

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056113	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/22/2026
NAME OF PROVIDER OR SUPPLIER Alexandria Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1515 N Alexandria Ave. Los Angeles, CA 90027	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Dispose of garbage and refuse properly. Based on observation, interview, and record review, the facility failed to properly dispose of garbage when: a. The trash can was not completely closed when not in use in the kitchen. b. The dumpster (a movable waste container designed to be brought and taken away by special collection vehicle, or to a bin that specially designed garbage truck lifts) contained dried brown residue on its exterior and the surrounding floors had visible trash and debris. These failures had potential to attract birds, flies, insects, pests (animal or microorganism that has a negative effect on humans) and possibly spread infection to 164 of 164 facility residents. Findings: a. During an observation on 5/18/2026 at 11:50 a.m., of the grey garbage can near the trayline (an area where foods were assembled from the steamtable to resident's plate) and dishwashing machine, observed the garbage can was not completely covered and it was not in use. During an interview on 5/18/2026 at 12:48 p.m., with the Dietary Supervisor (DS), the DS stated that the garbage lid should be on top and completely closed to prevent the smell of the garbage attracting flies. The DS stated the garbage can was not completely closed and it was not acceptable due to infection control concerns. b. During a concurrent observation and interview on 5/19/2026 at 10:43 a.m., of the dumpster located outside the facility with the DS, observed the dumpster surroundings had liters of paper, and wraps of condiments. Observed the body of the dumpster contained dry brownish spills. The DS stated it was not okay to have trash and spills on the dumpster because it could attract pests and it needed to be cleaned for infection control During an interview on 5/19/2026 at 10:58 a.m., with the Environmental Service Supervisor (EVSS), the EVSS stated they only sweep the dumpster area two times a day, particularly one time in the morning and one time in the afternoon. The EVSS stated the maintenance department oversees the power washing of the area. The EVSS stated there should not be any trash around the dumpster as it attracts flies and for infection control. During a review of the facility's policies and procedures (P&P) titled Environment, dated 1/4/2026, the P&P indicated, 6. All trash will be contained in covered, leak-proof containers that prevent cross contamination. 7. All trash will be properly disposed of in external receptacles (dumpsters) and the surrounding area will be free of debris. During a review of Food Code 2022, dated 1/18/2023, the Food Code 2022 indicated, 5-501.116 Cleaning Receptacles. Proper storage and disposal of garbage and refused are necessary to minimize the development of odors, prevent such waste from becoming an attractant and harborage of breeding places for insects and rodents, and prevent the soiling of food preparation and food service areas. Improperly handled garbage creates nuisance conditions, makes housekeeping difficult, and may be possible source of contamination of food, equipment, and utensils. Outside receptacles must be constructed with tight-fitting lids or covers to prevent the scattering of the garbage or refuse by birds, the breeding of flies, or the entry of rodents. Proper equipment and supplies must be made available to accomplish thorough and proper cleaning of garbage storage areas and receptacles so that unsanitary conditions can be eliminated. During a review of Food Code 2022, dated 1/18/2023, the Food Code 2022 indicated, 5-501.113 Covering Receptacles and waste handling units for refuse, recyclables, and returnable shall be kept covered: (A) Inside food establishment if the receptacles and units: (1) Contain food residue and are not in continuous use; or (2) After they are filled; and 174 (B) With tight-fitting lids or doors if kept outside the food establishment.		

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 056113
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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents were treated with respect and dignity including the right to be free from physical restraints (any manual method, physical or mechanical device, material or equipment that is attached or adjacent to the resident's body that he or she cannot easily remove that restricts freedom of movement or normal access to one's body) for four of five sampled residents (Residents 15, 155, 10, and 147) reviewed for physical restraints by failing to ensure: 1. Resident 15 did not have bilateral (both right and left side) foam wedge cushions (firm, triangular-shaped foam cushion used to elevate parts of the body) tucked under the fitted sheet while the resident lay in bed. 2. Resident 15's physical restraint assessment (a safety check performed by healthcare staff to determine if, how, and why a patient's freedom of movement should be temporarily limited) for the bed pad alarm (a pad with sensors that will alarm when a resident stands up unassisted to help prevent falls by alerting staff) was completed prior to use. This deficient practice had the potential to result in the restriction of the resident's freedom of movement, a decline in physical functioning, and mobility. 3. Resident 155's physical restraint assessment was completed prior to use. This deficient practice had the potential to result in the restriction of the resident's freedom of movement, a decline in physical functioning, and mobility. 4. Resident 147's Bed placed against the wall had a restraint assessment, a physician's order, and an informed consent (voluntary agreement to accept treatment and/or procedures after receiving education regarding the risks, benefits, and alternatives offered). 5. Resident 10's use of wheelchair lap tray (a padded bar or tray that sits across a user's lap) had a restraint assessment (a routine medical and safety check performed on a patient who is physically or chemically restrained) and the physician's order to release the restraint every two hours was followed. These deficient practices had the potential to result in the restriction of the resident's freedom of movement, a decline in physical functioning, and mobility. Findings: a. During a review of Resident 15's admission Record (AR- the front page of the chart that contains a summary of basic information about the resident), the AR indicated that the facility admitted the resident on 4/13/2023 with diagnoses including unspecified dementia (a progressive state of decline in mental abilities), seizures (a sudden, uncontrolled electrical disturbance in the brain which can cause uncontrolled jerking, blank stares, and loss of consciousness), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), and generalized muscle weakness. During a review of Resident 15's Minimum Data Set (MDS- a resident assessment tool), dated 2/9/2026, the MDS indicated the resident sometimes makes self-understood and sometimes has the ability to understand others. The MDS indicated that the resident was totally dependent on staff for oral hygiene, toileting hygiene, shower/bathe self, lower body dressing, putting on/taking off footwear, personal hygiene and moving from lying to sitting position and transfers. The MDS indicated the resident required substantial / maximal assistance from staff for rolling left to right. The MDS further indicated the resident used a bed alarm daily. During a review of Resident 15's Order Summary Report, the Order Summary Report indicated a physician order for a bed alarm while in bed, check for placement and function every shift, dated 7/2/2025. (continued on next page)		

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 15's Care Plan (CP) titled Resident is at risk for falls: cognitive loss, lack of safety awareness, muscle weakness, 4/25/2025 status post fall, 6/2/2025 status post fall, dated 5/8/2026, the CP indicated the resident with goals of having no falls with injury and interventions that included bed alarm while in bed. During a review of Resident 15's CP titled At risk for impaired bed mobility (moving within bed, getting in and out of bed), dated 11/29/2025, the CP indicated the resident with goals of maintaining or improving independence in bed mobility. During an observation on 5/18/2026 at 3:40 p.m. inside Resident 15's room, observed Resident 15 lying in bed and attempting to roll over onto her left side, observed the resident extended her arm out towards a doll on the floor. Observed a bed pad alarm flashing green and foam wedge cushions were placed under the fitted sheets on both sides of the resident at the hip area. During a concurrent observation and interview on 5/18/2026 at 3:45 p.m. with Certified Nursing Assistant (CNA) 5, inside Resident 15's room, observed CNA 5 entered the room and observed the resident. CNA 5 stated Resident 15 had a bed pad alarm. Observed CNA 5 then exited the room and the bilateral foam wedge cushions remained under the fitted sheets. During an observation on 5/18/2026 at 3:47 p.m., inside Resident 15's room, observed Licensed Vocational Nurse (LVN) 8 entered the room and handed the resident the doll. Observed LVN 8 then exited the room and the bilateral foam wedge cushions remained under the fitted sheets. During a concurrent observation and interview on 5/18/2026 at 3:58 p.m. with the Infection Preventionist (IP), inside Resident 15's room, observed the IP entered the room and stated the resident had a pad alarm and there were bilateral foam cushions tucked under the fitted sheet. The IP stated the resident should not have the foam cushions tucked under the sheet. Observed the IP removed the bilateral foam cushions from under the fitted sheet. During a follow-up interview on 5/18/2026 at 4 p.m. with the IP, outside of Resident 15's room, the IP stated a foam wedge cushion may be used as a resident positioning tool on top of the fitted sheet if the resident is able to remove it themselves. The IP stated when bilateral foam wedge cushions are tucked under the fitted sheet the resident cannot remove them, they restrict the resident's mobility, and the wedge cushions are considered a restraint. The IP stated CNA 5 and LVN 8 should have identified and removed the wedges, but they did not, potentially result in the resident attempting to climb over the wedges leading to a fall with injuries. During a concurrent interview and record review on 5/20/2026 at 11:17 a.m. with the Assistant Director of Nursing (ADON), Resident 15's Physical Restraint Assessments and physician orders were reviewed. The ADON stated foam wedge cushions are used for resident positioning and should not be used to prevent falls. The ADON stated when bilateral foam wedges are placed under the fitted sheets it prevents the resident from moving and is considered a restraint. The ADON stated Resident 15 was at risk for injuries from falls, did not have a physician's order or consent for the use of the foam wedge cushions, and should not have had bilateral foam cushions placed under the fitted sheets. During an interview on 5/21/2026 at 1:48 p.m. with CNA 4, CNA 4 stated on 5/18/2026, she (CNA 4) placed the bilateral wedge cushions under the fitted sheets of Resident 15 to prevent the resident (continued on next page)		

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 155's Care Plan (CP) titled Resident is at risk for falls/injury, dated 3/28/2026, the CP indicated the resident with goals of having no falls with injury and included interventions bed alarm while in bed. During a concurrent observation and interview on 5/18/2026 at 3:25 p.m. with Restorative Nurse Assistant (RNA) 1, inside Resident 155's room, Resident 155 was observed lying in bed with bed pad alarm underneath. RNA 1 stated CNA1 placed Resident 155 back to bed around 1 p.m. RNA 1 stated when Resident 155 goes back to bed they place the bed pad alarm. RNA 1 stated she (RNA 1) does not see any blinking light on the pad alarm device. RNA 1 stated she (RNA 1) will get LVN 1. During a concurrent observation and interview on 5/18/2026 at 3:30 p.m. with RNA 1 and LVN 1, inside Resident 155's room, LVN 1 stated the pad alarm device was not powered on, it was turned off. Observed LVN 1 turned the switch to on and the green light flashed. LVN 1 stated it was not turned on so it was working. LVN 1 stated Resident 155 has the pad alarm while in bed to alert the staff that she (Resident 155) is trying to get out of bed. LVN 1 stated when the device is not turned on Resident 155 could get out of bed unassisted and risk further falls. During a concurrent interview and record review on 5/20/2026 at 1:30 p.m. with the ADON, Resident 155's Physical Restraint Assessments were reviewed. The ADON stated that the physical restraint assessment for the use of bed pad alarm was not done and it should have been assessed so they know the plan and goal. The ADON stated monitor any adverse reaction regarding its use and if it limits the resident's mobility and ADLs due to the use of the bed pad alarm. The ADON stated it should have been completed for the initial assessment and then reassessed according to their policy and if there's a change in condition. The ADON stated when the physical restraint assessment for the use of bed pad alarm is not completed the resident could exhibit adverse effects such as decline in ADLs and/or mobility and they were not able to monitor it. During an interview on 5/20/2026 at 3:41 p.m. with the DON, the DON stated before the application of the bed pad alarm there has to be a physical restraint assessment, consent, care plan, and a physician order. The DON stated they use the form physical restraint assessment for bed pad alarm. The DON stated the purpose of the physical restraint assessment is to assess the effectiveness and outcome of the restraint that was applied on that assessment. During a review of the facility's P&P titled, Tab Alarms, Bed Alarms, Wanderguard System, last reviewed and approved on 1/14/2026, the P&P indicated that Tab alarms or bed alarms may be used on a resident who is deemed unsafe through the nursing assessment and documented on the resident's care plan that the resident is at risk for falls. Procedure 1. Nursing Assessment of each resident must be done on admission and change in status to evaluate if he/she is at risk for falls or elopement. 6. After applying the tab alarm or bed alarms in place, a safety check to make sure they are in proper working condition must be done before leaving the resident. During a review of the facility's P&P titled, Use of Restraints, last reviewed and approved on 1/14/2026, the P&P indicated that Restraints shall only be used for the safety and well-being of the resident(s) and only after other alternatives have been tried unsuccessfully. Restraints shall only be used to treat the resident's medical symptom(s) and never for discipline or staff convenience, or for the prevention of falls. When the use of restraints is indicated, the least restrictive alternative will be (continued on next page)		

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	used for the least amount of time necessary to, and the ongoing re-evaluation for the need for restraints will be documented.^^ Policy and Implementation^ 1. 'Physical' Restraints^ are defined as any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily, which restricts freedom of movement or restricts normal access to one's body.^ 2. The definition of restraint is based on the functional status of the resident and not the device. If the resident cannot remove a device in the same manner in which the staff applied it given that the resident's physical condition., and this restricts his/her typical ability to change position or place, that device is considered a restraint.^^ 19. Documentation^ regarding^ the use of restraints shall include:^ a. Full documentation of the episode leading to the use of the physical^ restraint. This includes not only the resident symptoms but also the conditions, circumstances, and environment associated with the episode^ b. A description of the resident's medical symptoms (i.e.,^ an indication^ or a characteristic of a physical or psychological condition) that^ warranted^ the use of restraints;^^ c. How the^ restraint use^ benefits^ the^ resident^ by addressing the medical symptom,^ d. The type of the physical^ restraint^ used;^ e. The length of effectiveness of the restraint time; and^^ f. Observation, range of motion and repositioning flow sheets.^ d. During a review of Resident^ 147's AR, the^ AR^ indicated^ that the facility^ originally admitted Resident 147 on 6/10/2017, and readmitted on [DATE], with diagnoses including metabolic encephalopathy (a temporary brain malfunction caused by chemical imbalances in the body rather than a direct head injury), generalized muscle weakness, polyp of colon (a small, abnormal clump of cells that grows on the inside lining of your large intestine).^ During a review of Resident 147's H&P dated 10/31/2024, the H&P^ indicated^ that Resident 147 did not have the capacity to understand and make decisions.^^ During a review of Resident 147's MDS dated [DATE], the MDS indicated Resident^ 147^ required supervision or touching assistance (helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity) with oral and toileting hygiene, lower body dressing and^ putting on/taking^ off footwear. The MDS indicated^ that the resident was independent to staff with roll left and right (The ability to roll from lying on back to left and right side, and return to lying on back on the bed), sit to lying (The ability to move from sitting on side of bed to lying flat on the bed), lying to sitting on side of bed (The ability to move from lying on the back to sitting on the side of the bed and with no^ back support). The MDS indicated Resident 147 was not using any physical restraints.^^ (continued on next page)		

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 5/18/2026 at 12:10 p.m. in Resident 147's room, observed Resident 147's bed was positioned against the wall on the left side.^^ During a concurrent observation and interview on 5/18/2026 at 12:22 p.m. with Registered Nurse (RN) 3 inside Resident 147's room, RN 3 stated that Resident 147's bed was positioned against the wall on the left side, which limits the resident's ability to move freely and access that side of the bed. RN 3 stated that this positioning may be considered a form of restraint. RN 3 stated that this could also be resident's preference. RN 3 interviewed Resident 147 if the bed positioned against the wall was the resident's preference. Resident 147 stated that this was not his preference. Resident 147 was uncertain why the bed was positioned against the wall. RN 3 stated placing the bed against the wall on one side posed a risk for injury, physical and psychological harm to the resident.^^ During a concurrent interview and record review on 5/20/2026 at 1:48 p.m. with RN 7, RN 7 stated that positioning a resident's bed against the wall may be considered a form of restraint, as it would limit resident's ability to move freely to the left side of the bed. RN 7 further stated that when a restraint is in use, there must be a physician's order, an informed consent, a restraint assessment and an individualized care plan (CP) addressing the use of the restraint. RN 7 reviewed Resident 147's electronic and paper medical records. RN 7 stated there were no physician's order, informed consent, restraint assessment and no documentation of Resident 147 requesting his bed to be placed against the wall. RN 7 stated failure to obtain these required elements had the potential to result in the use of an unauthorized restraint, placing the resident at risk for restricted movement, injury and decreased mobility.^^ e. During a review of Resident 10's AR, the AR indicated that the facility originally admitted Resident 10 on 5/31/2023, and readmitted on [DATE], with diagnoses including type two Diabetes Mellitus (DM - a disorder characterized by difficulty in blood sugar control and poor wound healing), history of falling, right eye blindness.^^ During a review of Resident 10's H&P dated 2/12/2025, the H&P indicated that Resident 10 did not have the capacity to understand and make decisions.^^ During a review of Resident 10's MDS, dated [DATE], the MDS indicated Resident 10 was dependent (helper does all of the effort) to staff with toileting hygiene, lower body dressing, putting on/taking off footwear, and required substantial/maximal assistance (helper does more than half the effort) with shower, upper body dressing, personal hygiene, sit to lying, lying to sitting on side of bed, chair/bed-to chair transfer (The ability to transfer to and from a bed to a chair (or wheelchair). The MDS indicated Resident 10 was using trunk restraint daily.^^ During a review of Resident 10's Order Summary Report (OSR), dated 2/15/2026, the OSR indicated may use lap tray when up on wheelchair per family request for postural support. Check and remove every two hours for positioning every day and evening shift.^^ During an observation on 5/20/2026 at 9:40 a.m. in Resident 10's room, observed Resident 10's wheelchair had lap tray resting on the wheelchair next to the resident's bed.^^ During a concurrent observation and interview on 5/20/2026 at 9:42 a.m. with CNA 7 inside Resident 10's room, CNA 7 stated that the wheelchair with lap tray, placed by the resident's bed, belonged to Resident 10. CNA 7 stated that lap tray was installed and used every time Resident 10 was up on wheelchair. CNA 7 stated the lap tray was used to help the resident to rest her hands on them.^^ (continued on next page)		

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 5/20/2026 at 9:45 a.m. with RN 7, RN 7 stated that Resident 10's lap tray was for the resident's postural support, to prevent Resident 10 from slouching on wheelchair. RN 7 stated that Resident 10 used lap tray every time she (Resident 10) was up on the chair. RN 7 stated that the resident was unable to remove the lap tray on her own. RN 7 stated that if the resident cannot remove the lap tray on her own, the lap tray would be considered a restraint. RN 7 reviewed Resident 10's CP addressing lap tray. The CP indicated that Resident 10 exhibited anxiety, restlessness of wanting to get up from wheelchair and/or bed. The intervention for the problem indicated that lap tray may be used when up on wheelchair per family request for postural support, check and remove lap tray every two hours for positioning. RN 7 stated that lap tray used to prevent the resident from getting up would be considered a restraint. RN 7 reviewed Resident 10's electronic and paper medical records, stated there was no documentation indicating restraint assessment and lap tray removal every two hours as indicated in Physician's order. RN 7 added that missed restraint assessment and lap tray removal every two hours as ordered by the physician could potentially lead to Resident 10 being exposed to an unassessed and unmonitored restraint, increasing the risk for impaired mobility, skin breakdown, decreased circulation, and injury. During an interview on 5/22/2026 at 2:35 p.m. with the DON, the DON stated that placing resident's bed against the wall may constitute a restraint, unless requested by the resident. Placing resident's bed against the wall required documented informed consent from the resident and/or responsible party, physician's order and completion of a comprehensive restraint assessment. Failure to secure informed consent, obtain physician's order, conduct restraint assessment, could place the resident at risk for restricted mobility, potential injury, psychosocial harm and violation of resident rights. The DON stated that not having a lap tray restraint assessment and not following a physician's order to release the restraint every two hours could lead to increased risk of physical harm, decreased circulation, skin breakdown, loss of mobility, and violation of resident's rights. During a review of facility's P&P titled Resident Rights, dated 1/14/2026, the P&P indicated, Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the residents' right to be free from corporal punishment or involuntary seclusion, and physical or chemical restraints not required to treat the residents' symptoms. During a review of the facility's P&P titled, Use of Restraints, dated 1/14/2026, indicated Restraints shall only be used for the safety and well-being of the resident(s) and only after other alternatives have been tried unsuccessfully. Restraints shall only be used to treat the resident's medical symptom(s) and never for discipline or staff convenience, or for the prevention of falls. When the use of restraints is indicated, the least restrictive alternative will be used for the least amount of time necessary, and the ongoing re-evaluation for the need for restraints will be documented. Policy Interpretation and Implementation 1. Physical Restraints are defined as any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily, which restricts freedom of movement or restricts normal access to one's body. 2. The definition of a restraint is based on the functional status of the resident and not the device. If the resident cannot remove a device in the same manner in which the staff applied it given that resident's physical condition, and this restricts his/her typical ability to (continued on next page)		

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	change position or place, that device is considered a restraint. 3. Examples of devices that are/may be considered physical restraints include leg restraints, arm restraints, hand mitts, soft ties or vest, wheelchair safety bars, geri-chairs, and lap cushions and trays that the resident cannot remove. 5. e. Restrained residents must be repositioned at least every two (2) hours on all shifts. 14. Residents and/or surrogate/sponsor shall be informed about the potential risks and benefits of all options under consideration, including the use of restraints, not using restraints, and the alternatives to restraint use.		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility's licensed nursing staff failed to provide care in accordance with professional standards of care to two of five sampled residents (Residents 13 and 14) reviewed for insulin (a hormone that removes excess sugar from the blood, can be produced by the body or given artificially via medication) use by failing to rotate (a method to ensure repeated injections are not administered in the same area) subcutaneous (sq, beneath the skin) insulin administration sites. The deficient practice had the potential for adverse effect (unwanted, unintended result) of the same site subcutaneous administration of insulin such as excessive bruising, lipodystrophy (abnormal distribution of fat) and cutaneous amyloidosis (is a condition in which clumps of abnormal proteins called amyloids build up in the skin). Findings: 1. During a review of Resident 14's admission Records (AR - the front page of the chart that contains a summary of basic information about the resident), the AR indicated that the facility originally admitted Resident 14 on 6/6/2024, and readmitted on [DATE], with diagnoses including end stage renal disease (ESRD - irreversible kidney failure), dependence on renal dialysis (a treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidney(s) have failed), type two Diabetes Mellitus (DM2-a disorder characterized by difficulty in blood sugar control and poor wound healing) with diabetic neuropathy (disease or dysfunction of one or more nerves, typically causing numbness or weakness in the hands and feet). During a review of Resident 14's Minimum Data Set (MDS - a resident assessment tool) dated 3/12/2026, the MDS indicated that the resident had intact cognitive (thinking or mental processing) skills for daily decision making. The MDS indicated that Resident 14 required substantial/maximal assistance (helper does more than half the effort) with toileting hygiene, shower, lower body dressing and putting on/taking off footwear. The MDS indicated the resident was on a high-risk drug class hypoglycemic medication (a type of medicine used to lower high blood sugar levels, primarily in people with Type 2 diabetes). During a review of Resident 14's Order Summary Report (OSR), the OSR indicated an order for: 5/2/2026 Insulin Aspart injection solution (a fast-acting, man-made version of human insulin) 100 units per milliliter (unit/ml, measures how concentrated insulin is, showing how many tiny doses of insulin are packed into a one mL vial) inject as per sliding scale (a pre-set chart used to determine rapid or short-acting insulin dosage based on blood sugar levels measured just before meals or at bedtime): if blood sugar (BS) 0 - 70 and the resident conscious give 4 ounces (oz) of juice, if unconscious give Glucagon 1 milligram (mg - measures the unit of measurement for mass/weight) intramuscularly (IM - a shot of medicine given deep into a muscle) and notify the physician; 140 - 199 = 1 Unit; 200 - 249 = 2 Units; 250 - 299 = 3 Units; 300 - 349 = 4 Units; 350 - 499 = 5 Units; more than (>) 400 = call the physician, subcutaneously (SQ) before meals and at bedtime for DM control. During a review of Resident 14's Location of Administration Report (LAR) for insulin for 5/2026, the LAR indicated insulin was subcutaneously administered on: Insulin Aspart Injection Solution 100 unit/ml 5/16/2026 at 9:24 p.m. on the Right Arm (RA) 5/17/2026 at 4:54 p.m. on the RA 5/18/2026 at 12:09 p.m. on the RA 5/19/2026 at 4:30 p.m. on the RA During a concurrent interview and record review on 5/20/2026 at 10:48 a.m. with Registered Nurse (RN) 7, RN 7 reviewed Resident 14's OSR, LAR and Care Plan (CP). RN 7 stated there was an order for Insulin Aspart for Resident 14. RN 7 stated that there was no documented care plan regarding insulin use. RN 7 further stated there were multiple instances that the licensed staff did not rotate the insulin administration sites for Resident 14. RN 7 stated it was important to rotate the insulin administration sites to prevent bruising, trauma and lipodystrophy on residents. RN 7 added administering insulin on sites of lipodystrophy will have an effect on its absorption causing hypo (low)/hyperglycemia (high blood sugar) on residents. 2. During a review of Resident 13's AR, the AR indicated that the facility originally admitted Resident 13 on 12/24/2021, and readmitted on [DATE], with diagnoses including type II DM, pleural effusion (an abnormal buildup of excess fluid in (continued on next page)		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the pleural space), generalized muscle weakness. During a review of Resident 13's MDS, dated [DATE], the MDS indicated that the resident had intact cognitive (thinking or mental processing) skills for daily decision making. The MDS indicated that Resident 13 was dependent (helper does all of the effort) to staff with toileting hygiene, shower, lower body dressing and putting on/takin off footwear. During a review of Resident 13's OSR, the OSR indicated an order for: 4/23/2026 Humalog (insulin Lispro - fast-acting man-made version of human insulin used to control blood sugar spikes right around mealtime) Injection Solution 100 unit/ml. Inject 6 Units SQ before meals for DM. 4/23/2026 Insulin Aspart Injection Solution 100 unit/ml. inject as per sliding: if BS less than (<) 70 and the resident conscious = 4 oz of juice or Glucogel (a concentrated, fast-acting sugar gel primarily used by people with diabetes to quickly treat dangerously low blood sugar), if unconscious = Glucagon 1 mg intramuscularly (IM - a shot of medicine given deep into a muscle) and notify the physician; 70 - 139 = 0 Unit; 140 - 199 = 1 Unit; 200 - 249 = 4 Units; 250 - 299 = 7 Units; 300 - 349 = 10 Units; 350 - 399 = 12 Units; if BS > 400 = 14 Units and call the physician, SQ before meals and at bedtime for DM. 4/23/2026 Lantus SQ Solution (Insulin Glargine) - long-acting man-made version of human insulin) 100 unit/ml. Inject 75 Units SQ in the evening for DM. During a review of Resident 13's Care Plan (CP) Report, the CP indicated the resident had a diagnosis of diabetes: insulin dependent. The CP interventions did not indicate intervention to rotate injections sites regularly. During a review of Resident 13's LAR for Insulin for 5/2026, the LAR indicated insulin was administered SW on: Humalog Injection Solution 100 unit/ml 5/2/2026 at 4:55 p.m. on the Abdomen - Right Upper Quadrant (RUQ) 5/3/2026 at 10:44 a.m. on the Abdomen - Left Lower Quadrant (LLQ) 5/3/2026 at 4:11 p.m. on the Abdomen - LLQ 5/8/2026 at 4:28 p.m. on the Abdomen - LLQ 8/18/2026 at 4:49 p.m. on the Right Arm (RA) Insulin Aspart Injection Solution 100 unit/ml 5/2/2026 at 9:02 p.m. on the Abdomen - RUQ 5/8/2026 at 4:28 p.m. on the Abdomen - LLQ 5/8/2026 at 8:25 p.m. on the Abdomen - LLQ 5/10/2026 at 3:49 p.m. on the Abdomen - LLQ 5/18/2026 at 4:51 p.m. on the RA Lantus SQ Solution 100 unit/ml 5/10/2026 at 4:34 p.m. on the Abdomen - LLQ During a concurrent interview and record review on 5/22/2026 at 9:22 a.m. with MDS Director (MDSD), the MDSD reviewed Resident 13's OSR, LAR and CP. The MDSD stated that there were three orders for insulin for Resident 13. The MDSD stated there were multiple instances that the licensed staff did not rotate the insulin administration sites for Resident 13. The MDSD stated CP addressing insulin use did not indicate rotating insulin injection sites regularly. The MDSD stated that licensed nurses must assess and rotate insulin administration sites prior to administration to ensure insulin is not repeatedly administered to the same location. The MDSD stated that the regular rotation of injection sites was essential to prevent complications such as bruising, lipodystrophy and muscle tissue damage. The MDSD further stated that not rotating sites may lead to decreased insulin absorption and reduced efficacy, which can result in poor blood glucose control. The MDSD added that CP interventions must reflect rotation of insulin injection sites. The MDSD stated the staff did not follow facility's Policies and Procedures (P&P), titled Insulin Administration Purpose and the Manufacturer's Specifications for Aspart, Humalog and Lispro. During an interview on 5/22/2026 at 2:40 p.m. with the Director of Nursing (DON), the DON stated Resident 13's and 14's insulin administration sites should be rotated to prevent lipodystrophy, muscle dystrophy, and abscesses. The DON stated that injecting insulin on the same site can cause poor absorption leading to less insulin efficacy and hyperglycemia. The DON stated the staff did not follow their policy and procedure (P&P) titled Insulin Administration and the Manufacturer's Specifications for Aspart, Humalog and Lispro. During a review of the facility's P&P titled Insulin Administration Purpose, last reviewed on 1/14/2026, the P&P indicated, Preparation. The nursing staff have access to specific instructions (from the manufacturer, if appropriate) on all forms of insulin delivery systems prior to their use. Steps in the Procedure (Insulin Injections via Syringe) . 20. Injection sites should be rotated, preferably within the same general area (abdomen, thigh, upper arm) . During a review of the facility-provided Product Monograph (PM - a highly detailed, scientific instruction manual for a medication) for the use of Humalog injection SQ with initial U.S. (United (continued on next page)		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	States) approval date 10/8/1996, the PM indicated, Subcutaneous administration, preferably by the patient, should be in the upper arms, thighs, buttocks or abdomen. Injection sites should be rotated so that the same site is not used more than approximately once a month, in order to reduce the risk of lipodystrophy and localized cutaneous amyloidosis (skin condition where misfolded proteins build up in the top layers of your skin). During a review of the facility-provided Highlights of Prescribing Information (HPI) on the use of Lantus for SQ injection with initial U.S. approval: 2000, the HPI indicated, Change (rotate) your injection sites within area you choose with each dose. Do not use the exact spot for each injection. During a review of the facility-provided HPI on the use of Insulin Aspart Injection for SQ use with initial U.S. approval: 2000, the HPI indicated Change (rotate) your injection sites within the area you choose with each dose to reduce your risk of getting lipodystrophy and localized cutaneous amyloidosis (skin with lumps) at the injection site.		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the resident environment was free of accident hazards and adequate supervision to prevent accidents for three of six sampled residents (Residents 140, 110, and 155) reviewed under the Accidents care area by failing to: 1. Ensure medications were not left at the bedside readily available for resident self- administration for Residents 140, 110, and 23. These deficient practices had the potential to result in resident harm from omission of medications, overdose of medications, and residents ingesting medications not intended for their use. 2. Ensure Resident 155's bed pad alarm (a pad with sensors that will alarm when a resident stands up unassisted to help prevent falls by alerting staff) was turned on when it was in use. ^ This deficient practice had the potential to result in Resident 155 sustaining an injury from a fall. 3. Ensure Resident 9's right floor mat did not have a chair on top of it. This deficient practice had the potential to result in resident injury from falls when the floor mat was damaged. Findings: a. During a review of Resident 140's admission Record (AR), the AR indicated that the facility admitted the resident on 5/9/2022 with diagnoses including hypertension (HTN-high blood pressure), hyperlipidemia (HLD - high cholesterol [a waxy substance that can build up in the blood resulting in stroke or heart issues]), chronic kidney disease (CKD a condition in which the kidneys are damaged and cannot filter blood as well as they should), and age related nuclear cataract (excessive amount of yellowing and light scattering affecting the center of the lens). During a review of Resident 140's Minimum Data Set (MDS- a resident assessment tool), dated 5/7/2026, the MDS indicated the resident had the ability to make himself understood and had the ability to understand others. The MDS indicated the resident required partial / moderate assistance from staff with activities of daily living (ADL- activities such as bathing, dressing and toileting a person performs daily) including shower/bathe self, lower body dressing, and putting on/taking off footwear. During a review of Resident 140's History and Physical (H&P), dated 5/14/2026, the H&P indicated the resident had fluctuating capacity (an individual experiences changes in their mental state, which can affect their decision-making abilities). During a review of Resident 140's Order Summary Report, the Order Summary Report indicated the following physician orders: - Benazepril HCl (medication to treat HTN) tablet 10 milligrams (mg, a unit of measurement), give one (1) tablet by mouth two times a day for HTN, hold (do not give) for systolic blood pressure (SBP, measures the pressure in your arteries [pathway that carries blood away from the heart]) less than (<) 100 millimeters of mercury (mmHg &ndash; measurement of pressure), dated 12/2/2024. - Fish Oil (supplement to treat HDL) oral capsule 1000 mg, give 1 capsule by mouth one time a day for Supplement, dated 4/4/2024.- Aspirin (medication that helps prevent blood clots [clumping of blood]) tablet chewable, 81 mg, give 1 tablet by mouth one time a day for cerebrovascular accident (CVA-stroke, loss of blood flow to a part of the brain) prophylaxis (prevention), dated 05/09/2022. During a concurrent observation and interview on 5/18/2026 at 9:50 a.m. with Resident 140, Resident 140 was observed lying in bed while no staff was present in the room. On the floor next to the resident's bed were two tablets and two clear capsules. Resident 140 stated the nurse left his medications during breakfast and they fell on the floor while he was eating. Resident 140 stated he thought he took some of the medications, but he was not sure. During an observation on 5/18/2026 at 9:58 a.m., Certified Nursing Assistant (CNA) 6 entered Resident 140's room and stood directly over the (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	two tablets and two capsules on the floor while speaking with the resident. CNA 6 exited the room and the two tablets and two capsules remained on the floor. During a concurrent observation, interview, and record review on 5/18/2026 at 10:05 a.m., at Resident 140's room, with Licensed Vocational Nurse (LVN) 7, reviewed Resident 140's medication administration records (MAR - a daily documentation record used by a licensed nurse to document medications and treatments given to a resident. LVN 7 stated the facility protocol for medication administration is the licensed nurse (LN) should watch the resident take the medication. LVN 7 stated medications should not be left at bedside for self-administration. LVN 7 stated if the resident does not take the medication, then the LN nurse should take the medications out of the room, place them in the medication cart, return to administer the medications when the resident is ready, and then document in the MAR after the medications are administered. LVN 7 stated earlier in the morning, she left Resident 140's medications at bedside for the resident to self-administer. LVN 7 stated she did not watch Resident 140 administer the medications because she was called away to attend to another resident. LVN 7 stated she should not have left the medications at bedside for the resident to self-administer, but she did. LVN 7 then entered Resident 140's room and stood directly over the two tablets and two capsules on the floor. Observed LVN 7 exited Resident 140's room and the medications remained on the floor. LVN 7 then re-entered Resident 140's room upon the request of the surveyor and stated there was a benazepril tablet, an aspirin tablet, and two fish oil capsules on the floor. LVN 7 stated she did not follow the facility medication administration protocol. LVN 7 stated it was not safe to leave resident medications unattended at bedside because the resident may not take the medications or another resident could take the medications. LVN 7 stated leaving medications at bedside causes a resident safety issue. During an interview on 5/18/2026 at 10:35 a.m. with the Assistant Director of Nursing (ADON), the ADON stated the medication administration process is to supervise the resident while they take the medications to ensure the medications are administered. The ADON stated residents have the right to self-administer medication after a medication self-administration assessment is completed and it is determined that the resident is safely able to do so. The ADON stated Resident 140 did not have a self-administration assessment completed and it was not safe for the resident to self-administer medications. The ADON stated even if a resident is able to self-administer medications, medications should never be left at bedside because other residents could take the medication. The ADON stated LVN 7 did not follow the facility protocol. During a concurrent interview and record review on 5/22/2026 at 1:45 p.m. with the Director of Nursing (DON), the DON reviewed the facility policy and procedure (P&P) regarding medication administration and medication self-administration. The DON stated LVN 7 did not follow the facility protocol for medication administration when she left medications at bedside for resident self-administration. The DON stated leaving medications at bedside could potentially affect other confused residents who could accidentally ingest the medication resulting in unstable vital signs (clinical measurements used to assess the body's most basic functions) leading to adverse reactions. The DON stated the facility did not have an accident prevention P&P, but medications are not left at bedside to prevent accidents from occurring. The DON stated the facility P&Ps were not followed. During a review of the facility's P&P titled, Self-Administration of Medications, last reviewed and approved on 1/14/2026, the P&P indicated that Residents have the right to self-administer medications if the interdisciplinary team has determined that it is clinically appropriate and safe for the resident to do so. Self-administered medications are stored in a safe and secure place, which is not accessible by other residents. 8.Any medications found at the bedside that are not authorized for self-administration are turned over to the nurse in charge or return to the family or responsible party. During a review of the facility's P&P titled, Bedside Medication Storage in the Facility, last reviewed (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	and approved on 1/14/2026, the P&P indicated that Bedside medication storage is permitted for residents who are able to self-administer medications, upon the written order of the prescriber and when it is deemed appropriate in the judgment of the facility's interdisciplinary resident assessment team. c. For residents who self-administer medications, the following conditions are met for bedside storage to occur: 1) The manner of storage prevents access by other residents. All nurses and aides are required to report to the charge nurse on duty any medications found at the bedside not authorized for bedside storage and to give unauthorized medications to the charge nurse for return to the family or responsible party. b. During a review of Resident 110's AR, the AR indicated that the facility admitted the resident on 3/27/2026 with diagnoses including liver (organ that removes toxins from the body's blood supply) cell carcinoma (cancer), cirrhosis of liver (permanent scarring that damages the liver), and cognitive communication deficit (difficulty with communication). During a review of Resident 110's MDS, dated [DATE], the MDS indicated the resident had the ability to make himself understood and had the ability to understand others. The MDS indicated the resident required partial to moderate assistance from staff with ADLs including showering and bathing self, toileting hygiene, lower body dressing, and mobility. During a review of Resident 110's Medication Self-Administration Evaluation form, dated 3/28/2026, the Medication Self-Administration Evaluation form indicated the resident was unable to demonstrate secure storage of medication kept in the room and self-administration of medication was not recommended. During a review of Resident 110's Order Summary Report, the Order Summary Report indicated a physician's order for lactulose (a laxative medication used to treat complications of cirrhosis) oral solution 20 grams (gm, a unit of measurement) 30 milliliters (mL, a unit of measurement), give 30 mL by mouth two times a day for liver cirrhosis related to liver cell carcinoma, dated 4/22/2026. During an interview on 5/18/2026 at 10:35 a.m. with the ADON, the ADON stated the medication administration process is to supervise the resident while they take the medications to ensure the medications are administered. The ADON stated residents have the right to self-administer medication after a medication self-administration assessment is completed and it is determined that the resident is safely able to do so. The ADON stated even if a resident is able to self-administer medications, medications should never be left at bedside because other residents could take the medication. During a concurrent observation and interview on 5/18/2026 at 10:40 a.m. with Resident 110, Resident 110 was observed lying in bed with a clear plastic cup containing approximately 20 mL of yellow tinted liquid on the bedside rolling table. Resident 110 stated the cup contained medication to help soothe his stomach. Resident 110 stated the nurse leaves the medication so he can take it whenever he wants to. Resident 110 stated he would drink the medication when he felt like it. During a concurrent observation and interview on 5/18/2026 at 10:45 a.m., with CNA 8, CNA 8 entered Resident 110's room. CNA 8 confirmed the clear cup contained liquid and she believed it was Mylanta (medication to treat stomach upset). CNA 8 was observed exiting the room and the medication remained at the bedside. During a concurrent observation and interview on 5/18/2026 at 10:50 a.m., with LVN 7, outside Resident 110's room, LVN 7 stated she gave Resident 110 a cup with 30 mL of lactulose and then closed the resident's curtain and left the room. LVN 7 stated she did not observe Resident 110 take (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the 30 mL of lactulose. LVN 7 stated she should have ensured the resident administered the 30 mL of lactulose, but she did not. LVN 7 stated residents should be supervised during medication administration to ensure medications are fully administered and not left at bedside for self-administration. During an interview on 5/20/2026 at 9:39 a.m. with the ADON, the ADON stated LVN 7 did not follow the facility protocol for medication administration when she left Resident 110's lactulose at bedside for self-administration. The ADON stated when medications are left at bedside the resident may not administer the medication resulting in increased confusion or other confused residents may take the medication resulting in adverse effects in the resident. During a concurrent interview and record review on 5/22/2026 at 1:45 p.m. with the DON, the DON reviewed the facility P&P regarding medication administration and medication self-administration. The DON stated LVN 7 did not follow the facility protocol for medication administration when she left medications at bedside for resident self-administration. The DON stated when LVN 7 left lactulose at Resident 110's bedside it could potentially result in the resident not taking the medication leading to irregularities in liver function resulting in increased confusion. The DON stated leaving medications at bedside could potentially affect other confused residents who could accidentally ingest the medication leading to adverse reactions. The DON stated the facility did not have an accident prevention P&P, but medications are not left at bedside to prevent accidents from occurring. The DON stated the facility P&Ps were not followed. During a review of the facility's P&P titled, Self-Administration of Medications, last reviewed and approved on 1/14/2026, the P&P indicated that Residents have the right to self-administer medications if the interdisciplinary team has determined that it is clinically appropriate and safe for the resident to do so. Self-administered medications are stored in a safe and secure place, which is not accessible by other residents. 8.Any medications found at the bedside that are not authorized for self-administration are turned over to the nurse in charge or return to the family or responsible party. During a review of the facility's P&P titled, Bedside Medication Storage in the Facility, last reviewed and approved on 1/14/2026, the P&P indicated that Bedside medication storage is permitted for residents who are able to self-administer medications, upon the written order of the prescriber and when it is deemed appropriate in the judgment of the facility's interdisciplinary resident assessment team. c. For residents who self-administer medications, the following conditions are met for bedside storage to occur: 1) The manner of storage prevents access by other residents. All nurses and aides are required to report to the charge nurse on duty any medications found at the bedside not authorized for bedside storage and to give unauthorized medications to the charge nurse for return to the family or responsible party. c. During a review of Resident 155's AR, the AR indicated that the facility admitted the resident on 4/1/2018 with diagnoses including dementia (a progressive state of decline in mental abilities), Alzheimer's disease (a disease characterized by a progressive decline in mental abilities), and generalized muscle weakness. During a review of Resident 155's H&P, dated 4/2/2026, the H&P indicated that the resident does not have the capacity to understand and make decisions. During a review of Resident 155's MDS, dated [DATE], the MDS indicated the resident sometimes makes self-understood and sometimes has the ability to understand others. The MDS indicated the resident has severely impaired cognitive skills for decision making. The MDS indicated that the resident was totally dependent on staff with ADLs including oral hygiene, toileting hygiene, shower/bathe self, lower body dressing, putting on/taking off footwear, personal hygiene and with mobility. During a review of Resident 155's physician order, dated 4/7/2026, the physician order indicated Bed alarm (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	while in bed (check for placement and function) every shift. During a review of Resident 155's CP titled Resident is at risk for falls/injury, dated 3/28/2026, the CP indicated the resident goal is to have no falls with injury and included interventions to use a bed alarm while in bed. During a concurrent observation and interview on 5/18/2026 at 3:25 p.m. with Restorative Nurse Assistant (RNA) 1, inside Resident 155's room, Resident 155 was observed lying in bed with bed pad alarm underneath. RNA 1 stated CNA 1 placed Resident 155 back to bed around 1 p.m. RNA 1 stated when Resident 155 goes back to bed they place the bed pad alarm. RNA 1 stated she does not see any blinking light on the pad alarm device. RNA 1 stated she will get LVN 1. During a concurrent observation and interview on 5/18/2026 at 3:30 p.m. with RNA 1 and LVN 1, inside Resident 155's room, LVN 1 stated the pad alarm device was not powered on, it was turned off. LVN 1 turned the switch to on and the green light flashed. LVN 1 stated it was not turned on so it was working. LVN 1 stated Resident 155 has the pad alarm while in bed to alert the staff that she is trying to get out of bed. LVN 1 stated when the device is not turned on Resident 155 could get out of bed unassisted and risk further falls. During an interview on 5/20/2026 at 1:45 p.m. with the ADON, the ADON stated whoever placed the bed pad alarm should check its function and placement to make sure they are working and must be done before leaving the resident. The ADON stated if placement is not the checked the resident could be leaning out then it won't alarm. The ADON stated checking for the function includes checking the battery, the connection and powered on because the resident could manipulate it and it was turned off. The ADON stated when bed pad alarm is not turned on then its effectiveness for fall precaution would not be followed. The ADON stated the staff would not be alerted the resident is trying to get out of bed and the resident could have another fall and sustain an injury." During a review of the undated Pad Alarm Attendant (PAA) 1 manufacturer specifications, the manufacturer specifications indicated that the on/off switch & can disable all functionality to preserve battery life. In-use light & notifies you at a glance that the unit is properly operating. Versatile & alarm can be used with bed and chair pads . During a review of the facility's P&P titled, Tab Alarms, Bed Alarms, Wander guard System, last reviewed and approved on 1/14/2026, the P&P indicated that Tab alarms or bed alarms may be used on a resident who is deemed unsafe through the nursing assessment and documented on the resident's care plan that the resident is at risk for falls. Procedure. 6. After applying the tab alarm or bed alarms in place, a safety check to make sure they are in proper working condition must be done before leaving the resident. d. During a review of Resident 23's admission Record (AR), the AR indicated the facility admitted the resident on 5/4/2026, with diagnoses including presence of left artificial hip joint (a surgically implanted, artificial metal or ceramic joint on left side that replaced the natural hip), muscle weakness and other reduced mobility and need for assistance with personal care. During a review of Resident 23's Minimum Data Set (MDS & a resident assessment tool), dated 5/19/2026, the MDS did not indicate any assessment for mental status. The MDS indicated an incomplete assessment of functional abilities. During a review of History and Physical (H&P) dated 5/4/2026, the H&P indicated that [Resident] remains mildly confused and required moderate to maximum assistance with transferring and ambulation. During a review of Resident 23's Care Plan, initiated on 5/5/2026, the Care Plan indicated a focus that patient shown decline on her bed mobility, transfer, and gait. The Care Plan also included a focus indicating that the resident exhibits or is at risk for alterations in comfort related to Surgical post-op with interventions including, to evaluate pain characteristics, quality, severity, location, etc., advise resident to request pain medication before pain becomes severe, and medicate resident, as ordered for pain and monitor for effectiveness and side effects, report to physician as indicated. During an initial observation on 5/18/2026 at 10:03 a.m. with Resident 23 inside resident's room, a Diclofenac Sodium Topical Gel, 1% (NSAID), a topical gel used for pain relief, was observed placed at the table to the right side of the resident's bed. Resident 23 stated that the topical gel has been there for days. Resident 23 stated that she has been applying the (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	gel by herself to her right knee and leg. During a concurrent observation and interview on 5/18/2026 at 10:04 a.m. with Licensed Vocational Nurse 5 (LVN 5), LVN 5 stated Resident 23 can make self-understood and can understand others. LVN 5 stated that the medication should not have been in resident's possession and should refrain from applying it by herself, given she has a prescribed ointment. LVN 5 stated that unsupervised use of the medication could result in overdosing and could potentially lead to drug interaction. During a concurrent interview and record review on 5/20/2026 at 9:35 a.m. with Registered Nurse 1 (RN 1), RN 1 stated that before a resident can self-administer any uncontrolled medications, there must be a self-administering assessment and physician's order for a resident to self-administer medications. RN 1 stated that Resident 23 did not have an assessment and order for self-administration of medication. RN 1 stated that nurses do not have control over how much was applied and could lead to overdosing. RN 1 further stated that residents can potentially have an adverse side effect like rash. During an interview on 5/22/2026 at 1:42 p.m. with the Director of Nursing (DON), the DON stated that medications should not be left at bedside especially if the resident does not have an order to self-administer medication. The DON stated that residents can have accidental ingestion which could potentially lead to complications and adverse reactions. During a review of the facility's Policy and Procedure (P&P) titled, Self-Administration of Medications, last reviewed and approved on 1/14/2026, the P&P indicated that Residents have the right to self-administer medications if the interdisciplinary team has determined that it is clinically appropriate and safe for the resident to do so. Self-administered medications are stored in a safe and secure place, which is not accessible by other residents.8.Any medications found at bedside that are not authorized for self-administration are turned over to the nurse in charge or return to the family or responsibly party. e. During a review of Resident 9's admission Record (AR), the AR indicated the facility admitted the resident on 4/10/2026, with diagnoses including left femur fracture (broken left thighbone), muscle weakness, dependence of supplemental oxygen (lungs cannot put enough oxygen from the normal air on their own).During a review of Resident 9's Care Plan, initiated on 4/10/2026, the Care Plan indicated a focus that the resident is at risk for falls/injury, impaired mobility, on antihypertensive medications, needs assist with transfers and bed mobility. The Care Plan indicated an intervention including low beds with bilateral floor mats and maintaining a clutter-free environment in the resident's room and consistent furniture arrangement. During a review of Resident 9's MDS dated [DATE], the MDS indicated the resident had the ability to make self-understood and understand others and had an intact cognition (means that a person's mental abilities &ndash; such as thinking, memory attention, and language &ndash; are working well and have not had experienced significant decline or impairment). The MDS indicated that the resident needs supervision or touching assistance with eating, and substantial/maximal assistance on toileting and other personal hygiene, and dependence on transfers and ambulation. During an observation on 5/18/2026 at 10:09 a.m., the floor mat to the right-side of Resident 9 was observed to have a black colored chair on top of the mat and had a plastic cup of water over the chair. During a concurrent observation and interview on 5/18/2026 at 10:10 a.m. with LVN 5, LVN 5 stated that floor mat is to protect residents from getting injured in a fall. LVN 5 stated that a chair was positioned on top of the floor mat, which should not have occurred. LVN 5 stated that if there is an object on top of the floor mat, the resident could hit the chair and possibly sustain an injury instead of landing safely in the floor mat. During an interview on 5/20/2026 at 9:52 a.m. with RN 1, RN 1 stated that placing an object on top of the floor mat is unacceptable. RN 1 stated that the whole point of placing a floor mat next to the resident's bed is for safety reasons. RN 1 further stated that residents could possibly fall and hit the chair that could lead to skin tears or fractures. During an interview on (continued on next page)		

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5/22/2026 at 1:42 p.m. with the Director of Nursing (DON), the DON stated that the purpose of floor mat is to prevent injury to residents during a fall. The DON stated that floor mats should be free from any objects for safety reasons. The DON stated that residents could possibly get hit by the object and cause to injure than landing on the floor mat safely. During a review of facility's Policy and Procedure (P&P) titled, Fall Management with effective date on 5/26/2021 indicated that Patients will be assessed for falls risk as part of the nursing assessment process. Those determined to be at risk will receive appropriate interventions to reduce risk and minimize injury. 2.Develop individualized plan of care, for example: including devices such as floor mats, bed to low position, alarm.		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure resident care was provided to residents consistent with professional standards of practice for three (3) of six sampled residents (Resident 9, 61, and 135) reviewed for respiratory care by failing to: 1. Ensure that Resident 9's oxygen (O2) nasal cannula (NC - a simple, two-pronged device that delivers extra oxygen to the nose) tubing was not touching the floor. 2. Ensure the oxygen concentrator (a medical device that pulls in regular room air, filters out the nitrogen, and delivers purified oxygen for you to breathe) humidifier (a refillable plastic bottle that infuses the normal flow of oxygen with water droplets) was labeled with a date, and the oxygen was running at the rate ordered by the physician for Resident 61. 3. Ensure the oxygen humidifier for Resident 155 was not empty and labeled with a date and ensured that the oxygen was running at the rate ordered by the physician. These deficient practices had the potential to result in inadequate oxygen delivery, leading to hypoxia (low levels of oxygen in body tissues) or oxygen toxicity (damage to the lungs that happens from breathing in too much oxygen), airway dryness and increased risk of respiratory infection. Findings: 1. During a review of Resident 9's admission Record (AR), the AR indicated the facility admitted the resident on 4/10/2026, with diagnoses including left femur fracture (broken left thighbone), muscle weakness, dependence of supplemental oxygen (Supplemental oxygen helps increase oxygen levels in the blood and reduce symptoms such as fatigue and shortness of breath). During a review of Resident 9's MDS dated [DATE], the MDS indicated the resident had the ability to make self-understood and understand others and had intact cognition (means that a person's mental abilities &ndash; such as thinking, memory attention, and language &ndash; are working well and have not had experienced significant decline or impairment). The MDS indicated that the resident needs supervision or touching assistance with eating, and substantial/maximal assistance with toileting and other personal hygiene, and dependence with transfers and ambulation. During a review of Resident 9's Care Plan, initiated on 4/18/2026, the Care Plan indicated that the resident exhibits or is at risk for respiratory complications related to other, with a goal indicating resident will have no signs/symptoms of respiratory distress x 30 days, and interventions indicating O2 as ordered via nasal cannula. During an initial observation on 5/18/2026 at 10:08 a.m. while inside Resident 9's room, Resident 9's oxygen tubing was not connected to resident 9's nose, and the nasal cannula tube was touching the bed, and the rest of the tubing was found touching the floor. During an observation and interview on 5/18/2026 at 10:09 a.m. with Licensed Vocational Nurse 5 (LVN 5), while inside Resident 9's room, LVN 5 stated that the oxygen tubing must not touch the floor and this does not comply with infection control protocols. LVN 5 stated that improper handling of oxygen tubing may increase the risk of respiratory infection complications due to potential infections among residents. During an interview on 5/19/2026 at 9:40 a.m. with Registered Nurse 1 (RN 1), RN 1 stated that oxygen tubing should not touch the floor, and the rest of the oxygen tubing must be placed inside a bag. RN 1 stated that oxygen tubing touching the floor poses an infection control issue, as it could possibly affect respiratory function if being used or reapplied. (continued on next page)		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/22/2026 at 1:42 p.m. with the Director of Nursing (DON), the DON stated that oxygen tubing that comes into contact with the floor is an infection control concern and increases the risk of respiratory complications for residents. The DON also stated that it is a safety concern as the tubing can get caught in another object and cause injury to residents. During a review of the facility's Policy and Procedure (P&P), titled Oxygen Administration reviewed and updated on 1/14/2026 the policy indicated in the General Guidelines 1. Oxygen therapy is administered by way of an oxygen mask, nasal cannula, and/or nasal catheter. b. The nasal cannula is a tube that is placed approximately one-half inch into the resident's nose. It is held in place by an elastic band placed around the resident's head. During a review of the facility's P&P, titled Changing of Nasal Cannula/Oxygen Tubing reviewed and updated on 1/14/2026, the policy indicated in the General Guidelines a. It is the policy of this facility to change nasal cannula and oxygen tubing weekly and as needed, if the nasal cannula is visibly soiled or damaged. b. Setup bags are dated and placed with each nasal cannula to prevent the nasal cannula from touching the floor when not being used. 2. During a review of Resident 135's admission Records (AR - the front page of the chart that contains a summary of basic information about the resident), the AR indicated that the facility admitted Resident 135 on 5/4/2026, with diagnoses including pneumonia (an infection/inflammation in the lungs), atrial fibrillation (AFib - an irregular, often rapid heart rhythm), acute systolic congestive heart failure (when the heart is suddenly too weak to squeeze blood out efficiently). During a review of Resident 135's History and Physical (H&P - a document with a patient's medical history and physical examination done by a physician) dated 5/7/2026, the H&P indicated that Resident 135 had the capacity to understand and make decisions. During a review of Resident 135's Minimum Data Set (MDS - a resident assessment tool) dated 5/10/2026, the MDS indicated that Resident 135 required partial/moderate assistance (helper does less than half the effort) with toileting hygiene, shower, lower body dressing and putting on and taking off footwear. During an observation on 5/18/2026 at 12:22 p.m. while in Resident 135's room, Resident 135 was receiving oxygen therapy via a nasal cannula (N/C &ndash; a flexible plastic tube delivering extra oxygen through two small prongs inserted into the nostrils) at 4 liters per minute (LPM - a measuring unit of liquid or gas flowing through a device in one minute) rate. The oxygen concentrator humidifier was empty and did not have a label with the date it was provided to the resident. During a concurrent observation and interview on 5/18/2026 at 12:27 p.m. with Registered Nurse (RN) 3 while in Resident 135's room, RN 3 stated that the oxygen concentrator humidifier was empty and was not labeled with the date it was provided to the resident. RN 3 stated that oxygen was flowing at 4 LPM via N/C. RN 3 stated that oxygen concentrator humidifier bottle was empty. RN 3 stated that empty humidifier placed Resident 135 at risk for airway dryness and scratched. RN 3 stated not labeling the humidifier with the date it was provided could potentially lead to respiratory infection and harm to the resident. During a concurrent interview and record review on 8/18/2026 at 12:35 p.m. with RN 3, RN 3 reviewed Resident 135's Order Summary Report (OSR). RN 3 stated that OSR dated 5/6/2026 indicated an order to infuse oxygen at 3 LPM via N/C continuously every shift related to acute systolic congestive heart (continued on next page)		

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide pain management consistent with professional standards of practice and the residents' goals and preferences for one of five sampled residents (Resident 4) reviewed for Unnecessary Medications by failing to ensure the Licensed Nurse (LN) administered as needed (PRN) oxycodone with acetaminophen (an opioid, also called a narcotic - powerful pain-reducing medication) per the physician's order and based on the assessed numeric pain rating scale (a standard pain scale with zero being no pain and ten [10] as the worst pain one can imagine). This deficient practice had the potential to result in side effects from unnecessary administration of narcotics including constipation, and mismanagement of resident pain resulting in limited resident participation in activities of daily living (ADLs -activities such as bathing, dressing and toileting a person performs daily), general activities, and mobility. Findings: During a review of Resident 4's admission Record (AR), the AR indicated the facility originally admitted the resident on 6/2/2017 and most recently admitted the resident on 1/22/2026 with diagnoses that included schizoaffective disorder (a mental illness that can affect thoughts, mood, and behavior), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest that can interfere with daily living), and spina bifida (a condition that occurs when the spine and spinal cord don't form properly). During a review of Resident 4's Minimum Data Set (MDS - resident assessment tool), dated 2/25/2026, the MDS indicated the resident was able to understand others and was able to make himself understood. The MDS further indicated the resident was dependent on staff for toileting and showering, required substantial / maximal assistance with lower body dressing and personal hygiene, and required partial / moderate assistance with moving from sitting to lying. During a review of Resident 4's Order Summary Report (OSR), the OSR indicated the following orders: - Document pain level for treatments before, during, and after treatment, administer PRN medication if pain is present, every day shift, dated 1/23/2026. - Acetaminophen oral tablet 325 milligrams (mg - a unit of measurement), give two tablets by mouth every six hours as needed for pain, dated 1/30/2026. - Oxycodone with acetaminophen 5-325 mg, give one tablet by mouth every six hours as needed for severe pain (pain scale eight [8] to 10), dated 2/9/2026. During a review of Resident 4's Care Plan (CP) titled, Resident exhibits or is at risk for alterations in comfort related to acute pain, chronic pain, neurogenic pain (nerve pain)., initiated on 1/10/2025, the CP indicated a goal that the resident would achieve acceptable level of pain control with interventions that included to evaluate pain characteristics, medicate resident as ordered, and report to physician as indicated. During a concurrent interview and record review on 5/20/2026 at 8:04 a.m. with the Minimum Data Set Coordinator (MDSC), Resident 4's physician orders and Medication Administration Record (MAR - a daily documentation record used by a licensed nurse to document medications and treatments given to a resident) were reviewed. The MDSC stated Resident 4 received acetaminophen as needed for pain and oxycodone with acetaminophen as needed for severe pain 8 to 10. The MDSC stated there were no pain parameters indicated for acetaminophen or any pain level below 8. The MDSC reviewed Resident 4's MAR and noted oxycodone with acetaminophen for pain level 8 to 10 was not administered per physician's orders on the following dates and times: - On 5/3/2026 at 1:44 p.m. for a pain level of six (6). - On 5/7/2026 at 11:20 a.m. for a pain level of 6. - On 5/10/2026 at 7:30 a.m. for a pain level of 6. - On 5/15/2026 at 7:30 a.m. for a pain level of seven (7). The MDSC further stated the licensed nurse should have clarified the pain medication orders to include as needed pain scale parameters for pain levels below 8 prior to administration, but they did not. During an interview on 5/20/2026 at 9:33 a.m. with Resident 4, inside Resident 4's room, the resident stated he received oxycodone with acetaminophen for pain and does not take any other pain medications. Resident 4 stated oxycodone with acetaminophen was not always affective. During a concurrent interview and record review on 5/20/2026 at 10:55 a.m. with Registered Nurse (RN) 5, Resident 4's physician orders (continued on next page)		

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	and MAR were reviewed. RN 5 stated she was caring for Resident 4 and the resident had occasional pain and was able to verbalize the numeric pain scale. RN 5 stated Resident 4 received oxycodone with acetaminophen as needed for pain 8-10. RN 5 reviewed Resident 4's MAR and noted that she administered oxycodone and acetaminophen for a pain level below 8 on the following dates and times: - On 5/3/2026 at 1:44 p.m. for a pain level of 6. - On 5/7/2026 at 11:20 a.m. for a pain level of 6. - On 5/10/2026 at 7:30 a.m. for a pain level of 6. - On 5/15/2026 at 7:30 a.m. for a pain level of 7. RN 5 then stated she misread the physician's order for PRN oxycodone with acetaminophen. RN 5 stated the writing on the order was small and she thought it said to administer for a pain level of 6 to 10. RN 5 stated it was important to avoid overuse of narcotics because of the risk for side effects. RN 5 stated she did not administer oxycodone with acetaminophen per the physician's orders potentially resulting in over sedation of the resident. During a concurrent interview and record review on 5/20/2026 at 12:07 p.m. with the Assistant Director of Nursing (ADON), Resident 4's physician orders and MAR were reviewed. The ADON stated it was important to administer PRN pain medication per the physician's orders. The ADON stated Resident 4 was not administered oxycodone with acetaminophen per the physicians' orders potentially resulting in poor pain management with overuse of opiates leading to the medication being less effective over time and other adverse effects like constipation, opiate overdose, or changes in level of consciousness. During a concurrent interview and record review on 5/22/2026 at 1:45 p.m. with the Director of Nursing (DON), the facility's policy and procedures (P&P) regarding pain medication was reviewed. The DON stated RN 5 should have followed the physician's order for the administration of PRN oxycodone with acetaminophen because the controlled medication has a risk of side effects and should only be administered when needed based on the resident's pain scale. The DON stated when oxycodone with acetaminophen was administered for a lower pain level there was the potential to result in unnecessary side effects like lethargy and sleepiness. The DON stated the facility P&P was not followed. During a review of the facility P&P titled, Administering Pain Medication, last reviewed and approved on 1/14/2026, the P&P indicated that The purpose of this procedure is to provide guidelines for assessing the resident's level of pain prior to administering analgesic pain medication. General Guidelines. 1. The pain management program is based on a facility-wide commitment [NAME] appropriate assessment and treatment of pain, based on professional standards of practice, the comprehensive care plan, and the resident's choices related to pain management.2. Pain management is defined as the process of alleviating the resident's pain based on his or her clinical condition and established treatment goals. 3. Pain management is a multidisciplinary process that includes the following: a. identifying signs and symptoms of and assessing existing pain;.6. When opioids are used for pain management, the resident is monitored for medication effectiveness, adverse effects, and potential overdose. a. Any resident who uses opioids for long-term management of chronic pain is at risk for opioid overdose. Equipment and Supplies. 1. Standardized pain assessment tools, as indicated per facility protocol. Steps in the Procedure. Administer pain medications as ordered.		

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure one of one sampled resident (Resident 14) who was receiving dialysis (clinical purification of blood as a substitute for the normal function of the kidney) treatment, received services consistent with professional standards of practice, by failing to ensure: 1. Licensed Nurses (LNs) followed the physician's order for a 1200 cc (cubic centimeter - unit of measurement used for liquids, (1cc equivalent to 1 ml (milliliter) - metric unit of measurement used for liquids) a day fluid restriction (limiting the total amount of liquids you consume each day) and monitored Resident 14's fluid intake. 2. LNs obtained a physician's order to monitor Resident 14's intake and output (I&O - the measurement of all the fluids that go into a person's body and all the fluids that leave it). 3. The facility developed and implemented a comprehensive, resident centered Care Plan (CP) addressing the 1200 cc a day fluid restriction. 4. LNs notified the physician of Resident 14's noncompliance with the prescribed fluid restriction. 5. The facility developed and implemented comprehensive, resident centered CP addressing Resident 14's noncompliance with fluid restrictions. These deficient practices had the potential to result in fluid overload (body holding too much water and salt) in resident on dialysis, leading to shortness of breath, swelling and fluid buildup in the lungs, increased strain on the heart, elevated blood pressure. It could also result in dehydration (body losing more fluids than it takes in) leading to electrolyte imbalance (too much or too little of essential minerals (like sodium, potassium, and calcium) in your body), hypotension (low blood pressure), confusion and weakness. Findings: During a review of Resident 14's admission Records (AR - the front page of the chart that contains a summary of basic information about the resident), the AR indicated that the facility originally admitted Resident 14 on 6/6/2024, and readmitted on [DATE], with diagnoses including end stage renal disease (ESRD - irreversible kidney failure), dependence on renal dialysis (a treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidney(s) have failed), type two Diabetes Mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing) with diabetic neuropathy (disease or dysfunction of one or more nerves, typically causing numbness or weakness in the hands and feet). During a review of Resident 14's Minimum Data Set (MDS- a resident assessment tool) dated 3/12/2026, the MDS indicated that the resident had intact cognitive (thinking or mental processing) skills for daily decision making. The MDS indicated that Resident 14 required substantial/maximal assistance (helper does more than half the effort) with toileting hygiene, shower, lower body dressing and putting on/taking off footwear. The MDS indicated the resident was on a high-risk drug class hypoglycemic medication (a type of medicine used to lower high blood sugar levels, primarily in people with Type two diabetes). During a review of Resident 14's Order Summary Report (OSR), the OSR indicated an order for fluid restriction of 1200 cc; Dietary = 720 cc, Nursing: 180 cc, 7 - 3 shift (work schedule) = 180 cc, 11 - 7 shift = 120 cc, every shift. The OSR review indicated no physician order to monitor Resident 14's I&O. During a review of resident 14's Medication Administration Report (MAR- a daily documentation record used by a licensed nurse to document medications and treatments given to a resident) for 5/2026, the MAR indicated no documentation of Resident 14's consumed fluid amount. During a review of Resident 14's CP Report, CR indicated no documentation of a CP addressing the resident's 1200 cc a day fluid restriction. During a concurrent observation and interview on 5/21/2026 at 10:55 a.m. with Certified Nurse Assistant (CNA) 4 inside Resident 14's room, observed a water pitcher containing 250 ml clear liquid, one 2/3 full bottle of Gatorade (flavored sugar water with added salts) drink on Resident 14's bedside table, and one bottle of unopened soda drink on Resident 14's nightstand. CNA 4 stated she (CNA 4) provided the resident with a pitcher of water with measurement markings, filled to 800 ml at the beginning of her shift (around 7 a.m.). CNA 4 stated that Resident 14 received additional fluids throughout the day, including a cup of coffee with breakfast, a cup of water or juice during lunch, (continued on next page)		

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	water when taking medications, and one to two cups of juice in between meals. CNA 4 stated Resident 14's visitors [NAME] Gatorade and a bottle of soda. CNA 4 added that she (CNA 4) repeatedly instructed the resident not to consume outside fluids due to Resident 14's dialysis status and ordered fluid restriction, however, the resident remained noncompliant. CNA 4 stated that she (CNA 4) was not instructed to document the amount of fluids consumed by the resident and that she (CNA 4) was not aware of any designated place to record that information. CNA 4 further stated she (CNA 4) only documents completion of the task by checking it off in the MAR, without recording the actual intake amount. CNA added that she (CNA 4) would not report the resident's fluid intake to a LN. During a concurrent interview and record review on 5/21/2026 at 11:05 a.m. with Registered Nurse (RN) 4, RN 4 stated when a resident placed on a fluid restriction, there should be a physician's order for an I&O, and CP addressing fluid restriction. RN 4 stated CNA's must be instructed to monitor resident's I&O, and report to CNs. RN 4 reviewed Resident 14's OSR, MAR for 5/2026 and CP. RN 4 stated there was an order for 1200 cc a day fluid restriction. RN 4 stated that MAR for 5/2026 indicated task completion for 1200 cc a day fluid restriction monitoring every shift and did not indicate the amount that Resident 14 had consumed. RN 4 reported CP addressing 1200 cc fluid restriction was not comprehensive and did not indicate resident centered interventions on how to meet the resident's needs. RN 4 further stated if Resident 14 was noncompliant with a fluid restriction, the staff needed to provide education to the resident on the importance of adhering to the restrictions. RN 4 stated that the physician must be notified of the noncompliance, and the noncompliance must be addressed in the CP. RN 4 reviewed Resident 14's Progress Notes (PN), and CP report. RN 4 stated there was not documentation of physician notification of Resident 14's noncompliance with 1200 cc fluid restriction. RN 4 further stated that there was no care plan developed addressing Resident 14's noncompliance with fluid restriction. RN 4 stated that residents on dialysis and on fluid restriction who were not properly monitored could experience complications such as fluid overload, shortness of breath, hypertension, dehydration and weakness. RN 4 added that failure to notify the physician of noncompliance and to update the care plan may prevent the interdisciplinary team (a group of experts from different fields who work closely together to solve a complex problem or care for a person's specific needs) from identifying patterns and implementing appropriate interventions. During an interview on 5/22/2026 at 2:40 p.m. with the Director of Nursing (DON), the DON stated that for a resident on a fluid restriction, failure to monitor fluid intake may result in fluid overload or dehydration, as well as complications such as edema, shortness of breath. The DON stated that comprehensive, resident centered care plan must be developed and implemented, including individualized intervention and monitoring requirement for the resident. The DON stated Resident 14's noncompliance with fluid restriction should have been communicated with the physician, and care planned. Not notifying the physician and not updating the CP can lead to failure to recognize and respond to changes in the resident's condition, resulting in unaddressed fluid overload or dehydration, delayed interventions, shortness of breath, low blood pressure and worsening of the resident's health condition. During a review of the facility's Policies and Procedures (P&P) titled Dialysis Care, last updated on 1/14/2026, the P&P indicated, .III. PROCEDURE. 2. Care Plan a. The Interdisciplinary Team (IDT) will ensure that the resident's Care Plan includes documentation of the resident's renal condition and necessary precautions (e.g., shunt site, weights, dietary and fluid restrictions, no B/P on affected side, lab draws, IV, injection on arm with shunt, observe for signs and symptoms of infection, etc.). i. The resident's Care Plan will be updated as needed. b. If the resident does not comply with his or her Care Plan, the Facility will document this non-compliance with following Care Plan and make the necessary adjustments, including providing additional education to the resident. Dialysis Care. b. Fluid Restrictions i. Dialysis residents are given fluid based on the fluid restriction as ordered by the physician. The Nursing Staff will notify the attending physician about resident's noncompliance to the fluid restriction. During a review of the facility's P&P, titled Encouraging and Restricting Fluids, last updated on 1/14/2026, the P&P indicated, Restricting Fluids: 1. Remove the (continued on next page)		

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	resident's water pitcher and cup from the room. Store in designated area. If the resident refuses to have the water pitcher removed, notify the supervisor and in turn, the physician. 6. Record the amount of fluid consumed on the intake side of the intake and output record. Record fluid intake in mls. Documentation. 6. The amount (in mls) of fluids consumed by the resident during the shift. 8. If the resident refused the treatment, the reason(s) why and the intervention taken.		

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to safely use bed rails (metal or plastic bars or guards attached to the sides of a bed to act as a barrier or support) for four of four sampled residents (Resident 14, 77, 82 and 108) by failing to ensure: 1. Resident 14's half (1/2) bed rails (a 1/2 (half-length) bed rail is a safety barrier that covers only the top portion of a bed, typically near the user's torso) had an informed consent (voluntary agreement to accept treatment and/or procedures after receiving education regarding the risks, benefits, and alternatives offered) and complete bed rail assessment on its use. 2. Resident 77's 1/2 bed rails had a physician's order, informed consent and a comprehensive, person-centered care plan for its use. 3. Resident 82's 1/2 bed rails had a physician's order, informed consent, bed rail assessment and comprehensive, person-centered care plan for its use. 4. Resident 108's 1/2 bed rails had a physician's order, complete bed rail assessment and comprehensive, person-centered care plan for its use. These deficient practices placed the residents at risk for potential accidents such as a body part being caught between the rails, falls if a resident attempts to climb over, around, between, or through the rails. Findings: 1. During a review of Resident 14's admission Records (AR - the front page of the chart that contains a summary of basic information about the resident), the AR indicated that the facility originally admitted Resident 14 on 6/6/2024, and readmitted on [DATE], with diagnoses including end stage renal disease (ESRD - irreversible kidney failure), dependence on renal dialysis (a treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidney(s) have failed), type two Diabetes Mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing) with diabetic neuropathy (disease or dysfunction of one or more nerves, typically causing numbness or weakness in the hands and feet). During a review of Resident 14's Minimum Data Set (MDS- a resident assessment tool) dated 3/12/2026 had intact cognitive (thinking or mental processing) skills for daily decision making. The MDS indicated that Resident 14 required substantial/maximal assistance (helper does more than half the effort) with toileting hygiene, shower, lower body dressing and putting on/taking off footwear. During an observation on 5/18/2026 at 10:13 a.m. inside Resident 14's room, observed Resident 14 lying in bed with bilateral 1/2 bed rails elevated. During a review of Resident 14's Order Summary Report (OSR), the OSR indicated an order for bed rails as an enabler for turning and positioning, dated 5/2/2025. During a review of Resident 14's Bed Rail Evaluation (BRE) dated 5/2/2026, the BRE indicated that the resident/resident representative was not informed about the medical needs that would be addressed by the use of side rails, educated about the benefits and potential side effects from the use of bed rails, and informed of alternatives attempted that failed to meet the resident's needs. During a review of Resident 14's Care Plan (CP) Report titled At risk for impaired bed mobility, the CP indicated an intervention to obtain informed consent from resident/resident representative for use of positioning to assist with moving within the bed, getting in and out of bed. During a concurrent observation and interview on 5/22/2026 at 12:48 p.m. with MDS Director (MDSD) inside Resident 14's room, observed Resident 14's bilateral 1/2 bed rails elevated. The MDSD stated the resident used the bed rails for repositioning and mobility. During a concurrent interview and record review on 5/22/2026 at 1:00 p.m. with MDSD, the MDSD reviewed Resident 14's electronic and paper medical records. The MDSD stated there was no documentation of bed rail informed consent. The MDSD reviewed BRE and stated the BRE was incomplete, because the BRE indicated resident/resident representative was not informed about the medical needs that would be addressed by the use of side rails, educated about the benefits and potential side effects from the use of bed rails, and informed of alternatives attempted that failed to meet the resident's needs. 2. During a review of Resident 77's AR, the AR (continued on next page)		

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	indicated that the facility officially admitted the resident on 3/5/2019, and readmitted on [DATE], with diagnoses including catheter-associated urinary tract infection (CAUTI - an infection in the bladder/urinary tract caused by urinary catheter (a hollow tube inserted into the bladder to drain or collect urine) use), stage 4 chronic kidney disease (CKD - kidneys are damaged and cannot filter blood the way they should), and DM. During a review of Resident 77's History and Physical (H&P), dated 11/25/2025, the H&P indicated the resident did not have the capacity to understand and make decisions. During a review of Resident 77's MDS, dated [DATE], the MDS indicated Resident 77 had intact cognitive skills. The MDS indicated the resident required substantial/maximal assistance with toileting hygiene, shower, lower body dressing and putting on/taking off footwear. During an observation on 5/18/2026 at 10:29 a.m. in Resident 77's room, observed Resident 77 lying in bed with bilateral 1/2 bed rails elevated. During a review of Resident 77's OSR, the OSR indicated no documentation of physician's order for bed rail use. During a review of Resident 77's Care Plan (CP) Report, the CP indicated no documentation of care plan for bed rail use. During a concurrent observation and interview on 5/22/2026 at 12:51 p.m. with MDSD inside Resident 77's room, observed Resident 77's bilateral 1/2 bed rails elevated. The MDSD stated the resident used the bed rails for repositioning and mobility. During a concurrent interview and record review on 5/22/2026 at 1:00 p.m. with MDSD, the MDSD reviewed Resident 77's electronic and paper medical records. The MDSD stated there were no physician's order, bed rail informed consent, and CP documented for Resident 77's bed rail use. 3. During a review of Resident 82's AR, the AR indicated that the facility officially admitted the resident on 3/10/2023, and readmitted on [DATE], with diagnoses including DM, hypertension (high blood pressure), hypothyroidism (when your thyroid gland doesn't produce enough essential hormones). During a review of Resident 82's H&P, dated 12/20/2024, the H&P indicated Resident 82 had the capacity to understand and make decisions. During a review of Resident 82's MDS, dated [DATE], the MDS indicated Resident 82 had moderately impaired cognitive skills (can manage basic self-care, need help with more complex tasks like managing money, taking medications correctly, or following multi-step directions). The MDS indicated Resident 82 was dependent (helper does all of the effort) on shoer and putting on/taking off footwear, required partial/moderate (helper does less than half the effort) with oral and personal hygiene and upper body dressing. During an observation on 5/18/2026 at 10:30 a.m. inside Resident 82's room, observed Resident 82 lying in bed with bilateral 1/2 bed rails elevated. During a review of Resident 82's OSR, the OSR indicated no documentation of physician's order for bed rail use. During a review of Resident 82's Care Plan (CP) Report, the CP indicated no documentation of care plan for bed rail use. During a concurrent observation and interview on 5/22/2026 at 12:53 p.m. with MDSD inside Resident 82's room, observed Resident 82's bilateral 1/2 bed rails elevated. The MDSD stated the resident used the bed rails for repositioning and mobility. During a concurrent interview and record review on 5/22/2026 at 1:00 p.m. with MDSD, the MDSD reviewed Resident 82's electronic and paper medical records. The MDSD stated there were no physician's order, BRE, bed rail informed consent, and CP documented for Resident 82's bed rail use. 4. During a review of Resident 108's AR, the AR indicated that the facility officially admitted the resident on 11/22/2024, and readmitted on [DATE], with diagnoses including DM, depression (a serious mood disorder that causes persistent feelings of sadness, emptiness, and a loss of interest in activities you normally enjoy), dysphagia (difficulty swallowing). During a review of Resident 108's H&P, dated 11/19/2025, the H&P indicated Resident 108 had fluctuating (changing) capacity to understand and make decisions. During a review of Resident 108's MDS, dated [DATE], the MDS indicated Resident 108 had moderately impaired cognitive skills. The MDS indicated Resident 108 required substantial/maximal assistance with toileting and personal hygiene, shower, lower body dressing, putting on/taking off footwear. During an observation on 5/18/2026 at 10:13 a.m. in Resident 108's room, observed Resident 108 lying in bed with bilateral 1/2 bed rails elevated. During a review of Resident 108's OSR, the OSR indicated no documentation of physician's order for bed rail use. During a review of Resident 108's Care Plan (CP) Report, the CP indicated no documentation of (continued on next page)		

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	care plan for bed rail use. During a concurrent observation and interview on 5/22/2026 at 12:29 p.m. with MDSD in Resident 108's room, observed Resident 108's bilateral 1/2 bed rails elevated. The MDSD stated the resident used the bed rails for repositioning and mobility. During a concurrent interview and record review on 5/22/2026 at 1: 10 p.m. with MDSD, the MDSD reviewed Resident 108's electronic and paper medical records. The MDSD stated there were no physician's order and CP documented for Resident 108's bed rail use. The MDSD reviewed Resident 108's BRE, dated 11/18/2025, and stated the BRE was incomplete, because the BRE indicated resident/resident representative was not informed about the medical needs that would be addressed by the use of side rails, educated about the benefits and potential side effects from the use of bed rails, and informed of alternatives attempted that failed to meet the resident's needs. During a subsequent interview on 5/22/2026 at 1:20 p.m. with the MDSD, the MDSD stated that bed rails were considered a form of restraint and require a physician's order, informed consent, bed rail assessment and a comprehensive, person-centered care plan. The MDSD stated if the physician's order was not in place, the use of bed rails would be unauthorized and could place the resident at risk for improper use. The MDSD further stated that if a care plan is not developed, staff may not have clear guidance on the proper use of bed rails. The MDSD added if the bed rail assessment was not completed, potential hazards such as entrapment, suffocation, or falls may not be identified. The MDSD stated if informed consent was not obtained, the resident/responsible party may not be aware of the risks, benefits, and alternatives of bed rail use. The MDSD added that lack of consent documentation may indicate resident's rights were not respected, the residents have the right to accept or decline the use of bed rails. During an interview on 5/22/2026 at 2:40 p.m. with the Director of Nursing (DON), the DON stated bed rails were considered a restraint, and required having physician's order, informed consent, bed rail assessment and a care plan. The DON stated the absence of any of these required elements can result in increased potential for resident harm, including injury, entrapment, falls, and violation of resident rights. During a review of facility's Policies and Procedures (P&P), titled Siderails, last reviewed on 1/14/2026, the P&P indicated, PROCEDURE Physical Restraint is defined by the Centers for Medicare and Medicaid Services (CMS) as any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body. III. The Licensed Nurse will complete the Bedrail Evaluation UDA and develop a Care Plan reflecting that evaluation. a. The IDT will discuss the risks involved with side rails with the resident and/or the resident's surrogate decision maker and caregivers and describe alternatives that may be safer and feasible (e.g., a lower bed, trapeze, transfer pole). b. Prior to placing a side rail on the bed informed consent will be obtained when side rail meets the definition of a physical restraint even when it is also be an enabler.		

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) by failing to: 1. Ensure Licensed Vocational Nurse (LVN) 7 administered benazepril (medication to treat high blood pressure), aspirin (medication that helps prevent blood clots [clumping of blood]), fish oil (supplement to treat high cholesterol), and refresh tears eye drops (medication to treat dry eyes) per the physician's orders on 5/18/2026. during the routine medication pass (a structured process of administering medications to ensure residents receive medications safely, accurately, and timely) for one of six sampled residents (Resident 140) reviewed for Accidents. 2. Ensure LVN 7 did not document the administration of benazepril, aspirin, and fish oil prior to leaving the medication for self-administration for one of six sampled residents (Resident 140) reviewed for Accidents. 3. Ensure LVN 7 did not document the administration of refresh tears eye drops prior to administering the medication for one of six sampled residents (Resident 140) reviewed for Accidents. 4. Ensure LVN 7 administered refresh tears eye drops per the facility policy and procedure (P&P), from one hour before to one hour after the scheduled administration time for one of six sampled residents (Resident 140) reviewed for Accidents. These deficient practices resulted in inaccurate MAR documentation and had the potential to result in increased blood pressure, cholesterol levels, and a risk for cerebrovascular accident (CVA-stroke, loss of blood flow to a part of the brain) for Resident 140. 5. Account for two doses of controlled substances (CS- medications which have potential for abuse and may lead to physical or psychological dependence) for Resident 72 in one of four inspected medication carts (Medication Cart Station 3) reviewed for Medication Storage and Labeling tasks. These deficient practices increased the opportunity for CS diversion (the transfer of a controlled substance or other medication from a lawful to an unlawful channel or distribution or use) and increased the risk that Resident 72's could have delayed medication treatment and continuity of care. Cross-reference F760 and F842. Findings: a. During a review of Resident 140's admission Record (AR), the AR indicated that the facility admitted the resident on 5/9/2022 with diagnoses including hypertension (HTN-high blood pressure), hyperlipidemia (HLD - high cholesterol [a waxy substance that can build up in the blood resulting in stroke or heart issues]), chronic kidney disease (CKD a condition in which the kidneys are damaged and cannot filter blood as well as they should), and age related nuclear cataract (excessive amount of yellowing and light scattering affecting the center of the lens). During a review of Resident 140's Minimum Data Set (MDS- a resident assessment tool), dated 5/7/2026, the MDS indicated the resident had the ability to make himself understood and had the ability to understand others. The MDS indicated the resident required partial to moderate assistance from staff with activities of daily living (ADL- activities such as bathing, dressing and toileting a person performs daily) including showering and bathing self, lower body dressing, and putting on and taking off footwear. During a review of Resident 140's History and Physical (H&P), dated 5/14/2026, the H&P indicated the resident had fluctuating capacity (an individual experiences changes in their mental state, which can affect their decision-making abilities). During a review of Resident 140's Order Summary Report, the Order Summary Report indicated the following physician orders: -Benazepril HCl tablet 10 milligrams (mg, a unit of measurement), give one (1) tablet by mouth two (continued on next page)		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	times a day for HTN, hold (do not give) for systolic blood pressure (SBP, measures the pressure in your arteries [pathway that carries blood away from the heart]) less than (<) 100 millimeters of mercury (mmHg &ndash; measurement of pressure), dated 12/2/2024. -Fish Oil oral capsule 1000 mg, give 1 capsule by mouth one time a day for Supplement, dated 4/4/2024.-Aspirin tablet chewable, 81 mg, give 1 tablet by mouth one time a day for cerebrovascular accident (CVA-stroke, loss of blood flow to a part of the brain) prophylaxis (prevention), dated 05/09/2022.-Refresh Tears Solution 0.5 % (carboxymethylcellulose Sodium, eye drop medication to treat dry eyes) Instill 1 drop in both eyes three times a day for dry eyes, dated 5/9/2022. During a concurrent observation and interview on 5/18/2026 at 9:50 a.m. with Resident 140, Resident 140 was observed lying in bed while no staff was observed in the room. On the floor next to the resident's bed there were two tablets and two clear capsules. Resident 140 stated the nurse left his medications during breakfast and they fell on the floor while he was eating. Resident 140 stated he thought he took some of the medications, but he was not sure. During a concurrent observation, interview, and record review on 5/18/2026 at 10:05 a.m., while at Resident 140's room, with LVN 7, Resident 140's medication administration records (MAR - a daily documentation record used by a licensed nurse to document medications and treatments given to a resident) were reviewed. LVN 7 stated the facility protocol for medication administration is that the licensed nurse (LN) should watch the resident take the medication and then document the administration after the medications are taken. LVN 7 stated medications should not be left at bedside for self-administration. LVN 7 stated if the resident does not take the medication, then the LN nurse should take the medications out of the room, place them in the medication cart, return to administer the medications when the resident is ready, and then document in the MAR after the medications are administered. LVN 7 stated earlier in the morning, she left Resident 140's medications at the bedside for the resident to self-administer. LVN 7 stated she did not watch Resident 140 administer the medications because she was called away to attend to another resident. LVN 7 stated she should not have left the medications at the bedside for the resident to self-administer, but she did. LVN 7 then stated she documented Resident 140's medications as administered in the MAR when the medications were left at bedside. LVN 7 stated she should not have documented Resident 140's medications prior to administration, but she did. LVN 7 then stated she did not yet administer Resident 140's refresh eye drops, but she had also documented the eye drops as administered in the MAR prior to administration. LVN 7 stated the eye drops should have been administered before 10 a.m., but they were not. LVN 7 then entered Resident 140's room and stood directly over the two tablets and two capsules on the floor and administered the refresh tears eye drops to Resident 140. LVN 7 exited Resident 140's room and the medications remained on the floor. LVN 7 then re-entered Resident 140's room upon the request of the surveyor and stated there was a benazepril tablet, an aspirin tablet, and two fish oil capsules on the floor. LVN 7 stated she did not follow the facility medication administration protocol. LVN 7 stated it was not safe to leave resident medications unattended at bedside because the resident may not take the medications. During a concurrent observation and interview on 5/18/2027 at 10:15 a.m., while in the hallway at the medication cart, the Assistant Director of Nursing (ADON) and LVN 7 compared Resident 140's medication bubble packs (a package that contains multiple sealed compartments with medication) with the medication found on the resident's floor. The ADON stated the medications were confirmed to be benazepril, aspirin, and fish oil. During an interview on 5/18/2026 at 10:35 a.m., with the ADON, the ADONstated the medication administration process is that the LN supervises the resident while they take the medications to ensure the medications are administered and then the LN documents in the MAR. The ADON stated (continued on next page)		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	documentation is to be done in the MAR after medications are administered to make sure the MAR reflects accurately what medications were taken and when. The ADON stated Resident 140 was not safe to self-administer medications. The ADON stated LVN 7 did not follow the facility protocol. During a follow-up concurrent interview and record review on 5/19/2026 at 2:22 p.m., with LVN 7, LVN 7 reviewed Resident 140's MAR and stated on 5/18/2026 she did not administer Resident 140's benazepril, aspirin, or fish oil because she could not determine if the medications found on the floor were the medications she left at bedside. LVN 7 stated she did not want to give additional doses of the medication if she was not sure. LVN 7 stated when Resident 140 did not receive the benazepril there was the potential that the resident's blood pressure would go up, without the aspirin there was the potential the resident could have a blood clot, and without the fish oil capsule there was the potential for an increase in the resident's cholesterol. During a follow-up concurrent interview and record review on 5/20/2026 at 9:39 a.m. with the ADON, the ADON reviewed Resident 140's MAR and stated there was no way to know if Resident 140 received benazepril, aspirin, or fish oil per the physician's orders on 5/19/2026 and it was considered a medication error. The ADON stated on 5/19/2026 LVN 7 documented benazepril, aspirin, and fish oil as administered, but they do not know if they were administered. The ADON stated LVN 7 should not have documented in the MAR prior to giving the medications, but she did. The ADON stated LVN 7 did not follow the facility process for documenting the administration of medication. The ADON further stated the facility process entails that medications are administered one hour before or one hour after the scheduled administration time at 9 a.m. The ADON stated Resident 140's refresh eye drops should have been administered before 10 a.m., but they were not. The ADON stated it was a medication error when the refresh eye drops were administered late. During a concurrent interview and record review on 5/22/2026 at 1:45 p.m. with the Director of Nursing (DON), administration when she left medications at the bedside for Resident 140 to self-administer. The DON stated it was a medication error when LVN 7 did not know if Resident 140 received benazepril, aspirin, and fish oil. The DON stated the medication error could potentially result in the resident developing issues from the missed medications like unregulated cholesterol, risk for blood clots, and high blood pressure. The DON then stated it was important to ensure medications are administered at the correct time so there is an adequate amount of time between doses. The DON stated it was a documentation and medication error when LVN 7 documented Resident 140's eye drops as administered at 9:36 a.m. on 5/18/2026, but LVN 7 did not administer the eye drops until after 10 a.m. The DON stated the eye drops were administered over one hour after the administration time and considered late. The DON further stated it was important to ensure the MAR reflected the actual time of medication administration so that the staff would know when the last dose of medication was administered and to be able to monitor any side effects. The DON stated the facility P&Ps were not followed when LVN 7 documented Resident 140's medications as administered prior to giving, and LVN 7 was not able to determine if Resident 140's medications were administered, the eye drops were administered late, and the MAR did not accurately reflect the time of the eye drops administration. During a review of the facility's P&P titled, Administering Medications, last reviewed and approved on 1/14/2026, the P&P indicated that Medications are administered in a safe and timely manner, and as prescribed. Staffing schedules are arranged to ensure that medications are administered without unnecessary interruptions. Medications are administered in accordance with prescriber orders, including any required time frame. Medication administration times are determined by resident need and benefit, not staff convenience. Medications are administered within one (1) hour of their (continued on next page)		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	prescribed time, unless otherwise specified. For residents not in their rooms or otherwise unavailable to receive medication on the pass, the MAR may be flagged. After completing the medication pass, the nurse will return to the missed resident to administer the medication. If a drug is withheld, refused, or given at a time other than the scheduled, document refusal. The individual administering the medication initials the resident's MAR on the appropriate line after giving each medication and before administering the next ones. As required or indicated for a medication, the individual administering the medication records in the resident's medical record: The date and time the medication was administered. Residents may self-administer their own medications only if the Attending Physician, in conjunction with the Interdisciplinary Care Planning Team, has determined that they have the decision-making capacity to do so safely. During a review of the facility's P&P titled, Medication Errors, last reviewed and approved on 1/14/2026, the P&P indicated that The Facility will work to keep medication error rates five percent or lower. Medication Error means the administration of medication:. At the wrong time. An omission in the documentation in the Medication administration Record may or may not constitute a medication error. During a review of the facility's P&P titled, Charting and Documentation, last reviewed and approved on 1/14/2026, the P&P indicated that 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. The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care. The following information is to be documented in the resident medical record: Medications administered. Documentation in the medical record will be . complete, and accurate. During a review of the facility's P&P titled, Documentation of Medication Administration, last reviewed and approved on 1/14/2026, the P&P indicated that A medication administration record is used to document all medications administered. A nurse or certified medication aide (where applicable) documents all medications administered to each resident on the resident's medication administration record (MAR). Administration of medications is documented immediately after it is given. b. During a review of Resident 72's AR, the AR indicated that the facility originally admitted the resident on 3/17/2025 and readmitted on [DATE] with diagnosis including urinary tract infection (UTI- an infection in the bladder/urinary tract), type II diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), and chronic pain. During a review of Resident 72's MDS, dated [DATE], the MDS indicated that the resident makes self-understood and has the ability to understand others. The MDS indicated that the resident was cognitively intact (a person's thinking, learning, and memory abilities are functioning normally and are not impaired). The MDS indicated that the resident was taking opioids (sometimes called narcotics, are medications prescribed by doctors to treat persistent or severe pain). During a review of Resident 72's physician order, the physician order indicated the following: -Dated 3/25/2026, Lyrica (a CS used for nerve pain) oral capsule 50 milligrams (mg &ndash; a unit of measurement) (pregabalin) give one (1) capsule by mouth every eight (8) hours for nerve pain. -Dated 5/2/2026, Methadone hydrochloride (a CS used for severe chronic pain) oral tablet 10 mg, give two tablets by mouth one time a day for pain management hold if respiratory rate less than 12 or with excess sedation. During a concurrent observation and interview on 5/20/2026 at 11:38 a.m., with LVN 3, at Medication Cart Station 2 T2, there was a discrepancy in the count between the Antibiotic or Controlled Drug Record (also known as Controlled Medication or CS or Controlled Drug Record or Controlled Drug (continued on next page)		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Administration Record) and the amount of medication remaining in the medication bubble pack for Resident 72: One dose of pregabalin capsule and one dose of a methadone tablet were missing from the medication bubble pack compared to the count indicated on the Antibiotic or Controlled Drug Record forms. The Antibiotic or Controlled Drug Record form for pregabalin indicated the medication bubble pack should have contained a total of 38 pregabalin 50 mg capsules, after the last administration of pregabalin 50 mg documented/signed off on 5/19/2026 at 10 p.m., however the medication bubble pack contained 37 pregabalin 50 mg capsules and contained no other documentation of subsequent administrations. The Antibiotic or Controlled Drug Record form for methadone indicated the medication bubble pack should have contained a total of seven (7) methadone 10 mg tablets, after the last administration of methadone documented/signed off on 5/20/2026 at 6 a.m., however the medication bubble pack contained six (6) methadone 10 mg tablets and contained no other documentation of subsequent administrations. LVN 3 stated he did not sign Resident 72's methadone 10 mg tablet this morning when he administered it at 9 a.m. LVN 3 stated the Antibiotic or Controlled Drug Record should have reflected 6 methadone 10 mg tablets, but he forgot to sign it this morning. LVN 3 stated he should have signed the Antibiotic or Controlled Drug Record right after administration and signing the Medication Administration Record. LVN 3 stated the pregabalin should have a total of 37 pregabalin 50 mg capsules, but it was not signed this morning. LVN 3 stated the count should be correct because these are controlled medications they want to make sure that the medication was administered to the resident and that he did not take it himself. During an interview on 5/20/2026 at 1:33 p.m., with the ADON, the ADON stated they signed off the Medication Administration Record and the Antibiotic or Controlled Drug Record before moving on to the next resident. The ADON stated that when the Antibiotic or Controlled Drug Record is not signed right away there is a tendency the licensed nurse will forget it and the count would not be correct. The ADON stated the Controlled Drug Record count, and the medication bubble pack should match. The ADON stated that when the Antibiotic or Controlled Drug Record and the medication bubble pack count are not correct there is potential for loss and diversion and the resident not receiving the medication. During a review of the facility's P&P titled, Controlled Substances, last reviewed and approved on 1/14/2026, the P&P indicated that The facility complies with all laws, regulations, and other requirements related to handling, storage, disposal, and documentation of controlled medications (listed as Schedule II-IV of the Comprehensive Drug Abuse Prevention and Control Act of 1976). 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. 3. Nursing staff count controlled medication inventory at the end of each shift, using these records to reconcile the inventory count. 4. The nurse coming on duty and the nurse going off duty make the count together and document and report any discrepancies to the director of nursing services.		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure all drugs and biologicals were stored appropriately in one of two medication rooms (Med Room Station 1) and one of four medication carts (Med Cart Station 3) observed during the Medication Storage and Labeling task by failing to: 1. Label the house supply of tuberculin purified protein derivative (PPD) (Aplisol - an injectable solution used in the skin test to detect tuberculosis [TB - a bacterial infection that primarily affects the lungs] infections) with an open date in accordance with manufacturer's requirements in Med Room Station 1. 2. Ensure the removal and disposal of Resident 112's hydrocodone-acetaminophen (used to treat moderate to severe pain) bubble pack (a medication packaging system that contains individual doses of medication per bubble) slot #28 with broken seal and was covered with tape in Med Cart Station 3. 3. Ensure the removal of expired medication, Resident 29's morphine, in Med Cart Station 3. These deficient practices had the potential to result in residents receiving medication that had become ineffective or toxic due to improper storage or labeling. Findings: a. During a concurrent observation and interview on 5/20/2026 at 11:23 a.m. with Licensed Vocational Nurse (LVN) 5, in Med Room Station 1, LVN 5 stated inside the medication refrigerator one tuberculin PPD vial was opened and used with no open date. LVN 5 stated it should have an open date because it's only good for 30 days. LVN 5 stated she will inform the Infection Preventionist and call the pharmacy to reorder. The tuberculin PPD box indicated fill date 4/3/2026 and instructions Once entered, vial should be discarded after 30 days. During an interview on 5/20/2026 at 1:36 p.m. with the Assistant Director of Nursing (ADON), the ADON stated the tuberculin PPD vial is a multi-dose vial and should have an open date of when it was first used because it's only good for certain number of days, 30 days once opened. The ADON stated the tuberculin PPD vial could be expired already, and the effectiveness would not be accurate. The ADON stated that when the tuberculin PPD is administered especially residents of advanced age could experience side effects such as rashes or itchiness. During a review of the facility's policy and procedure (P&P) titled, Medication Labeling and Storage, last reviewed and approved on 1/14/2026, the P&P indicated that the facility stores all medications and biologicals in locked compartments under proper temperature, humidity and light controls. Medication Labeling. 5. Multi-dose vials that have been opened or accessed (e.g., needle puncture) are dated and discarded within 28 days unless the manufacturer specifies a shorter or longer date for the open vial. 6. Multi-dose vials that are not opened or accessed are discarded according to the manufacturer's expiration date. b. During a review of Resident 112's Administration Record (AR), the AR indicated that the facility originally admitted the resident on 6/17/2022 and readmitted on [DATE] with diagnoses including fall, contracture (a stiffening/shortening at any joint, that reduces the joint's range of motion) of the left knee, right ankle, and left ankle, and asthma (a chronic [long-term] lung disease that can cause breathing problems). During a review of Resident 112's physician order, dated 5/4/2026, the physician order indicated hydrocodone-acetaminophen tablet 5-325 mg, give one (1) tablet by mouth every six (6) hours as needed for moderate to severe pain (4-10) not to exceed three (3) grams (g - a unit of measurement) of acetaminophen in 24 hours. Hold if respiratory rate less than 12 or with excess sedation. During a concurrent observation and interview on 5/20/2026 at 11:46 a.m. with LVN 2, in Medication Cart Station 3, LVN 2 stated Resident 112's hydrocodone-acetaminophen 5-325 mg bubble pack slot #28 with a broken seal and covered with tape. LVN 2 stated he does not know who put the tape over it and he did not notice it before. LVN 2 stated he will inform the supervisor to surrender and destroy 1 hydrocodone-acetaminophen 5-325 mg tablet in the bubble pack. LVN 2 stated it should not have been placed back inside and should not have been covered with tape. During an interview on 5/20/2026 at 1:40 p.m. with the ADON, the ADON stated once the (continued on next page)		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	medication is removed from the bubble pack and for whatever reason was not used or administered to the resident then it has to be surrendered to the Director of Nursing for destruction. The ADON stated that when the medication tablet is placed back in the bubble pack it could compromise the counting and the medication has already been contaminated. The ADON stated the medication could have fallen on the floor or left out. The ADON stated that when this medication is administered to the resident they could experience adverse reaction such as vomiting from contaminated medication. During a review of the facility's P&P titled, Controlled Substances, last reviewed and approved on 1/14/2026, the P&P indicated The facility complies with all laws, regulations, and other requirements related to handling, storage, disposal, and documentation of controlled medications (listed as Schedule II-IV of the Comprehensive Drug Abuse Prevention and Control Act of 1976). 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. 3. Nursing staff count controlled medication inventory at the end of each shift, using these records to reconcile the inventory count. 4. The nurse coming on duty and the nurse going off duty make the count together and document and report any discrepancies to the director of nursing services. 6. Unless otherwise instructed by the director of nursing services, when a resident refuses a non-unit dose medication (or it is not given), or a resident receives partial tablets or single dose ampules (or it is not given) the medication is destroyed and may not be returned to the container. c. During a review of Resident 29's AR, the AR indicated that the facility admitted the resident on 12/3/2024 with diagnosis including Alzheimer's disease (a disease characterized by a progressive decline in mental abilities), hypertension (HTN- high blood pressure), and Parkinson's disease (a progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movements). During a review of Resident 29's physician order, indicated the following: - dated 12/3/2024, the physician order indicated morphine sulfate oral solution 10 mg/ five (5) milliliters (ml - a unit of measurement) give 0.5 ml by mouth every two hours as needed for severe pain give by sublingual (under the tongue). - dated 4/17/2026, the physician order indicated morphine sulfate oral solution 10 mg/5 ml, give 0.5 ml sublingually every two hours as needed for severe pain (8-10) hold if respiratory rate less than 12 or excess sedation. During a concurrent observation and interview on 5/20/2026 at 11:50 a.m. with LVN 2, in Medication Cart Station 3, LVN 2 observed and stated Resident 29's morphine has a use by date of 12/3/2025. LVN 2 stated it should have been removed from the medication cart and disposed of when it expired on 12/3/2025. LVN 2 stated there is potential this medication could have been administered to Resident 29. During an interview on 5/20/2026 at 2:09 p.m. with the ADON, the ADON stated that expired medications should be removed from the medication cart on the same day when the medication expired. The ADON stated that when expired meds are not removed from the medication cart the licensed nurse could potentially administer expired medication to the resident. The ADON stated the licensed would not know if the medication is effective or not and if the resident is still having worsening pain or a change in condition or because the medication was ineffective. During a record review of the facility's P&P titled, Discarding and Destroying Medications, last reviewed and approved on 1/14/2026, the P&P indicated that Medications that cannot be returned to the dispensing pharmacy are disposed of in accordance with federal, state, and local regulations governing management of non-hazardous pharmaceuticals, hazardous waste, and controlled substances. 5. Schedule II, III, and IV (non-hazardous) controlled substances are disposed of in accordance with state regulations and federal guidelines regarding disposition of non-hazardous controlled medications. c. Disposal of controlled substances must take place immediately (no longer than three days) after discontinuation of use by the resident.		

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. Based on observation, interview, and record review, the facility failed to follow the menu to meet the nutritional needs of 68 to 164 residents, when staff did not provide the three (3) ounce (oz, unit of measurement) portion size of pork roast indicated on the menu spreadsheet (a sheet containing the kind and amount of food each diet would receive) and served 1.5 oz portion instead. This failure had the potential to result in a decrease in food flavor, a decrease in food and nutrient intake that could result in unplanned weight loss. Findings: During a review of the facility's menu spreadsheet titled Spring 2026, dated 5/18/2026, the spreadsheet indicated residents on a regular texture diet would include the following foods on the tray: Pork Roast 3 oz During an observation on 5/18/2026 at 11:53 a.m. of the food preparation, the roast pork was not uniform in size, some were bigger while some were smaller. During an interview on 5/18/2026 at 12:25 p.m. with [NAME] 1, [NAME] 1 stated he cut the pork roast from scratch as they were not individually pre-portioned. [NAME] 1 stated he did not weigh the pork roast so he would not know how heavy each portion size was. During a concurrent observation and interview on 5/18/2026 at 12:27 p.m. of the DS weighing random portions of pork roast using the facility food scale with the DS, the DS stated the portion size of the pork roast and the facility scales read: 1st portion: 2.52 oz 2nd portion: 3.7 oz 3rd portion: 3.93 oz The DS stated [NAME] 1 needed to weigh the pork roast, to ensure it was the right cut and portion. The DS stated they need to follow the spreadsheet to make sure residents are receiving the right nutrition that they are required to receive. The DS stated the residents would not be receiving the right nutrition and it would result in weight loss due to the lesser portions of pork roast, and residents could be at risk of not following their diets, would get sick and cause high blood pressure for those getting more portions of pork roast than the spreadsheet indicated. During a review of the facility's policies and procedures (P&P) titled, Menus, dated 1/14/2026, the P&P indicated, Menus will be planned in advance to meet the nutritional needs of the residents/patients in accordance with established national guidelines. Menus will be developed to meet the criteria through the use of an approved menu planning guideline. Procedure: Menu cycles will be developed and tailored to meet the needs and requirements of the facility. Menu cycles will include standardized recipes. Menu cycles will include nutritional analysis to ensure all the client (adolescent, adult, geriatric) nutritional needs are met in accordance with the most recent edition of the Food and Nutrition Board, Institute of Medicine, National Academies, and the Dietary Guidelines for Americans 2020-2025 edition. Menus will be served as written, unless a substitution is provided in response to preference, unavailability of an item, or a special meal. During a review of the facility's standardized recipe titled, Pork Roast/Gravy, dated 1/14/2026, the recipe indicated, Suggested portion: 3 oz.		

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to prepare food by methods that conserved temperature and flavor when hot foods were not served hot and pork roast, and seasoned black beans were not seasoned well and tasted bland. These failures had the potential to result in 157 of 164 facility residents including Resident 149, Resident 34, Resident 50, and Resident 163 to be at risk of unplanned weight loss, a consequence of poor food intake and receiving food from the kitchen. Findings: a). During a review of Resident 149's admission Record (AR), the AR indicated the facility initially admitted Resident 149 on 3/16/2017 with diagnosis including, but not limited to gastrointestinal reflux disease (GERD, stomach acid or contents frequently flow back in to the esophagus [the tube connecting the mouth and stomach]) without esophagitis (swelling or irritation of the tissues lining the esophagus), anxiety disorder (excessive fear or worry about a specific situation), and anemia (a condition in which the body does not have enough healthy red blood cells or hemoglobin to carry oxygen to the body's tissues). During a review of Resident 149's Minimum Data Sheet (MDS- a federally mandated resident assessment tool) dated 3/5/2026, the MDS indicated Resident 149 understood others and made self-understood. The MDS indicated Resident 149 required set-up and clean-up assistance (helper sets up or cleans up; residents complete the activity. Helper assists only prior to or following the activity) when eating. During a review of Resident 149's Order Recap Report, dated 4/15/2026, the report indicated Resident 149 was ordered a regular diet, regular texture with thin liquid consistency (diet with no restriction). During an interview on 5/18/2026 at 11:00 a.m. with Resident 149, Resident 149 stated the food products are substandard and gross. Resident 149 further stated the food is not good. b). During a review of Resident 34's AR, the AR indicated the facility admitted Resident 34 on 12/2/2025 with diagnosis including, but not limited to dysphagia, oropharyngeal phase (difficulty swallowing), depression (a constant feeling of sadness and loss of interest, which stops the individual from doing normal activities) and malignant neoplasm of the prostate (term for cancerous tumor located just below the bladder and surrounds the top portion of the tube that drains urine from the bladder). During a review of Resident 34's MDS dated [DATE], the MDS indicated Resident 34 understood others and makes self-understood. The MDS indicated Resident 34 required set-up and clean up assistance (helper provides verbal cues and/or touching/steadying and/or contract guard assistance as resident completes the activity. Assistance may be provided throughout the activity or intermittently) when eating. During a review of Resident 34's Order Summary Report, dated 12/18/2025, the report indicated Resident 34 was ordered Cardiac (diet avoiding foods high in fat, cholesterol, and salt), bite size texture (soft, tender and moist with no thin liquid leaking or dripping from the food), thin consistency. During an interview on 5/18/2026 at 11:28 a.m., with Resident 34, Resident 34 stated the food does not taste good. c). During a review of Resident 50's AR, the AR indicated the facility admitted Resident 50 on 4/1/2026 with diagnosis including, but not limited to dysphagia oropharyngeal phase, hyperlipidemia (high levels of fat and cholesterol in the blood) and unspecified protein-calorie malnutrition (a nutritional status in which reduced availability of nutrients leads to changes in body function). During a review of Resident 50's MDS dated [DATE], the MDS indicated Resident 50 understood others and make self-understood. The MDS indicated Resident 50 needed setup and clean-up assistance when eating. During a review of Resident 50's Order Summary Report, dated 5/14/2026, the report indicated Resident 50 was ordered a cardiac diet, easy to chew (diet consisting of food that is soft, tender and need less chewing), thin consistency diet. During an interview on 5/18/2026 at 12:56 p.m. with Resident 50, Resident 50 stated the food does not taste good. e). During a review of Resident 163's AR, the AR indicated the facility admitted Resident 163 on 5/1/2026 with diagnosis including, but not limited to GERD, essential hypertension (HTN, increased blood pressure), type 2 diabetes mellitus (a chronic condition in which the body does not make enough insulin [natural hormone produced by the pancreas] or (continued on next page)		

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	cannot use it properly resulting in increased blood sugar levels. During a review of Resident 163's Order Summary, dated 5/1/2026, the report indicated Resident 163 was ordered carbohydrate controlled (limiting amount of carbohydrates rich food in the diet), no added salt (NAS, no salt packet on the trays), regular texture, and thin consistency diet. During a review of Resident 163's MDS dated [DATE], the MDS indicated Resident 163 understood others and makes self-understood. The MDS indicated Resident 163 required supervision or touching assistance when eating. During an interview on 5/18/2026 at 4:00 p.m. with Resident 163, Resident 163 stated meals are very bland, with no seasoning and no flavor. During a review of the facility's menu spreadsheet (a sheet containing the kind and amount of food each diet would receive) titled Spring 2026 dated 5/18/2026, the spreadsheet indicated residents on a regular texture diet would include the following foods on the tray: Pork Roast 3 ounces (oz, a unit of measurement). Seasoned black beans 1/2 cup (c, a household measurement). Smothered cabbage 1/2 c. Cornbread/margarine 1 each. Beverage 8 oz. During a concurrent test tray (a process of tasting, temping, and evaluating the quality of food) observation and interview on 5/18/2026 at 2:04 p.m. of the regular diet, the Dietary Supervisor (DS) took the temperature of the following food using the facility thermometer. The DS stated the thermometer read the following temperature: Pork roast with gravy 104 degrees Fahrenheit (F, a degree of temperature) Seasoned black beans 90 F Smothered cabbage 111 F During a review of the facility's cook spreadsheet titled, Spring Menus, dated 5/18/2026, the spreadsheet indicated residents on a puree diet/International Dysphagia Initiative ([IDDSI] a framework for categorizing food textures and drink thickness) Level 4 would include the following foods on the tray: Pureed roast pork with gravy 1/2 c. Pureed seas black beans 1/2 c. Pureed smothered cabbage 1/4 c. Pureed corn bread with margarine 1/3c / 1 piece. Apple sauce 1/2 c. Beverage 8 oz. During a concurrent test tray observation and interview on 5/18/2026 at 2:05 p.m. of the puree diet, the DS took the temperature of the following foods using the facility thermometer. The DS stated the thermometer read the following temperature: Pureed pork roast 114 F. Pureed seasoned black beans 97 F. Pureed smothered cabbage 105 F. During an interview on 5/18/2026 at 2:07 p.m. with the DS, the DS stated the seasoned black beans needed to be more seasoned and pork roast was bland. The DS further stated that the food temperature could be a little hotter. The DS stated that residents would not eat the food and were not getting the full flavor of the meal and palatable temperatures. The DS stated residents could have a potentially poor food intake and weight loss if they don't eat the food. During a review of the facility's policies and procedures (P&P) titled Food: Quality and Palatability, dated 1/14/2026, the P&P indicated, Food will be prepared by methods that conserve nutritive value, flavor, and appearance. Food will be palatable, attractive and served in a manner, form, and texture to meet resident's needs. Definitions: Food attractiveness refers to the appearance of the food when served to the residents. Food palatability refers to the taste and flavor of the food. Proper (safe and appetizing) temperature-food should be at the appropriate temperature as determined by the type of food to ensure residents' satisfaction and minimize the risk of scalding and burns. 1. The dining services director and cook(s) are responsible for the food preparation. Menu items are prepared according to the menu, production guidelines, and standardized recipes. 2. The cook(s) prepare food in accordance with the recipes, and season for region and/or ethnic preferences, as appropriate. (2) [NAME] use proper cooking techniques to ensure color and flavor retention. During a review of the facility's P&P titled, Menus, dated 1/14/2026, the P&P indicated, Menus will be planned in advance to meet the nutritional needs of the residents/patients in accordance with established national guidelines. Menus will be developed to meet the criteria through the use of an approved menu planning guideline. Procedure: Menu cycles will include standardized recipes. During a review of the facility's recipe titled, Pork Roast dated 1/14/2026, the recipe indicated, ingredient: pork roast, black pepper, salt, garlic gloves. During a review of the facility's recipe titled, Seasoned Black Beans, dated 1/14/2026, the recipe indicated, ingredient: ground cumin, coriander, oregano, marjoram, dry black beans, onions, garlic gloves, jalapeno pepper, bay leaf, tomato puree, salt and black pepper.		

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. Based on observation, interview, and record review, the facility failed to prepare food in a form designed to meet individual needs when pureed corn bread was too sticky and did not fall from the spoon during the spoon tilt test (a method used to determine the stickiness of the food and ability of food to hold together) and the puree smothered cabbage did not hold its shape and it was flat on the plate causing it to touch the other food items. These failures had the potential to result in difficulty swallowing and difficulty in eating, and a decrease in food and nutrient intake to 33 of 33 residents on a puree diet (foods that are soft, pudding like consistency and hold its shape), resulting in unintended (not planned) weight loss and choking (when food gets stuck in your airway, blocking the flow of air to your lungs). Findings: During a review of the facility's cook spreadsheet (a sheet containing the kind and amount of food each diet would receive) titled, Spring Menus, dated 5/18/2026, the spreadsheet indicated residents on a puree diet/International Dysphagia Initiative ([IDDSI] a framework for categorizing food textures and drink thickness) Level 4 would include the following foods on the tray: Pureed roast pork with gravy 1/2 cup (c, a household measurement). Pureed seas black beans 1/2 c. Pureed smothered cabbage 1/4 c. Pureed corn bread with margarine 1/3 c/ 1 piece. Apple sauce 1/2 c. Beverage 8 oz. During a concurrent test tray (a process of tasting, temping, and evaluating the quality of food) observation and interview on 4/20/2026 at 2:36 p.m. of the puree tray with the Dietary Supervisor (DS), the DS stated the puree smothered cabbage did not hold its shape and it was flat on the plate causing it to touch the other food items. The DS further stated that the puree corn bread took time to fall off the spoon and it was after putting pressure while titling that it fell off from the spoon during the spoon tilt test. The DS stated the puree corn bread was sticky. The DS stated it would be hard for residents to swallow if the puree food is sticky and could cause choking as a potential outcome. The DS stated that puree food that is flat and does not hold its shape could also cause residents to choke as a potential outcome. During an interview on 5/19/2026 at 11:19 a.m., with the Registered Dietitian (RD), the DS stated she was not sure if the pureed food was checked on the trayline (an area where foods were assembled from the steamtable [kitchen appliance that keeps food warm at a safe temperature for serving] to resident's plates) but it is important to perform the spoon tilt test as food gets thickened over time and it gets too sticky resulting in residents having a harder time trying to swallow the food. The RD stated there would be a risk of difficulty swallowing and food not going down smoothly as a potential outcome. The RD further stated puree foods that are flat on the plate would not be presentable and not pleasant to look at and residents would not want to eat the food. During a review of the facility's policies and procedures titled Diet Manual, dated 1/14/2026, the P&P indicated, An approved diet manual will be used for menu planning for regular and therapeutic diet plans. 4. The dining services director and Registered Dietitian/Nutritionist (RDN), or other clinically qualified nutrition professionals, will ensure that the Diet Manual serves as a guide for ordering diets, and that the menus served will be consistent with the Diet Manual. During a review of the facility's diet manual, titled Dysphagia Texture, Puree IDDSI Level 4, dated 1/14/2026, the diet manual indicated, A diet used in the dietary management of dysphagia with the food texture should be prepared lump-free, not firm or sticky and holds it shape on a plate. The diet requires no biting or chewing. Any liquids must not separate from the food, and the food can fall off a spoon intact. The food is more easily swallowed and prevents aspiration. 3. Puree foods do not require chewing. They should have a pudding-like consistency without lumps (i.e. sour cream or mayonnaise thickness/moistness). All foods are appropriate if the consistency is pureed smooth without fibrous particles. Gravy or sauce may be added for lubrication or flavor enhancement. Should not be sticky. All prepared pureed recipes should be tested prior to service to ensure the texture meets the IDDSI guidelines. They should pass the fork drip test and spoon tilt test. It is recommended to use water in the preparation of puree recipes as utilizing water would not alter (continued on next page)		

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	nutritional composition. However, broth, milk, or juice may also be used. During a review of the IDDSI guideline website titled IDDSI, dated 7/2019, the IDSSI guideline indicated, Level 4 Pureed is usually eaten with a spoon, falls off spoon in a single spoonful when tilted and continues to hold shape on the plate, no lumps, not sticky, and liquid must not separate from solid. Food testing method: Spoon tilt test and fork drip test.		

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure meals and snacks are served at times in accordance with resident's needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times. Based on observations, interviews and record reviews, the facility failed to provide residents' meals at regular times scheduled in accordance with resident needs, preferences, and requests when lunch was served late on 5/18/2026. This deficient practice had the potential to result in hunger and frustration for 157 to 164 residents, including Resident 163. Findings: During a review of Resident 163's admission Record (AR), the AR indicated the facility admitted Resident 163 on 5/1/2026 with diagnosis including, but not limited to gastrointestinal reflux disease (GERD, stomach acid or contents frequently flow back in to the esophagus [the tube connecting the mouth and stomach]) without esophagitis (swelling or irritation of the tissues lining the esophagus), essential hypertension (HTN, increased blood pressure), type 2 diabetes mellitus (a chronic condition where body does not make enough insulin [natural hormone produced by the pancreas] or cannot use it properly resulting to increase of blood sugar levels. During a review of Resident 163's Order Summary, dated 5/1/2026, the report indicated Resident 163 was ordered a carbohydrate controlled (limiting amount of carbohydrates rich food in the diet), no added salt (NAS, no salt packet on the trays), regular texture, and thin consistency diet. During a review of Resident 163's Minimum Data Sheet (MDS- a federally mandated resident assessment tool) dated 5/8/2026, the MDS indicated Resident 163 understood others and make self-understood. The MDS indicated Resident 163 needed supervision or touching assistance (helper provides verbal cues and or touching/steadying and/or contract guard assistance as resident completes the activity. Assistance may be provided throughout the activity or intermittently) when eating. During an interview on 5/18/2026 at 4:00 p.m., with Resident 163, Resident 163 stated the food is often up to two (2) hours late. Resident 163 stated there are no meals that are later than the others, but lunch was late today. During a review of the facility document titled, Resident Council Minutes, dated 2/12/2026, the minutes indicated, sometimes the food cart comes out late. During an observation on 5/18/2026 at 11:53 a.m. kitchen staff were observed taking temperatures of the food on the steamtable (kitchen appliance that keeps food warm at a safe temperature for serving). During an interview on 5/18/2026 at 12:32 a.m. with the Dietary Supervisor (DS), the DS stated lunch is at 12 noon and they finish trayline (an area where foods were assembled from the steamtable to resident's plates) service, around 1:00 p.m. to 1:15 p.m. During an observation of the last meal cart on 5/18/2026 at 1:55 p.m., the meal cart arrived at Station 3. During an observation of the last meal cart in Station 3 on 5/18/2026 at 2:03 p.m., the nursing staff passed the last meal tray to residents in Station 3. During an interview on 5/19/2026 at 10:04 a.m., with the DS, the DS stated the lunch meal schedule was at 12:00 p.m. but they were behind yesterday because everybody was nervous and they needed to double check the texture of the food. The DS stated there were some days that residents complain of late meal service. The DS stated the dietary staff were not focused on meal planning and worrying about the meal preparation for dinner causing delays for lunch. The DS stated food could get cold, residents would have no appetite, and they could be upset as a potential outcome of late meals. During a review of the facility's policies and procedures titled, Mealtimes, dated 1/14/2026, the P&P indicated, lunch meal was at 12:00 p.m. to 1:15 p.m.		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure safe and sanitary food storage and food preparation practices in the kitchen when: 1. Kitchen and storage areas were not free from dirt and debris. a. Walk-in refrigerator racks had white dirt residue, black dirt and dry food particles. b. Walk-in refrigerator floor contained dry lettuce, trash and tape debris. c. Dry storage floor had cream of wheat particles. 2. Kitchen storage surfaces were not of cleanable surfaces a. Two (2) metal racks in the walk-in freezer had amber discoloration and rust. b. Four (4) of 4 racks had paint coming off in the dry storage area. c. Sixty-six (66) of 66 residents' trays had cracks, chips, and scratches. d. Three (3) drying racks were rusted with amber discoloration. 3. Mislabeled foods in the dry storage room area indicated expired foods. 4. There was no thermometer in the dry storage area. 5. One (1) dented (a metal container with a depression or hollow made by pressure or impact) can was stored with non-dented cans. 6. Observed cross-contamination in the kitchen a. Soiled towel was near the chopped cabbage during food preparation. b. Kitchen staff used the same chopping board and knife while chopping chicken tenders and bread. 7. [NAME] 2 and Dietary Aide 1 (DA 1) were wearing dangling earrings, bracelets and watches and [NAME] 2 was wearing nail polish during food preparation. These failures had the potential to result in harmful bacterial growth and cross contamination (transfer of harmful bacteria from one place to another) that could lead to foodborne illness (a disease caused by consuming food or drinks that are contaminated by germs or chemicals) in 157 of 164 medically compromised residents who received food and ice from the kitchen. Findings: 1.a. During an observation on 5/18/2026 at 8:31 a.m., of the walk-in refrigerator, observed the shelves had dry white dirt residue. During an interview on 5/18/2026 at 8:47 a.m., with the Dietary Supervisor (DS), the DS stated the racks contained foods residue, dry juice spills and dirt and there would be a risk of physical cross-contamination. The DS stated residents could get sick of salmonella, Escherichia coli (E. Coli, a type of bacteria that normally lives in the intestines of healthy humans and animals) and other food poisoning or food borne illness because of cross-contamination. During a review of the facility's policies and procedures (P&P) titled, Equipment, dated 1/14/2026, the P&P indicated, All food service equipment will be clean, sanitary, and in proper working order. 1. All equipment will be routinely cleaned and maintained in accordance with manufacturer's directions and training materials. 3. All food contact equipment will be cleaned and sanitized after every use. 4. All non-food contact equipment will be clean and free of debris. During a review of the facility's P&P titled, Refrigerator and Freezers, dated 1/14/2026, the P&P indicated, Refrigerator and freezers are kept clean, free of debris, and disinfected with sanitizing solution on a scheduled basis and more often as necessary. b. During an observation on 5/18/2026 at 8:31 a.m., of the walk-in refrigerator, observed vegetables, tape and box debris on the floor. During an interview on 5/18/2026 at 8:47 a.m. with the DS, the DS stated the staff clean the walk-in refrigerator right after each meal and deep clean every Sunday. The DS stated the floor was just cleaned and mopped a few minutes ago. The DS stated there was tape debris, dried lettuce and paper trash on the floor. The DS further stated the floor needed to be cleaned and make sure there are no stains and spills to prevent pests in the kitchen. During a review of the facility's P&P titled, Environment, dated 1/14/2026, the P&P indicated, All food preparation areas, food service areas, and dining areas will be maintained in a clean and sanitary condition. c. During a concurrent observation and interview on 5/18/2026 at 9:27 a.m., of the dry storage area floor with the DS, observed white particles on the floor. The DS stated it was cream of wheat debris, and it was important to have debris-free food floors to prevent pest in the storage area. The DS stated pests could spread viruses and infection to the residents as a potential outcome. During a review of the facility's P&P titled, Environment, dated 1/14/2026, the P&P indicated, The Dining Service Director will ensure that the kitchen is maintained in a clean and sanitary manner, (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	including floors, walls, ceilings, lightning, and ventilation. During a review of Food Code 2022, the Food Code 2022 indicated, 4-601.11 (E) Except when dry cleaning methods are used as specified under S 4-603.11, surfaces of utensils and equipment contacting food that is not time/temperature control for safety food shall be cleaned: (1) At any time when contamination may have occurred; (2) At least every 24 hours for iced tea dispensers and consumer self-service utensils such as tongs, scoops, or ladles; (3) Before restocking consumer self-service equipment and utensils such as condiment dispensers and display containers; and (4) In equipment such as ice bins and beverage dispensing nozzles and enclosed components of equipment such as ice makers, cooking oil storage tanks and distribution lines, beverage and syrup dispensing lines or tubes, coffee bean grinders, and water vending equipment: (a) At a frequency specified by the manufacturer, or (b) Absent manufacturer specification, at a frequency necessary to preclude accumulation of soil or mold. During a review of Food Code 2022, the Food Code 2022 indicated, 4-602.13 Nonfood-Contact Surfaces. Nonfood-contact surfaces of equipment shall be cleaned at a frequency necessary to preclude accumulation of soil residues. 2.a. During an observation on 5/18/2026 at 8:38 a.m., of the walk-in freezer, observed the racks used for food storage had rust and amber discoloration. During an interview on 5/18/2026 at 9:00 a.m. with the DS, the DS stated the racks have rust that could cause cross-contamination. The DS stated residents could get sick of foodborne illness as a potential outcome. During a review of the facility's P&P titled, Refrigerators and Freezers, dated 1/14/2026, the P&P indicated, Supervisors inspect refrigerators and freezers monthly for gasket condition, fan condition, presence of rust, excess condensation, and any other damage or maintenance needs. Necessary repairs are initiated immediately. b. During a concurrent observation and interview on 5/18/2026 at 9:03 a.m., of the racks in the dry storage area with the DS, observed the racks had cracks and rust. The DS stated the four (4) metal shelves' paint was peeling off. The DS stated food storage that has crack or chipped paint would not be a cleanable surface resulting in bacterial growth and cross contamination. c. During an observation on 5/18/2026 at 11:25 a.m. of the residents' trays, observed 66 of 66 residents' trays had cracks, chips and scratches. During an interview on 5/18/2026 at 12:08 p.m. with the DS, the DS stated residents' trays are cracked and chipped and they could not clean it resulting in bacterial growth. The DS stated residents could get foodborne illnesses as potential outcome of cross contamination of food from the cracked and chipped trays. d. During a concurrent observation and interview on 5/18/2026 at 12:51 p.m., of the dishwashing area with the DS, observed three (3) drying racks were rusted. The DS stated all three racks were rusted and it was not okay because of cross contamination. During a review of the facility's P&P titled, Storage Areas, Maintenance, dated 1/14/2026, the P&P indicated, All storage area must be kept free from accumulation of trash, rubbish, oily rags, paper, etc., at all times. During a review of Food Code 2022, dated 1/18/2023 the Food Code 2022 indicated, 4-202.11 Food-Contact Surfaces. (A) Multiuse Food-contact surfaces shall be (1) Smooth (2) Free of breaks, open seams, cracks, chips, inclusions, pits, and similar imperfections. (3) Free of sharp internal angles, corners, and crevices, (4) Finished to have smooth welds and joints. 3. During a concurrent observation and interview on 5/18/2026 at 9:16 a.m., of the food inside the dry storage area with the DS, observed the following foods with label of: - Cheerios used by date 5/19/2026 - [NAME] Krispies used by date 5/19/2026 - [NAME] powder used by date 5/15/2026 The DS stated the dietary aide mislabeled the food and it was important to properly label the food so the staff would know the expiration date of the food, it's not spoiled and how long the food has been in storage. The DS stated if the residents were given spoiled food, it could result in food borne illnesses. During a review of the facility's P&P titled, Receiving, dated 1/14/2026, the P&P indicated, 5. All food items will be appropriately labeled and dated either through manufacturer packaging or staff notation. During a review of the facility's P&P titled, Food Storage: Dry Goods, dated 1/14/2026, the P&P indicated, 6. Storage areas will be neat, arranged for easy identification, and date marked as appropriate. During a review of Food Code 2022, the Food Code 2022 indicated, 3-501.17 Commercially processed food, open and hold cold, (B) except specified in (E) (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- (G) of this section, refrigerated, ready-to-eat time/temperature control for food safety food prepared and packed by a food processing plant shall be clearly marked, at the time the original container is opened in a food establishment and if the food is held for more than 24 hours, to indicate the date or day by which the food shall be consumed on the premises, sold, or discarded, based on the temperature and time combinations specified in (A) of this section and (1) The day the original container is opened in the food establishment shall be counted as Day 1; and (2) The day or date marked by the food establishment may not exceed a manufacture's use-by- date if the manufacturer determined the use-by date based on food safety. 4. During a concurrent observation and interview on 5/18/2026 at 9:03 a.m., of the dry storage area with the DS, there was no thermometer inside the dry storage area. The DS stated they do not have a thermometer and do not monitor temperature in the dry storage area. During an interview on 5/18/2026 at 9:20 a.m. with the DS, the DS stated it was important to monitor the temperature in the dry storage area because if it's too hot or too cold the food could spoil. The DS stated acceptable temperature range for the dry storage area is 75-80 degrees Fahrenheit (F, a scale of temperature). The DS stated residents could get foodborne illness from consuming spoiled food as a potential outcome. The DS stated there was no particular reason why they do not monitor temperature in the dry storage area. During a review of the facility's P&P titled, Food Receiving and Storage, dated 1/14/2026, the P&P indicated, Non-refrigerated foods, disposable and napkins are stored in a designated dry storage unit which is temperature and humidity controlled, free of insects and rodents and kept clean. 5. During a concurrent observation and interview on 5/18/2027 at 9:22 a.m., of the dry storage area by the hallway, observed one (1) dented can stored with non-dented cans. The DS stated the dented cans are separated in the office because the food from the dented cans could be spoiled. The DS stated that when can is dented, air could go in and bacteria could develop. The DS stated consuming food from dented cans is not good because residents could get sick of foodborne illness. During a review of the facility's P&P titled, Receiving, dated 1/14/2026, the P&P indicated, Safe food handling procedures for time and temperature control will be practiced in the transportation, delivery, and subsequent storage of all food items. 4. All canned foods will be appropriately inspected for dents, rust and bulges. Damaged cans will be segregated and clearly identified for return to vendor or disposal, as appropriate. During a review of Food Code 2022, dated 1/18/2023, the Food Code 2022 indicated, 3-101.11 Safe Unadulterated, and Honestly Presented. Food shall be safe, unadulterated, and, as specified under 3-601.12, honestly presented. 3-201.11 Compliance with Food Law. A primary line of defense ensuring that food meets the requirements of S3-101.11 is to obtain food from approved sources, the implications of which are discussed below. However, it is also critical to monitor food products to ensure that, after harvesting, processing, they do not fail victim to conditions that endanger their safety, make them adulterated, or compromise their honest presentation. The regulatory community, industry, and consumers should exercise vigilance in controlling the conditions to which foods are subjected and be alert to signs of abuse. FDA considers food in hermetically sealed containers that are swelled or leaking to be adulterated and actionable under the Federal Food, Drug, and Cosmetic Act. Depending on the circumstances, rusted, and pitted or dented cans may also present a serious potential hazard. 6.a. During an observation on 5/18/2026 at 11:29 a.m., of the food preparation, observed [NAME] 1 chopping cabbage and lettuce leaves and there was a soiled towel hanging near the sink where he was preparing the vegetables. During an interview on 5/18/2026 at 12:10 p.m., with the DS, the DS stated the staff should put the soiled towels in the plastic bag and it is not acceptable to have the soiled towel hanging around the cabbage in the preparation sink because of cross contamination. During a review of the facility's P&P titled Food Preparation and Service, dated 1/14/2026, the facility indicated, Cross contamination can occur when harmful substances, i.e., chemical or disease-causing microorganisms are transferred to food by hands (including gloved hands), food contact surfaces, sponges, cloth towels, or utensils that are not adequately cleaned. b. During a concurrent observation and interview on 5/18/2026 at 12:39 p.m. of the trayline (an area where foods were (continued on next page)		

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

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	assembled from the steamtable [kitchen appliance that keeps food warm at a safe temperature for serving] to resident's plates) with the DS, observed Dietary Aide 1 (DA 1) sliced the bread into halves using soiled white chopping board and soiled knife used to cut chicken fingers in the countertop near the stove. The DS stated DA 1 should not use the same chopping board and knife used for chicken fingers because of cross-contamination. The DS stated if there was one resident allergic to chicken and ate the bread, residents could potentially have allergic reactions. During a review of the facility's P&P titled, Food Preparation and Service, dated 1/14/2026, the P&P indicated, Food preparation staff adhere to proper hand hygiene and sanitary practices to prevent the spread of foodborne illness. During a review of Food Code 2022, dated 1/18/2023, the Food Code 2022 indicated, 3-307.11 Miscellaneous Sources of Contamination. Food shall be protected from contamination that may result from a factor or source not specified under subparts 3-391 - 3-306. 7. During an observation on 5/18/2026 at 11:34 a.m., of the hamburger preparation in the preparation area, observed [NAME] 2 wearing two (2) dangling earrings, a watch, a bracelet and nail polish during food preparation. During an observation on 5/18/2026 at 11:46 a.m., of the food preparation, observed Dietary Aide 1 (DA 1) wearing a watch during food preparation. During an interview on 5/18/2026 at 12:13 a.m., with the DS, the DS stated kitchen staff are not allowed to wear jewelry and dangling earrings because it could fall into the food and contaminate it. The DS stated [NAME] 2 was wearing dangling earrings. The DS stated the only jewelry the kitchen staff could wear is a plain wedding band. During an interview on 5/18/2026 at 12:16 p.m., with the DS, the DS stated kitchen staff cannot wear nail polish because it could get chipped and could fall to the food causing cross-contamination. During a review of the facility's P&P titled, Staff Attire, dated 1/14/2026, the P&P indicated, All employees wear approved attire for the performance of their duties. 5. Hand jewelry will be limited to a plain band. Arm jewelry and dangling jewelry is not permitted. 6. Fingernails will be kept clean, trimmed, filed and maintained. 7. Use of nail polish, acrylic and gel nails are permitted unless wearing intact gloves, in good repair, when handling food. During a review of Food Code 2022, dated 1/18/2023, the Food Code 2022 indicated 2-303.11 Prohibition. Except for a plain ring such as wedding band, while preparing food, food employees may not wear jewelry including medical bracelets.		

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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** Based on observation, interview, and record review, the facility failed to maintain complete and accurate medical records in accordance with accepted professional standards for two (2) of five sampled residents (Resident 83 and 141) reviewed for medication administration task by failing to: 1. Ensure that the Psychotropic Medication Administration Disclosure had the physician's signature, and date when the resident signed the consent. 2. Ensure that Licensed Vocational Nurse (LVN) 7 and Registered Nurse (RN) 5 accurately documented Resident 141's administered medications as ordered on 5/16/2026 and 5/19/2026. These deficient practices had the potential to result in incomplete, inaccurate, and delayed records that could lead to miscommunication between healthcare providers and resident harm. Findings: 1. During a review of Resident 83's admission Record (AR), the AR indicated that the facility admitted the resident on 4/17/2026 with diagnoses including cerebral infarction (also known as ischemic stroke occurs when the blood supply to part of the brain is blocked or reduced), depression (a serious mood disorder that causes persistent sadness, loss of interest in activities), and muscle weakness. During a review of Resident 83's General Acute Care Hospital (GACH) History and Physical (H&P), dated 3/28/2026, the H&P indicated that the resident had the capacity to understand and make decisions. During a review of Resident 83's Minimum Data Set (MDS &ndash; a resident assessment tool), dated 4/23/2026, the MDS indicated that the resident was cognitively intact (a person's thinking, learning, and memory abilities are functioning normally, and are not impaired). The MDS indicated that the resident required partial to moderate assistance with eating and personal hygiene, substantial to maximal assistance with toileting hygiene, and bathing as well as with transferring and ambulating. During a review of Resident 83's physician order dated 4/28/2026, the physician order indicated to administer trazadone HCl (for insomnia or depression) oral tablet 50 mg (Trazadone HCl) 0.5 tablet by mouth at bedtime for depression manifested by (m/b) sleeplessness as evidenced by (AEB) less than six hours of sleep at night and Venlafaxine HCl ER (commonly sold as Effexor, used to treat depression) oral capsule extended release 24 hour 75 mg, give 1 capsule by mouth one time a day for depression m/b episodes of refusing to socializing/attending activities. During an interview on 5/21/2026 at 9:50 a.m. with Resident 83 while inside the resident's room, Resident 83 stated that she was familiar with the medications that she was taking. Resident 83 stated that when she came to the facility, she learned that additional medications were ordered for her. Resident 83 stated that she does not recall what those were and that no one had explained to her what type of medication she was taking. Resident 83 stated that she does not recall signing any papers regarding psychotropic medications and further stated that she may have signed a document considering that she was bombarded with many information and could not recall signing any document and further stated that she had never spoken to any physician regarding psychotropic medication since admission. During an interview and record review on 5/21/2026 at 10:06 a.m. with Registered Nurse 2 (RN 2), RN 2 stated that Resident 83 has an order for psychotropic medications and was ordered to start on 4/18/2026. RN 2 stated that before giving any psychotropic medications, a consent must be obtained (continued on next page)		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	from the resident. RN 2 stated that obtaining consent from the resident is the responsibility of the charge nurse or RN Supervisor RN 2 stated that the physician is required to personally examine the resident and provide an explanation for the proposed treatment and ensure follow-up occurs within 72 hours. RN 2 further stated that Resident 83 was not properly consented because the documentation was incomplete and no progress note showing that the physician explained to the resident the reasons for taking psychotropic medications. RN 2 stated that consent is important to ensure that the patient is aware and involved in the care as it is their right to know what kind of treatment they are receiving to avoid a medication error. During an interview on 5/22/2026 at 1:42 p.m. with the Director of Nursing (DON), the DON stated that psychotropic medications are high risk medications and residents must have continuous monitoring. The DON stated that the Psychotropic Medication Administration Disclosure form must be completed within 72 hours. The DON stated that prior to residents signing the consent form, the physician should communicate with the resident regarding the purpose of the treatment and its potential side effects. The DON further added that the policy and procedure for charting and documentation was not being followed. During a review of the facility's undated Policy and Procedure (P&P), titled Charting and Documentation dated 1/14/2026, the P&P indicated that 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. The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care. 1.Documentation in the medical record must be electronic, manual or a combination. 2.The following information is to be documented in the resident medical record:b. medications administered. 3.Documentation in the medical record will be objective (not opinionated or speculative), complete, and accurate.7.Documentation of procedures and treatments will include care-specific details, including: a. The date and time the procedure/treatment was provided. b. The name and title of the individual(s) who provided the care.f. Notification of family, physician or other staff, if indicated; and g. The signature and title of the individual documenting. During a review of the facility's P&P titled Informed Consent for Psychotropic Drugs reviewed and updated on 1/14/2026, the P&P indicated under Responsibilities: Prescribing Practitioner (e.g., Physician, nurse Practitioner, Physician Assistant within Scope) included: obtaining informed consent for all psychotropic medications prior to initiation or dose increase, discuss material information with the resident/representative in a language they understand, provide written information if available (e.g., FDA medication guides or side effects summaries), document the discussion, resident/representative's understanding, and consent/refusal in the medical record (.). 2. During a review of Resident 141's admission Record (AR), the AR indicated that the facility originally admitted Resident 141 on 11/12/2023 and readmitted on [DATE] with diagnoses including Parkinson's disease (a progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movements), anxiety disorder (an abnormal condition characterized by persistent and excessive worries that interfere with daily activities), and asthma (a chronic [long-term] lung disease that can cause breathing problems). During a review of Resident 141's Minimum Data Set (MDS- a resident assessment tool), dated 5/17/2026, the MDS indicated the resident makes self-understood and has the ability to understand others. The MDS indicated that the resident was cognitively intact (a person's thinking, learning, and memory abilities are functioning normally and are not impaired). (continued on next page)		

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 141's physician orders, the physician orders indicated the following: - Carbidopa-Levodopa (Sinemet- used to treat symptoms of Parkinson's disease) extended release (ER) oral tablet 25-100 milligrams (mg &ndash; a unit of measurement), give one (1) tablet by mouth five times a day for Parkinson's Disease, dated 8/22/2025. - Carbidopa-Levodopa oral tablet 25-100 mg, Give 0.5 tablet by mouth five times a day for Parkinson's Disease, give medication with Sinemet ER, dated 8/22/2025. - Docusate Sodium (DSS - stool softener) oral capsule 100 mg, give 1 capsule by mouth two times a day for bowel management, hold if with loose stool, dated 8/22/2025. - Entacapone (used in combination with Sinemet) tablet 200 mg, give 1 tablet by mouth five times a day for Parkinson's Disease give at the same time as Sinemet, dated 8/22/2025. - Entresto oral tablet 49-51 mg, give 1 tablet by mouth two times a day for congestive heart failure (CHF- a heart disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling), dated 8/22/2025. - Escitalopram oxalate (antidepressant) oral tablet 10 mg, give 1 tablet by mouth one time a day every other day for depression (a constant feeling of sadness and loss of interest, which stops the individual from doing normal activities) manifested by verbalization of having low mood due to current condition and physical limitations brought about his diagnosis of Parkinson's disease, dated 5/12/2026. - Gabapentin oral capsule 400 mg, give 1 capsule by mouth three times a day for neuropathy (disease or dysfunction of one or more nerves, typically causing numbness or weakness in the hands and feet), dated 5/9/2026 - Lorazepam oral tablet 1 mg, give 1 tablet by mouth every 12 hours for anxiety manifested by overconcern with health, dated 3/13/2026 - Omega 3 oral capsule 1000 mg, give 2 capsules by mouth one time a day for supplement, dated 8/22/2025. - Tizanidine hydrochloride oral tablet, give 1 mg by mouth two times a day for muscle relaxant, dated 5/1/2026. During a concurrent interview and record review on 5/20/2026 at 1:49 p.m., with the Assistant Director of Nursing (ADON), the ADON reviewed Resident 141's Medication Administration Record (MAR) for the month of 5/2026, the ADON stated LVN 7 was the charge nurse for Resident 141 on 5/19/2026 on the 7 a.m. to 3 p.m. shift. The ADON stated medications were not signed off for two doses of carbidopa-levodopa 25-100 mg 1 tablet, two doses of carbidopa levodopa 25-100 mg 0.5 mg tablet, DSS 100 mg 1 tablet, entacapone 200 mg 1 tablet, Entresto 49-51 mg 1 tablet, escitalopram 10 mg 1 tablet, gabapentin 400 mg 1 tablet, lorazepam 1 mg 1 tablet, omega 3 1000 mg 2 capsules, and tizanidine 1 mg 1 tablet. The ADON stated RN 5 was the charge nurse on 5/16/2026 and had not signed off for entacapone 200 mg 1 tablet. During an interview on 5/20/2026 at 1:56 p.m. with the ADON, the ADON stated that the medication administration documentation/signed off is done right after administering the medication. The ADON stated that when the licensed nurses do not document the medication they administer there would be no way of knowing if it was given or not. The ADON stated for medications used to treat Parkinson's disease symptoms when not taken the resident's could have increase in tremors, for gabapentin the resident could experience increase or unrelieved nerve pain and for DSS the resident is at increased risk for constipation. The ADON stated the checkmark on the MAR meant that the medication was given. The ADON stated that the standard of practice is to document once done, if it's not documented then it was not done. During a review of the facility's policy and procedure (P&P) titled, Documentation of Medication Administration, last reviewed and approved on 1/14/2026, the P&P indicated that a medication administration record is used to document all medications administered. Policy Interpretation and Implementation 1. A nurse or certified medication aide (where applicable) documents all medications administered to each resident on the resident's medication administration record (MAR). 2. Administration of medication is documented immediately after it is given.		

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For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. Based on interview and record review, the facility failed to ensure necessary care was provided consistently for one of one sampled resident (Resident 16) reviewed under hospice and end of life care area who was receiving hospice service (a program designed to provide a caring environment for meeting the physical and emotional needs of the terminally ill) by failing to: 1. Ensure Resident 16's medical records included documentation of the Certified Home Health Aide (CHHA) visit notes, the hospice plan of care, and the hospice calendar. 2. Ensure Hospice Provider (HP) 1 hospice calendar was followed for the CHHA visits on multiple days for the month of 1/2026 and 2/2026. These deficient practices had the potential to negatively affect Resident 16's physical comfort, psychosocial well-being, and had the potential to result in a delay or a lack of necessary care and services. Findings: During a review of Resident 16's admission Record (AR), the AR indicated that the facility admitted the resident on 10/21/2026, with diagnoses including malignant neoplasm (a tumor that can invade surrounding normal tissue and/or spread to other parts of the body) of the bronchus or lung, palliative care (medical care that relieves pain, symptoms and stress caused by serious illness), acute respiratory failure (a sudden and severe condition where the lungs cannot supply enough oxygen to the body), and chronic obstructive pulmonary disease (COPD - a chronic lung disease causing difficulty in breathing) with acute (sudden) exacerbation. During a review of Resident 16's History and Physical (H&P), dated 10/25/2025, the H&P indicated that the resident had the capacity to understand and make decisions. During a review of Resident 16's physician orders, dated 10/21/2025, the physician order indicated to admit the resident to Hospice Provider (HP) 1 under routine level of care with terminal (end-stage) diagnosis of malignant neoplasm of the lung. During a review of Resident 16's Minimum Data Set (MDS- a resident assessment tool), dated 4/27/2026, the MDS indicated the resident made self-understood and had the ability to understand others. The MDS indicated that the resident was moderately impaired cognition (when a person has trouble remembering, learning new things, concentrating, or making decisions that affect their everyday life). The MDS indicated the resident was dependent on staff with activities of daily living (ADLs- activities such as bathing, dressing and toileting a person performs daily) and mobility. The MDS indicated that hospice care was performed while Resident 16 was a resident of the facility. During a review of Resident 16's Certification of Terminal Illness (CTI-a document in which the physician certifies the patient is terminally ill with a prognosis of six months or less), the CTI indicated the following: - Effective date of Certification from 10/21/2025 to 1/18/2026. - Effective date of Certification from 1/19/2026 to 4/18/2026. - Effective date of Certification from 4/19/2026 to 6/17/2026. During a concurrent interview and record review on 5/20/2026 at 2:28 p.m. with Licensed Vocational Nurse (LVN) 4, Resident 16's hospice calendars, hospice visit notes, and plan of cares were reviewed. LVN 4 stated the hospice plan of care was dated 10/24/2025 and no subsequent hospice plan of care was available in the medical record after 10/24/2025. LVN 4 stated she (LVN 4) will call HP 1 to provide the documentation. During an interview on 5/20/2026 at 3:03 p.m. with the Director of Nursing (DON), the DON stated the hospice provider provides the hospice plan of care on initial and upon every hospice recertification. During a concurrent interview and record review on 5/20/2026 at 3:15 p.m. with the Assistant Director of Nursing (ADON), Resident 16's hospice calendars, hospice visit notes, and plan of cares were reviewed. The ADON stated there was no documentation for the month of 4/2026 and for 5/2026 regarding CHHA scheduled visits for Resident 16. The ADON stated the last hospice aide (HA) visit was 1/15/2026. The 1/2026 and 2/2026 hospice calendars indicated that HA visits on 1/20/2026, 1/23/2026, 1/27/2026, 1/30/2026, 2/2/2026, and 2/5/2026. The ADON stated they should have followed up with hospice. The ADON stated the hospice plan of care was not followed up until today, 5/20/2026, and their hospice policy and hospice agreement was not followed. The ADON stated that when the hospice plan of care is not followed, the (continued on next page)		

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	hospice calendar not available, the resident's comfort can be affected, and her care will be impaired because the purpose of the hospice service is to ensure the delivery of hospice care to the resident and provide comfort during their end of life. During a concurrent interview and record review on 5/20/2026 at 3:55 p.m. with the ADON, Resident 16's hospice physician order, dated 2/5/2026 was reviewed. The ADON stated the HA visit was discontinued on 2/5/2026 due to Resident 16's request to discontinue HA services. During a review of the facility's policy and procedure (P&P) titled, Hospice Care of Residents, last reviewed and approved on 1/14/2026, the P&P indicated that the purpose of this policy is to ensure that residents and their representatives are made aware of the availability of hospice care. Procedure. c. If the resident and/or surrogate decision maker decides to utilize hospice care, the Attending Physician will be contacted to make final determination. The Hospice and Facility will collaborate on a Care Plan for the resident. Facility and Hospice Staff will collaborate on a regular basis concerning the resident's care. e. Documentation. Hospice Notes will be included in the Facility Progress Notes. All documentation concerning hospice services will be maintained in the resident's medical record.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections by failing to ensure: 1. A disposable (one time use) yellow gown with a tear hanging on the washing machine was disposed of properly in the trash after being used. 2. Five out of six linen carts on the units were not covered with a permeable (material that allowed liquid or gas to pass through)/mesh material observed during infection control task. These deficient practices had the potential to cause cross-contamination (the invisible transfer of harmful germs, allergens, or chemicals from one object, surface, or food to another) of infection among residents and staff. Findings: 1. During an observation on 5/21/2026 at 2:00 p.m., inside the laundry area, observed a yellow disposable gown hanging on the washing machine. During a concurrent observation and interview on 5/21/2026 at 2:01 p.m. with the Laundry Aide (LA), the LA stated that the yellow gown hanging on the washing machine had already been used when she (LA) was sorting dirty linens and that she (LA) forgot to throw it away. The LA stated that the yellow gown is a disposable one and should only be used one time. The LA stated that not disposing of the used gown properly can possibly cause cross contamination. During an interview on 5/21/2026 at 2:06 p.m. with the Laundry Supervisor (LS), the LS stated that disposable gowns are to be discarded and one time use only. LS further stated that bacteria can be mixed from the dirty areas and could contaminate the clean ones. The LS stated that there is a possible transmission of bacteria and other organisms if any protective personal equipment like gowns were being reused. During an interview on 5/21/2026 at 2:15 p.m. with Infection Preventionist (IP), the IP stated that disposable gowns should be discarded immediately after each use. IP stated that it can cause cross contamination which can lead to infection among residents and staff. During an interview on 5/22/2026 at 1:42 p.m. with the Director of Nursing, the DON stated that once the disposable gown was used, it should have been removed and thrown away. The DON stated that it can potentially lead to infection due to cross contamination. During a review of the facility's Policy and Procedure (P&P), titled Standard Precautions reviewed and updated on 1/14/2026, the P&P indicated that Standard precautions are used in the care of all residents regardless of their diagnoses, or suspected or confirmed infection status. Standard precautions presume that all blood, body fluids, secretions, and excretions (.), non-intact skin and mucous membranes may contain transmissible infectious agents. 4. Gowns (b) Gowns (clean, non-sterile) are work to protect skin and prevent soiling of clothing during procedures and resident care activities that are likely to generate splashes or sprays of blood, secretions, or excretions or cause soiling of clothing (c) Gowns that are appropriate to the task are available to personnel at all times (d) Soiled gowns are removed as promptly as possible and hands washed to avoid transfer of microorganisms to other residents or environments (e) Gowns are not reused. 2. During an observation on 5/18/2026 at 10:30 a.m., during the resident screening, observed multiple linen carts in multiple stations, with clean linens covered with blue loosely woven/permeable mesh material. Observed on designated linen carts in the following areas: a. Linen Cart with blue-colored mesh in between room [ROOM NUMBER] and Utility room. b. Linen Cart with blue-colored mesh in between the Payroll Human Resources and room [ROOM NUMBER]. c. Linen Cart with blue-colored mesh in between room [ROOM NUMBER] and room [ROOM NUMBER] d. Linen Cart with blue-colored mesh in between room [ROOM NUMBER] and room [ROOM NUMBER] e. Linen Cart with -colored mesh in between room [ROOM NUMBER] and room [ROOM NUMBER] During a concurrent observation and interview on 5/21/2026 at 2:15 p.m. with IP, the IP stated that most of the linen carts have mesh covers and that there is only one linen cart on the floor that had a light brown non-mesh cover. The IP stated that with the mesh covers, the linens inside are visible from the outside. The IP stated that liquid or gas can seep through the mesh material. IP further stated that the (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	inside is not protected much from the microorganism causing bacteria. The IP stated that anyone can see through what is inside the cart and it can be inviting to take linen out by anyone, including visitors, and can possibly result in cross contamination. During an interview on 5/22/2026 at 1:42 p.m. with the DON, the DON stated that LS and IP are responsible for maintaining the linen carts. The DON stated that mesh covers are used for multiple carts, only one cart had a brown-solid (non-mesh)-covered material. The DON stated that any spills or bacteria may penetrate through the mesh-covered linen carts, thereby increasing the risk of cross contamination. During a review of the facility's P&P titled Departmental (Environmental Services) - Laundry and Linen reviewed and updated on 1/14/2026, the P&P indicated The purpose of this procedure is to provide a process for the safe and aseptic handling, washing, and storage of linen. 7. Ensure clean linen will remain hygienically clean (free of pathogens in sufficient numbers to cause human illness) through measures designed to protect it from environmental contamination, such as covering clean linen carts.		

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to treat one of one sampled resident (Resident 161) with respect and dignity when Certified Nurse Assistant (CNA) 3 failed to maintain privacy for Resident 161 while providing Activities of Daily Activities (ADL)~basic tasks that must be~accomplished~every day for an individual to thrive)~care.^ This deficient practice had the potential to cause emotional distress and~affect the resident's self-esteem and cause a loss of dignity^and decline in psychosocial wellbeing.^ Findings: During a review of Resident 161's admission Records~(AR - the front page of the chart that~contains~a summary of basic information about the resident), the AR indicated~that the facility originally admitted ^ Resident~161 on 6/16/2023, and readmitted on [DATE], with diagnoses including metabolic encephalopathy (a temporary brain malfunction caused by chemical imbalances in the body rather than a direct head injury), urinary tract infection (UTI - an infection in the bladder/urinary tract), dysphagia (difficulty swallowing). During a review of Resident 161's History and Physical (H&P - a document with patient's medical history and physical examination done by a physician) dated 1/22/2026, the H&P indicated that Resident 161 did not have the capacity to understand and make decisions. During a review of Resident 161's Minimum Data Set (MDS - a resident assessment tool) dated 4/28/2026, the MDS indicated Resident 161 was dependent (helped does all of the effort) to staff with eating, toileting hygiene, shoer, lower body dressing, putting on/taking off footwear. During a concurrent observation and interview on 5/18/2026 at 12:56 p.m. with CNA 3 inside Resident 161's room, observed CNA 3 leaving the privacy curtain partially open on the right side of the resident, where the curtain shared in between two residents, while providing~ADL morning~care~to~Resident 161, leaving Resident 161 exposed to the neighboring resident. CNA 3 stated that the privacy curtain should remain completely closed at all times while providing ADL care to the resident. CNA 3 stated that leaving Resident 161 exposed to the neighboring resident violated resident's privacy and the resident could feel embarrassed. During an interview on 5/22/2026 at 2:32 p.m. with the Director of Nursing (DON), the DON stated that the purpose of privacy curtains was to provide residents with privacy and dignity. ~The DON~stated ~that resident privacy curtains must be kept fully closed when providing ADL/morning care to residents, to ensure resident privacy and dignity.^The DON~stated~that the lack of privacy protection violated~residents' rights of dignity, exposed~residents to potential loss of dignity, psychological~discomfort~and emotional distress.^~ During a review of facility's Policies and Procedures (P&P) titled Dignity, dated 1/14/2026, the P&P indicated, Residents are treated with dignity and respect at all times. Staff promote, maintain, and protect resident privacy, including bodily privacy during assistance with personal care and during treatment procedures.		

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. Based on interview and record review, the facility failed to ensure residents were free from unnecessary psychotropic medication (medications that affect the mind, emotions, and behavior) and the use of chemical restraints (any drug that is used for discipline or staff convenience and not required to treat medical symptoms) for one of five sampled residents (Resident 4) reviewed for unnecessary medications by failing to ensure bupropion (medication used to treat depression [persistent feelings of sadness and loss of interest that can interfere with daily living]) was prescribed and monitored for specific, measurable behavioral manifestations. This deficient practice had the potential to result in the administration of unnecessary psychotropic medication and placed residents at increased risk for adverse effects (unwanted, uncomfortable, or dangerous effects that a drug may have) related to psychotropic medication therapy, such as sedation, drowsiness, dry mouth, blurred vision, muscle tremor, agitation, and possibly leading to impairment or decline in their mental or physical condition or functional or psychosocial status. Findings: During a review of Resident 4's admission Record (AR), the AR indicated the facility originally admitted the resident on 6/2/2017 and most recently admitted the resident on 1/22/2026 with diagnoses that included schizoaffective disorder (a mental illness that can affect thoughts, mood, and behavior), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest that can interfere with daily living), and spina bifida (a condition that occurs when the spine and spinal cord don't form properly). During a review of Resident 4's Minimum Data Set (MDS - resident assessment tool), dated 2/25/2026, the MDS indicated the resident was able to understand others and was able to make himself understood. The MDS further indicated the resident was dependent on staff for toileting and showering, required substantial / maximal assistance with lower body dressing and personal hygiene, and required partial / moderate assistance with moving from sitting to lying. The MDS indicated the resident was taking antidepressant medication, a high risk drug class of medication. During a review of Resident 4's Order Summary Report (OSR), the OSR indicated the following orders: - Bupropion HCL tablet extended release 12 hours, 100 milligrams (mg, a unit of measurement), give one tablet by mouth one time a day for depression manifested by feeling hopelessness, dated 4/29/2026. - Bupropion: monitor episodes of depression manifested by feeling hopelessness every shift, dated 1/22/2026. - Anti-depressant: monitor side effects related to bupropion: sedation, drowsiness, dry mouth, blurred vision, urinary retention, tachycardia (increased heart rate), muscle tremor, agitation, headache, skin rash, photosensitivity (skin) excess weight gain, every shift dated 1/22/2026. During a review of Resident 4's Care Plan (CP) titled, Resident is at risk for complications related to the use of psychotropic drugs. medication . bupropion., initiated on 1/27/2026, the CP indicated a goal that the resident will have the smallest most effective dose without side effects with interventions that included to monitor for continued need of medication as related to behavior and mood. During a concurrent interview and record review on 5/20/2026 at 8:04 a.m. with the Minimum Data Set Coordinator (MDSC), Resident 4's physician orders and Medication Administration Record (MAR - a daily documentation record used by a licensed nurse to document medications and treatments given to a resident) were reviewed. The MDSC stated psychotropic medications affect the minds of residents and require informed consent (voluntary agreement to accept treatment and/or procedures after receiving education regarding the risks, benefits, and alternatives offered) because they can potentially be considered a chemical restraint and can have adverse effects. The MDSC stated psychotropic medication are prescribed for behaviors that are monitored and measured with a goal to taper or discontinue the medication due to the possible adverse effects. The MDSC stated Resident 4 received bupropion, a psychotropic medication, for feeling hopelessness. The MDSC stated feelings are not behaviors and feeling hopelessness was not a specific measurable behavior. The MDSC stated there was no documented evidence that Resident 4 was monitored for behavioral (continued on next page)		

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	manifestations for the use of bupropion. During a concurrent interview and record review on 5/20/2026 at 9:39 a.m. with the Assistant Director of Nursing (ADON), Resident 4's physician orders and MAR were reviewed. The ADON stated psychotropic medications are high risk medications that affect resident mental processes and come with black box warnings (warning labels on medication that are added only when substantial clinical data shows the drug can cause severe harm, hospitalization, or death). The ADON stated it was important to monitor the specific resident behavior for the psychotropic medication, tally the behaviors daily, and measure the behaviors monthly to determine if a gradual dose reduction (GDR - tapering of a dose to determine if symptoms, conditions, or risks can be managed by a lower dose or if the medication can be discontinued) was possible. The ADON stated Resident 4 received bupropion, a psychotropic medication for feelings of hopelessness. The ADON stated resident feelings were not measurable behaviors. The ADON stated feelings can be expressed differently in different residents like verbalization of hopelessness or withdrawing from activities and it was important to know a resident's specific behavioral manifestations to be able to monitor the need for the medication. During a concurrent interview and record review on 5/20/2026 at 10:55 a.m. with Registered Nurse (RN) 5, Resident 4's physician orders and MAR were reviewed. RN 5 stated she was caring for Resident 4 and the resident was able to communicate his feelings. RN 5 stated Resident 4 expresses his feelings by verbalizing them. During a concurrent interview and record review on 5/22/2026 at 1:45 p.m. with the Director of Nursing (DON), the facility's policy and procedures (P&P) regarding psychotropic medications was reviewed. The DON stated psychotropic medications have the potential for serious adverse effects and if they are administered when not needed then it is considered the unnecessary administration of a high risk medication. The DON stated resident behaviors are monitored and evaluated for the possibility of a GDR. The DON stated feelings are not measurable behaviors and Resident 4 should have been monitored for verbalization of hopelessness and was not. The DON stated the facility P&P was not followed potentially resulting in the unnecessary administration of psychotropic medications to Resident 4. During a review of the facility P&P titled, Psychotropic Medication Use, last reviewed and approved on 1/14/2026, the P&P indicated that A psychotropic drug is any medication that affects brain activities associated with mental processes and behavior, which includes but is not limited to antipsychotics, anxiolytics, hypnotics and antidepressants. The Facility should comply with the State Operations Manual, and all other Applicable Law relating to the use of psychoactive medications, including gradual dose reductions. 1. The facility should not use psychotropic medications to address behaviors without first determining if there is a medical, physical, functional, psychological, social or environmental cause of the resident's behaviors. d. Facility staff should focus on an understanding of behaviors to enhance communication when the resident is in distress.3.Psychotropic medications to treat behaviors will be used appropriately to address specific underlying medical or psychiatric causes of behavioral symptoms. 4. All medications used to treat behaviors must have a clinical indication and be used in the lowest possible dose to achieve the desired therapeutic effect. All residents receiving medications used to treat behaviors should be monitored for: a. Efficacy. Facility staff should monitor behavioral triggers, episodes, and symptoms. Facility staff should document the number and/or intensity of symptoms and the resident's response to staff interventions.		

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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** Based on interview and record review, the facility failed to develop and implement a comprehensive person-centered care plan (CP-is a tool that ensures residents receive personalized, comprehensive, and goal-oriented care in a nursing home setting) for one of five sampled residents (Resident 14) addressing the resident's use of Insulin (a medication to treat high blood sugar level) Aspart injection solution (a fast-acting, man-made version of human insulin). This deficient practice had the potential to result in a delay of nursing care and medical interventions for the residents. Findings: During a review of Resident 14's admission Records (AR - the front page of the chart that contains a summary of basic information about the resident), the AR indicated that the facility originally admitted Resident 14 on 6/6/2024, and readmitted on [DATE], with diagnoses including end stage renal disease (ESRD - irreversible kidney failure), dependence on renal dialysis (a treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidney(s) have failed), type two Diabetes Mellitus (DM2-a disorder characterized by difficulty in blood sugar control and poor wound healing) with diabetic neuropathy (disease or dysfunction of one or more nerves, typically causing numbness or weakness in the hands and feet). During a review of Resident 14's Minimum Data Set (MDS - a resident assessment tool) dated 3/12/2026, the MDS indicated that the resident had intact cognitive (thinking or mental processing) skills for daily decision making. The MDS indicated that Resident 14 required substantial/maximal assistance (helper does more than half the effort) with toileting hygiene, shower, lower body dressing and putting on/taking off footwear. The MDS indicated the resident was on a high-risk drug class hypoglycemic medication (a type of medicine used to lower high blood sugar levels, primarily in people with DM2). During a review of Resident 14's Order Summary Report (OSR), the OSR indicated an order for: 5/2/2026 Insulin Aspart injection solution (a fast-acting, man-made version of human insulin) 100 units per milliliter (unit/ml, measures how concentrated insulin is, showing how many tiny doses of insulin are packed into a one mL vial) inject as per sliding scale (a pre-set chart used to determine rapid or short-acting insulin dosage based on blood sugar levels measured just before meals or at bedtime): if blood sugar (BS) 0 - 70 and the resident conscious give 4 ounces (oz) of juice, if unconscious give Glucagon 1 milligram (mg - measures the unit of measurement for mass/weight) intramuscularly (IM - a shot of medicine given deep into a muscle) and notify the physician; 140 - 199 = 1 Unit; 200 - 249 = 2 Units; 250 - 299 = 3 Units; 300 - 349 = 4 Units; 350 - 499 = 5 Units; more than (>) 400 = call the physician, subcutaneously (SQ) before meals and at bedtime for DM control. During a review of Resident 14's Care Plans, the CPs did not indicate documented evidence of a comprehensive care plan with goal and person-centered interventions addressing Resident 14's insulin use. During a concurrent interview and record review on 5/20/2026 at 10:48 a.m. with Registered Nurse (RN) 7, RN 7 reviewed Resident 14's OSR and CP. RN 7 stated that there was an order for Insulin Aspart for Resident 14. RN 7 stated that there was no documented care plan regarding insulin use. RN 7 stated it was important to develop and implement a comprehensive, resident-centered care plan for insulin administration because insulin was a high-risk medication. RN 7 further stated residents receiving insulin were at risk for hypoglycemia (low blood sugar) or hyperglycemia (high blood sugar) and required clear nursing interventions and guidance on necessary actions based on blood glucose levels. RN 7 added that not having comprehensive, resident-centered CP developed and implemented for insulin use for Resident 14, could potentially place the resident at risk for not receiving the necessary monitoring, interventions, and care needed to maintain safe blood glucose control. During an interview on 5/22/2026 at 2:40 p.m. with the Director of Nursing (DON), the DON stated the care plan was needed to address the problem and by identifying the problem they create specific interventions to achieve the goal of the problems. The DON stated if the care plan was present everybody will be on top of the (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	care and they will be able to provide ideal/appropriate care for the residents. During a review of facility's Policies and Procedures (P&P) titled Care Plan Comprehensive, last reviewed on 1/14/2026, the P&P indicated, The facility 's Interdisciplinary Team, in coordination with the resident and/or his/her family or representative, must develop and implement a comprehensive person-centered care plan for each resident, that includes measurable objectives and timeframes to meet a resident's medical, physical, and mental and psychosocial needs that are identified in the comprehensive assessment.		

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NAME OF PROVIDER OR SUPPLIER Alexandria Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1515 N Alexandria Ave. Los Angeles, CA 90027	
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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. Based on observation, interview, and record review, the facility failed to provide wound treatment and care in accordance with professional standards of practice and the comprehensive person-centered care plan by failing to administer wound care treatments per the physician's orders when calcium alginate dressings (a dressing that absorbs wound fluid resulting in a gel-like substance that promotes moist wound healing) were applied without a physician's order for one sampled resident (Resident 11). These deficient practices had the potential to result in a delay of healing or worsening of wounds on Resident 11's left toe and left leg. Findings: During a review of Resident 11's admission Record (AR), the AR indicated the facility originally admitted the resident on 12/26/2023 and most recently admitted the resident on 2/9/2026 with diagnoses that included pressure injury (PI - localized, pressure-related damage to the skin and/or underlying tissue usually over a bony prominence) of the sacral region (tailbone) Stage 4 (Full-thickness skin and tissue loss with exposed muscle, tendon, ligament, cartilage, or bone), diabetes mellitus (DM - a disorder characterized by difficulty in blood sugar control and poor wound healing), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), 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). During a review of Resident 11's Minimum Data Set (MDS - resident assessment tool), dated 4/16/2026, the MDS indicated the resident was sometimes able to understand others and rarely/never able to make herself understood. The MDS further indicated the resident had skin issues including diabetic foot ulcers (open sore or full-thickness wound on the lower extremity of a person with diabetes) and required skin treatments that included the application of ointments / medications and dressings. During a review of Resident 11's History and Physical (H&P), dated 2/10/2026, the H&P indicated the resident did not have the capacity to understand and make decisions. During a review of Resident 11's Care Plan (CP) titled, Resident at risk for skin breakdown related to has actual skin breakdown. left toe diabetic ulcer. left posterior leg diabetic ulcer., initiated 2/17/2026 and last revised on 4/21/2026, the CP indicated a goal that the wound / skin impairment will heal with interventions that included to provide wound treatment as ordered. During a review of Resident 11's CP titled, Resident at risk for. delay in wound healing., initiated 2/20/2026, the CP indicated a goal that the wound / skin impairment will heal with interventions that included to provide wound treatment as ordered. During a review of Resident 11's Order Summary Report, the Order Summary Report indicated the following physician treatment (TX) orders: [TX] Left Big Toe Diabetic Ulcer: Cleanse with normal saline (NS - a sterile solution), pat dry. Apply Santyl ointment (topical medication that removes dead tissue from wounds) with Mupirocin Ointment (a topical medication used to treat bacterial skin infections) 2 percent (%) and cover with dry dressing (DD), every day shift for DIABETIC ULCER for 30 Days, dated 4/22/2026. [TX] Left Posterior Leg Diabetic Ulcer: Cleanse with NS, pat dry. Apply Santyl ointment with Mupirocin Ointment 2% and cover with DD, dated 4/22/2026. [TX] Sacro coccyx (tailbone PI) extending to right and left buttocks: Cleanse with NS, pat dry. Apply theraHoney gel (a powerful medical-grade honey product) to wound bed, then apply collagen powder (a protein that aids in skin healing). Cover with calcium alginate and secure with a secondary DD, every day shift, for PI for 30 Days until finished, dated 5/19/2026. During a concurrent wound care observation, interview, and record review on 5/20/2026 at 10:05 a.m. with Treatment Nurse (TN) 1 and TN 2, Resident 11's physician orders were reviewed. Observed TN 1 provided wound care treatment to Resident 11's Sacro coccyx PI that included the application of a calcium alginate dressing. Observed TN 2 then provided wound care to Resident 11's left toe diabetic ulcer including the application of a calcium alginate dressing directly on the wound and covered with a DD. Observed TN 1 then began to provide wound care to Resident 11's left posterior diabetic ulcer when TN 1 clarified with TN 2 that a calcium alginate dressing should be applied to the wound. Observed TN 1 applied a calcium alginate dressing directly to the wound and covered with a DD. Immediately upon (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	exiting from the resident's room, TN 2 reviewed Resident 11's wound care treatment orders and stated there was no physician's order to apply calcium alginate to Resident 11's left toe and posterior leg, but calcium alginate dressings were applied. TN 2 stated he (TN 2) was confused between the treatment orders for the Sacro coccyx PI and the treatment orders for the left toe and posterior leg. TN 1 stated calcium alginate dressings are used to absorb wound drainage. TN 1 stated the physician did not want a calcium alginate dressing applied, so the dressing should not have been applied to the toe and leg. During an interview on 5/20/2026 at 11:36 a.m. with the Assistant Director of Nursing (ADON), the ADON stated the physician determines the wound care treatment orders. The ADON stated the process for applying wound care treatment is to review the physician's order, gather supplies, apply the treatment, and then document that the treatment was provided. The ADON stated calcium alginate dressings require a physician's order and are applied to open wounds to keep them moist. The ADON stated Resident 11's left toe and posterior leg wounds should only have had dry dressings applied. The ADON stated Resident 11's toe and leg should not have had calcium alginate dressings applied because the dressing becomes moist potentially affecting the healing process leading to a delay in wound healing. During a concurrent interview and record review on 5/22/2026 at 1:45 p.m. with the Director of Nursing (DON), the facility's policy and procedures (P&P) regarding wound care were reviewed. The DON stated the physician's orders should be followed when wound care treatments are provided because the treatments affect the healing process of the wound. The DON stated it would be out of a TNs scope of practice to decide to apply treatments without a physician's order. The DON stated when TN 1 and TN 2 applied calcium alginate dressings without a physician's order there was the potential to delay the healing process. The DON stated the facility P&P was not followed. During a review of the facility P&P's titled, Wound Care, last reviewed and approved on 1/14/2026, the P&P indicated that The purpose of this procedure is to provide guidelines for the care of wounds to promote healing. Preparation. 1. Verify there is a physician's order for this procedure. Assemble the equipment and supplies as needed. apply treatments as ordered. Apply appropriate dressing.		

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. Based on observation, interview, and record review, the facility failed to ensure one of one sampled resident (Resident 171) received proper care and services by failing to ensure the resident's urinal bottle (a portable, handheld container designed to collect urine when a person cannot get to the bathroom) was labeled with a date it was given, the resident's initials, and room number. This deficient practice had the potential to increase the risk for urinary tract infection (UTI - when germs infect the urinary tract or bladder infection). Findings: During a review of Resident 171's admission Record (AR), the AR indicated that the facility admitted the resident on 5/08/2026, with diagnoses including cellulitis of abdominal wall (a bacterial infection of the skin and underlying tissues in the belly), cirrhosis of the liver (a condition which the liver is scarred and permanently damaged), and depression (a serious mood disorder that causes persistent sadness, loss of interest in activities. During a review of Resident 171's Minimum Data Set (MDS, a resident assessment tool), dated 5/15/2026, the MDS indicated that the resident had the capacity to make self-understood and understand others. The MDS indicated that the resident needed supervision in eating and oral hygiene and partial/moderate assistance on toileting hygiene and was occasionally incontinent. During a review of Resident 171's Care Plan Report titled, Resident has history of MDRO (as microorganisms, predominantly bacteria, that are resistant to one or more classes of antimicrobial agents), MRSA (a type of bacteria that has developed a resistance to many common antibiotics) Date Colonized initiated on 5/05/2026, the Care Plan indicated an interventions including to handle all soiled linen as infectious according to facility protocol, preventing skin exposure or contamination, resident care equipment to be appropriately cleaned, disinfected or sterilized according to facility protocol, and monitor signs and symptoms of infection. During a concurrent observation and interview on 5/18/2026 at 12:30 p.m. with Licensed Vocational Nurse 6 (LVN 6), inside Resident 171's room, observed Resident's unlabeled urinal placed at the side of resident's bed hanging by the bedrail. LVN 6 stated that the urinal bottle should have been labeled with date when it was given, the resident's initials, and the room number. LVN 6 stated that not having a label can possibly interchange with another resident and can result to cross contamination. During an interview on 5/18/2026 at 12:40 p.m. with Certified Nurse Assistant (CNA 2) 2, CNA 2 stated that the urinal bottles are provided to residents for their own use. CNA 2 stated that before providing residents with urinal bottles, it should be labeled with date it was given, the resident's initials, and the room number. CNA 2 stated that any staff member on the floor can give urinal bottles to residents and change them every week or as needed. CNA 2 stated that unlabeled urinals can interchange with other residents which causes cross contamination. During an interview on 5/22/2026 at 1:42 p.m. with the Director of Nursing (DON), the DON stated that urinals must have a date when it was given and bed number. The DON stated that if the urinal is not labeled, it could potentially lead to infection due to cross contamination. The DON further stated that no date of change in urinal can cause bacterial growth which can possibly lead to UTI. During a review of facility's Policy and Procedure (P&P) titled, Bedpan/Urinal, Offering/Removing reviewed and updated on 1/14/2026, the P&P indicated If the resident prefers a urinal at his bedside, check it frequently. Empty and clean it as necessary. Note on the resident's care plan his request to keep the urinal at his bedside. 5.Check the feces or urine for unusual appearance. During a review of facility's P&P titled, Standard Precautions reviewed and updated on 1/14/2026, the P&P indicated that Standard precautions are used in the care of all residents regardless of their diagnoses or suspected or confirmed infection status. Standard precautions presume that all blood, body fluids, secretions, and excretions (except sweat), non-intact skin and mucous membranes may contain transmissible infectious agents.		

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. Based on observation, interview, and record review, the facility failed to ensure residents were free from any significant medication errors (means the observed or identified preparation or administration of medications or biologicals which are not in accordance with the prescriber's order, manufacturer's specifications, and accepted professional standards) for one of six sampled residents (Resident 140) reviewed for Accidents by failing to ensure Licensed Vocational Nurse (LVN) 7 administered benazepril (medication to treat high blood pressure) per the physician's orders on 5/18/2026 during the routine medication pass (a structured process of administering medications to ensure residents receive medications safely, accurately, and timely). This deficient practice had the potential to result in increased blood pressure in the resident leading to organ damage and possible hospitalization. Cross-reference F755 and F689. Findings: During a review of Resident 140's admission Record (AR), the AR indicated that the facility admitted the resident on 5/9/2022, with diagnoses including hypertension (HTN-high blood pressure), hyperlipidemia (HLD - high cholesterol [a waxy substance that can build up in the blood resulting in stroke or heart issues]), chronic kidney disease (CKD a condition in which the kidneys are damaged and cannot filter blood as well as they should), and age related nuclear cataract (excessive amount of yellowing and light scattering affecting the center of the lens). During a review of Resident 140's Minimum Data Set (MDS- a resident assessment tool), dated 5/7/2026, the MDS indicated the resident had the ability to make himself understood and had the ability to understand others. The MDS indicated the resident required partial / moderate assistance from staff with activities of daily living (ADL- activities such as bathing, dressing and toileting a person performs daily) including shower/bathe self, lower body dressing, and putting on/taking off footwear. During a review of Resident 140's History and Physical (H&P), dated 5/14/2026, the H&P indicated the resident had fluctuating capacity (an individual experiences changes in their mental state, which can affect their decision-making abilities). During a review of Resident 140's Order Summary Report, the Order Summary Report indicated the following physician orders: - Benazepril HCl tablet 10 milligrams (mg, a unit of measurement), give one (1) tablet by mouth two times a day for HTN, hold (do not give) for systolic blood pressure (SBP, measures the pressure in your arteries [pathway that carries blood away from the heart]) less than (<) 100 millimeters of mercury (mmHg - measurement of pressure), dated 12/2/2024. - Fish Oil (supplement to treat high cholesterol) oral capsule 1000 mg, give one capsule by mouth one time a day for Supplement, dated 4/4/2024. - Aspirin (medication that helps prevent blood clots [clumping of blood]) tablet chewable, 81 mg, give one tablet by mouth one time a day for cerebrovascular accident (CVA-stroke, loss of blood flow to a part of the brain) prophylaxis (prevention), dated 05/09/2022. During a review of Resident 140's Care Plan (CP) titled Resident is at risk for adverse reactions related to use of . benazepril, dated 11/25/2023 and last revised on 11/18/2025, the CP indicated the resident had a goal to avoid adverse reactions. During a concurrent observation and interview on 5/18/2026 at 9:50 a.m. with Resident 140, observed Resident 140 lay in bed while no staff were in the room. Observed on the floor next to the resident's bed two tablets and two clear capsules. Resident 140 stated the nurse left his medications during breakfast and they fell on the floor while he (Resident 140) was eating. Resident 140 stated he (Resident 140) thought he (Resident 140) took some of the medications, but he (Resident 140) was not sure. During a concurrent observation, interview, and record review on 5/18/2026 at 10:05 a.m., at Resident 140's room, with LVN 7, reviewed Resident 140's medication administration records (MAR - a daily documentation record used by a licensed nurse to document medications and treatments given to a resident). LVN 7 stated the facility protocol for medication administration is the licensed nurse (LN) should watch the resident take the medication and then document the administration after the medications are taken. LVN 7 stated medications should not be left at bedside for self-administration. LVN 7 stated if the resident does not take the medication, then the LN nurse should take the medications out of the room, place them in the (continued on next page)		

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	medication cart, return to administer the medications when the resident is ready, and then document in the MAR after the medications are administered. LVN 7 stated earlier in the morning, she (LVN 7) left Resident 140's medications at bedside for the resident to self-administer. LVN 7 stated she (LVN 7) did not watch Resident 140 administer the medications because she (LVN 7) was called away to attend to another resident. Observed LVN 7 then entered Resident 140's room and stood directly over the two tablets and two capsules on the floor. Observed LVN 7 exited Resident 140's room and the medications remained on the floor. LVN 7 then re-entered Resident 140's room upon the request of the surveyor and stated there was a benazepril tablet, an aspirin tablet, and two fish oil capsules on the floor. LVN 7 stated she (LVN 7) did not follow the facility medication administration protocol. LVN 7 stated it was not safe to leave resident medications unattended at bedside because the resident may not take the medications. During a concurrent observation and interview on 5/18/2027 at 10:15 a.m., in the hallway at the medication cart, observed the Assistant Director of Nursing (ADON) and LVN 7 compared Resident 140's medication bubble packs (a package that contains multiple sealed compartments with medication) to the medication found on the resident's floor. The ADON stated the medications were confirmed to be benazepril, aspirin, and fish oil. During an interview on 5/18/2026 at 10:35 a.m. with the ADON, the ADON stated the medication administration process is the LN supervises the resident while they take the medications to ensure the medications are administered. The ADON stated Resident 140 was not safe to self-administer medications. The ADON stated LVN 7 did not follow the facility protocol. During a follow-up concurrent interview and record review on 5/19/2026 at 2:22 p.m., with LVN 7, LVN 7 reviewed Resident 140's MAR and stated on 5/18/2026 she (LVN 7) did not administer Resident 140's benazepril because she (LVN 7) could not determine if the medications found on the floor were the medications she (LVN 7) left at bedside. LVN 7 stated she (LVN 7) did not want to give additional doses of the medication if she (LVN 7) was not sure. LVN 7 stated when Resident 140 did not receive the benazepril there was the potential that the resident's blood pressure would go up. During a follow-up concurrent interview and record review on 5/20/2026 at 9:39 a.m. with the ADON, the ADON reviewed Resident 140's MAR and stated there was no way to know if Resident 140 received benazepril on 5/19/2026. The ADON stated it was considered a significant medication error when LVN 7 was unable to determine if Resident 140 received benazepril potentially resulting in elevated blood pressure leading to a change of condition affecting the resident's heart. During a concurrent interview and record review on 5/22/2026 at 1:45 p.m. with the Director of Nursing (DON), the DON reviewed Resident 140's MAR and the facility P&Ps regarding medication administration. The DON stated LVN 7 did not follow the facility protocol for medication administration when she (LVN 7) left medications at bedside for Resident 140 to self-administer. The DON stated it was a medication error when LVN 7 did not know if Resident 140 received benazepril. The DON stated the medication error could potentially result in the resident developing issues from the missed medications like high blood pressure. The DON stated the facility P&Ps were not followed. During a review of the facility's P&P titled, Administering Medications, last reviewed and approved on 1/14/2026, the P&P indicated that Medications are administered in a safe and timely manner, and as prescribed. Staffing schedules are arranged to ensure that medications are administered without unnecessary interruptions. Medications are administered in accordance with prescriber orders, including any required time frame. Medication administration times are determined by resident need and benefit, not staff convenience. Medications are administered within one (1) hour of their prescribed time, unless otherwise specified. For residents not in their rooms or otherwise unavailable to receive medication on the pass, the MAR may be flagged. After completing the medication pass, the nurse will return to the missed resident to administer the medication. If a drug is withheld, refused, or given at a time other than the scheduled, document refusal. The individual administering the medication initials the resident's MAR on the appropriate line after giving each medication and before administering the next ones. As required or indicated for a medication, the individual administering the medication records in the resident's medical record: The date and time the medication was (continued on next page)		

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Centers for Medicare & Medicaid Services

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	administered. Residents may self-administer their own medications only if the Attending Physician, in conjunction with the Interdisciplinary Care Planning Team, has determined that they have the decision-making capacity to do so safely.		