STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056082	A. Building B. Wing	05/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Canyon Springs Post-Acute	180 North Jackson Avenue San Jose, CA 95116

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44583 Based on observation, interview, and record review, the facility failed to maintain respect, and dignity to two of three sampled residents (Residents 20 and 591) when: 1. Certified nursing assistant C (CNA C) was standing while feeding Resident 20; and, 2. Restorative Nurse Assistant (RNA) K was standing while feeding Resident 591. These failures had the potential to negatively affect resident's emotional and psychosocial well-being. Findings: 1. Review of Resident 20's clinical record titled, Admission Record, dated 5/7/2025, indicated Resident 20 was admitted to the facility with diagnoses including dementia (a progressive state of decline in mental abilities), dysphagia (difficulty in swallowing), and adult failure to thrive (a decline caused by chronic diseases and functional impairments which can cause weight loss, decreased appetite, poor nutrition, and inactivity). Review of Resident 20's quarterly minimum data set (MDS - a federally mandated resident assessment tool) assessment dated [DATE], indicated Resident 20's brief interview for mental status (BIMS, a tool used to assess cognition [knowing, learning, and understanding things]) score was 05 (a score of 0 to 7 indicates severe cognitive impairment, 8-12 moderate impairment, 13-15 patient is cognitively intact). During a concurrent observation and interview with CNA C on 5/5/2025 at 8:46 a.m., inside Resident 20's room, Resident 20 was sitting up in bed being spoon-fed by CNA C with breakfast food while CNA C was standing, and the privacy curtain was not drawn. CNA C confirmed the above observation and stated she preferred to assist Resident 20 with meals while standing because she wanted to see Resident 20's face while being fed. CNA C further stated that Resident 20 had asked her to sit down but CNA C refused. After five minutes of observation, CNA C sat on Resident 20's bed and continued to spoon-fed Resident 20. CNA C stated they did not have any available chair to sit on. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the director of staff development (DSD) on 5/6/2025 at 3:13 p.m., DSD confirmed staff should be seated in front of the residents during meal assistance. DSD stated staff should grab a chair when there was no chair inside the resident's room. DSD further stated staff should not sit on resident's bed during meal assistance. During a review of the facility's policy and procedure titled, Dignity, date revised 2/2021, indicated, Residents are treated with dignity and respect at all times . When assisting with care, residents are supported in exercising their rights. For example, residents are provided with a dignified dining experience. 49345 2. A review of Resident 591's medical record indicated an admitted [DATE]. Resident 591's diagnoses included cognitive communication deficit (trouble communicating because of problems with their thinking and processing abilities, not just their language skills), and dysphagia, oral phase (difficulty with the first stage of swallowing, which happens in the mouth). A review of Resident 591's Minimum Data Set (MDS - a federally mandated resident assessment tool) assessment dated [DATE], indicated Resident 591's brief interview for mental status (BIMS, a tool used to assess cognition [knowing, learning, and understanding things]) score was 13 (a score of 0 to 7 indicates severe cognitive impairment, 8-12 moderate impairment, 13-15 patient is cognitively intact). During a concurrent observation and interview on 5/5/25 at 8:56 a.m. inside Resident 591's room, Restorative Nurse Assistant (RNA) K was standing at bedside while feeding Resident 591. Resident 591 was sitting on the bed. RNA K stated it was okay to stand while feeding a resident. During an interview on 5/6/25 at 3:14 p.m. with the Director of Staff Development (DSD), the DSD stated staff must sit while feeding a resident. During an interview on 5/8/25 at 3:34 p.m. with the Director of Nursing (DON), the DON stated staff needed to sit down while feeding residents. A review of the facility's policy and procedure titled, Dignity, date revised 2/2021, indicated, Residents are treated with dignity and respect at all times . When assisting with care, residents are supported in exercising their rights. For example, residents are provided with a dignified dining experience.

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. 44583 Based on interview and record review, the facility failed to ensure three out of 35 sampled residents (Residents 77, 175, and 57) were free from chemical restraints (the use of medications such as psychotropic medications [drugs that affects brain activities associated with mental processes and behaviors, example is antipsychotics, antidepressants, anti-anxiety, hypnotics] not for therapeutic reasons, but to restrict a person's freedom of movement or control their behavior) when: 1. Resident 77 continued to receive lorazepam (brand name: Ativan; anti-anxiety - medication to treat agitation and anxiety) and trazodone (antidepressant - a medication used to manage and treat depression [low mood or loss of pleasure or interest in activities for long periods of time]) without clinical documentation of non-pharmacological interventions (treatments or strategies that aim to improve health or manage conditions without using medications, focusing instead on physical, psychological, or behavioral approaches) were attempted or provided for Resident 77's use of anti-anxiety and antidepressant medications; 2. Resident 175 continued to receive sertraline hydrochloride (HCl) (brand name: Zoloft, antidepressant) and mirtazapine (brand name: Remeron, antidepressant) without clinical documentation of non-pharmacological interventions were attempted or provided for Resident 175's use of antidepressants; and, 3. Resident 57 received Quetiapine (an antipsychotic medication that helps treat several kinds of mental health conditions) without target behavior monitoring. These failures had the potential for increased risks associated with the use of psychotropic medications that could negatively affect the residents' physical, mental and psychosocial well-being. Findings: 1. Review of Resident 77's clinical record titled, Admission Record, dated 5/9/2025, indicated Resident 77 was admitted to the facility with diagnoses including nontraumatic chronic subdural hemorrhage (a bleeding event within the brain where blood collects between the dura mater [the tough outer membrane covering the brain] and the brain tissue itself, but without an injury or trauma to the head), dementia (a progressive state of decline in mental abilities), anxiety disorder (a mental illness that causes constant fear) and history of falling. Review of Resident 77's clinical record titled, Order Summary Report, dated 5/9/2025, it indicated the following orders: a. Lorazepam 0.5 milligrams (mg - unit of measurement), Give 1 tablet by mouth in the evening for anxiety m/b [manifested by] repetitive physical movements (fidgeting and pacing), and b. Trazodone HCl 50 mg, Give 1 tablet by mouth at bedtime for Depression m/b difficulty sleeping. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of Resident 77's nursing progress notes and medication administration record (MAR - a daily documentation record used by a licensed nurse to document medications and treatments given to a resident) for 3/2025, 4/2025, and 5/1-5/8/2025, the documentation did not indicate non-pharmacological interventions were attempted or provided to Resident 77 for the use of lorazepam and trazodone. During a concurrent interview with director of nursing (DON) and record review of Resident 77's MAR dated 3/2025, 4/2025 and 5/1 - 5/8/2025 on 5/9/2025 at 8:29 a.m., DON confirmed there were no documentation which indicated non-pharmacological interventions were attempted or provided to Resident 77 for the use of both lorazepam and trazodone. DON stated the non-pharmacological interventions should be documented in Resident 77's MAR. 2. Review of Resident 175's clinical record titled, Admission Record, dated 5/9/2025, indicated, Resident 175 was admitted to the facility with diagnoses including type 2 diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), dementia, and depression. Review of Resident 175's clinical record titled, Order Summary Report, dated 5/9/2025, indicated the following orders: a. Mirtazapine 15 mg, Give 1 tablet by mouth at bedtime for Depression m/b difficulty falling asleep, and b. Sertraline HCl 100 mg, Give 1 tablet by mouth one time a day for Depression m/b verbalization of feeling sad. Review of Resident 175's nursing progress notes and MAR for the month of 3/2025, 4/2025, and 5/1-5/8/2025, the documentation did not indicate that non-pharmacological interventions were attempted or provided to Resident 175 for the use of antidepressants. During a concurrent interview with DON and record review of Resident 175's MAR dated 3/2025, 4/2025 and 5/1 - 5/8/2025 on 5/9/2025 at 8:06 a.m., DON confirmed there were no documentation which indicated non-pharmacological interventions were attempted or provided to Resident 175 for the use of both antidepressants. During a review of the facility's policy and procedure titled, Psychoactive/Psychotropic Medication Use, dated 4/2025, indicated, Psychoactive (also known as Psychotropic) medications may be administered following federal and state regulations if the medication is necessary to treat a specifically diagnosed condition and is appropriately documented in the medical record. Additionally, behavioral interventions, unless contraindicated, will be used to meet the individual needs of the resident. Psychotropic medication management for the resident will involve the facility interdisciplinary team consideration of the following indication and clinical need for medication . Management will also include preventing (where possible), identifying, and responding to adverse consequences; and identifying person-centered non-pharmacological interventions, unless contraindicated, to meet the individual needs of the resident, and minimize or discontinue the use of Psychotropic medication. 50855 (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. During a review of Resident 57's clinical record indicated Resident 57 was admitted to the facility with diagnosis including Alzheimer's disease (a progressive disease that destroys memory and mental functions). During a review of Resident 57's physician's order indicated an order for Quetiapine 25 milligram (mg, unit of measure), give 1 tablet by mouth at bedtime for Psychosis (a collection of symptoms that affect the mind, where there has been some loss of contact with reality) m/b (manifested by) paranoia (is excessive mistrust or suspicion of people), dated 3/19/2025. During a review of Resident 57's clinical record indicated there was no monitoring for the target behavior of Quetiapine for psychosis manifested by paranoia. During a concurrent interview and record review on 5/7/25 at 3:36 p.m., with the Director of Nursing (DON), the DON reviewed Resident 57's clinical record and she confirmed that there was no target behavior monitoring for Quetiapine. The DON stated Resident 57 should have behavior monitoring for Quetiapine. During a review of the facility's P&P titled Psychoactive/Psychotropic Medication Use, dated 4/2025, indicated, . e. Monitoring of a resident receiving Psychotropic medication will include evaluation of the effectiveness of the medication, as well as an assessment for possible adverse consequences. Behavioral symptoms are reevaluated periodically to determine the potential for reducing or discounting the drug based on the therapeutic goals and any adverse effect or possible functional impairment .

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44583 Based on observation, interview, and record review, the facility failed to accurately code the Minimum Data Set (MDS - a federally mandated resident assessment tool) assessments for one of 35 sampled residents (Resident 158) when Resident 158's five MDS assessments did not reflect Resident 158's feeding tube (a medical device, a thin and flexible tube, used to deliver nutrition and fluids directly into the digestive system when a person cannot eat or drink safely by mouth) and the percentage of intakes by artificial route. These failures resulted in inaccurate MDS assessments and had the potential to affect the residents' care. Findings: Review of Resident 158's clinical record titled, Admission Record, dated 5/9/5025, indicated Resident 158 was admitted to the facility with diagnoses including aphasia (a disorder that makes it difficult to speak) following cerebral infarction (also known as an ischemic stroke, is a condition where blood flow to the brain is interrupted, causing brain tissue to die), dysphagia (difficulty swallowing) following cerebral infarction, and gastrostomy (a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems) status. Review of Resident 158's clinical record titled, Order Summary Report, dated 5/9/2025, it revealed an order, Formula: Glucerna 1.2 via enteral pump at 85cc/hr [cubic centimeter per hour] x 15 hours (off from 07:00AM to 04:00PM) . It indicated the feeding to start at 4:00 p.m. and to end at 7:00 a.m. During observations on 5/5/2025 at 8:27 a.m., and 5/6/2025 at 9:22 a.m., inside Resident 158's room, Resident 158 was in bed and a feeding pump was observed in a pole positioned at the left side of Resident 158's bed. During a concurrent interview with MDS nurse G (MDSN G) and record review of Resident 158's MDS assessment on 5/8/2025 at 3:48 p.m., Resident 158's Annual assessment dated [DATE]; Quarterly review assessment dated [DATE]; 5-day scheduled assessment dated [DATE]; Quarterly review assessment dated [DATE] and Quarterly review assessment dated [DATE], revealed the following: 1. Section K0520B Nutritional Approaches: Feeding tube like gastrostomy tube was not coded or left blank; 2. Section K0710A Proportion of total calories the resident received through parenteral (also known as intravenous [IV] nutrition, which refers to the delivery of nutrients intravenously, bypassing the digestive system) or tube feeding was not coded or left blank; and, 3. Section K0710B Average fluid intake per day by tube feeding was not coded or left blank. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	MDSN G confirmed the above coding assessments and stated the facility's registered dietitian (RD) was the one who coded the mentioned MDS sections. During an interview with the director of nursing (DON) on 5/9/2025 at 8:40 a.m., DON confirmed Resident 158 had been on tube feeding since admission. During an interview with the RD on 5/9/2025 at 9:32 a.m., RD confirmed she was the one who completed Resident 158's MDS assessments' Section K - Swallowing/Nutritional Status. RD stated it was her error not to code Resident 158's feeding tube, total calories received and the fluid intake. RD further stated the MDS sections related to Resident 158's feeding tube should have been coded. Review of the Long-Term Care Facility Resident Assessment Instrument (RAI - a guide for facility staff to existing coding and transmission) 3.0 User's Manual Version 1.19.1, dated 10/2024, indicated, Coding Tip for K0520B * Only feeding tubes that are used to deliver nutritive substances and/or hydration during the assessment period are coded in K0520B. K0710: Percent Intake by Artificial Route. Item Rationale: Health-related Quality of Life *Nutritional approached that vary from the [NAME], such as parenteral/IV or feeding tubes, can diminish an individual's sense of dignity and self-worth as well as diminish pleasure from eating .K0710A, Proportion of Total Caloris the Resident Received through Parental or Tube Feeding: Steps for Assessment: 1. Review intake records within the last 7 days to determine actual intake through parenteral or tube feeding routes. 2. Calculate proportion of total calories received through these routes .Coding Instructions *Select the best response: 1. 25% or less 2. 26% to 50% 3. 51% or more .K0710B, Average Fluid Intake per Day by IV or Tube Feeding: Steps for Assessment 1. Review intake records from the last 7 days. 2. Add up the total amount of fluid received each day by IV and/or tube feedings only .Code for the average number of cc per day of fluid the resident received via IV or tube feeding. Record what was actually received by the resident, not what was ordered. Further review indicated, Item Rationale in Section Z0400: Signatures of Persons Completing the Assessment . * To obtain the signature of all persons who completed any part of the MDS. Legally, it is an attestation of accuracy with the primary responsibility for its accuracy with the person selecting the MDS item response. Each person completing a section or portion of a section of the MDS is required to sign the Attestation Statement. * Read the Attestation Statement carefully. You are certifying that the information you entered on the MDS, to the best of your knowledge, most accurately reflects the resident's status. Penalties may be applied for submitting false information.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50855 Based on interview and record review, the facility failed to develop and implement comprehensive care plans that included target symptoms, measurable objectives, and interventions for one of 35 sampled residents (Resident 16) when there were no care plan developed for schizophrenia (chronic brain disorder that affects how a person thinks, feels, and behaves). The failure had the potential for the residents not attaining their highest practicable physical, mental, and psychosocial well-being. Finding: During a review of Resident 16's clinical record indicated Resident 16 was admitted to the facility on [DATE] with diagnosis including schizophrenia. During a review of Resident 16's physician's order indicated an order dated 4/24/25 Aripiprazole (Antipsychotic It can treat schizophrenia) 15 mg (milligram, unit of measure) give one tablet by mouth in the morning for schizophrenia . During a review of Resident 16's clinical record indicated there was no comprehensive care plan developed for the resident's schizophrenia diagnosis. During a concurrent interview and record review on 5/07/25 at 3:45 p.m., with the Director of Nursing (DON), the DON reviewed Resident 16's care plan and she confirmed that there was no care plan developed for schizophrenia diagnosis. The DON further stated any active diagnosis should have a care plan. During a review of the facility's policy and procedures titled, Care Plans, Comprehensive Person-Centered, dated 2001, indicated, A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and function needs is developed and implemented for each resident.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. 44583 Based on observation, interview, and record review, the facility failed to provide services according to professional standards for two 11 sampled residents for medication administration (Residents 88 and 192) when: 1. Licensed vocational nurse I (LVN I) provided the wrong nutritional supplement (Boost Plus - brand name of the nutritional supplement) to Resident 88; 2. Registered nurse J (RN J) did not perform a push-pause method (or pulsatile flushing technique is a method to flush IV [intravenous] and catheters, which involves rapidly injecting fluid into the line, pausing briefly, then repeating the process) when flushing Resident 192's peripherally inserted central catheter (PICC, long slender, flexible tube inserted into a peripheral vein, typically in the upper arm, and advanced until the catheter tip terminates in the chest near the heart to obtain venous access) line with normal saline (NS). These failures had the potential to affect residents' care, health, and well-being. Findings: 1. During medication administration observation on 5/7/2025 at 8:50 a.m., LVN I prepared all the medications and the nutritional supplement for Resident 88. LVN I showed the carton of Boost Plus before she entered Resident 88's room. Additional observation at 8:55 a.m., LVN I poured the whole carton of Boost Plus in a cup and handed it to Resident 88. Resident 88 drank the supplement. During a review of Resident 88's clinical record titled, Order Summary Report, dated 5/7/2025, it indicated an order dated 4/10/2025, Ensure Plus two times a day for supplement. Further review indicated there was no order for Boost Plus. During a review of Resident 88's clinical record titled, Weight variance note, dated 4/6/2025, it indicated a note from the registered dietitian (RD) which revealed Resident 88 had weight loss, PO [by mouth] has been variable and not meeting needs. Would benefit from oral supplement to help meet needs. Hard to meet needs d/t [due to] advanced age, medical status and variable po intake. Recommend: .1 can ensure plus . During a concurrent interview with LVN I and review of Resident 88's order summary report, LVN I confirmed she gave Boost Plus to Resident 88 instead of Ensure Plus. LVN I stated the physician's order was Ensure Plus. During an interview with director of nursing (DON) on 5/9/2025 at 8:00 a.m., DON stated if the physician's order was Ensure Plus, the nurse should have given Ensure Plus to Resident 88 instead of Boost Plus. DON further stated, nurses should follow the physician's order. 2. During medication administration observation on 5/7/2025 at 9:37 a.m., inside Resident 192's room, RN J flushed Resident 192's PICC line with 10 milliliters (ml - volume of measurement) of NS quickly, without using the push-pause method on the syringe plunger. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a follow-up interview with RN J on 5/7/2025 at 9:49 a.m., RN J confirmed the above observation and stated he should have performed the push-pause method in flushing Resident 192's PICC line to prevent it from clogging. During an interview with DON on 5/9/2025 at 8:00 a.m., DON stated nurses should flush the PICC line with the use of a flush and pause motion, in order to maintain the patency of the line. During a review of an article titled, How to Flush a PICC Line or Tunneled Catheter, dated 5/2020, indicated, Unclamp catheter. Begin flushing using a push-pause method on the syringe plunger. Push the contents of the syringe into the catheter, leaving a small amount of fluid in the syringe.

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F 0693 Level of Harm - Minimal harm or potential for actual harm 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49345 Based on observation, interview and record review, the facility failed to ensure administration of enteral feeding (the delivery of nutrients through a feeding tube directly into the stomach) was consistent with and followed Physician's Order for one (Resident 51) out of three sampled residents when insufficient amount was administered, and oral care was not done. These failures had the potential to put Resident 51 at risk for dehydration, weight loss and infection. Findings: A review of Resident 51's clinical record indicated diagnoses of dysphagia following nontraumatic intracerebral hemorrhage (difficulty of swallowing after a stroke), hemiplegia and hemiparesis following nontraumatic intracerebral hemorrhage affecting right dominant side (complete paralysis and weakness on right side of the body after a stroke), aphasia following nontraumatic intracerebral hemorrhage (difficulty to speak, understand and write language after a stroke), and type 2 diabetes mellitus without complications (high levels of blood sugar). A review of Resident 51's Minimum Data Set (MDS - a federally mandated resident assessment tool) assessment dated [DATE], indicated Resident 51's brief interview for mental status (BIMS, a tool used to assess cognition [knowing, learning, and understanding things]) score was 6 (a score of 0 to 7 indicates severe cognitive impairment, 8-12 moderate impairment, 13-15 patient is cognitively intact). A review of Resident 51's Physician's Orders indicated, NPO [nothing by mouth] diet ordered on 8/29/23, Enteral Feed order every shift tube feeding formula: Jevity 1.2 @ 75 ml/hr [milliliter/hour, unit of measurement] via feeding pump continuous x 20 hours/day to provide 1500 ml, 1800 kcal [kilocalorie, unit of measurement] ordered on 10/23/23 and Enteral [pertaining to stomach]- License Nurse to ensure: oral care every shift ordered on 10/22/23. During a concurrent observation and interview on 5/7/25 at 9:10 a.m. with the Director of Nursing (DON) at Resident 51's bedside, the DON verified Resident 51 had whitish buildup in the inner corner of the mouth and the tongue. The DON also verified the presence of tartar (hardened dental plaque that can form on your teeth, both above and below the gum line) around Resident 51's teeth. The DON verified Resident 51's feeding tube set was disconnected, and the level of the feeding solution was 1200 ml. The label of the tube feeding set indicated it was started on 5/6/25 at 5:30 p.m. During a concurrent observation and interview on 5/7/25 at 9:24 a.m. with Certified Nurse Aide (CNA) M, CNA M verified there was no toothbrush for Resident 51 at bedside. CNA M showed lemon glycerin swab sticks (a medical swab with a lemon-flavored, glycerin-soaked tip, designed to help relieve dry mouth and provide temporary relief from minor oral discomfort) and foam-tipped swab sticks and stated those were used to clean Resident 51's mouth. CNA M stated she had not given oral care to Resident 51 yet that morning. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview on 5/7/25 at 9:28 a.m. with Licensed Vocational Nurse (LVN) N, LVN N stated Resident 51's tube feeding was stopped at 7:30 a.m. LVN N verified Resident 51's whitish build up in the mouth. During a concurrent observation and interview on 5/7/25 at 3:44 p.m. at Resident 51's bedside with LVN P, LVN P stated she was Resident 51's nurse for the afternoon shift. LVN P verified Resident 51's feeding tube was disconnected and was turned off. LVN P also verified Resident 51's feeding solution level was a little under 1100 ml. During a concurrent interview and record review on 5/7/25 at 3:50 p.m. with LVN N, LVN N stated she ran Resident 51's enteral feeding for a total of four hours during her morning shift. LVN N verified Resident 51's Physician Order for enteral feeding was 75 ml/hr for 20 hours per day for a total of 1500 ml. LVN N stated there was no documentation for the specific amount of enteral feeding administered for Resident 51. During a concurrent interview and record review on 5/7/25 at 4:08 p.m. with Registered Nurse (RN) D and Assistant Director of Nursing (ADON) E, RN D and ADON E verified Resident 51's Physician's order for enteral feeding. RN D and ADON E verified there was no hourly, per shift or daily documentation and monitoring of Resident 51's enteral feeding intake amount. During a concurrent interview and record review on 5/8/25 at 3:18 p.m. with the DON, the DON verified Resident 51's Physician Order for Enteral Feeding and NPO. The DON stated nurses should have checked the level of remaining enteral feeding solution during their report at the change of shift. The DON verified there was no monitoring for the accurate amount of enteral feeding solution administered for Resident 51. The DON stated it should have been accurately documented. The DON also stated Resident 51 was at risk for dehydration, weight loss and any change of condition due to inadequate monitoring of enteral feeding. During a concurrent interview and record review on 5/9/25 at 9:54 a.m. with Registered Dietician (RD), RD verified Resident 51's Physician's Order for enteral feeding and NPO. RD also verified there was no accurate monitoring and documentation of the amount of enteral feeding solution in milliliter administered to Resident 51. RD stated Resident 51 did not receive sufficient amount of enteral feeding as ordered by physician on 5/7/25. A review of facility's undated policy and procedure (P&P) entitled Enteral Tube Feeding via Continuous Pump, the P&P indicated, .Documentation: The person performing this procedure should record the following information in the resident's medical record: .3. Amount and type of enteral feeding. 4. The average fluid intake per day . A review of facility's policy and procedure (P&P) entitled Enteral Tube Feeding via Continuous Pump revised November 2018, the P&P indicated, .3. The dietician, with input from the provider and nurse: .b. Determines whether the resident's current intake is adequate to meet his or her nutritional needs .9. The nursing staff and provider monitor the resident for signs and symptoms of inadequate nutrition .15. Staff caring for residents with feeding tubes are trained on how to recognize and report complications relating to the administration of enteral nutrition products, such as: .b. inadequate nutrition .

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. 44583 Based on observation, interview and record review, the facility failed to ensure that a proper treatment services for oxygen (O2, a colorless, odorless gas) therapy was provided for one of four sampled residents (residents on oxygen therapy) when Resident 139 did not receive the correct flow of oxygen administration. This deficient practice had the potential for Resident 139 to have complication related to improper treatment while receiving O2 therapy. Findings: During an observation on 5/5/2025 at 8:24 a.m., inside Resident 139's room, Resident 139 was observed having breakfast in bed and with O2 therapy at 1.5 liters per minute (lpm) thru (via) a nasal cannula (NC - a small plastic tube, which fits into the person's nostrils for providing supplemental oxygen). During a concurrent observation and interview with licensed vocational nurse B (LVN B) on 5/6/2025 at 3:57 p.m., inside Resident 139's room, Resident 139 was observed in bed with O2 therapy at 1.5 lpm via NC. LVN B confirmed the oxygen flow was at 1.5 lpm. During a concurrent interview with LVN B and record review of Resident 139's oxygen order on 5/6/2025 at 4:09 p.m., LVN B confirmed the oxygen flow rate for Resident 139 was supposed to be at 1 lpm as ordered. LVN B stated they should have followed the doctor's order for oxygen therapy which was at 1 lpm and not at 1.5 lpm. Review of Resident 139's clinical record titled, Admission Record, dated 5/7/2025, indicated Resident 139 was admitted to the facility with diagnoses including chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing), other asthma (inflammatory disease of the airway that often causes wheezing, coughing, and shortness of breath), and unspecified diastolic (congestive) heart failure (CHF-a heart disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling). During an interview with the director of nursing (DON) on 5/9/2025 at 1:04 p.m., DON stated nurses should review the doctor's order first before they administer the oxygen to the resident. DON further stated nurses should follow the doctor's order related to oxygen therapy and they should sit down to see the oxygen regulator at an eye level to administer the correct oxygen flow rate. During a review of the facility's policy and procedure titled, Oxygen Administration, date revised 10/2010, indicated, Verify that there is a physician's order for this procedure. Review the physician's orders or facility protocol for oxygen administration .Adjust the oxygen delivery device so that it is comfortable for the resident and the proper flow of oxygen is being administered.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50855 Based on observation, interview, and record review, the facility failed to ensure the proper use of side or bed rails (adjustable rigid bars attached to the side of a bed) for one of 35 sampled residents (Resident 57) resident who used side or bed rails when there was no physician's order for bilateral (both) quarter upper bed rails prior to installing the bed rails, the care plan for bilateral quarter upper bed rails was not developed in a timely manner, and the informed consent for bilateral quarter upper bed rails was not obtained prior to installing the bed rails. These failures had the potential risk for injuries to the Resident 57. During an observation in Resident 57's room on 5/5/25 at 9:44 a.m., Resident 57's bed observed with bilateral quarter upper bed rails were up. During a review of Resident 57's clinical record indicated Resident 57 was admitted to the facility on [DATE] with diagnosis including Alzheimer's disease (a progressive disease that destroys memory and mental functions). During a review of Resident 57's clinical record titled Bed Rail and Entrapment Risk observation/Assessment, effective date 3/5/25, indicated in A. section I bed Rail use 1. Are bed Rails currently in use? a. Yes. 2. If yes, Bed Rail type in use: d. Quarter Rail(s). 2.b Bed Rails Location a. Left Upper, c. Right upper. 2c. Bed Rail(s) are in use: a. At all times when resident is in bed to enhance mobility. 3. Are Bed Rails being considered for use? a. yes . During a review of Resident 57's order summary report dated 5/7/25 at 16:05:29 PT (Pacific Time Zone) indicated there were no orders for bilateral upper quarter bed rails. During a review of Resident 57's clinical record indicated there were no care plans developed for the use of bilateral quarter upper bed rails. During a concurrent observation and interview inside Resident 57's room on 5/9/25 at 2:43 p.m., with Assistant Director of Nursing E (ADON E), she confirmed Resident 57's has bilateral quarter upper bed rails in use, ADON E stated prior to installing bed rails they should have a consent, assessment, physician order, and care plan. During a concurrent interview and record review on 5/9/25 at 2:50 p.m., with ADON E, she reviewed Resident 57's physician order for bed rails, dated 5/9/25 and a care plan, dated 5/9/25. ADON E confirmed the order and care plan was just made today 5/9/25. ADON E further stated they must have physician order prior to installing the bed rails and right away after installing they have to develop a bed rails care plan. During a review of Resident 57's clinical record indicated consent for bilateral quarter upper bed rails, dated 5/9/25. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 5/9/25 at 3:14 p.m., with the Director of Nursing (DON) the DON stated confirmed consent was just today 5/9/25 signed by Resident 57's husband. During a review of facility's policy and procedure (P&P) titled, Bed Safety and Bed Rails dated 2001, the P&P indicated, .8. Before using bed rails for any reason, the staff shall inform the resident or representative about the benefits and potential hazards associated with bed rails and obtain informed consent. The following information will be included in the consent: a. The assessed medical needs that will be addressed with the use of bed rails; b. The resident's risks from the use of bed rails and how these will be mitigated; c. The alternatives that were attempted but failed to meet the resident's needs; and d. The alternatives that were considered but not attempted and the reasons . During a review of the facility's policy and procedures titled, Care Plans, Comprehensive Person-Centered, dated 2001, indicated, A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and function needs is developed and implemented for each resident.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 44583 Based on interview and record review, the facility failed to ensure an account of all controlled drugs (medications with high potential for abuse and addiction) was maintained and reconciled for four of six randomly selected residents (Residents 137, 3, 135, and 16) when: 1. Nursing staff signed out the controlled drugs from the Controlled Substance Accountability Sheet (CSAS - an inventory sheet that keeps record of the usage of controlled medications) but did not document on the Medication Administration Record (MAR - a daily documentation record used by a licensed nurse to document medications and treatments given to a resident) to indicate the controlled medications were given to the resident (Residents 16). 2. Nursing staff documented in resident's MAR that indicated the controlled medications were given but did not document or sign out in resident's CSAS to indicate the controlled medications were taken out of the narcotic box (Residents 3, 135, and 137). These failures had the potential for misuse or diversion of controlled medications. Findings: 1. Review of Resident 16's order summary report, it indicated an order dated 3/10/2025, hydrocodone-acetaminophen [brand name: Norco, a potent controlled medication for pain] 10-325 milligram (mg - unit of measurement) to give one tablet by mouth every 4 hours as needed for pain scale of 6-10 (severe pain). Review of the CSAS for Resident 16's hydrocodone-acetaminophen 10-325 mg and April MAR, indicated on 4/20/2025 at 5:00 a.m., one tablet of hydrocodone-acetaminophen 10-325 mg was signed out by a nursing staff, but it was not documented on the MAR as given to Resident 16. During a concurrent interview and record review on 5/8/2025 at 1:05 p.m., with the director of nursing (DON), DON reviewed CSAS for Resident 16's hydrocodone-acetaminophen 10-325 mg and April MAR and confirmed one tablet of hydrocodone-acetaminophen 10-325 mg was not documented on the MAR around the time it was signed out on 4/20/2025 at 5:00 a.m. 2a. Review of Resident 3's order summary report, it indicated an order dated 3/28/2025, HYDROcodone-Acetaminophen Oral Tablet 5-325 MG (Hydrocodone-Acetaminophen) Give 1 tablet by mouth every 8 hours as needed for moderate to severe pain. Review of Resident 3's MAR for April and May 2025 and CSAS for hydrocodone-acetaminophen 5-325 mg, indicated one tablet of hydrocodone-acetaminophen 5-325 mg was documented as given in MAR on 4/24/2025 at 4:26 p.m. and on 5/4/2025 at 9:38 a.m., but they were not signed out on Resident 3's CSAS. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 5/8/2025 at 1:02 p.m., with the DON, DON reviewed Resident 3's MAR for April/May 2025 and CSAS for Resident 3's hydrocodone-acetaminophen 5-325 mg and confirmed one tablet of the controlled medication was documented as given in the MAR on 4/24/2025 at 4:26 p.m. and one tablet on 5/4/2025 at 9:38 a.m. but were not signed out in CSAS. DON stated resident's controlled medications were dispensed from their Automated Dispensing Unit (ADU - a medication packaging system that stores bulk oral solid medications in canisters and packages), and once nurses took out some controlled medications, they should document the quantity dispensed from ADU and the amount administered to residents on CSAS. DON confirmed there were no other CSAS found for Resident 3's hydrocodone-acetaminophen 5-325 mg. 2b. Review of Resident 135's order summary report, it indicated an order dated 2/20/2025, Tramadol Hydrochloride (HCl) (brand name: Ultram - a controlled medication used for short term relief of moderate to severe pain) 50 mg, Give 1 tablet by mouth every 6 hours as needed for moderate pain. Review of Resident 135's MAR for April 2025 and CSAS for Tramadol HCl 50 mg, indicated one tablet of Tramadol HCl 50 mg was documented as given in MAR on 4/1/2025 at 8:19 a.m. and one tablet at 6:04 p.m., but they were not signed out on Resident 135's CSAS. During a concurrent interview and record review on 5/8/2025 at 1:10 p.m., with the DON, DON reviewed Resident 135's MAR for April 2025 and CSAS for Resident 135's Tramadol HCl 50 mg and confirmed one tablet of the controlled medication were documented as given on 4/1/2025 at 8:19 a.m. and 1 tablet at 6:04 p. m. but were not signed out in CSAS. DON confirmed there were no other CSAS found for Resident 135's Tramadol HCl 50 mg. 2c. Review of Resident 137's order summary report, it indicated an order on 4/16/2025, hydrocodone-acetaminophen 5-325 mg, Give 1 tablet by mouth every 6 hours as needed for Severe pain . During a controlled substance count and interview with licensed vocational nurse Q (LVN Q) on 5/5/2025 at 3:12 p.m., LVN Q reviewed Resident 137's CSAS for hydrocodone-acetaminophen 5-325 mg and confirmed it indicated the quantity remaining was three of the hydrocodone-acetaminophen 5-325 mg tablets but the actual count of the controlled medication in the box was two tablets. LVN Q stated she took one tablet at around 1:30 p.m. for Resident 137's pain but forgot to sign it out in Resident 137's CSAS. LVN Q stated the controlled medication should be signed out from Resident 137's CSAS and signed as given in the MAR as soon as the resident took the medication. During a review of the facility's policy and procedure titled, Controlled Substances, date revised 11/2022, indicated, The facility complies with all laws, regulations, and other requirements related to handling, storage, disposal and documentation of controlled medications .If the count is correct, an individual resident controlled substance record is made for each resident who will be receiving controlled substance .This record contains: a. name of the resident; b. name and strength of the medication; c. quantity received; d. number on hand; .i. time of administration; .k. signature of nurse administering medication. Dispensing and Reconciling Controlled Substances 1. Controlled substance inventory is monitored and reconciled to identify loss or potential diversion in a manner that minimizes the time between loss/diversion and detection/follow-up. 2. The system of reconciling the receipt, dispensing and disposition of controlled substances includes the following: a. Records of personnel access and usage; b. Medication administration records .3. Nursing staff count controlled medication inventory at the end of each shift, using these records to reconcile the inventory count.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. 44583 Based on observation, interview, and record review, the facility had a medication error rate of 9.68% when three medication errors were observed out of 31 opportunities during medication administration for three of 11 residents (Residents 9, 193, and 79) when: 1. Resident 9 received the second dose of albuterol sulfate (an inhaler used to treat or prevent bronchospasm, or narrowing of the airways in the lungs) inhalation (or puff, the act of taking a substance into the body by breathing) without having to wait for one minute for first inhalation to be fully absorbed by the lungs; 2. Resident 193 received three puffs of budesonide -formoterol fumarate dihydrate (it is a combination of medications used to treat asthma [inflammatory disease of the airway that often causes wheezing, coughing, and shortness of breath] and chronic obstructive pulmonary disease [COPD, a long-lasting lung disease]) inhalation instead of two puffs as ordered by the physician; and 3. Resident 79 received five different medications through his gastrostomy tube (or G-tube, a tube inserted through the abdomen that delivers nutrition and medications directly to the stomach) without water flushes in between medications. These failures resulted in residents not receiving medications as prescribed and had the potential to result in residents not receiving the full therapeutic benefit of their medications or experiencing negative health outcomes. Findings: 1. During a medication administration observation on 5/7/2025 at 12:30 p.m., inside Resident 9's room, Resident 9 was seated on her wheelchair and licensed vocational nurse I (LVN I) instructed Resident 9 to take one puff of albuterol sulfate inhalation. Resident 9 took one puff of the medication and after 10 seconds, LVN I continued to administer one more puff of the medication. During an interview with LVN I on 5/7/2025 at 12:35 p.m., LVN I stated she could give the second puff once resident exhaled. LVN I asked, is there a time interval for the second puff? Review of Resident 9's medical record indicated a physician's order dated 6/24/2022 of albuterol sulfate, 2 puff inhale orally four times a day for SOB [shortness of breath] . During an interview with the director of nursing (DON) on 5/8/2025 at 1:56 p.m., DON stated she did not indicate the time interval in between two puffs of inhalers when she did her in-service with nurses. During a review of National Heart, Lung, and Blood Institute Publication Number 21-HL-8165 titled, HOW TO USE A METERED-DOSE INHALER, dated 10/2021, indicated, .If your plan says to take more than 1 puff of medicine, wait 1 minute between puffs . (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's undated policy and procedure titled, Administering Medications through a Metered Dose Inhaler, indicated, Repeat inhalation, if ordered. Allow at least one (1) minute between inhalations of the same medication . 2. During a medication administration observation on 5/8/2025 at 8:36 a.m., inside Resident 193's room, registered nurse R (RN R) handed the budesonide -formoterol fumarate dihydrate inhaler to Resident 193 who was sitting at the edge of the bed. RN R did not provide instructions to Resident 193 on how to use the inhaler, and Resident 193 was observed to self-administer three puffs of the inhaler. During an interview with RN R on 5/8/2025 at 8:40 a.m., RN R confirmed the above observation and stated she should have given Resident 193 instructions first on how to use the inhaler and how much she needed to self-administer before she handed the inhaler to Resident 193. RN R confirmed Resident 193 had an extra dose of the inhaler. During an interview with DON on 5/8/2025 at 1:56 p.m., DON stated nurses should have to explain what they were giving and the dosage of the inhaler before they provide the inhaler to residents who could self-administer. Review of Resident 193's medical record indicated an order dated 4/29/2025 of budesonide-formoterol fumarate dihydride, 2 inhalation inhale orally one time a day for asthma. During a review of the facility's undated policy and procedure titled, Administering Medications through a Metered Dose Inhaler, indicated, The purpose of this procedure is to provide guidelines for the safe administration of inhaled medications . Confirm the identity of the resident. Explain the procedure to the resident. During a review of the facility's policy and procedure titled, Administering Medications, date revised 4/2019, indicated, The individual administering the medication checks the label THREE (3) times to verify the right resident, right medication, right dosage, right time and right method (route) of administration before giving the medication. 3. During a medication administration observation on 5/8/2025 at 9:21 a.m., inside Resident 79's room, licensed vocational nurse S (LVN S) went inside the room with Resident 79's five different medications: Famotidine (a medication that reduces the amount of acid produced in the stomach) 20 milligram (mg, unit of measurement) one tablet, Aspirin (a drug that reduces pain, fever, inflammation and blood clotting) 81 mg one tablet, Senna (a laxative, derived from the Senna plant (a type of Cassia), used to relieve constipation) 8. 6 mg two tablets, Doxepin HCl (a hydrochloride salt form of antidepressant [a drug that treats depression] medication, it can also be used to treat chronic hives) two capsules and levetiracetam (common brand: Keppra, anticonvulsant - it can treat seizures) oral solution 7.5 milliliter (ml, volume of measurement). LVN S prepared the medications for G-tube administration. Each medication was separated into five medication cups. LVN S checked the G-tube placement, flushed it with 30 ml of water, then LVN S started to pour each medication one at a time without flushing in between medications with water. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with LVN S on 5/8/2025 at 9:57 a.m., LVN S confirmed the above observation and stated they were taught to just mix the diluted medication with extra five ml of water in order not to clog. LVN S further stated they never flushed the G-tube with water in between multiple medication administration. During an interview with DON on 5/8/2025 at 2:00 p.m., DON stated she was not sure if nurses had to flush the G-tube with water in between multiple medication administration. During a review of the facility's undated policy and procedure titled, Administering Medications through an Enteral Tube, indicated, The purpose of this procedure is to provide guidelines for the safe administration of medications through an enteral tube . If administering more than one medication, flush with 15 ml warm purified water (or prescribed amount) between medications.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Canyon Springs Post-Acute	180 North Jackson Avenue San Jose, CA 95116

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44583 Based on observation, interview, and record review, the facility failed to ensure medications were properly stored and labeled in two of four medication rooms and in four of seven medication carts when: Multiple opened inhalers, medications, and nasal sprays did not have an appropriate label of resident's named in the bottle or inhaler; [NAME]-dose vials were not labeled with open dates, or with an accurate expiration date, or being used past their discard dates; Opened or used eyedrops did not have a readable resident's name or had an unreadable open and expiration date; Multiple expired home medications were still stored in residents' overflow bin together with other medications that were still within the used by date; An expired over the counter (OTC) medication was still stored with other new OTC medications; and discontinued controlled medications (medications that the use and possession of are controlled by the federal government) and antibiotics (medications that fight bacterial infections) were still stored in the narcotic (controlled medications) box inside the medication carts. Also, one of the two medication refrigerators had discontinued resident's eye drops. These failures had the potential for residents to receive outdated and/or ineffective medications which could result in the residents not receiving the full benefit of the medications and negative health outcomes. The deficient practice had the potential for possible diversion of controlled medications. Findings: 1. During an inspection of Station 3 Medication Room on 5/5/2025 at 10:37 a.m. with both assistant director of nursing T (ADON T) and licensed vocational nurse U (LVN U), the following were identified and confirmed with ADON T and LVN U: a. An eyedrop gentamicin sulfate (medication used to treat eye infections) for Resident 97 had a label indicated it was delivered on 12/9/2024 and confirmed discontinued on 12/19/2024 was still stored in the medication refrigerator. ADON T stated weekend nurses should check the medication rooms and medication refrigerators for any expired or discontinued medications. ADON T further stated discontinued medications should have been removed from the medication refrigerator and discarded. b. Resident 36's medication from home (26 bottles) were expired and still stored together with Resident 36's medications that were still within the used by date bin: * Clopidogrel bisulfate (common brand: Plavix), it can prevent stroke, heart attack, and other heart problems) 75 milligrams (mg, unit of measurement): 5 bottles. Each bottle had indicated an expiration (exp) dated 3/5/2025; 4/16/2025; 3/18/2025; 4/1/2025; and 4/16/2025. * Famotidine 40 mg tablets (medication used to treat ulcers of the stomach and intestines and to prevent intestinal ulcers): 3 bottles. Each bottle had indicated an exp dated 3/5/2025; 4/1/2025; and 4/16/2025. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	*FeroSul 325 mg (an iron supplement to treat or prevent low blood levels of iron) 4 bottles. Each bottle had indicated an exp dated 3/5/2025; 4/16/2025; 4/1/2025; and 4/16/2025. *Tamsulosin hydrochloride (medication used to treat men with symptoms of an enlarged prostate [a gland that produces some of the fluid that carries sperm]) 0.4 mg : 5 bottles Each bottle had indicated an exp dated 4/16/2025; 3/18/2025; 3/5/2025; 4/1/2025; and 4/16/2025. * Sodium chloride (used to prevent or treat sodium deficiency) 1 gram: 4 bottles. Each bottle had indicated an exp dated 4/16/2025; 3/5/2025; 4/1/2025; and 4/16/2025. * Sertraline hydrochloride (a type of antidepressant used to treat depression and sometimes panic attacks) 25 mg: 4 bottles. Each bottle indicated an exp dated 4/16/2025; 3/18/2025; 4/1/2025; and 4/16/2025. * Rosuvastatin calcium 10 mg (medication used to lower cholesterol): 1 bottle with exp dated 4/16/2025. LVN U stated Resident 36's expired medications should have been discarded in the expired or discontinued medication bin. 2. During an inspection of Station 1 Medication Room on 5/5/2025 at 11:38 a.m. with registered nurse D (RN D), an over OTC medication, Aspirin 325 mg with label indicated an expiration date of 4/2025 was observed stored together with the other new OTC medications. RN D confirmed the above observation and stated the expired OTC medication should have been discarded. RN D stated nurses should check the expiration date of medications stored inside the medication room every Saturday and Sunday. 3. During an inspection of Station 2 Medication Cart on 5/5/2025 at 2:41 p.m. with licensed vocational nurse Q (LVN Q), the following were identified and confirmed with LVN Q: a. A bottle of clotrimazole topical solution (used to treat fungal infection that causes red scaly rash on different parts of the body) for Resident 156 did not have a label in the the bottle indicated Resident 156's name and instruction on how to use the medication; b. Another antifungal medication for Resident 156, clotrimazole cream did not have a label on the tube to indicate the medication was for Resident 156; c. Resident 107's inhaler, Breo Ellipta inhalation (used to treat asthma [inflammatory disease of the airway that often causes wheezing, coughing, and shortness of breath] and chronic obstructive pulmonary disease [COPD - a long-lasting lung disease]) did not have a label of Resident 107's name taped in the inhaler itself; d. The narcotic box still stored discontinued medications: * Lacosamide (used to control seizures) 100 mg - 1 tablet * Resident 57's Norco (generic name: hydrocodone-acetaminophen, a potent controlled medication for pain) (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5/325 mg - 1 tablet * Resident 16's linezolid (an antibiotic medication) 600 mg - 1 tablet * Norco 5/325 mg - 2 tablets * Buprenorphine-Naloxone (a combination medication used to treat opioid use disorder) sub 2-05 mg - 7 tablets * Resident 41's antibiotic, Cephalexin 500mg - 1 capsule All these medication had Controlled Substance Accountability Sheet (CSAS - an inventory sheet that keeps record of the usage of controlled medications) which indicated the last time the medications were signed out was 4/2025. LVN Q stated nurses should have given discharged controlled medications to the director of nursing (DON) and should not be stored in the narcotic box. 4. During an inspection of Medication Cart 4 for Station 3 on 5/5/2025 at 3:20 p.m. with licensed vocational nurse V (LVN V) and licensed vocational nurse W (LVN W), the following were identified and confirmed with both nurses: a. An azelastine eye drop (used to treat itchy eyes) had a label of unreadable open and expiration date; b. A bottle of Minoxidil external solution (topical medication used to treat hair loss) did not have a label of resident's name on the bottle; c. Systane lubricant eye drops did not have a readable label on the bottle; d. Opened or used insulin Lispro (a fast acting insulin used to lower blood sugar) injection did not have a label of date opened; e. Propionate nasal spray (used to relieve symptoms of allergies such as sneezing, runny nose, and itchy nose) had no label in the bottle of resident's name; f. 24-hour allergy nasal spray had no label on the bottle of resident's name; and g. The narcotic box still had tramadol (a synthetic opioid analgesic used to treat moderate to severe pain) 50 mg - 2 tablets of resident transferred to the hospital. Both LVN V and LVN W stated discontinued narcotics should have been given to the DON. 5. During an inspection of Medication Cart 6 for Station 4 on 5/5/2025 at 3:58 p.m., with licensed vocational nurse X (LVN X), the Ipatropium nasal solution (a medication used to relieve runny nose) had a label indicated the open date was 3/31/2025 and an expiration date of 4/31/2025 was still stored in Medication Cart 6. LVN X confirmed the nasal solution was expired and should have been discarded. LVN X stated the medication was a routine order and the resident was still getting it. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	6. During an inspection of Medication Cart 1 for Station 1 on 5/5/2025 at 4:28 p.m., with licensed vocational nurse Y (LVN Y), the following were identified and confirmed with LVN Y: a. The Bisacodyl (a medication used to treat constipation)10 mg tablet indicated in the box an expiration date of 2/2025. LVN Y stated the expired Bisacodyl should not be stored in the medication cart and should have been discarded; b. Resident 100's Lantus insulin (long acting insulin, used to manage high blood sugar level in people with diabetes) in a vial was observed to have an open date label indicated 4/5 and exp date 5/4. LVN Y stated Lantus insulin was good for 28 days once opened. LVN Y confirmed the label was incorrect, the exp date should have been 5/3 and stated it should have been discarded; and c. Resident 181's Lantus insulin in a vial was observed to have an open date label indicated 4/2 and exp date 4/30. LVN Y stated it should have been discarded. During an interview with DON on 5/8/2025 at 1:37 p.m., DON stated the following : all discontinued and expired medications should have been placed in the discontinued or expired medication box inside the medication room; resident's overflow home medications should be checked by nurses; central supply staff should check the OTC medication for the expiration date; and for discontinued antibiotics, nurse should have placed them in the discontinued medication bin. DON confirmed she collected all discontinued controlled substances every Friday and she did not get the chance to collect them yet. DON stated all nurses should discard expired medications. During a review of the facility's undated policy and procedure titled, Medication Labeling and Storage, indicated, It the facility has discontinued, outdated or deteriorated medications or biologicals, the dispensing pharmacy is contacted for instructions regarding returning or destroying these items. Labeling of medications and biologicals dispensed by the pharmacy is consistent with applicable federal and state requirements and currently accepted pharmaceutical practices. The medication label includes, at minimum: a. medication name (generic and/or brand); b. prescribed dose; c. strength; d. expiration date, when applicable; e. resident's name . For over the counter (OYC) medications in bulk containers .the label contains: .expiration date. Mutidose vials that have been opened or accessed (e.g., needle punctured) are dated and discarded within 28 days unless the manufacturer specifies a shorter or longer date for the open vial . During a review of the facility's policy and procedure titled, Controlled Substances, date revised 11/2022, indicated, Controlled substances remaining in the facility after the order has been discontinued or the resident has been discharged are securely locked in an area with restricted access until destroyed.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. 42819 Based on observation, interview, and record review, the facility failed to ensure that one of 35 sampled residents (Resident 160) received the planned menu meal or the food alternative, as indicated on the posted menu and consistent with the resident's preferences. As a result, Resident 160 did not receive the correct food items on multiple occasions. Findings: A review of Resident 160's Minimum Data Set (MDS, a resident assessment and care screening) dated 4/2/25, indicated a Brief Interview for Mental Status (BIMS, a brief screening tool used to assess thinking and memory) score of 15. A BIMS score of 13-15 indicates intact cognition (suggests no significant impairment in thinking, reasoning, memory, and problem solving). During a dining observation and concurrent interview on 5/5/25 at 1:23 p.m. in Resident 160's room, the resident's meal tray contained a beef patty and salad. Resident 160 confirmed the food items and stated he had received the same meal the day before. Resident 160's tray ticket documented a dislike of all pork. Resident 160 also reported that, several days earlier, he had requested barbecue chicken from the alternative menu but instead received two chicken nuggets. Observation of other residents showed they were served soft tacos and salad. During a follow-up interview on 5/6/25 at 3:15 p.m., Resident 160 stated he had not requested an alternative for lunch on 5/5/25. Resident 160 reviewed the facility's weekly menu, which listed soft tacos and salad. Resident 160 stated he likes soft tacos and should have received that meal instead of the repeated patty from the previous day. During an interview and concurrent review of the posted Spring menu and alternative meal options, on 5/6/25 at 3:30 p.m., the dietary manager (DM) confirmed the soft tacos on 5/5/25 were made with beef, not pork. The DM acknowledged that Resident 160 received a vegetable patty, not the planned menu item, and confirmed that no alternative had been requested. The DM reviewed the posted alternatives and verified that barbecue chicken was listed, but chicken nuggets were not. The DM stated Resident 160 should have received the requested barbecue chicken. During a follow-up interview at 3:50 p.m., the DM said she spoke with Resident 160, confirmed it was a kitchen error, and stated she would conduct in-service training for dietary staff on following the planned menu and honoring resident preferences. A review of the facility's policy titled Menu, revised October 2008, indicated that menus shall: a) meet the nutritional needs of residents; b) be prepared in advance; and c) be followed.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49345 Based on observation, interview and record review the facility failed to ensure clinical records were accurately and timely documented for two sampled residents (Resident 86 and Resident 595) when: 1. Resident 86's Discharge Order and Progress Notes were documented late. 2. Resident 595's Interdisciplinary Team Meeting (IDT, involves various healthcare professionals collaborating to plan and coordinate a resident's care) notes were documented late. These failures resulted in an inaccurate presentation of information. Findings: 1. A review of Resident 86's medical record indicated a discharge date of [DATE]. A review of Resident 86's progress notes indicated, Physician Notification of Discharge, Ombudsman Notification of Discharge and IDT Meeting notes were documented on 5/5/25. A review of Resident 86's Physician Orders indicated, order for discharge was created on 5/5/25. During a concurrent interview and record review on 5/6/25 at 3:50 p.m. with Case Manager (CM) O, CM O verified Resident 86 was discharged on [DATE]. CM O also verified the Notice of Proposed Discharge form was sent to the Ombudsman on 4/25/25 and IDT meeting was done on 4/23/25. CM O also verified Physician Order for discharge was given on 4/25/25. CM O stated she overlooked Physician's Order for discharge, and she was running behind on documentation. A review of facility's policy and procedure (P&P) entitled, Charting and Documentation revised July 2017 indicated, All services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional, or psychosocial condition, shall be documented in the resident's medical record . 2. A review of Resident 595's medical record indicated a discharge date of [DATE]. A review of Resident 595's Progress Notes indicated, IDT meeting notes were documented on 5/5/25. During a concurrent interview and record review on 5/6/25 at 3:50 p.m. with Case Manager (CM) O, CM O verified Resident 86 was discharged on [DATE]. CM O also verified Resident 595's IDT meeting was done on 1/23/25. During an interview on 5/8/25 at 4:17 p.m. with the Social Services Director (SSD), SSD stated IDT meeting documentation was usually done after the meeting. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of facility's policy and procedure (P&P) entitled, Charting and Documentation revised July 2017 indicated, All services provided to the resident, progress toward the care plan goals, or any changes in the resident's medical, physical, functional, or psychosocial condition, shall be documented in the resident's medical record .

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32398 Based on observation, interview, and record review, the facility failed to ensure staff implemented proper infection control practices when: 1. Staff did not use proper gloving technique during a wound dressing change when hand hygiene was not properly performed for Resident 13; 2. Resident 54's urine drainage bag was not covered with a protective bag and was not kept off the floor; 3. Residents' used basins, bed pans and a urinal were unlabeled and stored on top of residents' bathroom toilet tank and under the bathroom sink beside a garbage container; 4. Registered nurse Z (RN Z) used contaminated (something has become impure or unsuitable due to contact with something unclean, harmful, or undesirable) gloves to administer Resident 151's eye drops to both eyes; 5. Registered nurse J (RN J) placed Resident 192's antibiotic (a medication used to treat bacterial infections) bag, intravenous tubing (IV, a soft, flexible tube used to administer medication or fluids through the vein), alcohol swabs, and normal saline (solution of salt and water) in a syringe on top of Resident 192's overbed table with visible beverage and food stains without wiping the table or placement of a protective sheet; 6. Licensed vocational nurse I (LVN I) wiped the used glucometer (an electronic device which displays a reading of blood sugar level) with one micro-kill bleach cloth wipes (germicidal wipes), then used the same cloth wipes to wipe the glucose strip (a test strip to check blood sugar level) container and also wiped the medication cart with the same used, contaminated cloth wipes; 7. Licensed vocational nurse B (LVN B) donned (put on) and doffed (remove) gloves without hand hygiene (washing hands with soap and water or using an alcohol-based hand sanitizer) and wiped the used glucometer with one micro-kill bleach cloth wipes then used the same cloth wipes to wipe the unused glucometer; 8. Staff fed two Residents (Resident 71 and Resident 152) at the same time; 9a. Contact precaution (measures taken to prevent the spread of germs through direct or indirect contact with a patient or their environment) signage was not posted outside Resident 16's entrance door; and, 9b. A staff not wearing Personal Protective Equipment (PPE, refers to specialized clothing or equipment worn to protect nurses and other healthcare personnel from potential exposure to infectious diseases and other hazards.) when entering the room for resident on contact precaution. These failures had the potential for development and transmission of communicable diseases and infections in the facility. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Findings: 1. Resident 13 was admitted with diagnoses which included non-pressure chronic ulcer of skin (a persistent open sore that doesn't heal, and isn't caused by pressure, but rather by other factors like poor circulation, trauma, or underlying medical conditions) and local infection of the skin and subcutaneous tissue (a bacterial infection that affects the skin's deeper layers and underlying tissues). During an observation of a wound dressing change, by two treatment nurses (registered nurse A (RN A) and licensed vocational nurse B (LVN B)) for Resident 13 on 5/08/25 at 1:10 p.m. During the procedure, RN A and LVN B both changed their gloves numerous times without using any hand hygiene (washing hands nor using alcohol based hand sanitizer) after taking off their gloves. During an interview with LVN B on 5/8/25 at 1:27 p.m., she stated she did not use hand hygiene between each glove change. LVN B stated she should have used hand hygiene between glove changes. During an interview with RN A on 5/8/25 at 1:29 p.m., she stated they only used hand hygiene when they started. They did not have to use hand hygiene with each glove change, because they sanitized at the beginning. They changed gloves so they don't contaminate the wound. They did not need to use hand hygiene with each glove change. During an interview with the infection preventionist (IP) on 5/09/25 at 11:16 a.m., the IP stated the nurses need to use hand hygiene after every time they take off their gloves, they should use the alcohol based sanitizer. During a review of the facility's policy and procedure (P&P), titled Personal Protective Equipment-Using Gloves, revised 09/2010, indicated .Miscellaneous .5. Wash hands after removing gloves. (Note: Gloves do not replace hand washing.) Removing Gloves 1. Using one hand, pull the cuff down over the opposite hand turning the glove inside out. 4. discard the glove into the designated waste receptacle inside the room.6. Wash hands. During a review of the facility's policy and procedure (P&P), titled Handwashing/Hand Hygiene, revised 10/2023, indicated .Indications For Hand Hygiene 1. Hand hygiene is indicated: .g. immediately after glove removal.5. The use of gloves does not replace hand washing/hand hygiene.Applying and Removing Gloves 1. Perform hand hygiene before applying non-sterile gloves. [Apply gloves. Remove gloves] .5. Perform hand hygiene. 42819 2. A review of Resident 54's clinical record indicated that the resident had diagnoses including, but not limited to, infection and inflammatory reaction due to indwelling urethral catheter (an infection or immune response caused by a urinary catheter). (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	A review of Resident 54's Order Summary Report, dated 5/2025, indicated Resident 54 had a Suprapubic Catheter (a urinary catheter inserted through the lower abdomen directly into the bladder) due to Obstructive Uropathy (a blockage that prevents normal urine flow). The Order Summary Report also indicated that Resident 54 may use low bed (a bed positioned close to the floor to reduce fall injury risk). A review of Resident 54's Minimum Data Set (MDS, a resident assessment and care screening) dated 3/5/25, indicated a Brief Interview for Mental Status (BIMS, a screening tool used to assess thinking and memory) score of 10. A BIMS score of 9-12 indicates moderate cognitive impairment (difficulty with thinking and reasoning). During a concurrent observation and interview with Licensed Vocational Nurse H (LVN H) on 5/8/25 at 12:50 p.m., in Resident 54's room. Resident 54 was sitting on the edge of the bed. The catheter drainage bag was hanging from the left side of the bed frame and was touching the floor. The bed was positioned low, and the catheter drainage bag was not enclosed in a protective cover. A privacy shield covered only the front of the catheter drainage bag, which did not prevent contact with the floor. LVN H confirmed that the catheter drainage bag was touching the floor and was not covered with a protective bag. LVN H acknowledged that the catheter bag should be kept off the floor and covered to reduce the risk of infection. During an interview with the Infection Preventionist (IP) on 5/8/25, at 1:45 p.m., the IP was informed of the observation. The IP stated that catheter drainage bags should not touch the floor because it can cause infection. The IP also stated that when a resident has a low bed, the catheter drainage bag should be secured with a protective cover to prevent from making contact with the floor. A review of the facility's undated policy titled Catheter Care, Urinary indicated Be sure the catheter tubing and drainage bag are kept off the floor. 44583 3a. During an observation on 5/5/2025 at 8:33 a.m., inside Room AA's bathroom, there were six used basins, and one used bed pan stacked up on top of the toilet's tank. The basins and bed pan did not have a label. 3b. During an observation on 5/5/2025 at 8:54 a.m., inside Room BB's bathroom, there were four used basins stacked up on top of the toilet's tank. Room BB's (with three residents) bathroom was also shared with residents in Room CC (with three residents). During a concurrent observation and interview with certified nursing assistant AA (CNA AA) on 5/5/2025 at 8:58 a.m., inside the shared bathroom of Rooms BB and CC, CNA AA confirmed the basins were used and one basin had an unreadable label, the other three did not have a label of resident's room number or resident's name. CNA AA stated they stacked them up on the toilet's tank because they did not have a space to store them. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Canyon Springs Post-Acute	180 North Jackson Avenue San Jose, CA 95116

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	3c. During another concurrent observation and interview with CNA AA on 5/5/2025 at 9:01 a.m., inside Room DD's bathroom, there were five used basins stacked up and placed under the sink beside a garbage container. The bathroom was shared by residents in Rooms DD (two residents) and EE (two residents). CNA AA confirmed the above observations and stated two had unreadable labels while the other three basins did not have a label. CNA AA stated, we don't have space to store them. 3d. During an observation on 5/5/2025 at 9:07 a.m., inside Room FF's bathroom, there were three basins stacked up on top of the toilet's tank. 3e. During another concurrent observation and interview with CNA AA on 5/5/2025 at 9:17 a.m., inside Room GG's bathroom, there was one unlabeled urinal, one unlabeled kidney basin, and two basins stacked up on top of the toilet's tank. CNA AA confirmed the above observations and stated the used residents' items should be labeled. CNA AA further stated, they did not have any space to store them. During an interview with the facility's infection preventionist (IP) on 5/6/2025 at 3:02 p.m., IP confirmed all used basins, kidney basins, and urinals should be labeled and stored under the resident's bedside drawer when not in use. During an interview with the director of nursing (DON) on 5/9/2025 at 1:07 p.m., DON stated staff should label the basins, bed pans, and urinals with resident's room number and initials of their name. DON further stated, staff should clean, dry and store the used items under the resident's bedside drawer or in the bathroom individually wrapped in a plastic. During a review of the facility's policy and procedure titled, Cleaning and Disinfection of Resident-Care Items and Equipment, date revised 9/2022, indicated, Single resident-use items are cleaned/disinfected between uses by a single resident and disposed of afterwards (e.g. bedpans, urinals). 4. During a medication administration observation on 5/6/2025 at 5:38 p.m., RN Z donned a new pair of gloves while standing in front of the medication cart, touched the medication cart to lock it, walked across the room and went inside Resident 151's room. RN Z was observed to touch Resident 151's bed remote control to adjust the head of bed, touched the overbed table to move it out of the way and touched the chair to grab some tissues and used the same gloves to administer Resident 151's eye drops. RN Z pulled down Resident 151's lower eyelids to administer one drop of the medication in each eye and wiped Resident 151's eyes after. During an interview with RN Z on 5/6/2025 at 5:45 p.m., RN Z confirmed the above observations and stated she should have changed her gloves to a new one before she administered the eyedrops to Resident 151. 5. During a medication administration observation on 5/7/2025 at 9:20 a.m., RN J donned a new pair of gloves, placed Resident 192's antibiotic bag, IV tubing, alcohol swabs, and NS in a syringe on top of Resident 192's overbed table with visible beverage and food stains without wiping the table or a protective sheet underneath the IV items. RN J removed the NS syringe from the plastic wrap, touched the alcohol swab from the overbed table and wiped Resident 192's peripherally inserted central catheter (PICC, long slender, flexible tube inserted into a peripheral vein, typically in the upper arm, and advanced until the catheter tip terminates in the chest near the heart to obtain venous access) hub and started to flush the PICC line with NS. RN J unwrapped the IV tubing from the package and started to set up the IV antibiotic and hooked the end of the tubing to Resident 192's PICC line. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a follow-up interview with RN J on 5/7/2025 at 9:49 a.m., RN J confirmed the above observation and stated he should have wiped the table first with the germicidal cloth wipes before he placed the IV materials (IV tubings, NS flush syringe, IV bag, and alcohol swabs) on the table. During an interview with DON on 5/8/2025 at 1:56 p.m., DON stated nurses should place the IV materials in a tray prior to entering the room, instead of placing them on resident's overbed table. During a review of the facility's policy and procedure titled, Administering Medications, date revised 4/2019, indicated, Staff follows established facility infection control procedures (e.g. handwashing, antiseptic techniques, gloves, isolation precautions, etc.) for the administration of medications, as applicable. 6. During an observation on 5/7/2025 at 11:19 a.m., inside Resident 158's room, LVN I checked Resident 158's blood sugar level with the use of a glucometer device. After LVN I had obtained Resident 158's blood sugar level, she went back to the medication cart, took one germicidal cloth wipe then wiped the used glucometer, the glucose strip container and the medication cart with the same germicidal cloth wipe. During an interview with LVN I on 5/7/2025 at 11:41 a.m., LVN I confirmed the above observation and stated she should have changed the germicidal wipes to a new one before she wiped the glucose strip container and the medication cart. LVN I confirmed the glucometer was contaminated with Resident 158's blood. 7. During an observation on 5/7/2025 at 11:53 a.m., inside Resident 191's room, LVN B donned a new pair of gloves without performing hand hygiene, helped to pull up Resident 191 in bed with another certified nursing assistant (CNA). At 11:55 a.m., LVN B checked Resident 191's blood sugar level with the use of a glucometer, she removed the used gloves and donned a new pair of gloves without hand hygiene and started to wipe the used glucometer with the germicidal cloth wipes. LVN B was observed to wipe the other unused glucometer with the same germicidal cloth wipes. During an interview with LVN B on 5/7/2025 at 11:58 a.m., LVN B confirmed the above observation and stated she should have performed hand hygiene every time she removed her gloves to don a new pair of gloves. LVN B confirmed the germicidal cloth wipe used to wipe the used glucometer was already contaminated with Resident 191's blood and she should have used a new germicidal wipe to wipe the unused glucometer. During an interview with DON on 5/8/2025 at 1:56 p.m., DON stated nurses should not use a contaminated germicidal wipe to wipe another surface, they should use a new germicidal wipe. During a review of the facility's policy and procedure titled, Personal Protective Equipment-Using Gloves, date revised 9/2010, indicated, Putting on Sterile Gloves 1. Wash hands. 2. Obtain gloves .Removing Gloves .4. Discard the glove into the designated receptacle inside the room .6. Wash hands. During a review of the Micro-Kill Germicidal Wipes manufacturer's guidelines, it indicated to remove any visible soil or debris from the surface to disinfect, use the wipe to thoroughly wet the surface, allow the surface to remain wet for the required contact time and discard the wipe once the contact time is complete. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	49345 8. During dining observation on 5/5/25 at 12:55 p.m. in the Facility's Communal Dining Area, Certified Nurse Aide (CNA)L was in a round table seated in between Resident 71 and Resident 152. CNA L was feeding both residents at the same time. Hand hygiene was not done in between feeding residents. During an interview on 5/5/25 at 12:59 p.m. with CNA L and Director of Staff Development (DSD), CNA L stated she helped Resident 71 because the resident liked her. DSD stated it was not okay to feed two residents at the same time by a staff. During an interview on 5/8/25 at 3:34 p.m. with the Director of Nursing (DON), the DON stated residents were at risk for choking if staff fed two residents at the same time because they cannot focus. A review of Resident 71's clinical record indicated diagnoses of hemiplegia and hemiparesis following nontraumatic intracerebral hemorrhage affecting right dominant side (complete paralysis and weakness on right side of the body after a stroke), and muscle weakness. A review of Resident 71's Minimum Data Set (MDS - a federally mandated resident assessment tool) assessment dated [DATE], indicated Resident 51's brief interview for mental status (BIMS, a tool used to assess cognition [knowing, learning, and understanding things]) score was 10 (a score of 0 to 7 indicates severe cognitive impairment, 8-12 moderate impairment, 13-15 patient is cognitively intact). A review of Resident 152's clinical record indicated diagnoses of dysphagia, unspecified (difficulty in swallowing) and, muscle weakness. A review of Resident 152's Minimum Data Set (MDS - a federally mandated resident assessment tool) assessment dated [DATE], indicated Resident 51's brief interview for mental status (BIMS, a tool used to assess cognition [knowing, learning, and understanding things]) score was 6 (a score of 0 to 7 indicates severe cognitive impairment, 8-12 moderate impairment, 13-15 patient is cognitively intact). A review of facility's policy and procedure (P&P) entitled, Handwashing/Hand Hygiene revised October 2023, the P&P indicated, This facility considers hand hygiene the primary means to prevent the spread of healthcare-associated infections .Indications for Hand Hygiene 1. Hand hygiene is indicated: a. immediately before touching a resident; .d. after touching a resident . 50855 9.a During an observation on 5/5/25 at 11:34 a.m., outside Resident 16's room there were signs posted outside the door of instructions on how to wear PPE, but there was no signage posted what type of precautions Resident 16 is on. During an interview on 5/6/25 at 10:30 am with Registered Nurse D (RN D), RN D stated Resident 16 is on contact isolation. She stated staff need to wear PPE when touching the resident and no need to wear PPE if away from the resident. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a concurrent observation and interview on 5/6/25 at 1:34 p.m., with the infection prevention nurse (IP), the IP checked Resident 16's door and confirmed there was no contact isolation posted outside Resident 16's door. The IP stated there should be signage posted for contact isolation. She further stated that staff need to wear PPE when going inside Resident 16's room even without touching the resident. During a review of Resident 16's physician's order dated 4/10/25 indicated, Contact Isolation in Place: Dx: (diagnosis) Septic Knee(a serious infection in the knee joint, often caused by bacteria entering the joint through the bloodstream or direct injury)- VRE (Vancomycin Resistant Enterococci, a type of bacteria that has become resistant to vancomycin [a powerful antibiotic used to treat infections]) q shift (every shift). During a concurrent interview and record review on 5/9/25 at 8:52 a.m., with the IP, the IP reviewed Resident 16 physician's order and confirmed Resident has an order for contact Isolation for VRE. During a review of the facility's policy and procedures titled, Isolation - Categories of Transmission-Based Precautions, dated 3/28/2024, indicated, .6. When a resident is placed on transmission-based precautions, appropriate notification is placed on the room entrance door and on the front of the chart so that personnel and visitors are aware of the need for and the type of precaution. a. The signage informs the staff of the type of CDC precaution(s). instructions for use of PPE, and/or instructions to see a nurse before entering the room . 9.b During an observation on 5/7/25 at 2:49 p.m., the Director of Staff Development Assistant (DSDA) was observed not wearing PPE inside Resident 16's room, the DSDA standing next to Resident 16's bed (foot board). During an interview shortly after the observation on 5/7/25 at 2:52 p.m., with the DSDA, the DSDA confirmed not wearing PPE inside Resident 16 room, the DSDA reviewed the contact isolation signage posted outside Resident 16's door. The DSDA stated that they need to wear gown when going inside Resident 16's room without touching the resident. During a concurrent interview and record review on 5/9/25 at 8:52 a.m., with the IP the IP reviewed Resident 16 physician's order and confirmed Resident 16 has an order for contact isolation for VRE. The IP further stated staff going inside Resident 16's room need to wear PPE. During a review of the facility's policy and procedures titled, Isolation - Categories of Transmission-Based Precautions, dated 3/28/2024, indicated, .Contact precautions .7. Staff and visitors wear gloves (clean, non-sterile) when entering the room .8. Staff and visitors wear a disposable gown upon entering the room and remove before leaving the room and avoid touching potential contaminated surfaces with clothing after gown is removed .

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. 50855 Based on observation, interview, and record review, the facility failed to ensure the call light (a visible and audible alarm activated by a call button) for two of 35 sampled residents (Resident 55 and Resident 148) was within reach. This deficient practice had the potential to result in a delay in meeting Resident 55 and Resident 148's needs for toileting and activities of daily living. Findings: 1. During an observation inside Resident 55's room on 5/5/25 at 9:38 a.m., Resident 55 was observed lying in bed, the call light was not in Resident 55's bed. During a concurrent observation and interview inside Resident 55's room on 5/5/25 at 3:00 p.m., with Certified Nursing Assistant F (CNA F), CNA F looked for the call light button and found it hanging on the feeding tube pole (a device used to support and secure feeding bags or feeding pumps during tube feeding). CNA F confirmed the call light was not within the reach of Resident 55. CNA F further stated Resident 55's call light should not be hanging in the feeding tube pole. During a review of Resident 55's clinical record indicated Resident 55 was admitted to the facility with diagnosis including cerebral palsy (is a brain disorder that appears in infancy or early childhood and permanently affects body movement and muscle coordination). During a review of Resident 55's Brief Interview for Mental Status (BIMS, a short performance-based cognitive screener for nursing home (NH) residents.), dated 4/15/25 BIMS is 14 (the range of 13-15, which suggests that the person is cognitively intact.) During a review of Resident 55's Minimum Data Set (MDS- a federally mandated resident assessment tool) Functional Abilities, dated 3/13/25, indicated Resident 55 was dependent with eating, oral hygiene, toileting hygiene, and shower/bathing self, upper and lower body dressing, and personal hygiene. A further review of Resident 55's MDS Functional Abilities indicated Resident 55 was dependent with rolling left and right, sit to lying, lying to sitting on side of bed, sit to stand, and chair/bed-to-chair transfer. During an interview on 5/7/25 at 4:01 p.m., with the Director of Nursing (DON), the DON stated Resident 55 is dependent on ADL's. She stated Resident 55 call light should always be in reach to call for help. 2. During an observation inside Resident 148's room on 5/5/25 at 2:48 p.m., Resident 148 was observed lying in bed, the call light was not on the bed, it was clipped onto the privacy curtains and not within the reach of Resident 148. During a concurrent observation and interview inside Resident 148's room on 5/5/25 at 2:51 p.m., with Registered Nurse D (RN D), RN D confirmed the call light was clipped on the privacy curtains away from Resident 148. RN D stated the call light should be in the reach of Resident 148 and not hanging on the privacy curtains. (continued on next page)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 148's clinical records indicated Resident 55 was admitted to the facility with diagnoses including hemiplegia (a condition characterized by paralysis or weakness affecting one side of the body) and hemiparesis (a condition characterized by weakness on one side of the body). During a review of Resident 148's BIMS, dated 2/18/25, the BIMS was 9 (8-12 indicates moderate cognitive impairment). During a review of Resident 55's Minimum Data Set (MDS- a federally mandated resident assessment tool) Functional Abilities, dated 2/18/25, indicated Resident 148 was dependent with eating, oral hygiene, toileting hygiene, and shower/bathing self, upper and lower body dressing, and personal hygiene. A further review of Resident 148's MDS Functional Abilities indicated Resident 148 was dependent with rolling left and right, sit to lying, lying to sitting on side of bed, sit to stand, and chair/bed-to-chair transfer. During an interview on 5/7/25 at 4:03 p.m., with the Director of Nursing (DON), the DON stated Resident 148's call light should be always in reach to call for help. During a review of the facility's policy and procedures titled, Call System, Residents, dated 2001, indicated, Residents are provided with a means to call staff for assistance through a communication system that directly calls a staff member or a centralized work station. 1. Each resident is provided with a means to call staff directly for assistance from his/her bed, from toileting/bathing facilities and from the floor .