| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 056056 | A. Building<br>B. Wing | 04/10/2026 |

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| F 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide care in a manner that maintained a resident's respect and dignity for six (6) of eight (8) sampled residents (Resident 3, 21, 51, 84, 106, 123) when: 1. Certified Nurse Assistant (CNA) 1 and CNA 4 failed to maintain privacy for Residents 21 and 84 while providing Activities of Daily Activities (ADL - basic tasks that must be accomplished every day for an individual to thrive) care. 2. CNA 8 and CNA 3 were standing over Resident 51 and 106 while assisting the residents during mealtime. 3. The staff failed to cover urinary catheter (a hollow tube inserted into the bladder to drain or collect urine) bags with dignity bags (device used to cover the contents of a urinary catheter bag) for Residents 3 and 123. These deficient practices had the potential to cause emotional distress and affect the residents' self-esteem and cause a loss of dignity and decline in psychosocial wellbeing. Findings: Findings:<br><br>1. a. During a review of Resident 21's admission Records (the front page of the chart thatˆcontainsˆa summary of basic information about the resident), the admission Records indicated that the facility admitted Resident 21 on 12/31/2024, with diagnoses including dysphagia (difficulty swallowing), Diabetes Mellitus (DM- a disorder characterized by difficulty in blood sugar control and poor wound healing), end stage renal disease (ESRD- a medical condition in which a person's kidneys cease functioning on a permanent basis).<br><br>During a review of Resident 21's History and Physical (H&P- a document with patient's medical history and physical examination done by a physician) dated 2/1/2026, the H&P indicated that Resident 21 had the capacity to consent.<br><br>During a review of Resident 21's Minimum Data Set (MDS - a resident assessment tool) dated 12/18/2025, the MDS indicated Resident 21 required substantial/maximal assistance (helper does more than half the effort) with shower, lower body dressing, putting on/off footwear and partial/moderate assistance (helper does less than half the effort) with toileting hygiene, and upper body dressing.<br><br>During an observation on 4/6/2026 at 9:29 a.m. with CNA 1 in Resident 21's room, observed CNA 1 providing ADL morning care to Resident 21. Observed CNA 1 leaving the privacy curtain partially open when getting wet towels from the bathroom, leaving Resident 21's undressed body exposed and seen from the hallway.<br><br>During an interview on 4/6/2026 at 9:35 a.m. with CNA 1, CNA 1 stated that she (CNA1) left the curtain partially open while going in and out from Resident 21's bedside to the bathroom wetting towels to perform Resident 21's perineal care. CNA 1 stated leaving the privacy curtain open and residents' naked body exposed to others violates residents' privacy and residents may feel<br>(continued on next page) |



| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| F 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | embarrassed.^<br><br>1.b. During a review of Resident 84's admission Records, the admission Records indicated that the facility admitted Resident 84 on 4/1/2025, with diagnoses including cellulitis (a skin infection that causes swelling and redness) of bilateral lower limbs (BLE), acute thrombosis (the formation of a dangerous blood clot inside a vein or artery that obstructs blood flow) and embolism (an obstacle or blockage in a blood vessel) of BLE, and hypertension (HTN- high blood pressure).<br><br>During a review of Resident 84's H&P dated 4/2/2026, the H&P indicated that Resident 84 had the capacity to understand and make decisions.<br><br>During a review of Resident 84's MDS, the MDS indicated that Resident 84 required partial/moderate assistance with shower and lower body dressing, and setup or clean-up assistance with toileting, and personal hygiene.<br><br>During a concurrent observation and interview on 4/7/2026 at 10:16 a.m. with CNA 4, in Resident 84's room, observed CNA 4 providing ADL morning care to Resident 84. Observed the privacy curtain left open about two feet. CNA 4 stated the privacy curtain was not long enough to completely close the area. CNA 4 stated it was very important to provide the resident privacy before starting morning care, to maintain the resident's dignity and privacy.<br><br>During an interview on 4/8/2026 at 8:57 a.m. with Registered Nurse (RN) 1, RN 1 stated to maintain residents' privacy and dignity staff need to close privacy curtains before providing care. RN 1 stated not having privacy curtains closed while providing care for residents were violation of residents` dignity and privacy, and this may cause emotional harm, loss of trust, and refusal of care.^<br><br>During an interview on 4/10/2026 at 11:34 a.m. with the Director of Nursing (DON), the DON stated that resident privacy curtains must be kept fully closed when providing ADL/morning care to residents, to ensure resident privacy and dignity. The DON stated that the lack of privacy protection violated residents' rights of dignity, exposed residents to potential loss of dignity, psychological discomfort and emotional distress.^<br><br>2. a. During a review of Resident 51's admission Record, the admission Record indicated the facility admitted the resident on 3/20/2026, with diagnoses including hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) and hemiparesis (partial paralysis of the arm, leg, and trunk on the same side of the body) following cerebrovascular disease (CVA-stroke, loss of blood flow to a part of the brain) affecting left dominant side, peripheral vascular disease (PVD - a slow progressive narrowing of the blood flow to the arms and legs), and generalized muscle weakness.<br><br>During a review of Resident 51's H&P, dated 3/22/2026, the H&P indicated that the resident did not have the capacity to understand and make decisions.<br><br>During a review of Resident 51's MDS, dated [DATE], the MDS indicated Resident 51 had severely impaired cognition (mental action or process of acquiring knowledge and understanding) and was usually able to understand and make his needs known. The MDS further indicated Resident 51 required substantial/maximal assistance to total assistance from staff with all ADLs.<br><br>During a concurrent observation and interview on 4/6/2026 at 1:10 p.m. with CNA 8, inside Resident 51's room, observed Resident 51 lying in bed with the head of the bed elevated to position the<br>(continued on next page) |

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| F 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | resident in upright seated posture. Observed CNA 8 assisting Resident 51 with lunch while standing over the resident. CNA 8 stated staff should be sitting at eye level while assisting residents with eating to respect the dignity of the residents. CNA 8 stated that she (CNA 4) forgot to get a chair and that she (CNA 4) should be sitting at eye level while assisting the resident with eating to respect the dignity of Resident 51 and to make sure the resident was tolerating the food.<br><br>2. b. During a review of Resident 106's admission Record, the admission Record indicated the facility admitted the resident on 3/18/2024, with diagnoses includingˆparaplegia (paralysisˆthat affectsˆtheˆlegs, making it impossible to stand or walk),ˆschizophrenia (a mental illness that is characterized by disturbances in thought), and generalized muscle weakness.ˆ<br><br>During a review of Residentˆ106's H&P, dated 3/5/2026, the H&Pˆindicated ˆthe resident ˆhadˆ the capacity to understand and make decisions.ˆ<br><br>During a review of Residentˆ106's MDS, dated [DATE], the MDS indicated Residentˆ106 hadˆan intactˆcognition and wasˆusually ableˆto understand and make herˆneeds known. The MDS further indicatedˆResidentˆ106ˆrequiredˆsupervision or touchingˆassistanceˆwith eating andˆoral hygiene, andˆsubstantial/maximalˆassistanceˆfrom staff with allˆotherˆADLs.ˆ<br><br>During a concurrent observation and interview on 4/6/2026 at 1:14ˆp.m. with CNA 3, inside Residentˆ106's room,ˆobservedˆResidentˆ106ˆlying in bed with the head of the bed elevated to to position the resident in upright seated posture. Observed CNAˆ3ˆassisting Residentˆ106 with lunch while standing over the resident. CNAˆ3ˆstated staff should be sitting at eye level whileˆassistingˆresidents with eating to respect the dignity of the residents. CNAˆ3ˆstatedˆthat there were no more chairs availableˆand he (CNA 3) should have notified his supervisor. CNA 3 stated that whileˆassistingˆResident 106ˆwith eating,ˆhe (CNA 3) should beˆsitting at eyeˆlevelˆto respect the dignity of Residentˆ106ˆand to make sure the resident wasˆchewingˆthe foodˆproperly.ˆ<br><br>During an interview on 4/9/2026 at 2:53 p.m. with RN 1, RN 1 stated that while assisting residents with meals, the staff are supposed to be sitting at eye level to respect the residentsˆ'dignity and to ensure that the residents were tolerating the diet and there were no signs and symptoms of choking. RNˆ1stated that CNAˆ3ˆshould have been sitting down at eye level whileˆassistingˆResidentˆ106ˆduring lunch on 4/6/2026 and CNA 8 should have been sitting down at eye level while assisting Resident 51 during lunch on 4/6/2026 to ensure that the residents did not have any signs and symptoms of chokingˆas well asˆrespecting the residents' right to be treated with respect and dignityˆandˆnot standing overˆthem.ˆ<br><br>During an interview on 4/10/2026 at 9:30 a.m. with the DON, the DON stated the staff should be assisting the residents with eating at eye level and should be sitting down. The DON stated it was important that the staff be sitting at eye level while assisting the residents with eating to preserve the residents' dignity and to observe if the resident was chewing the food properly and/or if there were signs of choking or aspirations. The DON stated CNA 3 and CNA 8 should have grabbed a chair and sat down while assisting Resident 51 and Resident 106 with eating for safety and dignity.<br><br>During a review of facility's Policies and Procedures (P&P) titled Promoting/Maintaining Resident Dignity, dated 12/19/2022, the P&P indicated, It is the practice of this facility to protect and promote resident rights and treat each resident with respect and dignity as well as care for each resident in a manner and in an environment, that maintains or enhances resident's quality of life by recognizing each resident's individuality. Maintain residents' privacy.<br>(continued on next page) |

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| F 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | 3. a. During a review of Resident 123's Admission, the admission Records indicated that the facility originally admitted Resident 123 on 1/28/2028, and readmitted on [DATE], with diagnoses including DM, neuromuscular dysfunction of bladder (the nerves that tell your bladder when to squeeze or relax are damaged, causing poor control over storing or emptying urine), HTN.<br><br>During a review of Resident 123's H&P, dated 4/6/2026, the H&P indicated that Resident 123 had a capacity to understand and make decisions.<br><br>During a review of Resident 123's MDS dated [DATE], the MDS indicated Resident 123 required substantial/maximal assistance with toileting hygiene, shower self, lower body dressing, and was dependent (helper does all of the effort) to staff for putting on/taking off footwear.<br><br>During an observation on 4/6/2026 9:48 a.m. inside Resident 123's room, observed Resident 123's indwelling catheter bag was not covered with dignity bag.^<br><br>During a concurrent observation and interview on 4/6/2026 12:27 p.m. with CNA 2 and CNA 4 inside Resident 123's room, CNA 2 stated Resident 123's catheter bag was not covered with a dignity bag. CNA 4 stated that all urinary catheter bags must be covered with dignity bags to provide residents with dignity and privacy. CNA 2 stated that urine might be visible through uncovered catheter bag, which can potentially make resident embarrassed and take away their privacy.<br><br>3. b. During a review of Resident 3's admission Records, the admission Records indicated that the facility originally admitted Resident 3 on 7/29/2019, and readmitted on [DATE], with diagnoses including hydronephrosis (the swelling of a kidney caused by a backup of urine (pee) that cannot drain properly into the bladder), neuromuscular dysfunction of bladder (the swelling of a kidney caused by a backup of urine (pee) that cannot drain properly into the bladder), schizoaffective disorder (a mental illness that can affect thoughts, mood, and behavior).<br><br>During a review of Resident 3's H&P dated 10/30/2025, the H&P indicated that Resident 3 had the capacity to understand and make decisions.<br><br>During a review of Resident 3's MDS, the MDS indicated that Resident 3 was cognitively intact. Resident 3 was dependent to staff with all ADLs.<br><br>During an observation on 4/6/2026 at 11:29 a.m. inside Resident 3's room, observed no dignity bag covering Resident 3's urinary catheter drainage bag.<br><br>During a Concurrent observation and interview on 4/6/2026 at 12:36 p.m. with CNA 2 in Resident 3's room, CNA 2 stated that Resident 3's urinary catheter bag was not covered with dignity bag.^ CNA 2 stated not having dignity bag covering the urinary catheter bag may potentially cause the residents to feel embarrassed and uncomfortable.^^<br><br>During an interview on 4/10/2026 11:40 a.m. with DON, the DON stated that urinary catheter drainage bag must be covered by dignity bag at all times. The DON stated not covering the drainage bag may potentially result resident embarrassment, emotional distress, decreased self-esteem, and loss of trust in facility staff.<br><br>During a review of facility's P&P, titled Catheter Care, dated 12/19/2022, the P&P indicated, Privacy bags will be available and catheter drainage bags will be covered at all times while in use. |

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| F 0558<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Reasonably accommodate the needs and preferences of each resident.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that the call light (an alerting device for nurses or other nursing personnel to assist a patient when in need) was within reach of five of nine sampled residents (Resident 45, 15, 103, 102, 96) reviewed under environment task. The deficient practiceˆhad the potential to place the resident at risk for delayed assistance, potentially affecting safety and timely care.ˆ Findings: 1.During a review of Resident 45's admission Records (the front page of the chart thatˆcontainsˆa summary of basic information about the resident), the admission Records indicated that the facility originally admitted Resident 45 on 7/1/2024, and readmitted on [DATE], with diagnoses including end stage renal disease (ESRD- a medical condition in which a person's kidneys cease functioning on a permanent basis), Diabetes Mellitus (DM - a disorder characterized by difficulty in blood sugar control and poor wound healing), absence of left leg below knee, heart failure (a condition in which the heart muscle can't pump enough blood to meet the body's needs for blood and oxygen).<br><br>During a review of Resident 45's History and Physical (H&P- a document with patient's medical history and physical examination done by a physician) dated 4/30/2025, the H&P indicated that Resident 45 had the capacity to understand and make decisions.<br><br>During a review of Resident 45's Minimum Data Set (MDS - a resident assessment tool) dated 6/16/2025, the MDS indicated Resident 45 required partial/moderate assistance (helper does less than half the effort) with oral hygiene, toileting hygiene, shower/bath, upper body dressing. The MDS indicated Resident 45 required partial/moderate assistance with toilet transfer (the ability to get [NAME] bd off a toilet or commode) and tub/shower transfer (the ability to get in and out of tub/shower).<br><br>During a concurrent observation and interview on 4/6/2026 at 10:17 a.m. with Certified Nursing Assistant (CNA) 2 inside Resident 45's room, observed Resident 45 sleeping in his bed with no call light within his reach. Observed CNA 2 finding Resident 45's call light on the floor, behind the bedside nightstand. CNA 2 stated that call lights should be within residents' reach at all times. CNA 2 further stated that not having a call light within Resident 45's reach may place the resident at risk for falling when trying to reach for the call light and will result in an injury.<br><br>During an interview on 4/10/2026 at 8:40 a.m. with the Director of Nursing (DON), the DON stated that the purpose of the call light was for the residents to call for assistance. The DON added that if the call light is out of reach, residents may fall and get injured when trying to access it. ˆ<br><br>2a. During a review of Resident 15's admission Record (AR), the AR indicated that the facility admitted the resident on 3/3/2025, with diagnoses including Alzheimer's disease, unspecified (a disease characterized by a progressive decline in mental abilities), essential (primary) hypertension (high blood pressure with no known specific cause), and unsteadiness on feet (difficulty keeping balance when standing or walking).<br><br>During a review of Resident 15's MDS, dated [DATE], the MDS indicated the resident had the ability to make self-understood and understand others. The MDS further indicated that Resident 15 had moderate cognitive impairmentˆ(has some trouble with memory and thinking but can still function with support). The MDS indicated that the resident required partial/moderate assistanceˆon mobility and activities of daily livingˆ(ADLs,ˆactivities such as bathing, dressing and toileting a person<br>(continued on next page) |

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| F 0558<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During a concurrent observation and interview on 4/6/2026, at 10:04 a.m., withˆLVN 8 inside Resident 103`s room, observed Resident 103's call light on left side of the bed under mattress. LVN 8 stated that call light was stuck under the mattress, and the resident would not be able to reach the call light and call for assistance. LVN 8 stated that call light is used to call for help or in case of an emergency. LVN 8 stated the call light needs to be assessable 24 hours and if the call light is not accessible then the resident would not be able to call and it could be an emergency.ˆ<br><br>During a concurrent interview and record review on 4/8/2026, at 8:19 a.m., with RN 1, Resident 103's FRE and Care Plans were reviewed. RN 1 stated Resident 15 is at risk for falls and should always have call light within reach. RN 1 stated that all staff were responsible for making sure call light was within reach of the resident so resident can call for assistance when needed and prevent a potential fall or injury while reaching for the call that is not within reach of the resident.<br><br>During a concurrent interview and record review on 4/10/2026, at 8:25 a.m. withˆthe DON, Resident 103`s FRE and CPs were reviewed. The DON stated that Resident 103 is at risk for falls and call light should always be within reach. The DON stated that all staff are responsible for ensuring call light is within reach. The DONˆstatedˆthe staff did not follow the policy and procedure (P&P) titled Call Lights: Accessibility and Timely Response.<br><br>3. During a review of Resident 102's admission Record, the admission Record indicated the facility originally admitted the resident on 4/02/2021, and readmitted on [DATE], with diagnoses including cardiac arrest (a sudden, unexpected stop of the heart's pumping function, not a blockage), gastrostomy (a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems), history of falling, dysphagia (difficulty swallowing), muscle weakness, and anxiety disorder (a mental health disorder characterized by feelings of worry or fear that are strong enough to interfere with one's daily activities).<br><br>During a review of Resident 102's H&P dated 4/10/2025, the H&P indicated Resident 102 did not have the capacity to understand and make decisions.<br><br>During a review of Resident 102's MDS dated [DATE], the MDS indicated that that the resident had severely impaired cognition. The MDS further indicated that Resident 102 required substantial or maximal assistance to personal hygiene, dressing, and repositioning, and was dependent to staff for bathing and all other activities of daily living (ADLs – routine task/activities such as bathing dressing and toileting a person performs daily to care for themselves).<br><br>During a review of Resident 102's care plan initiated on 12/04/2022, the care plan indicated that Resident 102 is at risk for falls with interventions indicating to place the call light within reach while in bed or close proximity to the bed and remind resident to use call light when attempting to ambulate or transfer to keep resident from falling.<br><br>During a concurrent observation and interview on 4/6/2026 at 10:20 a.m. inside Resident 102's room, with LVN 3, Resident 102 was observed awake, lying in bed and the call light was placed on the top right part of the bed next to the pillow. LVN 3 stated that the call light was not within reach for Resident 102 to call for assistance. Resident 102 observed attempted to reach for the call light but had limited range of motion to his right arm. LVN 3 stated that it is important for the call light to be within reach so that residents can address their needs.<br><br>During an interview on 4/6/2026 at 11:45 a.m. with Certified Nursing Assistant (CNA)7, CNA 7 stated<br>(continued on next page) |

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| F 0558<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | that she (CNA 7) did not know why Resident 102's call light was not within reach. CNA 7 stated that Resident 102 is able to tell his needs sometimes depending on his mood. CNA 7 further stated that Resident 102 would engage in conversation but oftentimes remain quiet but when needs are not met, Resident 102 would scream and attempt to throw things around.<br><br>During a telephone interview on 4/7/2026 at 12:54 a.m. with Resident 102's Responsible Party (RP) 2, RP 2 stated that Resident 102 is not fully able to address all his needs, but when Resident 102 starts getting restless, it might be that his needs are not met. RP 2 stated that Resident 102 can occasionally use the call light, but his roommate mostly is the one telling staff about Resident 102's needs.<br><br>During a concurrent interview and record review on 4/8/2026 at 8:17 a.m. with RN 1, Resident 102`s fall risk assessments were reviewed. RN 1 stated that Resident 102 was at risk for fall due to history of falls. RN 1 stated that it is important to have the call light within reach for resident's needs to be addressed and prevent injuries.<br><br>During an interview on 4/10/2026 at 8:20 a.m. with the DON, the DON stated that call light is needed for a resident to ask for assistance. The DON stated that residents could potentially fall if the call light is not within reach.<br><br>4. During a review of Resident 96's AR, the AR indicated the facility admitted the resident on 7/30/2021, and readmitted the resident on 1/14/2026, with diagnoses including major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), anxiety disorder (a mental health condition characterized by excessive, uncontrollable, and persistent fear or worry that interferes with daily life), and disorders of bone density (a measurement of the amount of minerals—mainly calcium and phosphorus—contained within a certain volume of your bone) and structure.<br><br>During a review of Resident 96's H&P, dated 9/13/2025, the H&P indicated the resident did not have the capacity to understand and make decisions.<br><br>During a review of Resident 96's MDS dated [DATE], the MDS indicated the resident had the ability to make self-understood and understand others and had severe cognitive impairment (a profound loss of mental capacity where a person cannot function independently, manage daily tasks, or comprehend the world around them). The MDS indicated the resident was needing substantial/maximal assistance on mobility and activities of daily living (ADLs, activities such as bathing, dressing and toileting a person performs daily).<br><br>During a review of Resident 96's Fall Risk Assessment (FR), dated 1/15/2026, the FR indicated the resident was at risk for falls.<br><br>During a review of Resident 96's Care Plan (CP) Report titled, The resident is at risk for falls related to unaware of safety needs, initiated on 4/7/2026, the CP indicated an intervention to place the resident's call light within reach and encourage the resident to use it for assistance as needed. The resident needs prompt response to all requests for assistance.<br><br>During a concurrent observation and interview on 4/6/2026, at 9:45 a.m., with CNA 11, inside Resident 96's room, observed Resident 96's call light dangling at the left side of the bed touching the floor. CNA 11 stated the call light should always be within the reach of the resident so they can call for help<br>(continued on next page) |

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| F 0558<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | when needed.<br><br>During a concurrent interview and record review on 4/8/2026, at 7:50 a.m. with RN 1, Resident 96's FR and CPs were reviewed. RN 1 stated Resident 96's call light should always be within the resident's reach, and all staff were responsible to make sure it is always within reach of the resident so the resident can call for assistance when needed. RN 1 stated the failure of the staff to ensure the call light was within reach had predisposed the resident to have no ability to call for help as needed and had the potential to fall and sustain an injury while reaching for the call light on the floor.<br><br>During an interview on 4/10/2026, at 8:10 a.m., with the DON, the DON stated that Resident 96's call light should always be within the reach of the resident so they can make their needs known. The DON stated all staff were responsible for ensuring the call light is within reach during their resident's rounds. The DON stated the staff did not follow the policy and procedure (P&P) titled Call Lights: Accessibility and Timely Response.<br><br>During a review of the facility's recent P&P titled, Call Lights: Accessibility and Timely Response, last reviewed on 3/18/2026, the P&P indicated the purpose of this policy is to assure the facility is adequately equipped with a call light.<br><br>Policy Explanation and Compliance Guidelines:<br><br>- Staff will ensure the call light is within reach of resident and secured, as needed.<br><br>- The call system will be accessible to residents while in their bed or other sleeping accommodations within the resident's room. |

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| F 0604<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents were treated with respect and dignity including the right to be free from physical restraints (any manual method, physical or mechanical device, material or equipment that is attached or adjacent to the resident's body that he or she cannot easily remove that restricts freedom of movement or normal access to one's body)ˆfor ˆthree of three sampled residents (Residents 71, 102, and 106) reviewed for physical restraints by failing to ensure: 1. Resident 71`s use of a bed placed against the wall was assessed on a quarterly basis. The most recent assessment was completed on 10/2/2025.ˆ The deficient practice had the potential to result in the restriction of residents' freedom of movement, a decline in physical functioning, and psychosocial harm (any damage to a person's mental health, emotional well-being, or social functioning caused by their environment, particularly in the workplace). 2. There was a physician's order prior to placement of Resident 102`s bed against the wall.ˆˆ This deficientˆpracticeˆresulted in unnecessary restraint and placedˆResident 102ˆat risk of physical harm fromˆrestricting movements freely.ˆˆ 3. Residents 187'sˆwedgeˆpillows on both sides were not tucked under the fitted sheet.ˆ Thisˆdeficientˆpracticeˆhadˆtheˆpotentialˆtoˆresultˆinˆtheˆrestrictionˆofˆresidents'ˆfreedomˆofˆmovement,ˆaˆdeclineˆinˆphysicalˆfunctioning,ˆpsychosocialˆharm,ˆphysicalˆharmˆfromˆentrapmentˆ(aˆstateˆinˆwhichˆaˆpersonˆisˆtrappedˆbyˆtheˆbedˆrailˆinˆaˆpositionˆthatˆtheyˆcannotˆmoveˆfrom),ˆandˆdeathˆofˆresidents.ˆ Findings:ˆ a. During a review of Resident 71's admission Record (AR), the AR indicated the facility admitted the resident on 10/2/2023, with diagnoses including repeated falls, morbid obesityˆ(a serious chronic disease defined as being 100 pounds or more over ideal body weight, or having a BMI of 40 or higher), and muscle spasm.ˆ<br><br>During a review of Resident 71's History and Physical (H&P), dated 2/1/2026, the H&Pˆindicatedˆtheˆresidentˆhadˆaˆcapacityˆtoˆconsent.ˆ<br><br>During a review of Resident 71's Minimum Data Set (MDS, a resident assessment tool), dated 9/4/2025, the MDS indicated the resident had the ability to make self-understood and understand others and had intact cognitionˆ(having a clear, sharp, and functioning mind that allows a person to think, learn, remember, and make decisions effectively). The MDS indicated the resident independent to needing partialˆassistanceˆon mobility and activities of daily livingˆ(ADLs,ˆactivities such as bathing, dressing and toileting a person performs daily).ˆ ˆ<br><br>During a review of Resident 71's Order Summary Report (OSR), dated 1/2/2025, the OSR indicated an order for bed against the wall per resident's preference. The OSR further indicated to monitor for change in preference.ˆˆ<br><br>During a review of Resident 71's Device Evaluation (DE), dated 10/2/2025, the DEˆindicatedˆa device use of bed against the wall. The DE indicated the resident and/or responsible party verbalized understanding and agreed the use of the device and understands the potential risks of using the device including but not limited to, bruising, skin tear, falls, startling (surprising)/upsetting, feeling isolated, pressure injuryˆ(localized damage to the skin and underlying tissue, usually over a bony area), entrapmentˆ(a dangerous situation where a person (usually a patient in a hospital or nursing home) gets caught, stuck, or tangled in the gaps around their bed), strangulation (injuries result from external forces applied to the neck), suffocation (the state of being unable to breathe), and death.ˆ<br><br>During a review of Resident 71's Fall Risk Assessment (FR), dated 2/17/2026, the FRˆindicatedˆthe<br>(continued on next page) |

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| F 0604<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | resident was not at risk for falls.ˆ<br><br>During a review of Resident 71's Care Plan (CP) Report titled, Resident has preference for bed to be positioned against the wall for comfort and personal preference, initiated on 12/2/2024, the CP indicated an intervention to regularly assess the patient`s comfort and safety with the bed quarterly and as needed.ˆ<br><br>During a concurrent observation, interview, and record review on 4/7/2026, at 9:58 a.m., withˆTreatment Nurse (TN)ˆ1, inside Resident 71's room, observed Resident 71's bed was placed against the wall on the right side of the resident's bed with bilateralˆhalf (1/2)ˆside railsˆ(or half-length rail- a safety device for hospital-style beds that covers only a portion of the bed's length, typically the area around the torso and hips)ˆon. TN 1 stated every time they apply restraints such as placing the resident`s bed against the wall, they need a physician's order, an informed consentˆ(voluntary agreement to accept treatment and/or procedures after receiving education regarding the risks, benefits, and alternatives offered), a restraint assessment, and a care plan to ensure its safe use. TN 1ˆstatedˆshe (TN1) cannot find a restraint assessment on the use of Resident 71's bed placed against the wall. TN 1ˆstatedˆthe use of restraints on residents should be reassessed on a quarterly basis to ensure they remain safe use and clinically indicated.ˆ<br><br>During a concurrent interview and record review on 4/7/2026, at 2:41 p.m., withˆRegistered Nurse (RN)ˆ1, Resident 71's OSR, DE, FR, and CPs were reviewed. RN 1ˆstated that Resident 71`s use of restraint bed placed against the wall was last assessed on 10/2/2025. RN 1 stated restraints use should be assessed quarterly and as neededˆfor resident's safety and to prevent accidents such as bumping of the resident on the wall or entrapment. RN 1ˆstatedˆthe policy and procedure titled Assessment Frequency/Timeliness was not followed by the facility. RN 1ˆstatedˆtheir failure to assess the use of Resident 71's restraint bed placed against the wall had predisposed (caused to have a tendency toward) the resident to bed entrapment.ˆ<br><br>During an interview on 4/10/2026, at 8:10 a.m., with theˆDirector of Nursing (DON), the DONˆstatedˆevery time they apply restraints to residents they need a physician's order, an informed consent, a restraint assessment, and a care plan for its safe use.ˆ"The DONˆstatedˆthe staff should have assessed the use of the restraint bed placed against the wall on Resident 71 quarterly to ensure its safe use and is still needed. The DONˆstatedˆthe failure of the staff to quarterly assess the resident on restraint use had predisposed the resident to accidents such as falls and entrapment.ˆ<br><br>During a review of the facility's recent policy and procedureˆ(P&P)ˆtitled, Assessment Frequency/Timeliness, last revised 3/18/2026, the P&P indicated the purpose of this policy is to provide a system to complete standardized assessments in a timely manner, according to the current RAI Manual.ˆ<br><br>Policy Explanation and Compliance Guidelines:ˆ<br><br>4. A quarterly review assessment will be completed no less than onceˆevery three months. It must be completed within 92 days of the ARD of the most recent OBRA assessmentˆ<br><br>During a review of the facility's recentˆP&PˆtitledˆRestraint Free Environment, last reviewed on 3/18/2026, the P&P indicated it is the policy of this facility that each resident shall attain and maintain his/her highest practicable well-being in an environment that prohibits the use of restraints for discipline or convenience and limits restraint use to circumstances in which the resident has<br>(continued on next page) |

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| F 0604<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | medical symptoms that warrant the use of restraints.ˆ<br><br>Definitions:ˆ<br><br>Physical Restraint refers to any manual method or physical or mechanical device, material, or equipment attached orˆadjacent toˆthe resident's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body. Physical restraints may include, but are not limited to:ˆ<br><br>-Placing a chair to bed close enough to a wall that the resident is prevented from rising out of the chair of voluntarily getting out of bed.ˆ<br><br>Compliance Guidelinesˆ<br><br>- A physician's order alone is not sufficient toˆwarrantˆthe use of a physical restraint. The facilityˆis responsible forˆthe appropriateness of the determination to use a restraint.ˆ<br><br>- The resident/resident's representative may request the use of a physical restraint; however, the facilityˆis responsible forˆevaluating the appropriateness of the request. The facility shall explain to the resident/resident representative, the potentialˆrisksˆand benefits of using a restraint, not using a restraint, and alternatives to restraint use. Potential negative outcomes should also be explained including, but not limited to.ˆ<br><br>b. During a review of Resident 102's AR, theˆAR indicated the facilityˆoriginally admitted the resident on 4/02/2021, and readmitted on [DATE], ˆwith diagnoses including cardiac arrestˆ(a sudden, unexpectedˆstop of the heart's pumping function, not a blockage),ˆgastrostomyˆ(a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems), acute renal failureˆ(a condition in which the kidneys suddenly cannot filter waste from the blood), history of falling, dysphagiaˆ(difficulty swallowing), muscleˆweakness, and anxiety disorderˆ(a mental health disorder characterized by feelings of worryˆor fear that are strong enough to interfere with one's daily activities).ˆ<br><br>During a review of Resident 102's H&Pˆdatedˆ4/10/2025, the H&Pˆindicatedˆ Resident 102 did not have the capacity to understand and make decisions.ˆˆ<br><br>During a review of Resident 102's MDS dated [DATE], the MDS indicated that the resident had severely impaired cognition. The MDSˆfurtherˆindicatedˆthatˆResidentˆ102ˆrequiredˆsubstantial or maximalˆassistanceˆforˆpersonal hygiene,ˆdressing, andˆrepositioning, and was dependent on staff for bathingˆand all other activities of daily living (ADLsˆ–ˆroutine task/activities such as bathing dressing and toileting a person performs daily to care for themselves).ˆˆ<br><br>During a review of Residentˆ102's care planˆ(CP)ˆ titled ˆResident prefers to have bed be against the wall initiated onˆ12/26/2023, the CP indicatedˆto explain risks and complication of having bed be against the wall, offer to have bed be moved in the middle of the room. The CP also indicated thatˆResident/RP prefers to have bed be against the wall with interventions to monitor for changes in skin related to possibly bumping against the wall, explain risks and complications of preference of resident, encourage to have bed not be against the wall and respect resident's rights.ˆˆ<br><br>During an observation onˆ4/06/2026 at 10:06ˆa.m.ˆinside Resident102's<br>(continued on next page) |

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| F 0604<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | room,ˆResidentˆ102ˆwasˆobservedˆawake,ˆlyingˆflat in bed andˆhaving the bed against the wall.ˆˆˆ<br><br>During a concurrent interview and record review on 4/8/2026 at 8:17ˆa.m.ˆwith Registered Nurse (RN 1), RN 1ˆstatedˆthatˆResident 102's bedˆwas positioned against the wall becauseˆthere was a consent made by Resident 102`s Responsible Party (RP 2)ˆonˆ12/28/2023.ˆRN 1ˆstatedˆthat licensed staff completed an assessment, obtained a consent,ˆand developed a care plan for placing Resident 102`s bed against the wall, however, licensed staff did not obtain a physician order for placing the resident`s bed against the wall.ˆRN 1ˆstatedˆthat there should have been an order before putting the bed against the wallˆfor safety reasons. RN 1ˆstatedˆthatˆplacing theˆbed against the wall will impede (block) the movement ofˆresidents.ˆ<br><br>During an interview on 4/10/2026 atˆ8:20ˆa.m.ˆwith the DON,ˆtheˆDONˆstatedˆthat if a bed is placed against the wall andˆrestrictsˆa resident`s movement, it is considered a restraint.ˆTheˆDONˆstatedˆthat beforeˆapplying forˆany restraints, thereˆshould be an assessment, care plan,ˆconsentˆandˆphysician'sˆorder.ˆTheˆDON furtherˆstatedˆthatˆif residents' bedˆisˆplaced against the wall, theyˆcould be at risk for entrapment.ˆ<br><br>During a review of the facility's Policy and Procedures (P&P)ˆtitled, Restrain Free Environment, revised onˆ12/19/2022, the P&P indicated that,ˆIt is the policy of this facility that each resident shall attain and maintain his/her highest practicable well-being in an environment that prohibits the use of restraints for discipline or convenience and limits restraint use to circumstances in which the resident has medical symptoms that warrant the use of restraints.ˆˆ<br><br>- Physical Restraint refers to any manual method or physical or mechanical device, material, or equipment attached toˆadjacent toˆthe resident's body that the individual cannot remove easily which restricts freedom of movement or normalˆaccess to one's body. Physical restraints may include, but are not limited to:ˆ<br><br>- Placing a chair or bed close enough to a wall that the resident is prevented from rising out of the chair or voluntarily getting out of bed.ˆˆ<br><br>c. During a review of Resident 106's AR, the AR indicated the facility admitted the resident on 3/18/2024, with diagnoses including paraplegia (paralysis that affects the legs, making it impossible to stand or walk), schizophrenia (a mental illness that is characterized by disturbances in thought), and generalized muscle weakness.ˆ<br><br>During a review of Resident 106's H&P, dated 3/5/2026, the H&Pˆindicatedˆthat the resident had the capacity to understand and make decisions. The H&P furtherˆindicatedˆthat the resident had a diagnosis of schizophrenia.ˆ<br><br>During a review of Resident 106's MDS, dated [DATE], the MDS indicated Resident 106 had an intact cognition and wasˆusually ableˆto understand and make her needs known. The MDS furtherˆindicatedˆResident 106 required supervision or touchingˆassistanceˆwith eating and oral hygiene, and substantial/maximalˆassistanceˆfrom staff with all other ADLs.ˆ<br><br>During a review of Residentˆ106's fall riskˆevaluationˆdatedˆ2/20/2026, the fall riskˆevaluationˆindicatedˆthatˆResidentˆ106ˆwasˆnot a risk for falls.ˆ<br><br>During an observation onˆ4/6/2026ˆat 10:01 a.m. inside Residentˆ106's room,ˆobservedˆResident<br>(continued on next page) |

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| F 0604<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | 106 lyingˆasleep in bed.ˆObservedˆwedgeˆpillowsˆwereˆtucked under Residentˆ106's fitted sheet on both sides of the bed.ˆ<br><br>During a concurrent observation and interview onˆ4/6/2026ˆat 10:08ˆa.m., inside Residentˆ106's room with Certified Nursing Assistant (CNA)ˆ3, CNAˆ3ˆstated Residentˆ106ˆhadˆthe wedgeˆpillows tucked under the fitted sheet on both sides of the bed for safety as the residentˆleans too far towards the left sideˆof the bed and to keep the resident in upright position while in bed.ˆCNA 3 stated that the wedge pillowsˆare forˆcomfort andˆpositioning. CNAˆ3ˆstatedˆthatˆResidentˆ106 was unable to remove the pillowsˆby herself as sheˆhadˆweakness on both arms and is restricting Resident 106's movement.ˆˆ<br><br>During an interview onˆ4/6/2026 at 10:23 a.m. with Licensed Vocational Nurse (LVN) 3, LVN 3 stated that she is familiar with Resident 106ˆand placement of wedge pillows under the fitted sheetˆis toˆkeep the resident on her side andˆto prevent the resident from falling. LVN 3 stated that placement if wedge pillows under the fitted sheet is a practice in the facility. LVN 3 statedˆthat Resident 106 had weakness on both upper arms andˆwas unableˆto remove the wedge pillows if tucked under the fitted sheet.ˆ<br><br>During a concurrent interview andˆrecordˆreview onˆ4/9/2026ˆatˆ2:20 p.m., reviewed Residentˆ106's fall riskˆevaluation, restraint assessment, physician's order, informed consent, and care plan with RN 1. RN 1ˆstatedˆthat Resident 106 was not a risk for falls, there was no physician's order to placeˆthe wedge pillows under the fitted sheet.ˆRN 1ˆstatedˆthat Resident 106 was unable to remove the wedge pillows if tucked under the fitted sheet as she had weakness on both upper arms.ˆRN 1ˆstatedˆthat the wedge pillowsˆunder the fitted sheet can be considered a restraint as it was restrictingˆthe resident to move freely. RN 1ˆstatedˆthat wedge pillows can be used but should be placed on top of the fitted sheet.ˆRN 1ˆstatedˆthat Resident 106's wedge pillows should have been placed on top of the fitted sheet.ˆRN 1ˆstatedˆthat Resident 106ˆwas not able toˆremove theˆwedge pillowsˆunder the fitted sheet and itˆrestrictedˆthe residentˆto move freely.ˆ<br><br>During an interview on 4/10/2026 at 8:50 a.m. with the DON, the DONˆstatedˆthat ˆwhen applying a restraint on a resident, there should be a restraint assessment, physician's order, informed consent, and care plan. The DONˆstatedˆthatˆwedge pillows are primarily used as positioning devices and are supposed to be placed by staff on top of theˆfitted sheet where the residents can remove it on their own and be able to move freely. The DONˆstatedˆthat placing the wedge pillows under the fitted sheet restricts a resident movement and the residents are unable to remove the device, hence, considered a restraint. The DONˆstatedˆthatˆtheˆstaffˆshouldˆnot haveˆplaced the wedge pillows under Resident 106's fitted sheet as the resident was unable to remove theˆpillows freely andˆrestrictˆthe resident to move freelyˆwhich can lead to a decline in physical functioning.ˆˆ<br><br>During a review of the facility's policy and procedure (P&P) titled, Restraint Free Environment, last reviewed on 3/18/2026, the P&P indicated thatˆit is the facility's policy thatˆeach resident shall attain and maintain his/her highest practicable well-being in an environment that prohibits the use of restraints for discipline or convenience and limits restraint use to circumstances in which the resident has medical symptoms that warrant the use of restraints. The P&P furtherˆindicated:ˆ<br><br>- Physical Restraint refers to any manual method or physical or mechanicalˆdevice, material, or equipmentˆadjacent toˆthe resident's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body.ˆˆ<br>(continued on next page) |

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| F 0604<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | - Before a resident is restrained, the facility willˆdetermineˆthe presence of a specific medical symptom that would require the use of restraints andˆdetermine:ˆ<br><br>a. How the use of restraints would treat the medical symptom.ˆ<br><br>b. The length of time the restraint isˆanticipatedˆto be usedˆto treat the medical symptom, who may apply the restraint, and the time and frequencyˆthat the restraint will be released.ˆ<br><br>c. The type of direct monitoring and supervision that will be providedˆduring the use of the restraint.ˆ<br><br>d. How the resident will request staffˆassistanceˆand how his/her needs will be met.ˆ<br><br>e. How toˆassistˆthe resident inˆattainingˆor maintaining hisˆor her highestˆpracticableˆlevel of physical and psychosocial well-being.ˆ |

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| | 056056 | A. Building<br>B. Wing | 04/10/2026 |

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| F 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.<br><br>Based on observation, interview, and record review, the facility failed to update a resident's comprehensive care plan (a document outlining a detailed approach to care customized to an individual resident's need) for one of five sampled residents (Resident 91) reviewed under the urinary catheter (also known as Foley catheter, is a hollow flexible tube inserted in the bladder through the urethra to drain urine) or UTI (urinary tract infection - an infection in the bladder/urinary tract) care area to include notifying Resident 91's physician when the indwelling urinary catheter becomes dislodged or removed, place a urinary catheter securement device, and follow Resident 91's physician order to change Resident 91's indwelling urinary catheter every 30 days. These deficient practices had the potential to result in inconsistent implementation of the care plan that may lead to catheter acquired urinary tract infection (CAUTI) and not up-to-date implementation of interventions. Cross-reference F690. Findings: During a review of Resident 91's admission Record (AR), the AR indicated that the facility admitted the resident on 6/21/2024, with diagnoses including peripheral vascular disease (PVD - a slow progressive narrowing of the blood flow to the arms and legs), obstructive (a blockage in your body that makes it difficult or impossible to urinate) and reflex uropathy (the backward flow of urine from the bladder up into the ureters and kidneys), and benign prostatic hyperplasia (BPH - a condition in which the prostate gland is larger than normal) with lower urinary tract symptoms. During a review of Resident 91's History and Physical (H&P), dated 3/9/2026, the H&P indicated the resident was alert and oriented x4 (medical abbreviation for Person, Place, Time, and Event/Situation), follows commands, and was verbally responsive. During a review of Resident 91's Minimum Data Set (MDS - a resident assessment tool), dated 2/26/2026, the MDS indicated the resident was cognitively intact (a person's thinking, learning, and memory abilities are functioning normally and are not impaired). The MDS indicated the resident required assistance with toileting hygiene, shower/bathe self, upper and lower body dressing and with mobility. The MDS indicated the resident with an indwelling catheter During a review of Resident 91's physician orders, dated 12/23/2025, the physician orders indicated to maintain indwelling Foley catheter 16 Fr/30 cc (balloon size filled with the amount of sterile water after insertion that keeps the catheter secured inside the bladder, ensuring it does not slip out) balloon to bedside straight drainage, for diagnosis/history of BPH/obstructive uropathy. Routine Foley catheter changes every 30 days. Maintain closed drainage system. During a concurrent observation and interview on 4/9/2026 at 10:16 a.m., inside Resident 91's room, with Registered Nurse (RN) 1, Resident 91 stated that his indwelling urinary catheter came out about a week and a half ago and it was replaced on the same day. Resident 91 stated his urinary drainage bag was replaced two weeks ago. Resident 91 stated that he (Resident 91) did not have the urinary catheter securement device for about a month because he (Resident 91) has a lot of hair and needs to be shaved. Resident 91 stated when they remove the urinary catheter securement device his hair goes with it and it was painful. Resident 91 stated his urinary catheter tubing and urinary drainage bag were not marked with dates ever since a resident of this facility. RN 1 stated Resident 91's urinary catheter tubing did not have a date of when it was placed, and urinary drainage bag did not have a date of when it was last changed. RN 1 stated Resident 91 did not have a urinary catheter securement device to hold the urinary catheter in place and Resident 91's urinary catheter size is 18 Fr / 10 cc balloon. During a concurrent interview and record review on 4/9/2026 at 2:05 p.m., with RN 1, Resident 91's nursing assessments, progress notes, and Care Plans (CP) were reviewed. RN1 stated staff developed a CP titled, Impaired urinary elimination., on 6/22/2024 for Resident 91 and the CP goal indicated that the resident will be free from CAUTI. RN 1 stated she (RN 1) does not see the interventions such as follow physician order for catheter size, replace or change Foley as needed due to dislodgement, call the doctor and get an order to reinsert if there is not already one, change the urinary indwelling catheter per protocol or as ordered, and to place urinary (continued on next page) |

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| F 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | catheter securement device. RNˆ1 stated there was no note notifying the doctor when the resident's Foley catheter was dislodged.ˆ During an interview on 4/10/2026 at 8:10 a.m., with the Director of Nursing (DON), the DON stated that the purpose of the care plan is to develop a plan of care for the resident. The DON stated the care plan is revised on admission and as needed. The DON stated the interventions she would expect for residents with urinary indwelling catheter to monitor urine, monitoring notification if any change, the size of the catheter, any signs of infection, physician orders for leaking or removed, and securement device care planned. The DON stated that when the care plan is not revised to reflect the resident's up-to-date condition and needs, the resident can receive physician orders or interventions such as the insertion of a Foley catheter that have not been explained or about their current condition and the purpose, risks, and benefits of the procedure. The DON stated the resident is at risk for UTI when the care plan is not followed. The DON stated that the purpose of the urinary securement device is to secure the urinary catheter in place. During a review of the facility's policy and procedure (P&P) titled, Appropriate Use of Indwelling Catheter, last reviewed and approved on 3/18/2026, the P&P indicated that 9. Indwelling urinary catheters (urethral or suprapubic) will be utilized in accordance with current standards of practice, with interventions to prevent complications to the extent possible. Possible complications include, but are not limited to: urinary tract infection, blockage of the catheter, expulsion of the catheter, pain, discomfort, and bleeding. 10. The plan of care will address the use of an indwelling urinary catheter, including strategies to prevent complications. During a review of the facility's P&P titled, Comprehensive Care Plans, last reviewed and approved on 3/18/2026, the P&P indicated that it is the facility's policy to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment. 5. The comprehensive care plan will be reviewed and revised by the interdisciplinary team after each comprehensive and quarterly MDS assessment. 6. The comprehensive care plan will include measurable objectives and timeframes to meet the resident's needs as identified in the resident's comprehensive assessment. The objectives will be utilized to monitor the resident's progress. Alternative interventions will be documented, as needed. |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the resident environment was free of accident hazards for four of eight sampled residents (Residents 13, 109, 138, and 106) reviewed for accidents by failing to ensure residents did not have a furniture or equipment on top of the floor mat (specially designed mats provide cushioning and support to patients who are at risk of falling, helping to prevent serious injuries) and bilateral padded siderails were in place as ordered by the physician. These deficient practices increased the risk of accidents such as falls with injuries. Findings: 1. During a review of Resident 13's admission Record (AR), the AR indicated the facility admitted the resident on 9/12/2024, and readmitted the resident on 2/21/2026, with diagnoses including abnormalities of gait (a person's specific manner or style of walking, running, or moving on foot) and mobility, disorders of bone density (a measure of how much calcium and other minerals are packed into a specific area of your bone) and structure of right shoulder, and lack of coordination.<br><br>During a review of Resident 13's History and Physical (H&P), dated 8/2/2025, the H&P indicated the resident had the capacity to understand and make decisions.<br><br>During a review of Resident 13's Minimum Data Set (MDS - a resident assessment tool), dated 9/2/2025, the MDS indicated the resident had the ability to make self-understood and understand others and had intact cognition (having a clear, sharp, and functioning mind that allows a person to think, learn, remember, and make decisions effectively). The MDS indicated the resident required partial to set up assistance on mobility and activities of daily living (ADLs - activities such as bathing, dressing and toileting a person performs daily).<br><br>During a review of Resident 13's Order Summary Report (OSR), dated 4/8/2026, the OSR did not indicate an order for floor mat.<br><br>During a review of Resident 13's Fall Risk (FR), dated 2/17/2026, the FR indicated the resident was at risk for falls.<br><br>During a concurrent observation and interview on 4/7/2026 at 10:25 a.m. with Licensed Vocational Nurse (LVN) 5, inside Resident 13's room, observed Resident 13's floor mat at the left side of the bed, with the wheel of the bed on top of the mat and the mat was halfway under the bed. LVN 5 stated the mat was not placed properly, half of the mat was under the bed and when the resident falls only half of the body will land on the mattress and the resident can sustain injury.<br><br>During a concurrent interview and record review on 4/7/2026 at 3:01 p.m. with Registered Nurse (RN) 1, Resident 13's OSR, FR, and CP were reviewed. RN 1 stated the floor mats should me checked at least every shift and when they go rounds on their residents. RN 1 stated the purpose of the floor mat was to provide a soft-landing space for resident when they fall. If there is a furniture or equipment on top of them or the mat was halfway under the bed the resident can sustain injury as the resident will hit what is on top of the mat or the resident can land on the floor without the cushion causing injury. RN 1 stated the resident was a fall risk and she was not able to find a physician's order nor a care plan on its use.<br><br>During an interview on 4/10/2026 at 8:10 a.m. with the Director of Nursing (DON), the DON stated the purpose of the floor mat is for fall intervention. The DON stated the floor mat of Resident 13 should<br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | have an order and should be care planned. The DON stated the floor mat minimizes the risk of injury to the resident by providing cushion when they fall. The DON stated the floor mat on Resident 13 was halfway under the bed and will not be able to catch the whole body when the resident falls and the resident may sustain a major injury. The DON stated the policy and procedure (P&P) titled Accidents and Supervision and manufacturer's specification titled Floor Mat (FM) 1 were not followed.<br><br>2. During a review of Resident 138's AR, the AR indicated the facility admitted the resident on 4/3/2026, with diagnoses including type 2 diabetes mellitus with diabetic polyneuropathy (high blood sugar has caused nerve damage, usually on the feet, leading to pain or loss of feeling); chronic kidney disease, stage four (4) (a condition that developed over time where kidneys are severely damaged and most of their function is lost being unable to clean waste and extra fluid from the blood); essential (primary) hypertension (high blood pressure with no known specific cause).<br><br>During a review of Resident 138's H&P, dated 4/6/2026, the H&Pˆindicated the resident had the capacity to understand and make decisions.ˆ<br><br>During a review of Resident 138's MDS, dated [DATE], the MDS indicated the resident had the ability to make self-understood and understand others. The MDS further indicated that Resident 138 had moderate cognitive impairmentˆ(has some trouble with memory and thinking but can still function with support). The MDS indicated that the resident needs partialˆto maximal assistanceˆon mobility and ADLs.<br><br>During a review of Resident 138's OSR, dated 4/4/2026, the OSR indicated an order for bilateral floor mats. Consent obtained from resident/responsible party.ˆ<br><br>During a review of Resident 138's Fall Risk Evaluation (FRE), dated 4/3/2026, the FREˆindicatedˆthe resident was at risk for falls.ˆ<br><br>During a review of Resident 138's CP Report, the focus was that Resident 138 is at risk for falls related to (r/t) gait (manner of walking)/balance problems, initiated on 4/3/2026, the CP indicated a goal of resident will be free of falls through the review date. Some interventions are to review information on past falls and attempt to determine cause of falls, record possible root causes, and alter remove any potential causes if possible.<br><br>During a concurrent observation and interview on 4/6/2026 at 9:36 a.m. withˆCertified Nursing Assistant (CNA)ˆ12, inside Resident 138's room, observed Resident 138's floor mat on the left side of the bed that had the bedside table on top of the floor mat. CNA 12 stated the floor mat is to prevent the resident from getting injured if the resident were to fall. CNA 12 stated bedside table should not be on top of the floor mat because if Resident 138 were to fall then resident can get injured with the table.<br><br>During a concurrent interview and record review on 4/8/2026 at 8:20 a.m. withˆRNˆ1, Resident 138's OSR, FRE, and CP were reviewed.ˆRN 1 stated Resident 138 is at risk for falls. RN 1 stated the floor mats are for high-risk fall residents and to prevent injury. RN 1 stated there should be no objects on top of the Resident 138's floor mat because it prevents the mat from serving its protective purpose in case residents were to fall. RN 1ˆstatedˆthe purpose of the floor matˆwasˆto prevent injuryˆto the resident.ˆRN 1 stated the staff need to ensure that there is nothing on top of the floor mat so it can serve its purpose.<br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During an interview on 4/10/2026 at 8:10 a.m. with theˆDON, the DONˆstatedˆthe floor mat is used for fall prevention to reduce injury if there is an incidence of fall. The DON stated the purpose of the floor mat is for fall intervention. The floor mat minimizes the risk for injury by providing cushion if they fall. The DON stated the floor mat will not catch the whole body; resident can get major injury if there is an object on top of floor mat.<br><br>3. During a review of Resident 109's AR, the AR indicated the facility admitted the resident on 6/2/2023, with diagnoses including legal blindness (cannot see clearly or cannot see much to the sides); essential (primary) hypertension (high blood pressure with no known specific cause); history of falls.<br><br>During a review of Resident 109's H&P, dated 6/10/2025, the H&Pˆindicated the resident had the capacity to understand and make decisions.ˆ<br><br>During a review of Resident 109's MDS, dated [DATE], the MDS indicated the resident had the ability to make self-understood and understand others. The MDS further indicated that Resident 109 is cognitively intact (thinking and memory are good). The MDS indicated Resident 109 needs maximal assistanceˆon mobility and ADLs.<br><br>During a review of Resident 109's Care Plan (CP) Report, the focus was that Resident 109 is at risk for falls: weakness, history of blindness with a goal of Resident 109 will have no falls with injury for 90 days. An intervention of assist resident/caregiver to organize belongings for a clutter-free environment in the resident's room and consistent furniture arrangement.<br><br>During a concurrent observation and interview on 4/6/2026 at 10:45 a.m. withˆCNA 1, inside Resident 109's room, observed the floor mat on the left side of the bed with the bedside table on top of it. CNA 1 stated the floor mat is for fall protection and the bedside table should not be on top of it, the resident can fall and can get injured with the table. CNA 1 stated the floor mat needs to be removed before placing the table because the mat can also cause the table to tip over since floor mat is not flat.<br><br>During a concurrent interview and record review on 4/8/2026, at 8:20 a.m., withˆRNˆ1, Resident 109's Fall Risk Evaluation and CP were reviewed.ˆRN 1 stated Resident 109 is at risk for falls. RN 1 stated the floor mats are for high-risk fall patients and to prevent injury. RN 1 stated there should be no objects on top of the floor mat of Resident 109 because it prevents the mat from serving its protective purpose in case the resident were to fall. RN 1ˆstatedˆthe purpose of the floor matˆwasˆto prevent injuryˆto the resident.ˆRN 1 stated the staff needs to ensure that there is nothing on top of the floor mat so it can serve its purpose.<br><br>During an interview on 4/10/2026 at 8:10 a.m. with theˆDON, the DONˆstatedˆthe floor mat is used for fall prevention to reduce injury if there is an incidence of fall. The DON stated the purpose of the floor mat is for fall intervention. The floor mat minimizes the risk of injury by providing cushion if they fall. The DON stated the floor mat will not catch the whole body; resident can get major injury if there is an object on top of floor mat.<br><br>4. During a review of Resident 106's AR, the AR indicated the facility admitted the resident on 3/18/2024, with diagnoses including paraplegia (paralysis that affects the legs, making it impossible to stand or walk), schizophrenia (a mental illness that is characterized by disturbances in thought), and generalized muscle weakness.<br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During a review of Resident 106's H&P, dated 3/5/2026, the H&P indicated the resident had the capacity to understand and make decisions. The H&P further indicated that Resident 106 had a history of seizure disorder (a sudden, uncontrolled electrical disturbance in the brain which can cause uncontrolled jerking, blank stares, and loss of consciousness).<br><br>During a review of Resident 106's MDS, dated [DATE], the MDS indicated Resident 106 had an intact cognition and was usually able to understand and make her needs known. The MDS further indicated Resident 106 required supervision or touching assistance with eating and oral hygiene, and substantial/maximal assistance from staff with all other ADLs.<br><br>During a review of Resident 106's FRE, dated 2/20/2026, the FRE indicated that Resident 106 was not a risk for falls.<br><br>During a review of Resident 106's Order Summary Report dated 4/10/2026, the Order Summary Report indicated the following physician's orders:<br><br>- 3/19/2024: Seizure precautionsˆevery shift.<br><br>- 10/28/2024: Floor mat (a cushioned floor pad designed to help prevent injury should a person fall) to right side of bed to decrease risk of injury every shift for fall precaution as a landing pad.<br><br>- 12/19/2025: Monitor padded side rails for seizure precautions every shift.<br><br>During a review of Resident 106's care plans (CP) indicated the following:<br><br>- Risk for falls initiated on 10/26/2026 and last revised on 3/5/2026, the CP indicated floor mats as one of the interventions to minimize Resident 106's falls.<br><br>- Risk for seizure initiated on 3/29/2024 and last revised on 11/25/2025, the CP indicated to maintain a safe environment and monitor the padded side rails as a few of the interventions to keep the resident free of any seizure related injury.<br><br>During a concurrent observation and interview on 4/6/2026 at 10:23 a.m. with CNA 3, inside Resident 106' s room, CNA 3 stated that the only device for Resident 106 was the use of wedge pillows to keep the resident upright in bed as the resident leans too far to the left side.<br><br>During a follow up concurrent interview and record review on 4/8/2026 at 12:35 p.m., inside Resident 106's room with CNA 3, CNA 3 stated that he was not aware of any other safety precautions for Resident 106 and the resident did not have any floor mat on the right side of the bed or padded side rails. CNA 3 stated he does not remember that Resident 106 had any seizure events recently.<br><br>During a concurrent interview and record review on 4/9/2026 at 2:36 p.m. with RN 1, Resident 106's AR, H&P, physician's orders, fall risk evaluations, and CP were reviewed. RN 1 stated that Resident 106's AR and H&P had a history of seizure disorder, the physician's order indicated seizure precautions every shift, floor mat on the right side of the bed, and padded side rails, and the CP indicated floor mat and padded siderails as interventions for Resident 106's safety. RN 1 stated that if there are physician orders and interventions to keep the residents free from any seizure related injury, the interventions and physician orders should be in place and implemented, and the nursing staff are responsible in making sure that these interventions are in place and monitor every shift as indicated<br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | in the physician's orders. RN 1 stated that Resident 106's floor mat on the right side of the bed and the padded side rails should have been in place as it placed Resident 106 at risk from accidents and/or any seizure related injury.<br><br>During an interview on 4/10/2026 at 9:13 a.m. with the DON, the DON stated that the purpose of floor mats is to prevent risk for incurring injury by providing a cushion for the resident during a fall incident and that the padded side rails are used to prevent any injury during a seizure activity. The DON stated that if there is a physician's order to place floor mat and padded side rails and indicated in the CP as well, the nursing staff should ensure that the order and interventions are implemented for the residents' safety and prevent injury. The DON stated that the nursing staff should have ensured that Resident 106's floor mat on the right side of the bed and the padded side rails should have been in place and provide cushion as it placed the resident at risk for accidents and incur injury in the event of a seizure activity.<br><br>During a review of the facility's recent P&P titled, Accidents and Supervision, last reviewed on 3/18/2026, the P&P indicated the resident environment will remain as free of accident hazards as is possible. Each resident will receive adequate supervision and assistive devices to prevent accidents. This includes:<br><br>1. Identifying hazard(s) and risk(s).<br><br>2. Evaluating and analyzing hazard(s) and risk(s).<br><br>3. Implementing intervention to reduce hazard(s) and risk(s).<br><br>4. Monitoring for effectiveness and modifying interventions when necessary.<br><br>During a review of the facility-provided Floor Mat (FM) 1 Owner's Manual (OM), printed on 11/2017, the OM indicated the Attendant Protector Foldable Bedside Mat may be placed next to a User's bed to help reduce the impact of a fall should a resident fall from the bed.<br><br>Directions For Use<br><br>4. Place the bedside mat flat on the floor, directly next to the bed, making sure it does NOT go under the bed.<br><br>Storage<br><br>5. Do not place objects on the product during storage. |

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| F 0690<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents with a urinary catheter (also known as Foley catheter - a hollow tube inserted into the bladder to drain or collect urine) received appropriate care and services to prevent urinary tract infections (UTI, an infection in the bladder/urinary tract) for seven of seven sampled residents (Resident 91, 135, 137, 51, 123, 3, and 61) reviewed for urinary catheter or UTI by failing to: 1a. Follow the physician order to insert indwelling urinary catheter 16 French (Fr - outer diameter of the catheter size) size when Resident 91 was observed with a gauge 18 Fr size indwelling urinary catheter. 1b. Label with a date when the indwelling urinary catheter was inserted for Resident 91. 1c. Place a urinary catheter securement device (an adhesive patch or strap that anchors a catheter tube to the skin) for Resident 91. 1d. Follow the physician's order to change Foley catheter every 30 days. 2. Ensure Resident 135's urinal bottle (a handheld container designed for collecting urine) was labeled with the name, room number, and the date the bottle was provided. 3. Ensure Resident 137 and 51's urinal bottles were labeled. These deficient practices had the potential for Residents 135, 137, and 51 to develop UTI. 4. Maintainˆ Resident 123'sˆ indwelling urinary catheterˆ (a hollow tube inserted into the bladder to drain or collect urine)ˆ in a manner that prevents urine backflow.ˆ 5. Failing to change urinary catheter every 30 days for Resident 3 and 61, consistent with physician's order. This deficient practice had the potential to result in trauma to Resident 91, 123, 3, and 61's urinary catheter insertion site, dislodgement and/or removal of the urinary catheter, and increased risk for catheter-associated UTI (CAUTI- an infection involving any part of the urinary system). Findings: 1. During a review of Resident 91's admission Record (AR), the AR indicated that the facility originally admitted the resident on 6/21/2024, with diagnoses including peripheral vascular disease (PVD - a slow progressive narrowing of the blood flow to the arms and legs), obstructive (a blockage in your body that makes it difficult or impossible to urinate) and reflex uropathy (the backward flow of urine from the bladder up into the ureters and kidneys), and benign prostatic hyperplasia (BPH – a condition in which the prostate gland is larger than normal) with lower urinary tract symptoms.<br><br>During a review of Resident 91's History and Physical (H&P), dated 3/9/2026, the H&P indicated the resident was alert and oriented x4 (medical abbreviation for Person, Place, Time, and Event/Situation), followed commands, and was verbally responsive.<br><br>During a review of Resident 91's Minimum Data Set (MDS – a resident assessment tool), dated 2/26/2026, the MDS indicated the resident was cognitively intact (a person's thinking, learning, and memory abilities are functioning normally and are not impaired). The MDS indicated the resident required assistance with toileting hygiene, shower/bathe self, upper and lower body dressing and with mobility. The MDS indicated the resident with an indwelling catheter<br><br>During a review of Resident 91's physician orders, dated 12/23/2025, the physician orders indicated to maintain indwelling Foley catheter 16 Fr/30 cc (balloon size filled with the amount of sterile water after insertion that keeps the catheter secured inside the bladder, ensuring it does not slip out) balloon to bedside straight drainage, for diagnosis/history of BPH/obstructive uropathy. Routine Foley catheter changes every 30 days. Maintain closed drainage system.<br><br>During a concurrent interview and record review on 4/9/2026 at 10:16 a.m., inside Resident 91's room, with Registered Nurse (RN) 1, Resident 91 stated his indwelling urinary catheter came out about a week and a half ago and it was replaced on the same day. Resident 91 stated his urinary drainage bag (continued on next page) |

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| F 0690<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | was replaced two weeks ago. Resident 91 stated he (Resident 91) did not have the urinary catheter securement device for about a month because he (Resident 91) has a lot of hair and the hair needs to be shaved. Resident 91 stated when they remove the urinary catheter securement device his hair goes with it and it was painful. Resident 91 stated his urinary catheter tubing and urinary drainage bag were not marked with dates ever since a resident of this facility. RN 1 stated Resident 91's urinary catheter tubing did not have a date of when it was placed, and urinary drainage bag did not have a date of when it was changed. RN 1 stated Resident 91 did not have a urinary catheter securement device to hold the urinary catheter in place and Resident 91's urinary catheter size is 18 Fr / 10 cc balloon.<br><br>During a concurrent interview and record review on 4/9/2026 at 10:21 a.m., with RN 1, Resident 91's physician orders, nursing assessment and progress notes were reviewed. RN 1 stated Resident 91`s current indwelling catheter order, dated 12/23/2025, indicated to maintain 16 Fr size urinary catheter, not 18 Fr size. RN 1 stated Resident 91`s physician order was not followed. RN 1 stated the licensed nurse that inserted the urinary catheter should have reviewed the order and clarified with the doctor regarding the urinary catheter size. RN 1 stated the licensed nurse should have documented when Resident 91`s urinary catheter came out and the catheter was changed in the nursing progress notes. RN 1 stated there was no documentation when the urinary catheter was replaced. RN 1 stated the treatment nurses are the ones responsible for placing the urinary securement device. RN1 further stated that urinary securement device is applied to make sure tubing is stabilized and to prevent trauma if resident moves. RN 1 stated when the physician order is not followed it can cause trauma on the site, resident may experience hematuria (blood in urine), pain, discomfort, and dislodgement. RN 1 stated the urinary drainage bag, and urinary indwelling catheter did not have a date of when it was changed. RN 1 stated the date is to ensure that the Foley catheter was changed and prevent infection from long-term use.ˆ<br><br>During a concurrent interview and record review on 4/9/2026 at 10:42 a.m., with Treatment Nurse (TN) 1, Resident 91's Treatment Administration Record (TAR) for the months of 1/2026, 2/2026, and 3/2026 were reviewed. TN 1 stated Resident 91 had an order to change Foley catheter every 30 days, and this is being done towards the end of the month. TN 1 stated once the resident's Foley catheter is changed, they would mark it on the TAR or documented in the progress notes. TN 1 stated the last time she (TN 1) changed Resident 91's urinary catheter was 3/20/2026. TN 1 stated she (TN 1) would also write the date of when it was changed on the white part of the urinary drainage bag. TN 1 stated Resident 91 has told him that someone has changed his urinary catheter tubing because it deflated. TN 1 stated the urinary securement device is changed as needed and regularly no longer than a week. TN 1 stated Resident 91 did not allow them to place the securement device because he (Resident 91) asked his CNA to shave his legs first. TN 1 stated there was no documentation that the Foley catheter was changed every 30 days. TN 1 stated the physician order should have been clarified and scheduled every 30 days then it would notify the licensed nurses that the resident's Foley catheter is due to be changed.<br><br>During a concurrent interview and record review on 4/9/2026 at 2:05 p.m., with RN 1, Resident 91's nursing assessments, progress notes, and Care Plan (CP) titled, Impaired urinary elimination., dated 6/22/2024 were reviewed. RN 1 stated Resident 91`s CP goal indicated that the resident will be free from CAUTI. RN 1 stated she (RN 1) does not see the interventions such as follow physician order for catheter size, replace or change Foley as needed due to dislodgement, call the doctor and get an order to reinsert if there is not already one, change urinary indwelling catheter per protocol or as ordered, and to place urinary catheter securement device. RNˆ1 stated there was no note notifying the doctor when the resident's Foley catheter was dislodged.ˆ<br>(continued on next page) |

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| F 0690<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During an interview on 4/10/2026 at 8:26 a.m., with the Director of Nursing (DON), the DON stated that the facility`s protocol for residents with urinary catheter is to have an order for indwelling catheter, monitor the catheter, and assess the residents for the use of indwelling urinary catheter which is done when it was placed and as needed. The DON stated for residents with indwelling urinary catheter reinserting the wrong size, which was done not as ordered, not placing a securement device, the resident could get an infection and catheter associated urinary tract infection. The DON stated the resident's urinary drainage bag should be labeled with a date it was last changed. The DON stated she (DON) can't say it's a policy but it's best practice to label with a date of when the urinary drainage bag was changed.<br><br>During a review of the facility's policy and procedure (P&P) titled, Appropriate Use of Indwelling Catheter, last reviewed and approved on 3/18/2026, the P&P indicated that it is the facility's policy to ensure that a resident who is continent of bladder on admission receives services and assistance to maintain continence unless his/her clinical condition is or becomes such that continence is not possible to maintain. An indwelling catheter will be utilized only when a resident's clinical condition demonstrates that catheterization was necessary. 4. The use of an indwelling urinary catheter will be in accordance with physician orders, which will include the diagnosis or clinical condition making the use the catheter necessary, size of the catheter, and frequency of change (if applicable). 9. Indwelling urinary catheters (urethral or suprapubic) will be utilized in accordance with current standards of practice, with interventions to prevent complications to the extent possible. Possible complications include, but are not limited to: urinary tract infection, blockage of the catheter, expulsion of the catheter, pain, discomfort, and bleeding. 10. The plan of care will address the use of an indwelling urinary catheter, including strategies to prevent complications.<br><br>2. During a review of Resident 135's AR, the AR indicated the facility admitted the resident on 8/6/2025, and readmitted the resident on 3/31/2026, with diagnoses including urinary tract infection, obstructive and reflux uropathy (a blockage in the urinary tract that hinders urine flow, causing backflow (reflux) and kidney injury), and benign prostatic hyperplasia (BPH, a common, non-cancerous enlargement of the prostate gland in older men).<br><br>During a review of Resident 135's H&P, dated 8/10/2025, the H&P indicated the resident had the capacity to consent.<br><br>During a review of Resident 135's MDS, dated [DATE], the MDS indicated the resident sometimes had the ability to make self-understood and understand others and had moderately impaired cognition (a noticeable, measurable decline in thinking skills—such as memory, language, or judgment—that is more severe than normal age-related forgetfulness but not severe enough to stop a person from living independently).<br><br>During a concurrent observation and interview on 4/6/2026, at 10 a.m., with Certified Nursing Assistant (CNA) 10, inside Resident 135's room, observed Resident 135's unlabeled urinal bottle at the side table of the resident. CNA 10 stated the urinal bottle should be labeled with the name of the resident and the date it was provided to ensure the urinal belongs to the resident and for infection control.<br><br>During an interview on 4/7/2026, at 2:57 p.m., with RN 1, RN 1 stated the urinal bottle of Resident 135 should have been labeled with the resident's name and the date it was provided to ensure the urinal belongs to the resident and they were not using the urinal for more than a week. RN 1 stated the urinal should be changed weekly and if needed (PRN) to prevent UTI on residents.<br>(continued on next page) |

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| F 0690<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During an interview on 4/10/2026, at 8:10 a.m., with the DON, the DON stated the urinal bottle of Resident 135 should have been labeled with the last name of the resident and the date it was last provided to ensure its safe use. The DON stated labeling the bottle with the resident's last name ensures the bottle is only used for the resident and to avoid switching of urinals among residents and the date it was last provided is affixed to ensure the urinal is changed every week for infection control. The DON stated the failure of the staff to label the urinal with the name of the resident and the date it was provided predisposed the resident to UTI. The DON stated the policy and procedure (P&P) titled Disinfection of Bedpans and Urinals was not followed by the staff.<br><br>During a review of the facility's recent P&P titled, Disinfection of Bedpans and Urinals, last reviewed on 3/18/2026, the P&P indicated bedpans and urinals are handled in a manner that prevent the spread of infection through personal equipment.<br><br>Policy Explanation and Compliance Guidelines:<br><br>1. Bedpans and urinals are for single resident use only.<br><br>3a. During a review of Resident 137's AR, the AR indicated the facility originally admitted the resident on 8/8/2025, and readmitted on [DATE], with diagnoses including absence of left leg below knee, generalized muscle weakness, and unsteadiness on feet.<br><br>During a review of Resident 137's H&P, dated 3/26/2026, the H&P indicated that Resident 137 had the capacity to understand and make decisions.<br><br>During a review of Resident 137's MDS, dated [DATE], the MDS indicated Resident 137 had an intact cognition (mental action or process of acquiring knowledge and understanding) and was able to understand others and make his needs known. The MDS further indicated Resident 137 was independent with all activities of daily living (ADLs - routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). The MDS indicated Resident 137 was always continent of bladder.<br><br>During a review of Resident 137's care plan (CP) on occasional incontinence of bowel and bladder initiated on 3/25/2026 and last revised on 4/7/2026, the CP indicated to establish voiding patterns and monitor/document/report as needed any possible causes of incontinence such as bladder infection, loss of bladder tone, weakening of control muscles, decreased bladder capacity and medication side effects as a few of the interventions for the resident to be continent at all times.<br><br>During a review of Resident 137's Bowel and Bladder Assessment form dated 3/25/2026, the Bowel and Bladder Assessment form indicated that resident was continent of bowel and bladder.<br><br>During a concurrent observation and interview on 4/6/2026, at 9:38 a.m., inside Resident 137's room with CNA 14, CNA 14 stated that the resident's urinal was hanging on the right side of the bed on a urinal holder and did not indicate Resident 137's name. CNA 14 stated that urinals are changed every week on Sundays by the night shift CNA and as needed if soiled and should be labeled with the resident's name and the date it was changed or provided to the resident. CNA 14 stated that Resident 137's urinal should have been labeled with the resident's name and the date it was changed to prevent switching of the urinals which can cause contamination and infection.<br><br>During an interview on 4/9/2026 at 2:23 p.m. with the Director of Staff Development (DSD), the DSD<br>(continued on next page) |

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| F 0690<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | stated that the facility practice in changing the urinals is every Sunday by the night shift CNAs and should be labeled with the resident's name and the date it was changed to ensure that the urinal belongs to specific resident and prevent switching which can cause cross contamination and infection. The DSD stated the Resident 137's urinal should have been labeled with Resident 137's name and the date it was changed to ensure that the urinal belongs to Resident 137 and that it was changed. The DSD stated that if the urinal did not have Resident 137's name and the date it was changed the staff would not know who it belongs to or if it was new which placed the resident at risk for acquiring UTI due to cross contamination (transfer of bacteria or other contaminants from one surface to another due to unsanitary handling procedures).<br><br>During an interview on 4/10/2026 at 9:09 a.m. with the DON, the DON stated that urinals are changed weekly on Sundays during the night shift CNAs and should be labeled with the resident name and the date provided to the resident to ensure that the urinal was not old and which resident it belongs to. The DON stated that Resident 137's urinal should have been labeled with Resident 137's name and the date provided to ensure that the urinal belongs to the resident and avoid switching urinal with other residents which placed Resident 137 at risk for acquiring infection or UTI due to cross contamination.<br><br>During a review of the facility's P&P titled, Disinfection of Bedpans and Urinals, last reviewed on 3/18/2026, the P&P indicated that bedpans and urinals are handled in a manner that prevent the spread of infection through personal equipment. The P&P further indicated that bedpans and urinals are for single resident use only.<br><br>3b. During a review of Resident 51's AR, the AR indicated the facility admitted the resident on 3/20/2026, with diagnoses including hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) and hemiparesis (partial paralysis of the arm, leg, and trunk on the same side of the body) following cerebrovascular disease (CVA-stroke, loss of blood flow to a part of the brain) affecting left dominant side, peripheral vascular disease (PVD - a slow progressive narrowing of the blood flow to the arms and legs), and generalized muscle weakness.<br><br>During a review of Resident 51's H&P, dated 3/22/2026, the H&P indicated the resident did not have the capacity to understand and make decisions.<br><br>During a review of Resident 51's MDS, dated [DATE], the MDS indicated Resident 51 had severely impaired cognition (mental action or process of acquiring knowledge and understanding) and was usually able to understand and make his needs known. The MDS further indicated Resident 51 required substantial/maximal assistance to total assistance from staff with all activities of daily living (ADLs - basic tasks that must be accomplished every day for an individual to thrive) and that the resident was frequently incontinent of bladder.<br><br>During a review of Resident 51's care plan (CP) on bowel and bladder incontinence initiated on 3/25/2026, the CP indicated to monitor/document for signs and symptoms of UTI and monitor/document/report as needed any possible causes of incontinence such as bladder infection, loss of bladder tone, weakening of control muscles, decreased bladder capacity and medication side effects as a few of the interventions to minimize the risk for infection via prompt recognition of symptoms of UTI.<br><br>During a review of Resident 51's Bowel and Bladder Assessment form dated 3/20/2026, the Bowel and Bladder Assessment form indicated that resident was incontinent of bowel and bladder.<br>(continued on next page) |

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| F 0690<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During a concurrent observation and interview on 4/6/2026 at 9:45 a.m. with CNA 8, inside Resident 51's room, CNA 8 stated that the resident's urinal was hanging on the right side of the bed on a urinal holder and did not indicate Resident 51's name. CNA 8 stated that urinals are changed every week on Sundays by the night shift CNA and as needed if soiled and should be labeled with the resident's name and the date it was changed. CNA 8 stated that Resident 51's urinal should have been labeled with the resident's name and the date it was changed to prevent switching of the urinals which can cause contamination and infection.<br><br>During an interview on 4/9/2026 at 2:23 p.m. with the DSD, the DSD stated that the facility practice in changing the urinals is every Sunday by the night shift CNAs and should be labeled with the resident's name and the date it was changed to ensure that the urinal belongs to specific resident and prevent switching which can cause cross contamination and infection. The DSD stated the Resident 51's urinal should have been labeled with Resident 51's name and the date it was changed to ensure that the urinal belongs to Resident 51 and that it was changed. The DSD stated that if the urinal did not have Resident 51's name and the date it was changed the staff would not know who it belongs to or if it was new which placed the resident at risk for acquiring UTI due to cross contamination.<br><br>During an interview on 4/10/2026 at 9:09 a.m. with the DON, the DON stated that urinals are changed weekly on Sundays during the night shift CNAs and should be labeled with the resident name and the date provided to the resident to ensure that the urinal was not old and which resident it belongs to. The DON stated that Resident 51's urinal should have been labeled with Resident 51's name and the date provided to ensure that the urinal belongs to the resident and avoid switching urinal with other residents which placed Resident 51 at risk for acquiring infection or UTI due to cross contamination.<br><br>During a review of the facility's P&P titled, Disinfection of Bedpans and Urinals, last reviewed on 3/18/2026, the P&P indicated that bedpans and urinals are handled in a manner that prevent the spread of infection through personal equipment. The P&P further indicated that bedpans and urinals are for single resident use only.<br><br>4. During a review of Resident 123's AR, the AR indicated that the facility originally admitted the resident on 1/28/2028, and readmitted on [DATE], with diagnoses including Diabetes Mellitus (DM - a disorder characterized by difficulty in blood sugar control and poor wound healing), neuromuscular dysfunction of bladder (the nerves that tell your bladder when to squeeze or relax are damaged, causing poor control over storing or emptying urine), hypertension (HTN - high blood pressure).<br><br>During a review of Resident 123's H&P, dated 4/6/2026, the H&P indicated that Resident 123 had a capacity to make and understand decisions, daily needs.<br><br>During a review of Resident 123's MDS, dated [DATE], the MDS indicated Resident 123 required substantial/maximal assistance (helper does more than half the effort) with toileting hygiene, shower self, lower body dressing, and dependent (helper does all of the effort) with putting on/taking off footwear.<br><br>During an observation and interview on 4/6/2026 9:48 a.m. with Resident 123 inside Resident 123's room, observed Resident 123's indwelling catheter drainage tubbing coiled in a loop.<br><br>During a concurrent observation and interview on 4/6/2026 12:27 p.m. with CNA 2 and CNA 4 inside Resident 123's room, CNA 2 stated when providing catheter care, catheter must be placed above the floor, and below resident's bladder level, the drainage tubbing must be straight, without coils. CNA 2<br>(continued on next page) |

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| F 0690<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | stated that Resident 123's catheter tubbing was coiled, which may potentially cause urine back flow, and put resident at risk for UTI.^<br><br>During an interview on 4/10/2026 at 11:34 a.m. with the DON, the DON stated the indwelling urinary catheter tubing must be maintained in straight, unobstructed position. The DON stated that coiled tubing may interfere with proper urine drainage and create backflow, which could increase the of urinary retention, discomfort, and potential CAUTI.^<br><br>5a. During a review of Resident 3's AR, the AR indicated that the facility originally admitted the resident on 7/29/2019, and readmitted to the facility on [DATE], with diagnoses including hydronephrosis (the swelling of a kidney caused by a backup of urine (pee) that cannot drain properly into the bladder), neuromuscular dysfunction of bladder (the swelling of a kidney caused by a backup of urine (pee) that cannot drain properly into the bladder), schizoaffective disorder (a mental illness that can affect thoughts, mood, and behavior).<br><br>During a review of Resident 3's H&P, dated 10/30/2025, the H&P indicated that Resident 3 had the capacity to understand and make decisions.<br><br>During a review of Resident 3's MDS, 11/19/2025, the MDS indicated that Resident 3 was cognitively intact. Resident 3 was dependent to staff with all activities of daily living (ADL).<br><br>During an observation on 4/6/2026 at 11:29 a.m., inside Resident 3's room, observed Resident 3 urinary catheter draining clear, yellow urine.^<br><br>During a concurrent interview and record review on 4/8/2026 at 9:05 a.m. with RN 1, RN 1 reviewed Resident 3's Order Summary Report. The Order Summary Report indicated a physician's order on 12/5/2025 for routine urinary catheter changes every 30 days. RN 1 reviewed Resident 3's TAR for March 2026. TAR indicated no documentation of Resident 3's catheter consistent with physician's order. RN 1 stated it was important to follow physician orders for catheter care, including timely catheter changes as ordered, to ensure residents safety and prevent UTI.<br><br>5b. During a review of Resident 61's AR, the AR indicated that the facility admitted the resident on 4/21/2023, and readmitted on [DATE], with diagnoses including Huntington disease (inherited condition that affects movement, thinking and behavior), hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) and hemiparesis (weakness or the inability to move on one side of the body) of the right side, obstructive uropathy (a blockage in the urinary system that prevents urine from flowing freely, causing it to back up into the kidneys).<br><br>During a review of Resident 61's H&P, dated 3/4/2026, the H&P indicated that Resident 61 had the capacity to understand and make decisions.<br><br>During a review of Resident 61's MDS, dated [DATE], the MDS indicated that Resident 61 was dependent (helper does all of the effort) with eating, oral hygiene, toileting hygiene, lower body dressing, putting on/taking off footwear, personal hygiene.<br><br>During a concurrent interview and record review on 4/8/2026 at 9:15 a.m. with RN 1, RN 1 reviewed Resident 61's Order Summary Report. The Order Summary Report indicated a physician's order on 12/6/2025 for routine urinary catheter change every 30 days. RN 1 reviewed Resident 61's TARs for months of February and March 2026. TARs indicated no documentation of Resident 61's catheter<br>(continued on next page) |

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| F 0690<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | consistent with physician's order. RN 1 stated it was important to follow physician orders for catheter care, including timely catheter changes as ordered, to ensure residents' safety and prevent UTI.<br><br>During an interview on 4/10/2026 at 9:00 a.m. with the DON, the DON stated that failure to follow physician's order for catheter change schedule may result in prolonged catheter use beyond recommended timeframes, increasing the risk for UTI, catheter blockage, and discomfort.^<br><br>During a review of facility's P&P, titled Incontinence, dated 12/19/2022, the P&P indicated, Residents that are incontinent of bladder or bowel will receive appropriate treatment to prevent infections and to restore continence to the extent possible. |

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| | 056056 | A. Building<br>B. Wing | 04/10/2026 |

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| The Meadows on Sunset Post Acute | 5154 Sunset Blvd<br>Los Angeles, CA 90027 |

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| F 0700<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents' bed rails (metal or plastic bars or guards attached to the sides of a bed to act as a barrier or support) prior to installation for three of three sampled residents (Residents 96, 85, and 5) reviewed for bed rails by failing to ensure: 1. Resident 96's use of bilateral half (1/2) side/bed rail (or half-length rail) is a safety device for hospital-style beds that covers only a portion of the bed's side, usually the top half near the headboard) had a/an: -Physician's order -Current consent, the resident was readmitted to the facility on [DATE], the consent on the electronic healthcare record was from 9/13/2025 -Correct care plan, the care plan on the electronic healthcare record was for bilateral 1/4 side rail. 2. Resident 85's use of bilateral grab bars (often called aˆbed assist railˆorˆbed handle) is a sturdy metal handle or railing installed on a bed to provide stability and support) had a/an: -Physician's order; -Informed consent; -Care plan on its use. -The bedrail assessment done on 3/10/2026 was for a 1/4 bilateral side rails not for a grab bar. 3. Resident 5's use of bilateral 1/2 side rail had a/an: -Clarification on the resident's use of side rails with the physician, there were 2 orders one for bilateral 1/2 side rails (which was applied) and one for bilateral 1/4 side rails (not applied). -Indicate what the consent was for. -Asses quarterly the use of the side rails. -Develop and implement a care plan on bilateral 1/2 side rails, the care plan was for bilateral 1/4 side rail. These deficient practices placed the residents at risk for potential accident such as a body part being caught between the rails, falls if a resident attempts to climb over, around, between, or through the rails. Findings: During a review of Resident 96's admission Record (AR), the AR indicated the facility admitted the resident on 7/30/2021, and readmitted the resident on 1/14/2026, with diagnoses of dementia (a progressive state of decline in mental abilities), epilepsy (a brain disorder characterized by recurring, unprovoked seizures caused by sudden, temporary bursts of abnormal electrical activity), and anxiety disorder (a mental health condition characterized by excessive, uncontrollable, and persistent fear or worry that interferes with daily life). During a review of Resident 96's History and Physical (H&P), dated 9/13/2025, the H&P indicated the resident did not have the capacity to understand and make decisions. During a review of Resident 96's Minimum Data Set (MDS - a resident assessment tool), dated 5/29/2025, the MDS indicated the resident had the ability to make self-understood and understand others and had severe cognitive impairment (a profound loss of mental capacity-such as memory, reasoning, and communication-that prevents a person from living independently). The MDS indicated the resident needed substantial/maximal assistance on mobility and activities of daily living (ADLs - activities such as bathing, dressing and toileting a person performs daily). During a review of Resident 96's Order Summary Report, dated 4/8/2026, the OSR did not indicate any order for bed rails. During a review of Resident 96's Restraint Informed Consent Form (RICF), dated 9/13/2025, the RICF indicated a consent for side rails. During a review of Resident 96's Fall Risk (FR), dated 1/15/2026, the FR indicated the resident was at risk for falls. During a review of Resident 96's Care Plan (CP) Report titled, Side railsˆmanagement. Risk for entrapment and impairment in skin discoloration related to quarter (1/4) bilateralˆside rails (a short, roughly 18-inch safety bar attached to the side of a hospital bed, typically near the headboard)ˆas an enabler for mobility and repositioning, last revised on 1/19/2026, the CP indicated an intervention to obtain informed consent. During a concurrent observation and interview on 4/7/2026, at 3:27 p.m., with Licensed Vocational Nurse (LVN) 9, inside Resident 96's room, observed Resident 96 had bilateral 1/2 bed rails up. LVN 9 stated the resident uses the bed rail for mobility. During a concurrent interview and record review on 4/7/2026 at 3:30 p.m. with Registered Nurse (RN) 1, Resident 96's OSR, FR, Consent, and CP were reviewed. RN 1 stated the resident does not have any order for bed rails, and the consent that was on the chart was<br>(continued on next page) |

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| F 0700<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | from 9/13/2025, the resident was readmitted to the facility on [DATE] and they should have obtained a new consent for the bilateral 1/2 bed rail. RN 1 also stated the care plan developed was for a 1/4 bilateral bed rail. RN 1 stated it was important have a physician's order on the use of 1/2 bilateral bed rail to ensure its safe use and to have an updated consent on the use of 1/2 bedrail to ensure the resident/representative are still agreeing with the proposed treatment and to honor their right to informed consent. RN 1 stated it was important to have an accurate care plan on the use of bed rails as it comes in different sizes or lengths. During an interview on 4/10/2026 at 8:10 a.m. with the Director of Nursing (DON), the DON stated Resident 96's use of bilateral 1/2 bed rails should have a physician's order, latest informed consent and correct, accurate care plan to ensure its safe use. The DON stated the bed rails can cause accidents to residents, that is why it should have all the components necessary to ensure its safe use. The DON stated the four components are physician's order, informed consent, bed rail assessment for entrapment (a dangerous, sometimes fatal, situation where a person using a hospital-style bed or a bed with rails becomesˆcaught, stuck, or tangled in the gapsˆbetween the mattress and the bed rails, headboard, footboard, or within the rails themselves), and a care plan. During a review of Resident 85's AR, the AR indicated the facility admitted the resident on 3/10/2026, with diagnoses including hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) and hemiparesis (weakness on one entire side of the body), dementia, and muscle weakness. During a review of Resident 85's H&P, dated 3/11/2026, the H&P indicated the resident did not have the capacity to understand and make decisions. During a review of Resident 85's MDS, dated [DATE], the MDS indicated the resident usually had the ability to make self-understood and sometimes had the ability to understand others and had severe cognitive impairment. The MDS indicated the resident was dependent to needing supervision assistance on mobility and ADLs. During a review of Resident 85' OSR, dated 4/8/2026, the OSR did not indicate an order for bilateral grab bars. During a review of Resident 85's Physician Document Informed Consent (PDIC), dated 3/10/2026, the PDIC indicated a consent for 1/4 bilateral upper side rails. During a review of Resident 85's FR, dated 3/10/2026, the FR indicated the resident was at risk for falls. During a review of Resident 85's Bed Rails (BR), dated 3/10/2026, the BR indicated an assessment for 1/4 bed rails. During a concurrent observation and interview on 4/7/2026, at 3:17 p.m., with Certified Nursing Assistant (CNA) 13, inside Resident 85's room, observed Resident 85 with bilateral upper grab bars on. CNA 13 stated the resident uses the grab bars for mobility. During a concurrent interview and record review on 4/7/2026 at 3:30 p.m. with RN 1, Resident 85's OSR, PDIC, FR, and BR were reviewed. RN 1 stated Resident 85's grab bars should have a physician's order, bed rail assessment, informed consent, and a care plan to ensure its safe use. RN 1 stated she found an assessment but it was intended for 1/4 bed rails not for a grab bar. During an interview on 4/10/2026 at 8:10 a.m. with the DON, the DON stated Resident 85's use of bilateral grab bars should have a physician's order, informed consent, bed rail assessment and a care plan to ensure its safe use. The DON stated the bed rails/grab bars can cause accidents to residents, that is why it should have all the components necessary to ensure its safe use. The DON stated the four components are physician's order, informed consent, bed rail assessment for entrapment, and a care plan. During a review of Resident 5's AR, the AR indicated the facility admitted the resident on 10/4/2025, with diagnoses including abnormalities of gait (a person's specific manner or style of walking, running, or moving on foot) and mobility, weakness, and disorders of bone. During a review of Resident 5's MDS, dated [DATE], the MDs indicated the resident had the ability to make self-understood and understand others and had intact cognition (having a clear, sharp, functioning mind that allows a person to think, learn, remember, and make decisions effectively). The MDS indicated the resident was dependent to needing supervision assistance on mobility and ADLs. During a review of Resident 5's OSR, dated 12/15/2025, the OSR indicated an order for -Bed rails 1/2 as an enabler for turning and repositioning in bed. -Bed rails 1/4 as an enabler for turning and repositioning in bed.ˆ During a review of Resident 5's RICF, dated 12/16/2025, the RCIF did not indicate what restraint was consented for. During a<br>(continued on next page) |

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| F 0700<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | review of Resident 5's GHC-Bed Safety Evaluation (BSE), dated 12/15/2025, the BSE indicated that there is no bed rail(s) to be used. During a review of Resident 5's BR, dated 4/7/2026, the BR indicated an assessment for 1/4 bed rails. During a review of Resident 5's CP Report titled Resident/Patient requires assistance/is dependent for mobility related to: Generalized weakness, initiated on 10/7/2025, the CP indicated a goal of resident will utilize bed rail(s) 1/4 side rails with assistance for turning and repositioning while in bed. During a concurrent observation and interview on 4/7/2026 at 4:02 p.m. with LVN 4, inside Resident 5's room, observed Resident 5 had bilateral 1/2 bed rails on. LVN 4 stated the resident uses them for mobility. During a concurrent interview and record review on 4/8/202 at 7:44 a.m., with RN 1, Resident 5's OSR, RICF, BSE, BR and CP were reviewed. RN 1 stated Resident 5's physician orders should have been clarified by the licensed nurses because there were two active orders, one for 1/2 bilateral bed rail which is applied and a 1/4 bilateral bed rail which is not applied to the resident. RN 1 stated the informed consent should specify what bed rails they were consenting for, the consent was not filled out completely, bed rails assessment should be done quarterly as needed. RN 1 stated the bed rail assessment was done for the second quarter of 2026; however, the first quarter bed rail assessment was not done. RN 1 stated the care plan was for 1/4 bilateral bed rail, the resident had 1/2 bilateral bed rail. RN 1 stated it was important to clarify the physician's order because there were multiple sizes of bed rails in the facility in use and each has unique considerations for safe use. RN 1 stated a completed consent helps the residents/representative understand the risks and benefit of the bed rail applied and bed rail assessments should be done quarterly to evaluate its safe use. RN 1 also stated a specific and accurate care plan provides a framework of care to be provided to the resident to achieve its intended goal. During an interview on 4/10/2026 at 8:10 a.m. with the DON, the DON stated Resident 5's use of bilateral 1/2 bed rails should have been clarified with the physician because there were two orders, the informed consent should have been filled out completely specifying what the consent was for, the bed rail assessment should have been done quarterly and an accurate care plan should have been developed and implemented to ensure its safe use. The DON stated the bed rails can cause accidents to residents, that is why it should have all the components necessary to ensure its safe use. The DON stated the four components are physician's order, informed consent, bed rail assessment for entrapment, and a care plan. During a review of the facility's recent policy and procedure (P&P) titled, Proper Use of Bed Rails, last reviewed on 3/18/2026, the P&P indicted it is the policy of this facility to utilize a person-centered approach when determining the use of bed rails. Appropriate alternative approaches are attempted prior to installing or using bed rails. If bed [NAME] are used, the facility ensures correct installation, use, and maintenance of the rails. Definitions: Bed Rails are adjustable metal or rigid plastic bars that attach to the bed. They are available in a variety of types, shapes, and sizes ranging from full to one-half, one-quarter, or one-eight lengths. Also, some bed rails are not designed as part of the bed by the manufacturer and may be installed on or used along the side of a bed. Examples of bed rails include, but are not limited to side rails, bed side rails, safety rails, grab bars and assist bars. Policy Explanation and Compliance Guidelines: Resident Assessment 2. The resident assessment must include an evaluation of the alternatives that were attempted prior to the installation or use of a bed rail and how these alternatives failed to meet the resident's assessed needs. 3. The resident assessment must also assess the resident's risk from using bed rails. Examples of the potential risks with the use of bed risks include: a. Accident hazards (e.g., falls, entrapment, and other injuries sustained from attempts to climb over, around, between, or through the rails, or over the footboard) . Informed Consent Informed consent from the resident or resident representative must be obtained after appropriate alternatives have been attempted prior to installation and use of bed rails. This information should be presented in an understandable manner, and consent given voluntarily, free from coercion. Ongoing Monitoring and Supervision 16. Responsibilities of ongoing monitoring and supervision are specified as follows: a. Direct care staff will be responsible for care and treatment in accordance with the plan of care. b. A nurse assigned to<br>(continued on next page) |

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| F 0700<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | the resident will complete reassessments in accordance with the facility's assessment schedule, but not less than quarterly, upon a significant change in status, or change in the type of bed/mattress/rail. During a review of the facility's recent P&P titled, Assessment Frequency/Timeliness, last revised 3/18/2026, the P&P indicated the purpose of this policy is to provide a system to complete standardized assessments in a timely manner, according to the current Resident Assessment Instrument (RAI) Manual (the official, comprehensive guide for nursing homes on how to assess, care for, and track the health of residents). Policy Explanation and Compliance Guidelines: 4. A quarterly review assessment will be completed no less than once every three months. It must be completed within 92 days of the Assessment Reference Date (ARD, the designated snapshot date or deadline day that defines the end of a 7-day observation period for a resident's clinical assessment) of the most recent Omnibus Budget Reconciliation Act of 1987 (OBRA) assessment (a comprehensive, federally mandated evaluation of a nursing home resident's physical, mental, and functional health). |

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| F 0760<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure that residents are free from significant medication errors.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure residents were free of any significant medication errors (means the observed or identified preparation or administration of medications or biologicals which are not in accordance with the prescriber's order, manufacturer's specifications, and accepted professional standards) for two of two sampled residents (Resident 8 and 2) reviewed for insulin (a hormone that removes excess sugar from the blood, can be produced by the body or given artificially via medication) use by failing to rotate subcutaneous (sq, beneath the skin) insulin administration sites. This deficient practice had the potential for adverse effect (unwanted, unintended result) of the same site subcutaneous administration of insulin such as excessive bruising, lipodystrophy (abnormal distribution of fat) and cutaneous amyloidosis (is a condition in which clumps of abnormal proteins called amyloids build up in the skin). Findings: 1. During a review of Resident 8's admission Record (AR), the AR indicated the facility admitted the resident on 4/18/2024, with diagnosis of type 2 diabetes mellitus (DM - a disorder characterized by difficulty in blood sugar control and poor wound healing). During a review of Resident 8's History and Physical (H&P), dated 8/10/2025, the H&P indicated the resident had the capacity to understand and make decisions. During a review of Resident 8's Minimum Data Set (MDS - a resident assessment tool), dated 7/21/2025, the MDS indicated the resident had the ability to make self-understood and understand others and had intact cognition (having a clear, sharp, and functioning mind that allows a person to think, learn, remember, and make decisions effectively). The MDS indicated the resident was on a high-risk drug class hypoglycemic medication (prescription medicines taken by mouth toˆlower high blood sugar levelsˆin people with type two diabetes). During a review of Resident 8's Order Summary Report (OSR), dated 2/27/2025, the OSR indicated an order for Insulin Glargine Subcutaneous Solution (Insulin Glargine). Inject 19 unit subcutaneously at bedtime for diabetes mellitus type 2 (DM II) Hold if blood glucose (BG) less than (< )100 milligrams per deciliter (mg/dl., measures the concentration of sugar (glucose) in your blood) During a review of Resident 8's Location of Administration Report (LAR) of Insulin from 1/1/2026 to 1/31/2026, the LAR indicated Insulin Glargine Subcutaneous Solution was administered on: 1/2/2026 at 8:33 p.m. on the Abdomen – Left Upper Quadrant (LUQ) 1/3/2026 at 8:12 p.m. on the Abdomen – LUQ 1/6/2026 at 8:06 p.m. on the Abdomen – Right Lower Quadrant (RLQ) 1/7/2026 at 11:14 p.m. on the Abdomen - RLQ 1/8/2026 at 8:57 p.m. on the Abdomen – RLQ 1/15/2026 at 10:09 p.m. on the Abdomen – Right Upper Quadrant (RUQ) 1/16/2026 at 9 p.m. on the Abdomen - RUQ 1/17/2026 at 9:25 p.m. on the Abdomen - RLQ 1/18/2026 at 9:02 p.m. on the Abdomen - RLQ 1/19/2026 at 10:42 p.m. on the Abdomen – RLQ 1/20/2026 at 9:45 p.m. on the Abdomen – Left Lower Quadrant (LLQ) 1/21/2026 at 8:16 p.m. on the Abdomen – LLQ During a review of Resident 8's Care Plan (CP) Report regarding the resident having a diagnosis of diabetes insulin dependent, last revised on 4/19/2024, the CP indicated the goal of the resident will be free of all signs and symptoms of hypo (low)/hyperglycemia (high blood sugar level). During a concurrent interview and record review on 4/7/2026, at 2:53 p.m., with RN 1, Resident 8's OSR, LAR, and CP were reviewed. RN 1 stated there was an order for Insulin Glargine Subcutaneous Solution (Insulin Glargine). Inject 19 unit subcutaneously at bedtime for DM II Hold if BG < 100 mg/dl. RN 1 stated there were multiple instances on 1/2026 that the insulin administration sites was not rotated. RN 1 stated that insulin was a significant medication. RN 1 stated insulin administration sites should be rotated to prevent Resident 8 from developing skin lumps that can affect the absorption of insulin. RN 1 stated the resident can suffer from hypo/hyperglycemia if the insulin was administered on sites with skin lumps. RN 1 stated not rotating insulin administration sites is a medication error. During an interview on 4/10/2026 at 8:10 a.m. with the Director of Nursing (DON), the DON stated the sites of insulin administration for Resident 8 should have been rotated to prevent lipodystrophy. The DON stated<br>(continued on next page) |

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| F 0760<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | insulin is considered as a significant medication and when administered on sites of lipodystrophy can cause malabsorption of insulin that can cause hypo/hyperglycemia on residents. The DON stated not rotating insulin administration sites as a medication error. The DON stated the licensed staff did not follow the policy and procedure (P&P) titled Timely Administration of Insulin and the facility-provided Highlights of Prescribing Information (HPI) on the use of Lantus.<br><br>2. During a review of Resident 2's AR, the admission Record indicated the facility originally admitted the resident on 4/9/2019, and readmitted the resident on 6/3/2025, with diagnoses including DM 2, difficulty in walking, and generalized muscle weakness. During a review of Resident 2's H&P, dated 6/4/2025, the H&P indicated had the capacity to understand and make decisions. During a review of Resident 2's MDS, dated [DATE], the MDS indicated the resident had an intact cognition (mental action or process of acquiring knowledge and understanding) and was able to understand and make his needs known. The MDS further indicated that the resident received insulin. During a review of Resident 2's Order Summary Report, dated 4/10/2026, the Order Summary Report indicated the following physician's orders:<br><br>2/3/2026: Insulin lispro injection solution (a short acting insulin) 100 unit per milliliter (unit/ml – a unit of measurement) inject subcutaneously before meals give no longer than 15 minutes before meals inject as per sliding scale: if blood sugar (BS – level of sugar in the blood) is 70 to 150 = seven (7) units; if BS is less than 70 give orange juice and call the physician; if 151 to 200 give eight (8) units; if 201 to 250 give (9) units; if 251 to 300 give ten (10) units; if 301 to 350 give 11 units; if more than 350, give 12 units and call the physician.<br><br>2/11/2026: 2/11/2026: Lantus subcutaneous solution (a long-acting insulin) 100 unit/ml (insulin glargine) inject 31 units subcutaneously at bedtime for DM 2. During a review of Resident 2's CP on diabetes, initiated on 4/10/2019, the CP indicated to administered medications as ordered as one of the interventions to keep resident free of all signs and symptoms of hypoglycemia (low level of sugar in the blood) or hyperglycemia (high level of sugar in the blood). During a concurrent interview and record review on 4/9/2026 at 2:22 p.m. reviewed Resident 2's physician's orders, care plan, and location of administration sites for insulin lispro and Lantus for 3/2026 with Registered Nurse (RN) 1. RN 1 stated Resident 2 had a physician's order for Lantus and insulin lispro and were administered as follows:<br><br>Insulin lispro injection solution 100 unit/ml 3/3/26 12:24 p.m. sq right arm (RA) 3/3/26 4:33 p.m. sq RA 3/15/26 5:18 p.m. sq left arm (LA) 3/16/26 6:19 a.m. sq LA 3/16/26 4:17 p.m. sq RA 3/17/26 5:23 a.m. sq RA 3/17/26 4:45 p.m. sq RA 3/18/26 5:23 a.m. sq left lower quadrant (LLQ) 3/19/26 5:46 a.m. sq LLQ 3/25/26 12:25 p.m. sq left upper quadrant (LUQ) 3/25/26 5:22 p.m. sq LUQ 3/30/26 12:21 p.m. sq LLQ 3/30/26 5:08 p.m. sq LLQ Lantus subcutaneous solution: 3/13/26 8:58 p.m. sq RA 3/14/26 10:07 p.m. sq RA 3/16/26 ˆ 9:00 p.m. sq RA 3/17/26 11:08 p.m. sq RA<br><br>RN 1 stated that the licensed nurses did not rotate the insulin administration sites. RN 1 stated that the administration sites for insulin should be rotated per standards of practice, manufacturer's guidelines, and per policy to prevent lumps in the skin which can affect the absorption of insulin. RN 1 stated the location of administration sites for Resident 2's Lantus and insulin aspart were not rotated. RN 1 stated that Resident 2's administration sites should have been rotated to prevent lumps on the resident's skin affecting the absorption of insulin which may lead to hyperglycemia or hypoglycemia. RN 1 stated that not rotating Resident 2's insulin administration sites can be considered a medication error by not following the manufacturer's guidelines and professional standards of care. During a concurrent interview and records review on 4/10/2026 at 8:30 a.m., reviewed Resident 2's<br>(continued on next page) |

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| F 0760<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | physician's orders, and Location of Administration sites for Lantus and insulin lispro with the DON. The DON stated insulin is considered a significant medication. The DON stated that Resident 2's insulin lispro and Lantus administration sites were not rotated for 3/2026. The DON stated that the insulin should be administered on the clean sites and rotated to prevent lipodystrophy. The DON stated that if the insulin was administered on the sites with lipodystrophy, the insulin will not be properly absorbed and not be effective which could lead to hypoglycemia or hyperglycemia. The DON stated that not rotating the insulin administration sites can be considered a significant medication error by not following the manufacturer's guideline and standards of practice.<br><br>During a review of the facility's recent P&P titled, Timely Administration of Insulin, last reviewed on 3/18/2026, the P&P indicated it is the policy of this facility to provide timely administration of insulin in order to meet the needs of each resident and to prevent adverse effects on a resident's condition. During a review of the facility's recent P&P titled, Medication Errors, last reviewed on 3/18/2026, the P&P indicated it is the policy of this facility to provide protections for the health, welfare, and rights of each resident by ensuring residents receive care and services safely in an environment free of significant medication errors. Medication error means the observed or identified preparation or administration of medications or biologicals which is not in accordance with the prescriber's order; manufacturer's specifications (not recommendations) regarding the preparation and administration of the medication or biological; or accepted professional standards and principles which apply to professionals providing services. During a review of the facility-provided HPI on the use of Lantus (insulin glargine injection) for subcutaneous injection, with initial U.S. approval in 2000, the HPI indicated to rotate injection sites to reduce the risk of lipodystrophy.<br><br>During a review of the facility provided HPI on the use of insulin lispro injection, with initial approval of 1996, the HPI indicated that injection sites should be rotated within the same region from one injection to the next to reduce the risk of lipodystrophy. |

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| | 056056 | A. Building<br>B. Wing | 04/10/2026 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| The Meadows on Sunset Post Acute | 5154 Sunset Blvd<br>Los Angeles, CA 90027 |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.<br><br>Based on observation, interview, and record review the facility failed to: 1. Label and date fresh foods held in the kitchen walk-in refrigerator. 2. Discard leftover food held in the kitchen walk-in refrigerator beyond seven days. 3. Record open dates on personal food items held in the resident refrigerator. These deficient practices had the potential to result in harmful bacterial growth that could lead to foodborne illness (a disease caused by consuming food or drinks that are contaminated by germs or toxins) in 125 of 132 medically compromised residents receiving meals from the kitchen and those who had food stored in the patient refrigerator. Findings: 1. During an observation on 4/6/2026 at 8:05 a.m. the walk-in refrigerator contained two 22-quart storage containers of mandarin oranges, two dome lids containing each a plate of lettuce, tomato, deli meat and boiled eggs, and an uncovered plastic food container of whole, raw brussels sprouts with no label identifying the contents, received or preparation date. During an interview with Dietary Supervisor (DS) on 4/7/2026 at 11:45 a.m. DS stated that unlabeled foods may increase the risk of food spoilage, cross-contamination, potentially leading to resident illness and decreased food and nutrient quality, especially lettuce. During a review of the facility's policy and procedure (P&P) titled, Food Safety and Food Storage, dated 11/4/2024, the P&P indicated elements of food safety practices includes the storage of food in a manner that helps prevent deterioration or contamination of the food, including growth of microorganisms, and that facility staff are to practice labeling, dating, and monitoring of refrigerated food, and keeping foods covered or in tight containers. 2. During an observation on 4/6/2026 at 8:05 a.m. the walk-in refrigerator contained a metal pan and lid labeled, Mix Fruit, dated 3/30/2026. The contents of the pan contained chunks of fruit white and golden yellow in color and was suspended in liquid. During a review of the facility's P&P posted in the kitchen titled, Food Storage and Retention Guide, dated 2017, the P&P indicated ready-to-eat foods, including canned fruits, are to be kept refrigerated up to 7 days. Day 1 is the date of preparation. During an observation on 4/7/2026, at 10:28 a.m., the same pan of fruit cocktail was observed in the walk-in refrigerator however was now labeled by 4/7/26. During a concurrent interview with the DS, the DS stated that leftovers are usually consumed within 4-6 days. The DS counted the open days of the leftovers, including the opened date as the first date, resulting in the current held time at the ninth day. The DS stated the labeled date was counted incorrectly and that the fruit cocktail should be discarded as it poses a risk for cross-contamination which could make residents sick. 3. During an observation on 4/6/2026, at 9:48 a.m., the resident refrigerator located in the utility room across from Nurse Station 2 contained six bags of food containers, one plastic container with half of a tuna salad sandwich, one plastic container with a half-eaten frosted cake approximately six inches in diameter with no labeled receive dates. The freezer contained 5 frozen pasta dinners, an opened box of individually wrapped ice cream bars, and a half-eaten quart of ice cream, and a pint of ice cream with no resident name, room number, or receive/open date. During an interview on 4/7/2026, at 10:30 a.m., with the Infection Preventionist (IP), the IP was asked how food quality and freshness is qualified and the IP stated, When it goes bad, it either doesn't smell right or look right. The IP was asked if there is a policy to guide monitoring of food items in the resident refrigerator where IP stated, I'm not sure. During a concurrent review of previous findings, the IP confirms there were missing dates on food items observed in the refrigerator. The IP reviewed the P&P titled, Outside Food Refrigerator, the IP stated that foods with a manufacturer printed expiration or use by date are exempt from the three-day policy, however no such documentation is detailed in the policy. Further review of store-bought items, i.e., tuna sandwich and cake, demonstrated a lack of date printed by the manufacturer. During a concurrent observation, a resealable plastic envelope with chocolates as in the resident refrigerator had no resident name or room number. The IP could not confirm whether this food item belonged to a resident or staff member. During a review of the facility's P&P titled, Outside Food Refrigerator, dated 9/22/2025, the P&P<br>(continued on next page) |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | indicated that food items that are already prepared must be approved per Nursing and labeled with content and dated, and will be thrown away if not consumed within three days. |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide and implement an infection prevention and control program.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to maintain an infection prevention and control program designed to provide safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections by, failing to ensure: 1. Three of three sampled linen carts (linen carts 10, 11, and 12) were kept in good condition that were free of holes, tears, and rips. 2. Linens were free of contamination. This deficient practice had the potential to result in contaminated linens, sheets, towels, and gowns being provided to the residents. 3. Employee COVID-19 (an infectious disease caused by the SARS-CoV-2 virus) Vaccination Policy was updated and matched facility's practice. These deficient practices had the potential to lead to staff confusion, noncompliance with infection control practices, increasing the risk for the spread of infection among residents and within the facility. Findings: a. During a concurrent observation and interview on 4/6/2026 at 9:37 a.m., in Station 1 hallway near rooms [ROOM NUMBERS], linen cart #12's cover had rips, tears, and holes, exposing gowns, linens, sheets, and blankets. Certified Nursing Assistant (CNA) 3 stated this cart belongs to him (CNA 3). CNA 3 stated he (CNA 3) does not know what happened to his (CNA 3) linen cart and why its ripped and torn because he (CNA 3) got it like this from the laundry. CNA 3 stated he (CNA 3) did not tell anyone about the condition of his (CNA 3) linen cart because he (CNA 3) does not know who to take it to. CNA 3 stated it should not be like this and should be covered.<br><br>During a concurrent observation and interview on 4/6/2026 at 9:52 a.m. in Station 1 hallway near room [ROOM NUMBER], linen cart #10's cover had tears, holes, and the top left corner facing the opening of the linen cart was taped. CNA 5 stated this linen cart belongs to her (CNA 5). CNA 5 stated the linen cart has holes, torn, and has been taped on the side. CNA 5 stated she (CNA 5) got it like this from the laundry.<br><br>During a concurrent observation and interview on 4/6/2026 at 10:33 a.m., in Station 1 hallway near room [ROOM NUMBER], linen cart #11's cover had tears and holes. CNA 6 stated this linen cart belongs to her (CNA 6). CNA 6 stated this linen cart is old and has holes. CNA 6 stated they do not have the same linen carts assigned every time, it changes, but they have had it like this for a long time. CNA 6 stated she (CNA 6) has not told anyone about the tears and holes of linen cart cover.<br><br>During a concurrent observation and interview on 4/6/2026 at 11:43 a.m. with CNA 3 in facility's hallway, CNA 3 stated two (2) of 2 linen cart covers were partially torn at the top and the linen was not fully covered. CNA 3 stated not having clean linen cart fully covered, may potentially cause clean linen contamination, infection spread among the residents and cause harm.<br><br>During an interview on 4/9/2026 at 1:52 p.m., with the Laundry Staff (LS) stated she (LS) cleans the linen cart that the CNAs uses. The LS stated some of the linen carts were not in good condition and some of the cart covers were torn and ripped. The LS stated she (LS) has told the Environmental Director (ED) about it and should be able to tell me more.<br><br>During an interview on 4/9/2026 at 2 p.m. with the ED, the ED stated he (ED) noticed on Monday, 4/6/2026, that some of the linen cart covers had holes and tears. The ED stated he (ED) did not see linen cart #12's cover that was ripped. The ED stated linen cart covers with tears, holes, and ripped are not in good condition and it was not acceptable to go out to the stations.<br><br>During a follow-up interview on 4/9/2026 at 2:48 p.m., with the ED, the ED stated when the linen<br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | carts' covers were not in good condition such as rips, tears, and holes, people can be touching and contaminating it and contamination by the walls and the dust in the air. The ED stated the condition of the linen carts was not brought to his (ED) attention until Monday, 4/6/2026. The ED stated linens not covered are an infection control problem.<br><br>During an interview on 4/10/2026 at 8:36 a.m., with the Director of Nursing (DON), the DON stated that the linen carts covering is for infection control. The DON stated she (DON) would discuss it with the Administrator, and the CNAs would keep it in a bag and carry it to the resident room. The DON stated that when the linens are exposed the resident could be wearing dirty gowns and lying on dirty linens and sheets and at risk of exposure to microbes that got on it.<br><br>During a review of the facility's policy and procedure (P&P) titled, Handling Clean Linen, last reviewed and approved on 3/18/2026, the P&P indicated that It is the policy of this facility to handle, store, process, and transport clean linen in a safe and sanitary method to prevent contamination of the linen, which can lead to infection. 2. Linen can become contaminated with pathogens from contact with intact skin or body substances, or from environmental contaminants or contaminated hands.<br><br>b. During a concurrent observation and interview on 4/9/2026 at 1:06 p.m. with LS, in the laundry area, observed LS folding bedsheets and blankets holding them up in the air, and two bedsheets' corners touching the floor. The LS stated the bedsheets got contaminated when touched the floor and could cause infection spread to residents.<br><br>During an interview on 4/9/2026 at 1:15 p.m. with the ED, the ED stated that contaminated linens that touched dirty surfaces, torn and ripped linen cart covers, increase the risk for infection spread among residents.<br><br>During an interview on 4/10/2026 at^8:40 a.m. with the DON, the DON stated all clean linen should be folded and processed on designated clean folding surfaces. The DON stated that using contaminated linens could expose residents to infections and other health problems. ^<br><br>During a review of facility's P&P titled Handling Clean Linen, dated 12/19/2022, the P&P indicated, It is the policy of this facility to handle, store, process, and transport clean linen in a safe and sanitary method to prevent contamination of the linen, which can lead to infection. Clean linens must be transported by methods that ensure cleanliness and protect from dust and soil during intra or inter-facility loading, transport and unloading.<br><br>c. During a concurrent interview and record review on 4/9/2026 at 9:30 a.m. with Infection Preventionist (IP), the facility's P&P titled, Employee COVID-19 Vaccinations, dated 3/13/2023, was reviewed. The IP stated that employees were no longer mandated to receive COVID-19 vaccinations. The IP reviewed the facility's P&P titled, Employee COVID-19 Vaccinations, dated 3/13/2023. The P&P indicated The facility will ensure that all staff (except for staff who have been granted exemptions to the vaccination requirements, or those staff for whom COVID-19 must be temporarily delayed, as recommended by the CDC [Centers for Disease Control and Prevention], due to clinical precautions and considerations) are fully vaccinated or up to date for COVID-19. The IP stated that the facility's written employee COVID-19 vaccination policy had not been updated to reflect the current requirements and practices implemented within the facility.<br><br>During a concurrent interview and record review on 4/9/2026 at 10:35 a.m. with the DON, the facility's P&P titled, Employee COVID-19 Vaccinations, dated 3/13/2023, was reviewed. The DON stated the (continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | facility's current practice did not require employees to receive COVID-19 vaccination. The DON stated the facility's employee COVID-19 vaccination policy had not been updated to reflect current practice. The DON further stated that the written policy not aligning with facility practice may result in unvaccinated staff working without clearly defined infection control precautions, compromising the effectiveness of the Infection Prevention and Control Program ([IPCP] - a mandatory, written safety plan for nursing homes and healthcare facilities designed to stop the spread of infections among residents and staff), and potentially increase the risk of COVID-19 transmission among staff and residents. |

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| F 0563<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Honor the resident's right to receive visitors of his or her choosing, at the time of his or her choosing.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure visitation restrictions were addressed for one (1) of three (3) sampled residents (Resident 41) when the facility was not aware of Resident 41's responsible party's (RP) request for no visitors without the RP's presence. This deficient practice had the potential for Resident 41 to have unwanted visitors that could cause anxiety or distress to the resident. Findings: During a review of Resident 41's admission Record, the admission Record indicated the resident was admitted on [DATE] with diagnoses including end stage renal disease (ESRD - irreversible kidney failure), unspecified dementia (progressive state of decline in mental abilities), hyperlipidemia (abnormally high levels of fat in the blood), anemia (a condition where the body does not have enough healthy red blood cells), pneumonia (an infection/inflammation of the lungs), and nicotine dependence (a physical and mental addiction to tobacco). During a review of Resident 41's History and Physical (H&P), dated 2/23/2026, the H&P indicated Resident 41 lacks capacity to make and understand decisions. The H&P further indicated that Resident 41 has a designated family representative. During a review of Resident 41's Minimum Data Set (MDS - a resident assessment tool), dated 3/2/2026, the MDS indicated the resident has adequate hearing, clear speech and vision, makes self-understood and understands others. The MDS indicated the resident requires extensive assistance from nursing staff with bed mobility, transferring, toileting and personal hygiene, and partial to moderate assistance with eating. During a review of Resident 41's Advance Healthcare Directive Acknowledgement Form, dated 2/24/2026, the Advance Directive Healthcare Directive Acknowledgement Form indicated Resident 41's resident representative is RP 1. During a concurrent interview and record review on 4/8/2026 at 2:24 p.m. with the Business Office Manager (BOM), an email sent from Resident 41's RP 1, dated 3/1/2026, was reviewed. The BOM stated the email indicated a request for Resident 41 to not have any visitors without RP 1's presence and to specifically to alert all Certified Nursing Assistants (CNAs) and Charge Nurses. The BOM stated that upon receiving the email, she (BOM) immediately informed and forwarded a copy of the email to the Social Services Director (SSD). The BOM stated she (BOM) had no knowledge of what happened thereafter. During an interview on 4/8/2026 at 2:35 p.m. with the SSD, the SSD stated that he (SSD) verbally reported the request to the department head, but was unable to elaborate more of the reporting. During an interview on 4/8/2026 at 3:13 p.m. with the Director of Nursing (DON), the DON stated that she (DON) did not know about the email and stated that it is the first time she (DON) had seen the email. The DON stated that she (DON) does not know any residents who have visiting restrictions. During an interview on 4/8/2026 at 3:46 p.m. with Licensed Vocational Nurse (LVN) 4 , LVN 4 stated that he (LVN 4) started working in the facility for two (2) months. LVN 4 stated that he (LVN 4) does not have any knowledge as to any residents requiring visiting restrictions. LVN 4 stated that any request from a resident or a family representative should be reported to the DON so that every member of staff would be notified to prevent unwanted visitors. During interview on 4/9/2026 at 9:17 a.m. with Registered Nurse (RN) 1 , RN 1 stated that she (RN 1) does not know any residents with visiting restrictions. RN 1 stated that there was no documentation made by the SSD regarding visiting restrictions for Resident 41. RN 1 stated that she (RN 1) does not know what the protocol is regarding visiting restrictions. RN 1 stated unwanted visitors can agitate residents and can cause unnecessary distress. During an interview on 4/9/2026 at 10:30 a.m. with the SSD, the SSD stated that requests for visiting restrictions must be communicated to not just the head departments, but also to the front desk and the staff, to make sure the RP's request is addressed to prevent unwanted visitors. During an interview on 4/10/2026 at 8:20 a.m. with the DON, the DON stated that Resident 41's RP's request should have been communicated to all staff. The DON stated the failure to inform staff could lead to unwanted visitors, which could potentially anger residents. During a review of the facility's policy and procedure (P&P) titled, Resident's Rights, last revised on 12/19/2022, the P&P<br>(continued on next page) |

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| F 0563<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | indicated, The resident has the right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility. During a review of the facility's P&P titled, Resident Right to Access and Visitation, last revised on 12/19/2022, the P&P indicated, It is the policy of this facility to support and facilitate the resident's right to receive visitors of their choosing, at the time of their choosing, subject to the resident's right to deny visitation when applicable, and in a manner that does not impose on the rights of other residents. Visitation will be person-centered, consider the residents' physical, mental, and psychosocial well-being, and support their quality of life. |

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| F 0576<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure residents have reasonable access to and privacy in their use of communication methods.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that mail is being delivered to three (3) out of ten (10) sampled residents (Resident 17, Resident 88, and Resident 130) on Saturdays. This deficiency had the potential for residents to feel isolated and worry that their mail might get lost. Findings: During a review of Resident 17's admission Record, the admission Record indicated the facility originally admitted Resident 17 on 6/01/2022 and was readmitted on [DATE] with diagnoses including fusion of spine (a surgical procedure that joins two or more spine bone together into one solid bone to stop painful movement), cellulitis (a skin infection that causes swelling and redness), muscle weakness, asthma (respiratory condition marked by spasms in the bronchi of the lungs causing difficulty in breathing), diabetes mellitus (DM - a disorder characterized by difficulty in blood sugar control and poor wound healing) and major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest). During a review of Resident 17's History and Physical (H&P), dated 10/8/2025, the H&P indicated Resident 17 has the capacity to understand and make decisions. During a review of Resident 88's admission Record, the admission Record indicated the facility originally admitted Resident 88 on 11/10/2021 and was readmitted on [DATE] with diagnoses including Bell's palsy (a condition that causes sudden weakness in the muscles on one side of the face), major depressive disorder, muscle weakness, hypertension (high blood pressure) and dysphagia (difficulty swallowing). During a review of Resident 88's H&P, dated 6/27/2025, the H&P indicated Resident 88 has the capacity to understand others and make decisions. During a review of Resident 130's admission Record, the admission Record indicated the Resident 130 was admitted on [DATE] with diagnoses including cerebral infarction (also know as a stroke, when blood flow to part of the brain is blocked or significantly reduced, causing brain tissue to die from lack of oxygen and nutrients), peripheral vascular disease (a slow, progressive circulation disorder involving the narrowing, blockage, or spasms of blood vessels), facial weakness, DM, anxiety disorder (a mental health disorder characterized by feeling worry or fear that are strong enough to interfere with one's daily activity, and hyperlipidemia (abnormally high levels of fats in the blood). During a review of Resident 130's H&P, dated 1/08/2026, the H&P indicated Resident 130 has the capacity to understand others and make decisions. During an interview on 4/7/2026 at 10:45 a.m. with Resident 17, Resident 88, and Resident 130, the residents stated that they receive their mail on weekdays but not on Saturdays. Residents 17, 88, and 130 stated that they never knew that they could also receive mail on Saturdays until it was brought up during the meeting knowing that business office is always closed on weekends. During an interview on 4/8/2026 at 2:59 p.m. with the Business Office Manager (BOM), the BOM stated her (BOM) workdays are Monday through Friday. The BOM stated that upon receiving the mail, she (BOM) only collects mail for monetary items and forwards the rest to the Activity Director, who is responsible for distributing mail to the residents. The BOM stated that mail delivered on Saturdays is placed in the mailbox by the wall outside the facility or to be handed to the receptionist, and those mails are to be distributed on Mondays. The BOM stated that the office is closed on weekends and does not provide mail to residents on Saturdays. The BOM further stated that business office is the only one who has access to the mailbox.ˆ During an interview on 4/9/2026 at 9:20 a.m. with Activities Director (AD), the AD stated that he (AD) receives the mail from the business office staff and distributes the mail to residents Monday through Friday. The AD stated that on Saturdays, the receptionist receives the mail because the business office is closed on the weekends.ˆ During an interview on 4/9/2026 at 9:33 a.m. with the Receptionist, the Receptionist stated that on Saturdays, the mail carrier delivers the mail to the receptionist. The Receptionist further stated that he (Receptionist) holds the mail until Monday to hand it to BOM because the business office is closed on weekends. The Receptionist further stated mail is not delivered to residents on Saturdays. During an interview on 4/10/2026 at 8:20 a.m. with Director of Nursing (DON), (continued on next page) |

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| The Meadows on Sunset Post Acute | 5154 Sunset Blvd<br>Los Angeles, CA 90027 |

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| F 0576<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | the DON stated the BOM is responsible for the mail and hands it over to the AD which is distributed from Monday through Friday. The DON stated residents do not get their mail on Saturdays because Business Office is closed on the weekends. A review of the facility's policy and procedure (P&P) titled, Resident's Rights, revised on 4/6/2026, the P&P indicated under Information and Communication: The resident has the right to send and receive mail, and to receive letters, packages and other materials delivered to the facility for the resident through a means other than a postal service (.). |

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| | 056056 | A. Building<br>B. Wing | 04/10/2026 |

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| F 0578<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to inform and provide written information to all adult residents concerning the right to accept and refuse medical and surgical treatment and, at the resident's option,ˆtoˆformulate an advance directiveˆ(a legal document indicating resident preference on end-of-life treatment decisions)ˆfor two (2) ofˆfour (4)ˆsampled residents (Resident 12 and 71)ˆ with the Social Services Director (SSD) by failing toˆensure the Advanced Healthcare Directive Acknowledgement Form was completed.ˆˆ This deficient practice violated the resident's rights and/or representative's right to be fully informed of theˆoptionˆto formulate their advanced directives.ˆˆ Findings:ˆ 1. During a review of Resident 12's admission Record (AR), the AR indicated Resident 12 was originally admitted on [DATE] and re-admitted on [DATE] to the facility with a diagnosis of encounter for orthopedic aftercare following surgical amputation (care and treatment a patient receives after an arm, legs, fingers, etc. has been surgically removed); osteomyelitis, unspecified (inflammation of the bone or bone marrow, usually due to infection); Type 2 diabetes mellitus without complications (a disorder characterized by difficulty in blood sugar control and poor wound healing).<br><br>During a review of Resident 12's History and Physical (H&P), dated 2/23/2026, the H&P indicated Resident 12 was alert, oriented x4 (person, place, time, and situation), and has the capacity to consent.<br><br>During a review of Resident 12's Minimum Data Set (MDS - an assessment and care screening tool), dated 12/8/2025, the MDS indicated Resident 12 had the ability to make self-understood and to understand others. The MDS further indicated that Resident 12 had intact cognitive function (normal thinking). The MDS indicated the resident required partial/ moderate assistance with bed mobility, transfer, dressing, toilet use, and personal hygiene.<br><br>During a review of Resident 12's Advanced Healthcare Directive (AHCD) Acknowledgment Form, dated 2/18/2026, the AHCD Acknowledgment Form indicated the resident received information regarding the right to make an Advanced Healthcare Directive however, the information if the resident had an advanced healthcare directive, does not have an advanced directive, or if assistance for formulation of advanced directive was offered to the resident was not filled out.ˆ<br><br>During a concurrent interview and record review on 4/8/2026 at 8:33 a.m. with Registered Nurse (RN) 1, Resident 12's AHCD Acknowledgement Form was reviewed. RN 1 stated the advanced directive acknowledgement form was not completed correctly, as it does not indicate whether the resident has or does not have an advance directive. RN 1 stated that by not documenting whether the resident has an advanced directive, the resident's wishes may not be known or followed. RN 1 stated staff should have verified whether the resident wanted to complete an advance directive or not.<br><br>During a concurrent interview and record review on 4/8/2026 at 11:30 a.m. with the Social Services Director (SSD), Resident 12's AHCD Acknowledgement Form was reviewed. The SSD stated that upon admission the information for Advanced Directive (AD) was collected. The SSD stated that the purpose of AD is to know if they have an advocate to make healthcare decisions for them in case something happens to resident or in an emergency. The SSD stated if the resident does not have an advanced directive and wants to formulate one the SSD will assist with formulating an advanced directive. The SSD stated the AHCD for Resident 12 was not filled out correctly it is missing whether<br>(continued on next page) |

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| F 0578<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | the resident has an advanced directive or not and if assistance for formulation of advanced directive was offered to the resident. The SSD stated that the SSD would not know if the resident had an advanced directive by reviewing the advanced directive acknowledgement form of the resident.<br><br>During an interview on 4/10/2026 at 8:10 a.m. with the Director of Nursing (DON), Resident 12's AHCD Acknowledgement Form was reviewed. The DON stated that on admission the SSD is responsible for completing the AHCD form with the resident and responsible party. The DON stated Resident 12's AHCD form was not accurately filled out. The DON stated the form is missing whether the resident has an advanced directive or does not have one and if assistance for formulation of advanced directive was offered to the resident. The DON stated it is important for the AHCD form to be filled out correctly to fulfill resident wishes.<br><br>2. During a review of Resident 71's AR, the AR indicated the facility admitted the resident on 10/2/2023, with diagnoses including chronic respiratory failureˆ(a long-term condition where the lungs cannot adequately get oxygen into the blood or remove carbon dioxide, lasting longer than a month), major depressive disorderˆ(a mood disorder that causes a persistent feeling of sadness and loss of interest), and anxiety disorderˆ(a mental health condition characterized by excessive, uncontrollable, and persistent fear or worry that interferes with daily life).ˆ<br><br>During a review of Resident 71's H&P, dated 2/1/2026, the H&Pˆindicatedˆthedˆresident had the capacity to consent.ˆ<br><br>During a review of Resident 71's MDS, dated [DATE], the MDS indicated the resident had the ability to make self-understood and understand others, and hadˆintact cognitionˆ(having a clear, sharp, and functioning mind that allows a person to think, learn, remember, and make decisions effectively).ˆˆ<br><br>During a review of Resident 71's AHCD Acknowledgment Form, dated 10/16/2023, the AHCD indicated the resident received information regarding the right to make an Advanced Healthcare Directive however, the information if the resident had an advanced healthcare directive, does not have an advanced directive, or if assistance for formulation of advanced directive was offered to the resident was not filled out. ˆ<br><br>During a review of Resident 71's Care Plan (CP) Report regarding the resident had an establishedˆPhysician Ordersˆfor Life-Sustaining Treatmentˆ(POLST -ˆa form that contains written medical orders for healthcare professionals regarding specific medical treatments that can or cannot be done at the end-of life), (Full Code), last revised onˆ12/28/2023, the CP indicated an intervention to offer opportunity to complete Advanced Directive.ˆ<br><br>During a concurrent interview and record review on 4/7/2026 at 11:31 a.m. with the SSD, Resident 71's AHCD was reviewed. The SSDˆstatedˆthe AHCD was incomplete and they should have checked the second (2nd)ˆboxˆindicatingˆthe resident did not have an advanced directive and would like to receive more information or the third (3rd)ˆboxˆindicatingˆthey did not have an advance directive and does not want any information at this time. The SSDˆstatedˆby checking the 2ndˆor 3rdˆbox of the form they were able to honor their choice or their right to formulate an advanced directive completely.ˆ<br><br>During an interview and record review on 4/10/2026, at 8:10 a.m., with the DON, Resident 71's AHCD was reviewed. The ADON stated the 2ndˆor 3rdˆbox should be checked on the AHCDˆformˆso they know if they have an advanced healthcare directive and follow their wishes. The DONˆstatedˆthe<br>(continued on next page) |

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| F 0578<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | SSDˆis responsible forˆcompleting the advanced directive form. The DONˆstatedˆthe failure of SSD to complete the form had denied the resident of their right to formulate an advanced healthcare directive.ˆ<br><br>During a review of the facility's recent policy and procedureˆ(P&P)ˆtitled, Residents' Rights Regarding Treatment and Advanced Directives, last reviewed on 3/18/2026, the P&P indicated it is the policy of this facility to support and facilitate a resident's right to request, refuse and/or discontinue medical or surgical treatment and to formulate anˆadvanceˆdirective.ˆ<br><br>Policy Explanation and Compliance Guidelines:ˆ<br><br>1. On admission, the facility willˆdetermineˆif the resident has executed an advanced directive, and if not,ˆdetermineˆwhether the resident, if cognitively able to, would like to formulate an advance directive.ˆ<br><br>In the event the resident is unable to formulate and AD due to cognitive impairment orˆdeemedˆby the medical doctor that the resident is incapable of making decisions on his or her own, the facility will provide information and education to the representative.ˆ<br><br>3. Upon admission, should the resident have an advance directive, copies will be made and placed on the chart as well as communicated to the staff.ˆ |

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| F 0584<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure a homelike environment for one of one sampled resident (Resident 54) by not maintaining functional closet drawers. This deficient practice violated Resident 54's rights to a safe, clean, sanitary, and homelike environment. Findings: During a review of Resident 54's admission Record (the front page of the chart thatˆcontainsˆa summary of basic information about the resident), the admission Record indicated Resident 54 was admitted to the facility on [DATE], with diagnoses including chronic kidney disease (progressive damage and loss of function in the kidneys), Diabetes Mellitus (DM - a disorder characterized by difficulty in blood sugar control and poor wound healing), hypertension (HTN - high blood pressure). During a review of Resident 54's History and Physical (H&P - a document with resident's medical history and physical examination done by a physician), dated 9/27/2024, the H&P indicated that Resident 54 had a Brief Interview for Mental Status (BIMS - an assessment tool used by facilities to screen and identify memory, orientation, and judgement status of the resident) score of 15. A BIMS score of 15 indicated Resident 54 had intact cognition. During a review of Resident 54's Minimum Data Set (MDS - a resident assessment tool), dated 9/18/2025, the MDS indicated Resident 54 was independent (resident completed the activity by themselves with no assistance from a helper) with eating, oral, personal and toileting hygiene, upper body dressing. The MDS indicated Resident 54 required setup or clean up assistance with showering and putting on/taking off footwear. During a concurrent observation and interview on 4/6/2026 at 10:04 a.m. with Resident 54 inside Resident 54's room, observed some of Resident 54's personal belongings on Resident 54's bed. Resident 54 stated that the closet drawer provided to him had been broken for two (2) months. Observed the closet drawer had a broken bottom. ˆ During a concurrent observation and interview on 4/6/2026 at 10:45 a.m. with the Maintenance Assistant (MA) in Resident 54's room, observed the MA addressing Resident 54's broken drawer in the resident's closet. The MA stated that broken drawers should be addressed promptly to ensure residents maintain a homelike environment, dignity and ability to safely store and access personal belongings.ˆ During an interview on 4/10/2026 at 11:29 a.m. with Director of Nursing (DON), the DON stated when broken furniture is identified, staff need to place a work order and address the findings to maintenance department immediately. The DON stated having nonfunctioning furniture can negatively affect resident's mood and psychosocial wellbeing, potentially leading to feeling frustration, decreased independence, and reduced quality of life. During a review of the facility's policy and procedure (P&P) titled, Safe and Homelike Environment, dated 12/19/2022, the P&P indicated, In accordance with residents' rights, the facility will provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. Housekeeping and maintenance services will be provided as necessary to maintain a sanitary, orderly and comfortable environment. |

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| F 0645<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | PASARR screening for Mental disorders or Intellectual Disabilities<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure residents are screened using the Preadmission Screening and Resident Review (PASRR - a federal requirement to help ensure that individuals are not appropriately placed in nursing homes for long-term care) for a mental disorder (MD - a health condition that significantly affects a person's thinking, emotional regulation, mood, or behavior, making it difficult to cope with daily life) or intellectual disability (ID - a condition that limits intelligence and disrupts abilities necessary for living independently) prior to admission and that individuals identified with serious mental illness (SMI - a health condition that significantly affects how a person thinks, feels, behaves, or interacts with others) and/or ID/developmental disability (DD - a group of conditions due to an impairment in physical, learning, language, or behavior areas)/related conditions (RC) receive the care and services in maintaining his/her highest practicable level in the most appropriate setting for one (1) of 1 sampled resident (Resident 106), by failing to submit a new Level I PASRR for the resident who had a discrepancy in the previous PASRR Level I Screening. This deficient practice had the potential to result in inappropriate placement and unidentified specialized services for the residents. Findings: During a review of Resident 106's admission Record (AR), the AR indicated the facility admitted the resident on 3/18/2024, with diagnoses including paraplegia (paralysis that affects the legs, making it impossible to stand or walk), schizophrenia (a mental illness that is characterized by disturbances in thought), and generalized muscle weakness. During a review of Resident 106's History and Physical (H&P), dated 3/5/2026, the H&P indicated the resident had the capacity to understand and make decisions. The H&P further indicated that the resident had a diagnosis of schizophrenia. During a review of Resident 106's Minimum Data Set (MDS - a resident assessment tool), dated 2/20/2026, the MDS indicated Resident 106 had intact cognition (the mental process of acquiring knowledge and understanding through thought, experience, and the senses) and was usually able to understand and make her needs known. The MDS further indicated Resident 106 required supervision or touching assistance with eating and oral hygiene, and substantial/maximal assistance from staff with all other activities of daily living (ADL - activities such as bathing, dressing and toileting a person performs daily). The MDS further indicated that Resident 106 had a diagnosis of schizophrenia. During a review of Resident 106's PASRR Level I Screening, dated 3/11/2023, the PASRR Level I Screening indicated that the resident had a serious diagnosed mental disorder and that the resident required a Level II Screening. During a review of Resident 106's PASRR Level II Screening, dated 3/17/2023, the PASRR Level II Screening indicated that the Level II Screening was unable to be complete as the resident did not have a SMI. The Level II Screening further indicated that the case is closed and to submit a new Level I Screening to reopen the case. During a concurrent interview and record review on 4/8/2026 at 10:40 a.m., with MDS Coordinator (MDSC) 1, Resident 106's PASRR Level I and Level II Screening, H&P, and AR were reviewed. MDSC 1 stated Resident 106's H&P and AR indicated Resident 106 had a diagnosis of schizophrenia upon admission on [DATE], and the PASRR Level II Screening indicated that the case was closed as the resident did not have a SMI. MDSC 1 stated that the Admissions Director (AdmD) is responsible in ensuring that the residents had a PASRR screening prior to admission and ensure accuracy. MDSC 1 stated she is not sure who is responsible in submitting a new Level I Screening if there was a discrepancy. During an interview on 4/8/2026 at 11:13 a.m. with the Social Services Director (SSD), the SSD stated that he reviews the PASRR Level I Screening with the AdmD and reviews it during the stand-up morning meetings for accuracy. The SSD stated that he is not sure who is directly responsible in ensuring that the PASRR is accurate and matches with the admission diagnosis on the AR and H&P. During a concurrent interview and record review on 4/10/2026 at 8:12 a.m. with the Director of Nursing (DON), Resident 106's PASRR Level I and Level II Screening, H&P, and AR were reviewed. The DON stated the Level I and II Screening indicated that Resident 106 did not have a SMI.<br>(continued on next page) |

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| F 0645<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | The DON stated the H&P and AR indicated the resident had a diagnosis of schizophrenia upon admission to the facility. The DON stated that the AdmD obtains and submits a new Level I Screening for new admissions when the previous facility or hospital did not do a Level I Screening or if there was a discrepancy. The DON further stated that the AdmD should have ensured that Resident 106's Level I Screening matched the diagnosis in the AR and H&P. The DON stated that a Level I Screening should have been submitted by the AdmD indicating that Resident 106 had a SMI as it placed the resident at risk for not receiving or delay in the specialized services and care the resident needed. During a review of the facility's policy and procedure (P&P) titled, Resident Assessment - Coordination with PASARR Program, last reviewed on 3/18/2026, the P&P indicated that the facility coordinates assessments with the PASRR program to ensure that individuals with a MD, ID, or related condition receives care and services int he most integrated setting appropriate to their needs. The P&P further indicated: - Policy Explanation and Compliance Guidance: - All applicants to the facility will be screened for serious mental disorders, or ID, and related conditions in accordance with the state's rules for screening. a. PASRR Level 1 - initial prescreening that is completed prior to admission ii. Positive Level I Screen - necessitates a PASRR Level II Evaluation prior to admission. b. PASRR Level II - a comprehensive evaluation by the appropriate state-designated authority that determines whether the individual had MD, ID, or related condition, determines the appropriate setting for the individual, and recommends any specialized services and/or rehabilitative services the individual needs. - The SSD or designee shall be responsible for keeping track of each resident's PASRR screening status and referring to the appropriate authority. - Recommendations, such as specialized services, for a PASRR Level II determination and/or PASRR evaluation report will be incorporated into the resident's assessment, care planning, and transitions of care. |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to develop and implement a comprehensive person-centered care plan (a tool that ensures residents receive personalized, comprehensive, and goal-oriented care in a nursing home setting) for one (1) of 1 sampled resident (Resident 106) reviewed under Preadmission Screening and Resident Review (PASRR - a federal requirement to help ensure that individuals are not appropriately placed in nursing homes for long-term care) care area addressing the resident's diagnoses of schizophrenia (a mental illness that is characterized by disturbances in thought). These deficient practices had the potential for a delay in the delivery of the necessary care and services the resident needs. Findings: During a review of Resident 106's admission Record (AR), the AR indicated the facility admitted the resident on 3/18/2024, with diagnoses including paraplegia (paralysis that affects the legs, making it impossible to stand or walk), schizophrenia, and generalized muscle weakness. During a review of Resident 106's H&P, dated 3/5/2026, the H&P indicated that the resident had the capacity to understand and make decisions. The H&P further indicated that the resident had a diagnosis of schizophrenia. During a review of Resident 106's MDS, dated [DATE], the MDS indicated Resident 106 had an intact cognition and was usually able to understand and make her needs known. The MDS further indicated Resident 106 required supervision or touching assistance with eating and oral hygiene, and substantial/maximal assistance from staff with all other ADLs. The MDS further indicated that Resident 106 had a diagnosis of schizophrenia. During a review of Resident 106's care plans (CP), there was no CP developed and implementing addressing that Resident 106 had schizophrenia. During a concurrent interview and record review on 4/9/2026 at 2:51 p.m. with Registered Nurse (RN) 1, Resident 106's AR, H&P, and CP were reviewed. RN 1 stated that the AR and H&P indicated that Resident 106 had a diagnosis of schizophrenia. RN 1 stated there was no care plan developed and implemented addressing Resident 106's diagnosis of schizophrenia. RN 1 stated that comprehensive CP are developed within 14 days of admission and revised as needed. RN 1 stated the CP are important to ensure that the staff were aware of the plan of care of the residents to be able to provide the care they need. RN 1 stated a comprehensive CP should have been developed and implemented timely to ensure that all the staff involved in Resident 106's care know how to properly care for the resident to meet Resident 106's needs. During an interview on 4/10/2026 at 8:12 a.m. with the Director of Nursing (DON). The DON stated baseline care plans are developed within 48 hours of admission and comprehensive care plans are developed seven (7) days after completion of the admission MDS assessment or 21 days after admission and reviewed quarterly and revised as needed to ensure the appropriate services needed were provided to the residents. The DON stated that Resident 106's care plan should have been developed and implemented timely so the staff involved in her care would be aware of the current plan of care to prevent delay in providing the care and services she needs. During a review of the facility's policy and procedure (P&P) titled, Comprehensive Care Plans, last reviewed on 3/18/2026, the P&P indicated that the facility develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental, and psychosocial needs that are identified in the resident's comprehensive assessment. The P&P further indicated: - Person-centered care means to focus on the resident as the focus of control and support the resident in making their own choices and having control over their daily lives. - The care planning process will include an assessment of the resident's strengths and needs and will incorporate the resident's personal and cultural preferences in developing goals of care. Services provided or arranged by the facility, as outlined by the comprehensive care plan, should be culturally competent and trauma informed. - The comprehensive care plan will be developed within 7 days after the<br>(continued on next page) |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | completion of the comprehensive MDS assessment. - The comprehensive care plan will describe, at a minimum, the services to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, any specialized services or specialized rehabilitation services the nursing facility will provide as a result of PASRR recommendation. - The comprehensive care plan will be prepared by an interdisciplinary team (IDT - a group of health care professionals with various areas of expertise who work together toward the goals of the patients), that include, but it not limited to the attending physician or non-physician designee, MDSC, activities staff, SSD or designee, therapists, responsible party, Administration, and mental health professional. - The comprehensive care plan will be reviewed and revised by the IDT after each comprehensive and quarterly MDS assessment. - The comprehensive care plan will include measurable objectives and timeframes to meet the resident's needs as identified in the comprehensive assessment and utilize to monitor the resident's progress. |

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| F 0676<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure effective communication for one of one sampled resident (Resident 61) with hearing impairment, when the facility did not provide communication board (a device that displays symbols, photos, or illustrations to help individuals with limited hearing or language skills to communicate) or other alternative communication tools. This deficient practice had the potential to result in Resident 61's unmet needs, misunderstanding of care and instructions, decreased participation in care, and increased risk for harm due to inability to effectively communicate. Findings: During a review of Resident 61's admission Records (the front page of the chart thatˆcontainsˆa summary of basic information about the resident), the admission Records indicated the facility admitted Resident 61 on 4/21/2023, and readmitted on [DATE] with diagnoses including Huntington disease (inherited condition that affects movement, thinking and behavior), hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) and hemiparesis (weakness or the inability to move on one side of the body) of the right side, obstructive uropathy (a blockage in the urinary system that prevents urine from flowing freely, causing it to back up into the kidneys). During a review of Resident 61's History and Physical (H&P- a document with patient's medical history and physical examination done by a physician) dated 3/4/2026, the H&P indicated that Resident 61 had the capacity to understand and make decisions. During a review of Resident 61's Minimum Data Set (MDS - a resident assessment tool) dated 1/22/2026, the MDS indicated Resident 61 had moderate hearing difficulty (speaker has to increase volume and speak distinctly). The MDS indicated that Resident 61 was dependent (helper does all of the effort) to staff with eating, oral hygiene, toileting hygiene, lower body dressing, putting on/taking off footwear, and personal hygiene. During an interview on 4/6/2026 at 10:48 a.m. with Resident 61 in Resident 61's room, Resident 61 stated that he (Resident 61) was unable to hear any questions asked. Attempts were made to communicate with Resident 61 using slower speech, simple words, and increased volume. Resident 61 stated he (Resident 61) continued to have difficulty hearing and was unable to understand what was being asked. No communication board or other alternative communication tools were observed inside Resident 61's room. During a concurrent interview and record review on 4/6/2026 at 2:12 p.m. with Licensed Vocational Nurse (LVN) 1, LVN 1 stated that Resident 61 had hearing impairment. LVN 1 was uncertain about the cause of Resident 61's hearing impairment. LVN 1 stated that she (LVN 1) communicated with Resident 61 by talking slowly and with a loud voice. LVN 1 stated residents with hearing impairment are referred to social services for Ear, Nose and Throat (ENT) doctor consult. During a subsequent observation and interview on 4/6/2026 at 2:29 p.m. with LVN 1 in Resident 61's room, observed LVN 1 attempting to communicate with Resident 61 by asking questions. Resident 61 stated he (Resident 61) was unable to hear what LVN 1 was asking. Observed LVN 1 searching for communication board. LVN 1 stated there was no communication board or other communication tools present in Resident 61's room. LVN 1 further stated that the absence of communication board may place Resident 61 at risk for social isolation, depression, and anxiety due to impaired ability to effectively communicate his needs and concerns. During a concurrent interview and record review on 4/8/2026 at 11:38 a.m. with Social Service Director (SSD), the SSD stated that residents with identified hearing impairment were referred to ENT for consultation. The SSD stated that communication boards and visual tools are utilized to help residents understand provided information and express their needs. The SSD further stated that If residents are not provided with appropriate tools, their needs won't be met, putting residents at risk for psychosocial distress.ˆ During an interview on 4/10/2026 at 8:40 a.m. with the Director of Nursing (DON), the DON stated that for residents with hearing impairment the facility was responsible for ensuring that communication tools such as communication board, hearing amplifiers, or other interventions as specified in their<br>(continued on next page) |

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| | 056056 | A. Building<br>B. Wing | 04/10/2026 |

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| F 0676<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | care plan are provided and utilized. The DON stated that without these tools residents may not be able to communicate their needs, which can result in unmet care needs, misinterpretation of requests and potential negative outcomes affecting resident safety and quality of care.ˆ During a review of facility's Policies and Procedures (P&P) titled Effective Communication, updated 7/17/2023, the P&P indicated, It is the policy of this facility to accommodate needs when communicating with residents who have difficulties with communication to promote dignity, understanding, and safety. Staff will communicate with the residents, using techniques identified in their plan of care, and in accordance with his/her established routine for communication, as possible. Adaptive techniques include but are not limited to using communication boards or writing materials. |

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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide care and assistance to perform activities of daily living for any resident who is unable.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide necessary Activities of Daily Living (ADL - activities such as bathing, dressing and toileting a person performs daily) care, specifically grooming, including nail care, for one of one sampled resident (Resident 43). This failure had the potential to result in poor hygiene, increased risk of infection, skin injury from scratching for Resident 43. Findings: During a review of Resident 43's admission Record (the front page of the chart thatˆcontainsˆa summary of basic information about the resident), the admission Record indicated Resident 43 was originally admitted to the facility on [DATE], then readmitted to the facility on [DATE], with diagnoses including Diabetes Mellitus (DM - a disorder characterized by difficulty in blood sugar control and poor wound healing), peripheral vascular disease (a common condition in which narrowed arteries reduce blood flow to the arms or legs), atrial fibrillation (an irregular and often very rapid heart rhythm), right foot amputation (the removal of a leg, foot or toes from the body). During a review of Resident 43's History and Physical (H&P - a document with resident's medical history and physical examination done by a physician), dated 7/9/2025, the H&P indicated that Resident 43 has a capacity to understand and make decisions. During a review of Resident 43's Minimum Data Set (MDS - a resident assessment tool), dated 10/1/2025, the MDS indicated Resident 43 requires substantial/maximal assistance (helper does more than half the effort) with toileting hygiene, upper and lower body dressing, putting on/taking off footwear. During a review of Resident 43's care plan (a personalized, written roadmap for managing a person's health and daily needs), revised on 1/2/2026, the care plan indicated that Resident 43 was at risk for decreased ability to perform ADL(s) in bathing, grooming, personal hygiene, dressing, eating, bed mobility, transfer, locomotion, toileting. The care plan indicated an intervention for staff to provide assistance of one person with personal hygiene, including grooming. During an observation on 4/6/2026 at 10:20 a.m. in Resident 43's room, observed Resident 43 with long fingernails on both hands with visible dark debris underneath nails.ˆˆ During a concurrent observation and interview on 4/6/2026 at 10:30 a.m. with Certified Nurse Assistance (CNA) 2, CNA 2 stated CNAs were responsible to keep residents clean and groomed. CNA 2 stated that Resident 43's fingernails were too long, had black dirt residue under the fingernails. CNA 2 stated that long nails could potentially result in resident scratching himself, causing skin injury, infection and harm. During an interview on 4/8/2026 at 9:31 a.m. with Registered Nurse (RN) 1, RN 1 stated all licensed personnel were responsible for ensuring residents' grooming and hygiene needs are met. RN 1 stated nailcare should be provided during routine care, including showers and morning hygiene. RN 1 stated that poor nail hygiene may lead to accumulation of bacteria under the nails, which can be transferred when residents touch their mouth, eyes or skin, increasing risk for infection. During an interview on 4/10/2026 11:34 a.m. with the Director of Nursing (DON), the DON stated that CNAs are responsible to provide routine ADL care, including nail care. The DON stated not maintaining clean, short nails may allow accumulation of bacteria under the nails and increase the risk of resident scratching themselves causing skin breakdown, introduce infection to skin, wounds and eyes. During a review of facility's Policies and Procedures (P&P) titled, Nail Care, dated 12/19/2022, the P&P indicated, Routine cleaning and inspection of nails will be provided during ADL care on an ongoing basis. Routine nail care, to include trimming and filing, will be provided on a regular schedule. Nail care will be provided between scheduled occasions as the need arises. |

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| F 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate pressure ulcer care and prevent new ulcers from developing.<br><br>Based on observation, interview, and record review, the facility failed to ensure residents with pressure ulcers/injury (a skin and tissue injury caused by prolonged pressure on the skin, often over bony areas) received necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing for one of four sampled residents (Resident 85) reviewed under pressure ulcer/injury by failing to ensure the low air loss mattress (LALM, a specialized bed mattress that helps prevent and treat pressure ulcers by using a continuous flow of air to regulate temperature and moisture on the skin) of Resident 85 was set according to the resident's weight. The deficient practices had the potential for worsening of Resident 85`s pressure injury. Findings: During a review of Resident 85's admission Record (AR), the AR indicated the facility admitted the resident on 3/10/2026, with diagnoses including hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) and hemiparesis (weakness on one side of the body), muscle weakness, and cerebral infarction (a type of ischemic stroke that occurs when a portion of the brain dies because it is not getting enough blood). During a review of Resident 85's History and Physical (H&P), dated 3/11/2026, the H&P indicated the resident did not have the capacity to understand and make decisions. During a review of Resident 85's Minimum Data Set (MDS, a resident assessment tool), dated 3/17/2026, the MDS indicated the resident usually makes self-understood and sometimes had the ability to understand others and had severe cognitive impairment (a profound loss of mental capacity-such as memory, reasoning, and language-that makes it impossible for a person to live or function independently). The MDS indicated the resident was dependent to needing supervision assistance on mobility and activities of daily living (ADLs, activities such as bathing, dressing and toileting a person performs daily). The MDS indicated the resident was frequently incontinent of urine and stool (feces). The MDS indicated the resident was at risk for developing pressure injuries. During a review of Resident 85's Order Summary Report (OSR), dated 3/29/2026, the OSR indicated an order for: -Treatment Order: Low Air Loss Mattress for wound management every shift (QS): (Specify Settings) Monitor for Setting accuracy and functionality. every shift for skin Maintenance. -Treatment Order: Abrasion (Coccyx, tailbone) Cleanse with Soap and Water, Pat Dry, apply Zinc, leave open to air, every day shift for Abrasion for 21 Days and if needed (PRN). Every shift for Abrasion for 21 Days AND as needed for Abrasion for 21 Days. During a review of Resident 85's Braden Scale for Predicting Pressure Ulcer Risk Evaluation (BS- an evidence-based clinical tool used to assess a patient's risk of developing pressure ulcers) dated 3/31/2026, the BS indicated that the resident was at risk for developing pressure injuries. During a review of Resident 85's Weights and Vitals Summary (WVS), dated 4/4/2026, the WVS indicated Resident 85's weight was 121 pounds (lbs., a unit of weight) During a review of Resident 85's Care Plan (CP) Report regarding the resident being at risk for impaired skin integrity related to surgical scar and pressure over left lateral spine, last revised on 3/18/2026, the CP indicated an intervention to use pressure-redistributing mattress per facility protocol. During a concurrent observation and interview on 4/6/2026 at 10:11 a.m., with Licensed Vocational Nurse (LVN) 6, observed Resident 85's LALM set at 80 or the softest setting. LVN 6 stated there was a sticker on the LALM machine indicating the setting should be 180, so the setting should be adjusted to 180. LVN 6 stated the purpose of the LALM was to promote good skin circulation and to prevent pressure ulcer on residents. LVN 6 stated the failure of the licensed staff to set the bed according to the resident's weight could lead to worsening of pressure sore. During an interview and record review on 4/7/2026, at 3:16 p.m., with Registered Nurse (RN) 1, reviewed Resident 85's OSR, BS, WVS, and CP. RN 1 stated the LALM should be set according to resident's weight. RN 1 stated the resident's latest weight was 121 lbs., so the LALM setting should be 120 not 180. RN 1 also stated the resident already had a skin abrasion on the coccyx and it could aggravate the problem by not setting the LALM accordingly. RN 1 stated the resident's Braden score was 16 meaning at risk for developing pressure injuries. During an interview<br>(continued on next page) |

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| F 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | on 4/10/2026, at 8:10 a.m., with the Director of Nursing (DON), the DON stated Resident 85's LALM should be set according to the resident's weight. The resident's weight was 121 lbs. so the LALM setting should be 120. The DON stated the failure of the staff to set the LALM according to the resident's weight can promote further development of skin breakdown. The DON stated the Treatment Nurses should be checking the LALM setting every shift to ensure the LALM was on the correct settings. The DON stated the policy and procedure (P&P) titled Pressure Injury Prevention Guidelines and the facility-provided Low Air Loss Mattress 1 User Manual (UM) were not followed. During a review of the facility's recent P&P titled, Pressure Injury Prevention Guidelines, last reviewed on 3/18/2026, the P&P indicated to prevent the formation of avoidable pressure injuries and to promote healing of existing pressure injuries, it is the policy of this facility to implement evidence-based interventions for all residents who are assessed at risk or who have a pressure injury present. Policy Explanation and Compliance Guidelines: 1. Interventions will be implemented in accordance with physician's orders, including the type of prevention devices to be used and, for tasks, the frequency for performing them. Pressure Injury Prevention Guidelines Pressure Relieving Devices: 1. Provide alternative support surfaces as needed. During a review of the facility-provided Low Air Loss Mattress (LALM) 1 Alternating Pressure and Low Air Loss Mattress System Item # 14530 UM, copyright 2018, the UM indicated to turn the pressure knob to set a comfortable pressure level by using the weight scale as a guide. |

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| F 0693<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube.<br><br>Based on observation, interview, and record review, the facility failed to ensure staff providing care and services to the resident who had a feeding tube (are soft plastic tubes through which liquid nutrition travels through the gastrointestinal tract [the series of organs that food and liquids pass through as they are digested, absorbed, and leave the body as feces]) were aware of, competent in, and utilized facility protocols regarding feeding tube nutrition and care for one of twenty-two sampled residents (Resident 136) observed during initial screening of the residents by failing to label the water flush bag for enteral fluid hydration (is the process of delivering water and essential fluids directly into the stomach or small intestine to keep the body hydrated, typically using a feeding tube) with the rate of infusion. The deficient practice had the potential for under or overhydrating the resident causing fluid imbalance. Findings: During a review of Resident 136's admission Record (AR), the AR indicated the facility admitted the resident on 3/27/2026, with diagnoses including gastrostomy (a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems), type two (2) diabetes mellitus (DM, a disorder characterized by difficulty in blood sugar control and poor wound healing), and chronic kidney disease (a long-term condition where kidneys are damaged or cannot filter blood properly, causing waste and fluid to build up in the body). During a review of Resident 136's History and Physical (H&P), dated 3/30/2026, the H&P indicated the resident did not have the capacity to understand and make decisions. During a review of Resident 136's Order Summary Report (OSR), dated 4/3/2026, the OSR indicated an order of enteral feed order two times a day for enteral water flush at 30 milliliters per hour (ml/hr., measures the speed of a fluid infusion, specifically how many milliliters (mL) of medication or fluid are delivered into the body over one hour) for 20 hours via pump to provide 600 cubic centimeters (cc, a standard metric unit of volume), total 1364 ml + med flush in 24 hours. Gastrostomy tube (GT- a soft, flexible tube inserted through the skin of the belly directly into the stomach) GT, pump on at 2 p.m. and Turn GT pump off @ 10 a.m. (or until volumetric dose is met). During a review of Resident 136's Care Plan (CP) Report regarding the resident having a nutritional problem or potential nutritional problem related to DM, Syndrome of Inappropriate Antidiuretic Hormone (SIADH, a condition where the body produces too much antidiuretic hormone (ADH), causing the kidneys to retain excessive water), gastroesophageal reflux disease (GERD, a chronic, more severe form of acid reflux), osteoarthritis (a progressive disorder of the joints, caused by a gradual loss of cartilage) and dependence on enteral nutrition, last revised on 4/2/2026, the CP indicated an intervention to monitor for signs and symptoms (s/s) of dehydration (abnormal loss of water from the body) as evidenced by poor skin turgor (a sign of dehydration where the skin loses its elasticity and fails to snap back instantly after being pinched), dry mucous membranes and to provide, serve enteral/flush as ordered and monitor tolerance, intake and output (I&O), tube feeding (TF) tolerance. During a concurrent observation and interview on 4/6/2026, at 10:36 a.m., with Licensed Vocational Nurse (LVN) 1, observed Resident 136's water flush bag not labeled with the rate of infusion hanging on an intravenous (IV, within a vein) pole attached to a feeding pump. LVN 1 stated the just like the enteral feeding formula of the resident the water flush bag should be labeled with the rate of infusion to ensure accurate dosage of water hydration was being provided to the resident. During a concurrent interview and record review on 4/7/2026, at 2:32 p.m., with Registered Nurse (RN) 1, reviewed Resident 136's OSR and CP and the picture of the water flush bag taken on 4/6/2026. RN 1 stated the water flush bag on the picture was missing the rate of infusion. RN 1 stated they use the enteral and hydration water bag labels to hand off during change of shift report to another licensed nurse to verify current orders of the physician for the enteral feeding and water flush. RN 1 stated if it is not completely labeled, they will not be able to tell the exact order of the physician and can cause error. RN 1 stated there will be a potential for under or overhydrating the resident contributing to the<br>(continued on next page) |

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| F 0693<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | resident's medical problem. During an interview and record review on 4/10/2026, at 8:10 a.m., with the Director of Nursing (DON), reviewed the picture of the water flush bag of Resident 136 taken on 4/6/2026. The DON stated the bag was not labeled with the rate of infusion. The DON stated just like the enteral feeding formula, the bag should be labeled with the name of the resident, the date and time it was hung, the name of the formula, the rate of infusion, and the initials of the licensed nurse who hung the bag. The DON stated the failure of the staff to label the water flush bag with the rate of infusion can potentially cause under or overhydration to the resident. The DON stated the licensed staff use the label to communicate to the incoming nurse the latest order for enteral feeding and flush, if there was a change in the physician's order, the label has to be changed and affixed with the new order. During a review of the facility provided Information on tube feedings, undated, the Information indicated to make sure that the enteral formula container is labeled with the patient's identifiers; formula name (and strength if diluted); date and time of formula preparation; date and time the formula was hung; administration route; rate of administration; administration duration (if cycled or intermittent); initials of who prepared, hung, and checked the enteral formula against the order; expiration date and time; dosing weight (if appropriate); and notation ENTERAL USE ONLY. |

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| F 0694<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide for the safe, appropriate administration of IV fluids for a resident when needed.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure parenteral fluids (are liquids that are administered intravenously or by injection to bypass the digestive system) were administered consistent with professional standards of practice for one (1) of one (1) sampled resident (Resident 28) reviewed during a random observation by failing to ensure Resident 28's midline catheter (a long, thin, flexible tube that is inserted into a large vein in the upper arm) indicated the date of the last dressing change. This deficient practice had the potential to place Resident 28 at risk for developing complications such as inflammation of the vein and infection. Findings: During a review of Resident 28's admission Record, the admission Record indicated the facility originally admitted the resident on 7/18/2025, and readmitted in the facility on 3/2/2026, with diagnoses including osteomyelitis (inflammation of bone or bone marrow, usually due to infection), absence of right toes, and absence of right leg above knee. During a review of Resident 28's History and Physical (H&P) dated 1/2/2026, the H&P indicated the resident had the capacity to understand and make decisions. During a review of Resident 28's Minimum Data Set (MDS, a resident assessment tool), dated 4/15/2026, the MDS indicated Resident 28 had an intact cognition (mental action or process of acquiring knowledge and understanding) and was able to understand others and make his needs known. The MDS further indicated Resident 28 had impairment on the lower extremity and was independent with eating and oral hygiene; setup or clean-up assistance with upper body dressing; supervision or touching assistance to partial or moderate assistance from staff with all other activities of daily living (ADLs - basic tasks that must be accomplished every day for an individual to thrive). During a review of Resident 28's Order Summary Report, the Order Summary Report indicated the following physician's orders: - 3/3/2026: Intravenous (IV - way of delivering medicine or fluids into the vein) tubing changes every 24 hours. - 3/3/2026: IV site check every shift. [NAME] without signs and symptoms of complications and no adverse reactions from IV therapies unless addressed in nurse's notes every shift. - 3/7/2026: Peripherally inserted central catheter (PICC - a long, thin tube inserted through a vein in the arm and passed through to the larger veins near the heart used for long-term intravenous access)/midline (a type of IV catheter inserted into a vein in the upper arm with the tip located just below the armpit) transparent dressing change per sterile technique every day shift every Saturday for site maintenance. During a review of Resident 28's care plan (CP) on potential for infection and/or complications related to IV access initiated on 3/26/3036, the CP indicated to observe the IV site frequently for signs and symptoms of complications such as redness, swelling, pain, drainage, and leakage to maintain the IV access free of complications. During an observation on 4/6/2026 at 10:33 a.m. inside Resident 28's room, observed Resident 28 was lying in bed with an IV line on the right upper arm dated 3/28/2026. During a concurrent observation and interview on 4/6/2026 at 11:08 a.m. inside Resident 28's room with Registered Nurse (RN) 2, RN 2 stated that Resident 28's midline catheter indicated a date of 3/28/2026. RN 2 stated that the date indicated was the date the midline site dressing was last changed. RN 2 stated midline/PICC line/peripheral (through the skin into the small vein on the hand or arm) line dressing changes are every seven (7) days per facility policy and/or as needed if soiled. RN 2 stated that the date on Resident 28's midline dressing was past the 7 days, and the dressing should have been changed on 4/4/2026. RN 2 stated that not changing the midline dressing as scheduled on 4/4/2026 placed Resident 28 at risk for developing inflammation and infection on the insertion site. During an interview on 4/10/2026 at 9:39 a.m. with the Director of Nursing (DON), the DON stated that the RNs are responsible for changing the IV sites regardless of the type of IV site every 7 days and as needed. The DON stated IV sites should be labeled with the date it was last changed so the staff would be aware that it was changed timely and the dressing was not old. The DON stated that if the date on Resident 28's midline dressing was 3/28/2026, the dressing was not changed timely and should have been changed on 4/4/2026. The DON stated that<br>(continued on next page) |

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| F 0694<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | not changing Resident 28's midline catheter dressing timely on 4/4/2026 placed the resident at risk for infection on the insertion site. During a review of the facility's policy and procedure (P&P) titled, PICC/Midline/CVAD Dressing Change, last reviewed on 3/18/2026, the P&P indicated that it is the facility's policy to change PICC, midline or central venous access device (CVD) dressing weekly, if soiled, in a manner to decrease potential for infection and/or cross-contamination. |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide safe and appropriate respiratory care for a resident when needed.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure respiratory care provided to residents was consistent with professional standards of practice for two of two sampled residents (Residents 71 and 78) reviewed for respiratory care by failing to ensure: 1. Resident 71's oxygen tubing (a small, soft plastic tube used to give someone extra oxygen) was kept off the floor. The deficient practice had the potential for residents to develop complications such as shortness of breath and desaturation (low levels of oxygen in the blood) and respiratory infections. 2. Resident 78`s oxygen tubing was not touching the floor, trash can, and under the bedside table. This deficient practice had the potential to result in placing Resident 78 at risk for infection. Findings: 1. During a review of Resident 71's admission Record (AR), the AR indicated that the facility admitted the resident on 10/2/2023, with diagnoses including chronic respiratory failure (a long-term condition where the lungs cannot properly move oxygen into the blood or remove carbon dioxide) with hypercapnia (a medical condition defined byˆtoo much carbon dioxide in the blood), obstructive sleep apnea (a common sleep disorder where breathing repeatedly stops and starts because throat muscles relax and block the airway during sleep), and morbid obesity (a chronic, complex disease defined by a Body Mass Index (BMI) of 40 or higher, or a BMI of 35 or higher accompanied by serious weight-related health conditions).<br><br>During a review of Resident 71's History and Physical (H&P), dated 2/1/2026, the H&P indicated the resident had the capacity to consent.<br><br>During a review of Resident 71's Minimum Data Set (MDS, a resident assessment tool), dated 9/4/2025, the MDS indicated the resident had the ability to make self-understood and understand others and had intact cognition (having a clear, sharp, and functioning mind that allows a person to think, learn, remember, and make decisions effectively).<br><br>During a review of Resident 71's Order Summary Report (OSR), dated 3/9/2026, the OSR indicated an order for:<br><br>- Oxygen orders: Administer Oxygen inhalation at two (2)- four (4) liter per minute (liters/min or LPM, measures the speed at which oxygen flows from a device (concentrator or tank) to you, indicating the volume of pure oxygen delivered every 60 seconds) via nasal cannula (NC, a lightweight, flexible plastic tube that hooks over the ears and features two small prongs that sit just inside the nostrils to deliver supplemental oxygen) if needed (PRN). May titrate (the process ofˆadjusting the amount of supplemental oxygenˆa person receives—increasing or decreasing the flow rate—to keep their blood oxygen levels within a specific, healthy target range) oxygen (O2) up to five (5) LPM to keep oxygen saturation (O2 sat, a measurement of the percentage of hemoglobin in red blood cells that is carrying oxygen compared to those that are not) greater than (>) 90%. Indication: shortness of breath, or O2 saturation <92% as needed.<br><br>- Oxygen orders: Change nasal cannula/mask, oxygen tubing, and humidifier (a medical device that adds moisture to the dry oxygen produced by a concentrator or tank before it reaches the patient) every week as needed. Change oxygen nasal cannula PRN when soiled. Changed oxygen humidifier PRN when consumed.<br><br>During a review of Resident 71's Care Plan (CP) Report titled, Require enhanced standard/barrier precautions (infection control steps in nursing homes requiring staff to wear gowns and gloves during (continued on next page) |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | high-contact care (like dressing, bathing, or changing linens) for residents with, or at risk for, tough-to-treat germs) due to flu like symptoms, initiated on 2/2/2025, the CP indicated a goal of to prevent risk for multi-drug resistant organism (MDRO, a type of germ—usually bacteria—that has developed the ability to resist the drugs (antibiotics) meant to kill it) colonization (superbug bacteria are living on or in your body (such as on your skin, in your nose, or in your gut)ˆwithout causing you to feel sick or have symptoms of an infection) or transmission, and an intervention to observed standard precautions- emphasis on hand washing technique before and after handling and proper disposal of soiled items.<br><br>During a concurrent observation and interview on 4/6/2026, at 11:09 a.m., with Certified Nursing Assistant (CNA) 9, inside Resident 71's room, observed Resident 71's oxygen via nasal cannula at the foot of the bed coiled to an oxygen concentrator (a medical device that acts like a specialized air filter for people with breathing issues) with most of the tubing touching the floor, disconnected from the resident. CNA 9 stated the oxygen tubing was touching the floor and needed to be changed due to infection issue.<br><br>During an interview on 4/7/2026, at 2:49 p.m., with Registered Nurse (RN) 1, RN 1 stated all staff were responsible for ensuring oxygen tubing of the residents were off the floor. RN 1 stated when staff sees the tubing on the floor, they should immediately remove the tubing and replace them with a new one to prevent respiratory infections to the resident. RN 1 stated the failure of the staff to keep Resident 71`s oxygen tubing off the floor can predispose the resident to the development of respiratory infections. RN 1 stated the policy and procedure (P&P) titled Oxygen Administration was not followed.<br><br>During an interview on 4/10/2026, at 8:10 a.m., with the Director of Nursing (DON), the DON stated Resident 71's oxygen tubing should have been placed in a clear plastic bag with the date of when the tubing was provided and the name of the resident to ensure its safe use. The DON stated the failure of the staff to keep the oxygen off the floor of Resident 71 had predisposed the resident to develop respiratory infection when the resident uses the contaminated tubing. The DON stated the P&P Oxygen Administration was not followed on this instance.<br><br>During a review of the facility's recent P&P titled, Oxygen Administration, last reviewed on 3/18/2026, the P&P indicated oxygen us administered to residents who need it, consistent with professional standards of practice, the comprehensive person-centered care plans, and the resident's goals and preferences.<br><br>Policy Explanation and Compliance Guidelines:<br><br>1. Staff shall perform hand hygiene and don gloves when administering oxygen or when in contact with oxygen equipment. Other infection control measures include:<br><br>b. Change oxygen tubing and mask/cannula weekly and as needed if it becomes soiled or contaminated.<br><br>2. During a review of Resident 78's AR, the AR indicated that the facility originally admitted Resident 78 on 6/7/2021, and re-admitted on [DATE], with diagnoses including gangrene, not elsewhere classified (a serious condition where a body part turns black or dark, damaged, and starts to die); acute systolic (congestive) heart failure (the heart suddenly gets weak and can't pump blood properly, causing fluid buildup in the body); type two diabetes mellitus without complications (a disorder (continued on next page) |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | characterized by difficulty in blood sugar control and poor wound healing).<br><br>During a review of Resident 78's H&P dated 11/5/25, the H&P indicated that resident had the capacity to understand and make decisions.<br><br>During a review of Resident 78's MDS dated [DATE], the MDS indicated Resident 78 was able to make self- understood and has the ability to understand others. The MDS further indicated that Resident 78 had intact cognitive function (normal thinking). The MDS indicated the resident required maximal assistance to supervision with bed mobility, transfer, dressing, toilet use, and personal hygiene.<br><br>During a concurrent observation and interview on 4/8/2026, at 9:50 a.m., with Licensed Vocational Nurse (LVN) 7 inside Resident 78's room, observed Resident 78`s oxygen tubing touching the floor, touching the trash can and was under the table. LVN 7 stated the oxygen tubing should not touch the floor or touch the trash can for infection prevention. LVN 7 stated the tubing can get caught on the wheel of the bed side table and get pulled out. LVN 7 stated that she (LVN 7) will change Resident 78`s oxygen tubing.<br><br>During a concurrent observation and interview on 4/8/2026, at 2:35p.m., with Registered Nurse (RN) 1, observed a picture taken of Resident 78`s oxygen tubing touching the floor. RN 1 stated that it is not appropriate for oxygen tubing to be touching the floor or trash can because the resident can possibly get an infection. RN 1 also stated that oxygen tubing should not be under table because it can cause a blockage if wheel goes over the tubing or can get tangled on the wheel and the resident would not receive oxygen needed. RN 1 stated the oxygen tubing needs to be free of environmental objects and not touching the floor and needs to be immediately changed.^<br><br>During an interview on 4/10/2026, at 9:00 a.m., with the DON, the DON stated the oxygen tubing should not be touching the floor to prevent respiratory infection. The DON stated that by the tubing touching the floor and trash can, there was a potential for Resident 78 to get an infection. The DON stated there was a risk for pulling the oxygen tubing off the resident or it could have got kinked with the table wheel and resident would not be able to receive oxygen.<br><br>During a review of the facility's policy and procedure (P&P) titled, Oxygen Administration last reviewed on 3/18/2026, the P&P indicated oxygen is administered to residents who need it, consistent with professional standards of practice, the comprehensive person-centered care plans, and the resident's goals and preferences.<br><br>Policy Explanation and Compliance Guidelines:<br><br>1. Staff shall perform hand hygiene and done gloves when administering oxygen or when in contact with oxygen equipment. Other infection control measures include:<br><br>b. Change oxygen tubing and mask/cannula weekly and as needed if it becomes soiled or contaminated. |

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| F 0697<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide safe, appropriate pain management for a resident who requires such services.<br><br>Based on observation, interview, and record review,ˆLicensed Vocational Nurse (LVN)ˆ2 failed toˆaccurately identify the resident and assess the resident's pain level (also known as the pain scale, a 0-10 numerical scale to help healthcare providers assess pain severity and manage treatment that ranges from 0 [no pain] to 10 [worst imaginable pain], with 1-3 being mild, 4-6 moderate, and 7-10 severe) prior to administrating pain medication for one (1) of 1 sampled resident (Residentˆ117).ˆˆ This deficient practiceˆhas the potential toˆresult inˆmedication error and effective pain management, which may negativelyˆimpactˆResident 117's comfort, safety, and overall well-being.ˆ Findings:ˆ During a review of Residentˆ117'sˆadmission Record (AR), theˆARˆindicated the facility admitted Residentˆ117 onˆ3/19/2025, with diagnoses including alcoholic cirrhosis of the liver without ascites (the liver has been damaged from alcohol but it has not caused fluid to collect in the abdomen); heart failure, unspecified (the heart is weak and cannot pump blood around the body properly); hypothyroidism, unspecified (thyroid gland [a small gland in the neck] is not making enough hormones for the body). During a review of Resident 117's Minimum Data Set (MDS - a resident assessment tool), datedˆ3/9/2026,ˆthe MDS indicatedˆResident 117ˆwas ableˆto make self-understood and ableˆto understand others. The MDS furtherˆindicatedˆthat Resident 117ˆhadˆhad intact cognitive function (normal thinking). The MDS indicated the resident required supervision with bed mobility, transfer, dressing, toilet use, and personal hygiene. During a review of Resident 117's Order Summary Report (OSR), datedˆ12/27/2025, the OSR indicated an order forˆAcetaminophenˆ325 milligrams (mg - a unit of measure for weight) (Acetaminophen) give two (2) tablets by mouthˆevery four (4) hours as needed for Pain Level:1-6/10. During aˆconcurrentˆobservation, interview, and record reviewˆof Resident 117 on 4/6/2026 at 10:25ˆa.m.ˆwith Licensed Vocational Nurse (LVN) 2, Resident 117 was complaining of leg pain and requested medication. Observed LVN 2 administer medication but did not identify Resident 117 and did not assess the resident's pain level. LVN 2 reviewed the Order Summary Report (OSR), Acetaminophen 325 mg, give 2 tablets by mouth every 4 hours as needed for pain level 1-6/10 was ordered. LVN 2 stated that LVN 2 did not ask for the pain level but should have asked about Resident 117's pain level. LVN 2 stated that earlier LVN 2 had medicated the resident for 8/10 pain level with hydrocodone and only had acetaminophen available for pain medication. Resident 117 stated her current pain level was 8/10. LVN 2 stated that LVN 2 should have not administered pain medication but instead call the doctor because Resident 117's pain level was 8/10 and acetaminophen was for pain level 1-6/10. LVN 2 stated that another intervention that could have been done was nonpharmaceutical, such as reposition legs. LVN 2 stated LVN 2 did not verify Resident 117's name and birthday. LVN 2 stated Resident 117 had a bracelet with information and could have verified the resident's identity. LVN 2 stated that a medication error could have occurred because it could have been the wrong resident and given the wrong medication causing an allergic reaction. During an interview on 4/8/2026 atˆ8:50 a.m.ˆwith Registered Nurse (RN) 1, RN 1 stated LVN 2 should have identified the resident, assessed the resident's pain level, used non-pharmacological interventions, and follow the OSR. RN 1 stated that a medication error could have occurred, including the possibility of administering wrong medication to the wrong resident. RN 1 stated that if the pain level is not assessed, it is not possible to determine which pain medication should be given. During a concurrent interview and record review on 4/10/2026, at 10 a.m.ˆwith Director of Nursing (DON), Resident 117's OSR was reviewed. The DON stated that before LVN 2 administers medication, LVN 2 needs to verify the resident's identity, assess pain level, verify the OSR, do non-pharmacological interventions, and then administer pain medication. The DON stated not identifying a resident had a potential for medication error and if pain level was not assessed then LVN 2 would not know if medication was effective. During a review of the facility's policy and procedure (P&P) titled,ˆ Pain Management,ˆlast reviewedˆon 3/18/26, the P&PˆindicatedˆPolicy Explanation and Compliance Guidelines: The facility will utilize A systemic approach for recognition, assessment, (continued on next page) |

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| F 0697<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | treatment, and monitoring of pain. Pain Assessment: 1. The facility will use a pain assessment tool, which is appropriate for the resident's cognitive status, to assist staff in consistent assessment of a resident's pain. Pain Management and Treatment: 6. Non-pharmacological interventions will include but are not limited to: a. Environmental comfort measures (e.g., adjusting room temperature, smoothing linens, comfortable seating, assistive devices or pressure redistributing mattress and positioning) b. Loosening any constrictive bandages, clothing or device c. Applying splinting (e.g., pillow or folded blanket) d. Physical modalities (e.g., cold compress, warm shower/bath, massage, turning and repositioning) e. Exercises to address stiffness and prevent contractures as well as restorative nursing programs to maintain joint mobility f. Cognitive/behavioral interventions (e.g., music relaxation techniques, activities, diversions, spiritual and comfort support, teaching the resident coping techniques and educating about pain) |

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| F 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure one of one sampled resident's (Resident 61) hearing assessment was accurately documented to reflect Resident 61's impaired hearing. This deficient practice resulted in inaccurate clinical documentation and had the potential to impact Resident 61's care planning and communication interventions. Findings: During a review of Resident 61's admission Records (the front page of the chart thatˆcontainsˆa summary of basic information about the resident), the admission Records indicated Resident 61 was originally admitted to the facility on [DATE], then readmitted to the facility on [DATE] with diagnoses including Huntington disease (inherited condition that affects movement, thinking and behavior), hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) and hemiparesis (weakness or the inability to move on one side of the body) of the right side, obstructive uropathy (a blockage in the urinary system that prevents urine from flowing freely, causing it to back up into the kidneys). During a review of Resident 61's History and Physical (H&P - a document with resident's medical history and physical examination done by a physician), dated 3/4/2026, the H&P indicated that Resident 61 has a capacity to understand and make decisions. During a review of Resident 61's Minimum Data Set (MDS - a resident assessment tool) dated 1/22/2026, the MDS indicated Resident 61 has moderate hearing difficulty (speaker has to increase volume and speak distinctly). The MDS indicated that Resident 61 was dependent (helper does all of the effort) with eating, oral hygiene, toileting hygiene, lower body dressing, putting on/taking off footwear, personal hygiene. During an interview on 4/6/2026, at 10:48 a.m., with Resident 61 in Resident 61's room, Resident 61 stated he was unable to hear any questions asked. Attempts were made to communicate with Resident 61 using slower speech, simple words, and increased volume. Resident 61 stated he continued to have difficulty hearing and was unable to understand what was being asked. No communication board or other alternative communication tools observed in Resident 61's room. During a concurrent interview and record review on 4/6/2026 at 2:12 p.m. with Licensed Vocational Nurse (LVN) 1, LVN 1 stated Resident 61 had hearing impairment. LVN 1 was uncertain about the cause of Resident 61's hearing impairment. LVN 1 stated that she communicated with Resident 61 by talking slowly and with a loud voice. LVN 1 stated residents with hearing impairment are referred to social services for Ear, Nose and Throat (ENT) doctor consultation scheduling. LVN 1 reviewed Resident 61's Order Summary Report. The Order Summary Report indicated a physician's order on 2/19/2026 for ENT consult for hearing loss. LVN 1 reviewed weekly Nursing Assessment (a comprehensive, head-to-toe check-up conducted by a nurse to monitor a resident's progress, ensure treatments are working, and catch new problems early), dated 4/6/2026. The Nursing Summary indicated Resident 61 had adequate hearing.ˆLVN 1 reviewed Resident 61's care plan and the care plan indicated no documentation for hearing impairment and impaired communication. During a subsequent observation and interview on 4/6/2026 at 2:29 p.m. with LVN 1 in Resident 61's room, observed LVN 1 attempting to communicate with Resident 61 by asking questions. Resident 61 stated he was unable to hear what LVN 1 was asking. Observed LVN 1 searching for communication board. LVN 1 stated there was no communication board or other communication tools present in Resident 61's room. LVN 1 further stated that the absence of communication board may place Resident 61 at risk for social isolation, depression, and anxiety due to impaired ability to effectively communicate his needs and concerns. LVN 1 further stated that Resident 61's hearing assessment documented on Nursing assessment dated [DATE] was inaccurate. LVN 1 stated accurate assessment was crucial, because it could affect Resident 61's safety, care and quality of life.ˆ During a concurrent interview and record review on 4/8/2026 at 9:33 a.m. with Registered Nurse (RN) 1, RN 1 reviewed Resident 61's weekly Nursing Assessments, dated 4/6/2026, 3/23/2026, 3/16/2026, and 3/9/2026 indicated adequate hearing. RN 1 reviewed<br>(continued on next page) |

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| F 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 61's progress notes for February and March 2026, indicated no documentation for follow up for ENT consultation. RN 1 stated accurate nursing assessment was important, to develop accurate, resident centered care plan, to provide necessary care to the residents. During a concurrent interview and record review on 4/8/2026 at 11:38 a.m. with Social Services Director (SSD), the SSD stated that residents with identified hearing impairment are referred to ENT for consultation, individualized care plan is developed to address the resident's communication needs. The SSD stated that communication boards and visual tools are utilized to help residents understand provided information and express their needs. The SSD reviewed Resident 61's assessments and progress notes for February and March 2026. The SSD stated no documentation of social work assessment or progress notes had been completed or documented. During an interview on 4/10/2026 at 8:40 a.m. with Director of Nursing (DON), the DON stated importance of accurate assessment to develop an appropriate and effective care plan. The DON stated inadequately developed care plan can lead to unmet resident needs, delays in necessary interventions and potential negative impacts on resident safety. The DON further stated inaccurate hearing assessment may result in ineffective care planning related to communication needs. The DON stated this could lead to residents' inability to communicate needs, which may negatively impact resident safety and quality of care. During a review of facility's Policies and Procedures (P&P) titled Documentation in Medical Record, dated 12/19/2022, the P&P indicated, Each resident's medical record shall contain a representation of the experiences of the resident and include enough information to provide a picture of the resident's progress. Documentation shall be accurate, relevant, and complete, containing sufficient details about the resident's care and/or responses to care. |

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| F 0849<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services.<br><br>Based on interview and record review, the facility failed to ensure that the hospice (compassionate care for people who are near the end of life) provides services to the resident in a way that meets his/her needs in a timely manner including review of the resident's record for pertinent documentation regarding the delivery of hospice care for one of one sampled resident (Resident 5) reviewed for hospice and end of life by failing to ensure hospice care services were provided according to Hospice Orders/Visit Frequency List. The deficient practice had the potential to result in a delay or lack of coordination in delivery of hospice care and services to residents. Findings: During a review of Resident 5's admission Record (AR), the AR indicated the facility admitted the resident on 10/4/2025, and readmitted the resident on 12/15/2025, with diagnoses including malignant neoplasm of pancreas (a dangerous, fast-growing tumor that starts when cells in the pancreas (an organ aiding digestion and blood sugar control) mutate and multiply uncontrollably), malignant neoplasm of bone (a cancerous tumor that starts in the bone, where cells grow and divide uncontrollably, forming a mass), and chronic kidney disease stage 3B (a moderate-to-severe reduction in kidney function, where kidneys filter waste inefficiently). During a review of Resident 5's Minimum Data Set (MDS - a resident assessment tool), dated 12/22/2025, the MDS indicated the resident had the ability to make self-understood and understand others and had intact cognition (having a clear, sharp, and functioning mind that allows a person to think, learn, remember, and make decisions effectively). During a review of Resident 5's Order Summary Report (OSR), dated 12/15/2026, the OSR indicated an order for: - Admit under Hospice A under supervision of Dr. X. - do not resuscitate (DNR) - Comfort Care ONLY - No transfers, no intravenous (within a vein) fluids (IV's). If resident has change of condition call Hospice A. During a review of Resident 5's Physician Orders for Life-Sustaining Treatment (POLST - a form that contains written medical orders for healthcare professionals regarding specific medical treatments that can or cannot be done at the end-of life), dated 12/17/2025, the POLST indicated do not attempt resuscitation/DNR (Allow Natural Death), comfort-focused treatment, and no artificial means of nutrition, including feeding tubes. During a review of Resident 5's Visit Frequency Grid (VFG), dated 4/8/2026, the VFG indicated planned visits by discipline for the week: Week 12/24/2025: Nurse Visits: Two (2) Social Worker (SW) Visits: One (1) Chaplain (CHAP) Visits: 1 Home Health Aid (HHA) Visits: 2 Week 12/31/2025: Nurse Visits: 2 SW Visits: No Visit (NV) CHAP Visits: NV HHA Visits: 2 Week 1/7/2026: Nurse Visits: 1 SW Visits: NV CHAP Visits: NV HHA Visits: 1 Week 1/14/2026: Nurse Visits: 3 SW Visits: 1 CHAP Visits: NV HHA Visits: 1 Week 1/21/2026: Nurse Visits: 8 SW Visits: 4 CHAP Visits: NV HHA Visits: 1 Week 1/28/2026: Nurse Visits: 1 SW Visits: 2 CHAP Visits: NV HHA Visits: 2 Week 2/4/2026: Nurse Visits: 1 SW Visits: 2 CHAP Visits: NV HHA Visits: 1 Week 2/11/2026: Nurse Visits: 3 SW Visits: NV CHAP Visits: NV HHA Visits: 1 Week 2/18/2026: Nurse Visits: 2 SW Visits: 1 CHAP Visits: 1 HHA Visits: 1 Week 2/25/2026: Nurse Visits: 1 SW Visits: 1 CHAP Visits: NV HHA Visits: 1 Week 3/4/2026: Nurse Visits: 3 SW Visits: NV CHAP Visits: NV HHA Visits: 1 Week 3/11/2026: Nurse Visits: 3 SW Visits: 1 CHAP Visits: 1 HHA Visits: 1 Week 3/18/2026: Nurse Visits: 1 SW Visits: NV CHAP Visits: NV HHA Visits: 1 Week 3/25/2026: Nurse Visits: 2 SW Visits: NV CHAP Visits: NV HHA Visits: 1 Week 4/1/2026: Nurse Visits: 1 SW Visits: NV CHAP Visits: NV HHA Visits: 1 During a review of Resident 5's Vitas Staff Assignments (VSA) for 1/2026 to 4/2026, the VSA had missing signatures not congruent to VFG. During a review of Resident 5's Vitas Visit Description Log (VVDL) for 1/2026 to 4/2026, the VVDL had missing signatures not congruent to VFG. During a review of Resident 5's Visit Notes (VN) on the Hospice Binder for 1/2026 to 4/2026, the VN indicated and was verified with Social Services Director (SSD): Week of 1/14/2026 only 1 Nurse visit done per Visit Frequency Grid needed 3 times (X). Week of 1/21/2026 only 2 Nurse visits done per Visit Frequency Grid needed 8X, 0 SW visit done per Visit Frequency Grid needed 4X. Week of 2/4/2026 1 SW visit done per Visit Frequency Grid needed 2X. Week of 2/11/2026 only 2 RN visits<br>(continued on next page) |

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| | 056056 | A. Building<br>B. Wing | 04/10/2026 |

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| F 0849<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | done per Visit Frequency Grid needed 3X. Week of 2/18/2026 only 1 RN visit done per Visit Frequency Grid needed 2X, 0 CHAP visit done per Visit Frequency Grid needed 1X. Week of 2/25/2026 only 1 RN visit done per Visit Frequency Grid needed 2X, 0 CHAP visit done per Visit Frequency Grid needed 1X. Week of 3/4/2026 only 1 RN visit done per Visit Frequency Grid needed 3X. Week of 3/11/2026 only 0 CHAP visit done per Visit Frequency Grid needed 1X. Week of 4/1/2026 only 0 HHA visit done per Visit Frequency Grid needed 1X. During a concurrent interview and record review on 4/8/2026, at 8:27 a.m., with the SSD, reviewed Resident 5's Hospice Binder. The SSD stated he cannot find the physician's order of frequency of Nurse, SW, CHAP, and HHA visit on the binder. The SSD also stated there were a lot of Visit Notes missing on the binder and he cannot reconcile how frequent each entity should be visiting the resident since he cannot find the Physician's orders. The SSD stated he was responsible for coordinating the care of hospice residents in the facility. The SSD stated he and the medical records were responsible for making sure the services needed for hospice residents were documented and filed in the Hospice binder. During a concurrent interview and record review on 4/8/2026, at 11:24 a.m., with the SSD, Resident 5's Visit Frequency Grid (VFG), dated 4/8/2026, was reviewed. The SSD stated the order was just faxed to them that day. Confirmed with the SSD the missing visit notes on Resident 5's Hospice Binder, and the VSA and VVDL was not congruent to the frequency of visits outlined in VFG. The SSD stated he was not able to verify if the frequency of visits were complete because he did not have the Physician's order on hand. The SSD stated it was important to have the Hospice Binder of Resident 5 complete at all times to monitor, coordinate, and ensure the hospice services were being provided to the resident. During an interview on 4/10/2026 at 8:10 a.m. with the Director of Nursing (DON), the DON stated the SSD and the medical records should have ensured the Hospice Binder of Resident 5 was complete with the physician's order, signatures of entity visits and visit notes to ensure the hospice care were provided to the resident. The DON stated the SSD was designated as the Hospice Coordinator and should have ensured the records were complete and hospice care were provided according to physician's order. The DON stated the failure of the SSD to ensure the Hospice Binder of Resident 5 was complete had predisposed the resident to delay of care and services and unverified treatments due to missing documentations. During a review of the facility's recent policy and procedure (P&P) titled, Coordination of Hospice Services, last reviewed on 3/18/2026, the P&P indicated when a resident/resident representative chooses to receive hospice care and services, the facility will coordinate and provide care in cooperation with hospice staff in order to promote the resident's highest practicable physical, mental, and psychosocial well-being. Policy Explanation and Compliance Guidelines: 2. When a resident participates in the hospice program, the facility interdisciplinary team will collaborate and coordinate the plan of care with the hospice team. This collaboration may include orientation to the facility's related policies and procedures such as patient rights, appropriate forms and record keeping requirements. A coordinated plan of care between the facility, hospice agency and resident/representative will be developed and shall include but not limited to resident's right, directives for managing pain and other uncomfortable symptoms and respite care program. The care plan and any related forms shall be revised and updated as necessary to reflect the resident's current status. 3. The plan of care will identify the care and services that each entity will provide in order to meet the needs of the resident and his/her expressed desire for hospice care including respite hospice care a. The hospice provider retains the primary responsibility for the provision of hospice care and services that are necessary for the care of the resident's terminal illness and related conditions. b. The facility retains primary responsibility for implementing those aspects of care that are not related to the duties of the hospice. 4. The facility will monitor and evaluate the resident's response to the hospice care plans. |

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| F 0881<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Implement a program that monitors antibiotic use.<br><br>Based on interview and record review, the facility failed to implement its antibiotic (ATB - a medicine that fights bacterial infections by killing bacteria or stopping them from multiplying) stewardship program (a coherent set of actions which promote using antimicrobials responsibly) that includes antibiotic use protocols and a system to monitor antibiotic use for (1) of three (3) sampled residents (Resident 28) reviewed for antibiotic use by failing to ensure the physician indicated a reason for the continued use of antibiotics when the resident did not meet the criteria. This deficient practice placed Resident 28 at risk for development of resistance to antibiotics which may lead to multidrug resistant organisms (MDRO - organisms primarily bacteria that have developed resistance to multiple classes of antibiotics making infections difficult to treat). Findings: During a review of Resident 28's admission Record, the admission Record indicated the facility originally admitted the resident on 7/18/2025 and readmitted in the facility on 3/2/2026 with diagnoses including osteomyelitis (inflammation of bone or bone marrow, usually due to infection), absence of right toes, and absence of right leg above knee. During a review of Resident 28's History and Physical (H&P), dated 1/2/2026, the H&P indicated the resident had the capacity to understand and make decisions. During a review of Resident 28's Minimum Data Set (MDS - a resident assessment tool), dated 4/15/2026, the MDS indicated Resident 28 had an intact cognition (mental action or process of acquiring knowledge and understanding) and was able to understand others and make his needs known. The MDS further indicated Resident 28 had impairment on the lower extremity and was independent with eating and oral hygiene; setup or clean-up assistance with upper body dressing; supervision or touching assistance to partial or moderate assistance from staff with all other activities of daily living (ADLs - basic tasks that must be accomplished every day for an individual to thrive). The MDS indicated Resident 28 had intravenous (IV - through the vein) access and was on IV antibiotics. During a review of Resident 28's Order Summary Report, the Order Summary Report indicated the following physician's orders: - 3/3/2026: levofloxacin (an antibiotic used to treat various bacterial infections) 500 milligrams (mg - a unit of measurement) give 1 tablet by mouth 1 time a day for urinary tract infection (UTI - an infection in the bladder/urinary tract) for five (5) days. - 3/3/2026: ertapenem sodium (a broad-spectrum antibiotic [effective against a wide variety of bacteria] used to treat various bacterial infections) injection solution reconstituted 1 gram (gm - a unit of measurement) use 1 dose intravenously every 24 hours for ESBL (extended-spectrum beta-lactamase - a type of enzyme found in strains of some bacteria that make certain antibiotics ineffective) until 4/9/2026. - 3/9/2026: vancomycin hydrochloride (a type of antibiotic used to treat complicated skin infections, bloodstream infections, bone and joint infections) IV solution 500 mg per 100 milliliters (ml - a unit of measurement). Use 500 mg intravenously every 12 hours for diabetic infection of left foot until 4/6/2026. During a review of Resident 28's Infection Screening Evaluation forms, dated 3/2/2026, for acute dysuria (difficulty urinating) and redness on the wound/skin indicated Resident 28 did not have any fever, no respirations more than (>) 25 per minute, no low blood pressure, no pulse rate > 100 beats per minute, and there were no other symptoms noted. During a review of Resident 28's Antibiotic Time Out forms, dated 3/6/2026, for the use levofloxacin, ertapenem sodium, and vancomycin hydrochloride, the Antibiotic Time Out forms indicated that the resident remained afebrile (no fever), no trending up and down for the temperature, respirations, pulse rate, and blood pressure, and there were no current symptoms of infections. The Antibiotic Time Out forms further indicated that the physician was notified and aware of Resident 28's current clinical status and the rationale for an antibiotic time out and the physician stated to continue with the current antibiotic orders but did not indicate the physician's reason for continuing the antibiotic therapy. During a concurrent interview and record review on 4/9/2026, at 1:40 p.m., with the Infection Preventionist (IP), Resident 28's physician's orders, infection screening evaluation forms, and antibiotic time out forms were reviewed. The IP stated Resident 28 had physician's orders for levofloxacin and ertapenem sodium on 3/3/2026<br>(continued on next page) |

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| F 0881<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | and vancomycin hydrochloride on 3/9/026. The IP stated antibiotic time out forms dated 3/6/2026 for levofloxacin, ertapenem sodium, and vancomycin hydrochloride indicated that Resident 28 did not meet the criteria for the use of the antibiotics and the physician was made aware and stated to continue with the antibiotic regimen. The IP stated that the physician verbally stated that the antibiotic therapy cannot be stopped abruptly. The IP stated she did not document in the form what the physician stated. The IP stated she should have documented in the form the physician's reason per facility policy on antibiotic stewardship program. The IP stated that if Resident 28 continued to receive the antibiotic but did not meet the criteria upon evaluation, the resident can develop resistance to stronger antibiotics. During an interview on 4/10/2026, at 9:45 a.m., with the Director of Nursing (DON), the DON stated that every time there is an antibiotic order, the licensed nurse who received the order and the IP will fill out the infection screening evaluation form and antibiotic time out form to ensure that the antibiotic use for the resident is appropriate. The DON stated that the IP will notify the physician that the resident did not meet the criteria and document in the antibiotic time out form the reason. The DON stated that the IP should have documented in the antibiotic time out form the physician's reason for continuation of the antibiotic therapy. The DON stated that if there is no appropriate indication for Resident 28's use of levofloxacin, ertapenem sodium, and vancomycin hydrochloride, it placed Resident 28 at risk for development of resistance to most antibiotics resulting to MDROs which make it harder to treat future infections. During a review of the facility's policy and procedure (P&P) titled, Antibiotic Stewardship Program, last reviewed on 3/18/2026, the P&P indicated that the purpose of the program is to optimize the treatment of infections while reducing the adverse events associated with antibiotic use. The P&P further indicated: - The IP coordinates all antibiotic stewardship activities, maintains documentation, and serves as a resource for all clinical staff. - The Medical Director serves as the primary medical point of contact for the program and serves as a liaison between the facility and other medical staff members. - The attending physicians prescribe appropriate antibiotics in accordance with standards of practice and facility protocols. - All prescriptions for antibiotics shall specify the dose, duration, and indication for use. - Antibiotic orders obtained upon admission, whether new admission or readmission, to the facility shall be reviewed for appropriateness. |

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| F 0908<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Keep all essential equipment working safely.<br><br>Based on observation, interview, and record review, the facility failed to maintain mechanical, electrical, and resident care equipment in safe operating condition for one (1) of nine (9) sampled residents (Resident 129) reviewed under the environment task by: 1. Failing to ensure Resident 129's bed controller (device used to change the height and angle of the bed) cord did not have exposed wires and was covered with black plastic tape. 2. Failing to ensure Resident 129's bed control's touch pad cover was not peeling off and properly functioning. These deficient practices had the potential to place Resident 129 at risk of incurring injury. Findings: During a review of Resident 129's admission Record, the admission Record indicated the facility admitted the resident on 3/14/2026 with diagnoses including dementia (a progressive state of decline in mental abilities), difficulty in walking, and generalized muscle weakness. During a review of Resident 129's History and Physical (H&P), dated 3/16/2026, the H&P indicated that Resident 129 did not have the capacity to understand and make decisions. During a review of Resident 129's Minimum Data Set (MDS - a resident assessment tool), dated 3/18/2026, the MDS indicated Resident 129 was sometimes able to understand others, sometimes able to make his needs known and had severely impaired cognition (mental action or process of acquiring knowledge and understanding). The MDS further indicated Resident 129 required partial or moderate assistance with rolling left and right, sit to lying and lying to sitting on side of bed; substantial/maximal assistance with eating, oral hygiene, bathing self, sit to stand, and chair to bed, ed to chair transfers; total assistance from staff with all other activities of daily living (ADLs - basic tasks that must be accomplished every day for an individual to thrive). During an observation on 4/6/2026 at 9:47 a.m., inside Resident 129's room, observed Resident 129 lying in bed asleep. Observed the bed control placed on Resident 129's left side with the bed control's touch pad cover peeling and the cord had some exposed wires covered with black plastic material tape. During a concurrent observation and interview on 4/6/2026 at 9:51 a.m. inside Resident 129's room with Licensed Vocational Nurse (LVN) 1, LVN 1 stated that Resident 129's bed control's touch pad cover was peeling off, and the bed control cord had some exposed wires and was covered at least 12 inches with a black electrical tape. When tested for functionality, LVN 1 pressed the up-arrow button to adjust the height of the bed at least three (3) times before the bed started moving up. LVN 1 stated that the bed control was not functioning properly due to the touch pad cover peeling off. LVN 1 stated that she was not aware that Resident 129's bed control was in disrepair. LVN 1 stated that when staff observe any resident care equipment is in disrepair, the maintenance department should be notified as soon as possible to replace the equipment promptly. LVN 1 stated that keeping an equipment in disrepair such as and the bed control touch pad cover peeling off and the cord with exposed wires covered with black electrical tape can potentially cause electrical shock and injury to the resident. LVN 1 stated that the maintenance department should have been notified timely by staff to replace Resident 129's bed control that is in disrepair as the practice placed Resident 129 at risk for discomfort and/or injury due to electrical shock from the exposed wires and the bed not functioning well. During an interview on 4/9/2026 at 2:45 p.m. with Registered Nurse (RN) 1, RN 1 stated that every time a staff member observes any resident care equipment that is in disrepair, the maintenance department should be notified as soon as possible to replace the equipment as any equipment not in safe operating condition did not provide a safe environment for the resident. RN 1 stated that Resident 129's bed control should have been replaced immediately as the bed control that was in disrepair was not providing safe environment for Resident 129 and can cause discomfort or injury to the resident such as electrical shock. During an interview on 4/10/2026 at 8:45 a.m. with the Director of Nursing (DON), the DON stated that the maintenance department makes rounds at least monthly to ensure that the resident care equipment is in good, safe working condition. The DON stated that if the maintenance department did not see the broken equipment, the staff would be responsible in notifying maintenance to replace the equipment as it did not provide a safe environment for the<br>(continued on next page) |

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| F 0908<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | residents. The DON stated that there is a logbook for maintenance orders at each nursing station desk. The DON stated that Resident 129's bed control should have been replaced as the bed control that was in disrepair did not provide a safe environment for Resident 129 and placed the resident at risk for any discomfort, and/or electrical injury due to bed control touch pad cover that was peeling off and exposed wires on the cord covered with electrical tape. During a review of the facility's policy and procedure (P&P) titled, Safe and Homelike Environment, last reviewed on 3/18/2026, the P&P indicated that in accordance with the residents' rights, the facility will provide a safe, clean, comfortable, and homelike environment ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. The P&P further indicated that the housekeeping and maintenance services will be provided as necessary to maintain a sanitary, orderly and comfortable environment. During a review of the facility's P&P titled, Preventative Maintenance Program, last reviewed on 3/18/2026, the P&P indicated that a preventative maintenance program shall be developed and implemented to ensure the provision of a safe, functional, sanitary, and comfortable environment for residents, staff, and the public. The P&P further indicated that the Maintenance Director (MD) is responsible for developing and maintaining a schedule of maintenance services to ensure that the buildings, grounds, and equipment are maintained in a safe and operable manner. |