagnoses which included chronic pain syndrome and pain in thoracic spine. During a review of Resident 3's Treatment Administration Record (TAR-a daily documentation record used by a licensed nurse to document medications and treatments given to a resident, physician orders). Resident 3 received multiple daily wound treatments for pressure Ulcer/injury stage 3 (Full-thickness loss of skin. Dead and black tissue may be visible) located to right lower buttock and deep tissue injury (DTI- a severe type of pressure sore that develops deep within the soft tissue or muscle near a bone, presenting as a localized area of persistent, non-blanchable deep red, maroon, or purple skin) located to left and right heel. During a review of Resident 3's Order Summary Report (OSR, physician orders), dated 7/7/26, indicated, Morphine (pain medication) 15 mg (milligram, unit of measurement) give 1 tablet by mouth every 8 hours for pain management. During a review of Resident 3's OSR, dated 7/7/26, indicated, acetaminophen (pain medication) 325 mg .give 2 tablet by mouth every 6 hours as needed for mild pain (1-3 on the pain scale) .During a review of Resident 3's OSR, dated 7/7/26, indicated, licensed nurse (LN) to document Pain-Record highest level of pain every shift. During a concurrent observation, interview and record review on 7/7/26 at 1:24 p.m. in the hallway in front and outside of Resident 3's room, Resident 3 moaned and yelled, .ow, ow, it hurts! LN 2 confirmed the wound doctor and LN 1 were inside providing treatment for Resident 3. LN 2 stated that Resident 3 was always complaining he was in pain and per review of Resident 3's medical record, was given only morphine at 6 a.m. and not given acetaminophen. LN 2 further stated that Resident 3's yelling in pain was his baseline. LN 2 acknowledged that administration of pain medication was important to keep Resident 3 comfortable during wound treatment. During a review of Resident 3's Medication Administration Records (MARs, physician orders), the MARs indicated Resident 3 had 21 episodes of pain greater than 2 in June 2026 with 21 missed opportunities to administer acetaminophen. In July 2026, Resident 3 had 5 episodes of pain greater than 2 with 5 missed opportunities to administer acetaminophen. No documented evidence that acetaminophen was offered, refused or given. During a concurrent observation and interview on 7/9/26 at 10 a.m. in Resident 3's room, Certified Nursing Assistant (CNA)1 and CNA 2 assisted Resident 3 with activities of daily living (ADLs- routine tasks/activities such as bathing, dressing and toileting). Resident 3 was observed continuously grimacing, groaning, moaning and yelling ow, ow it hurts. LN 1 did not ask Resident 3 what was his pain level. Resident 3 continued to moan and yell ow! This surveyor prompted LN 1 at 10:20 a.m. to ask Resident 3 what his pain level was and Resident 3 stated 10/10 (10 is highest level) pain. LN 1 exited room and reported pain level to LN 3. LN 1 came back and CNA 1 and CNA 2 continued wound treatments without any pain medication administered to Resident 3. Resident 3 continued to moan and yell ow! LN 1, CNA 1 and CNA 2 exited Resident 3's room at 10:55 a.m. Resident 3 was heard moaning inside the room from outside of the hallway. During a concurrent interview and record review on 7/9/26 at 11:13 a.m. with LN 3, LN 3 confirmed Resident 3 had 10/10 (highest) pain scale. LN 3 also confirmed no documented evidence of pain assessment and pain medication administration prior to (continued on next page)		

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident 3's wound treatment. Resident 3's MAR was reviewed and indicated a new pain medication started on 7/7/26, oxycodone (pain medicine) Give 5mg every 4 hours as needed for moderate pain, then give 10mg every 4 hours as needed for severe pain AND Give 2 tablet by mouth every 4 hours as needed for Severe Pain (7-10/10). Review of Resident 3's Medication Audit Report and MAR indicated, LN 3 administered oxycodone at 11:15 a.m., which indicated pain medication was given not prior to but after the wound treatment. During a review of Resident 3's care plan intervention for pain, initiated on 9/9/25, indicated, .will not have discomfort.anticipate need for pain relief and respond immediately to any complaint of pain.reassess for pain meds PRN.During an interview on 7/10/26 at 9:30 a.m. with the Director of Nursing (DON), the DON stated it was the expectation of LNs to pre-medicate resident (prior to care provision), and if resident was in pain during wound treatment, to administer as needed pain medication as soon as possible and come back when the pain has alleviated. The DON further stated that a pain scale assessment should be used to assess pain. During a review of the facility's policy and procedure (P&P), titled, Pain Recognition and Management , revised May 2007, indicated, .recognize when a resident is experiencing pain and identify circumstances when pain can be anticipated .manages or prevents pain, consistent with assessment and plan of care, current professional standards of practice.using a scale of 1-10.During a review of the facility's P&P, titled Wound Care, undated, indicated, Review the resident's care plan to assess for any special needs of the resident.a. For example, the resident may have a PRN order for pain medication to be administered.During a review of the facility's P&P, titled Resident Rights, undated, indicated, .Employees shall treat all residents with.dignity.these rights include the residents' right to a dignified existence.		

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have a policy regarding use and storage of foods brought to residents by family and other visitors. Based on observation, interview and record review, the facility failed to store resident food in a sanitary manner in the resident refrigerator for a census of 104 when an 8 oz. (ounce, a unit of measurement) package of cheese, and two plastic bags with take-out food did not have residents' name and were undated. These failures had the potential to cause food borne illness in a vulnerable population. During a concurrent observation and interview on 7/7/26 at 12:47 p.m., with the Director of Staff Development (DSD), observed in the resident refrigerator in the memory care unit with an opened package of cheese and two bags with take-out food. These items were undated and were not labeled with the residents' names. The DSD confirmed that she would not be able to tell who the food items belonged to and they should be dated. The DSD stated that the takeout food should be thrown out after seventy-two hours. During an interview on 7/8/26 at 11:10 a.m., with the Registered Dietician (RD), the RD stated that the food in the resident's refrigerator should be dated. If the food is not dated, staff can't determine how long it has been there or when it should be discarded. RD further stated that if spoiled or expired food is not discarded there is a risk for food borne illness. Review of the policy and procedure (P&P), titled, Foods Brought by Family or Visitor, dated 7/21/21, the P&P indicated, Resident food will be stored at the facility. all foods shall be labeled, with the resident's name, location and date. perishable food will be checked by activities staff and discarded after 72 hours.		