STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056117	A. Building B. Wing	05/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Rowland	330 W. Rowland Street Covina, CA 91723

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure staff promoted dignity while assisting one of one sampled resident (Resident 64) during meals by feeding the resident at eye level to maintain face-to-face contact with the resident. This deficient practice had the potential to affect Resident 64's self-worth, dignity, and safety. Findings: During a review of Resident 64's admission Record (AR), the admission Record indicated Resident 64 was admitted on [DATE] with diagnoses that included Parkinson's disease (a progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movements), dementia (a progressive state of decline in mental abilities), and diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing). During a review of Resident 64's Order Summary Report, dated 1/10/2025, the Order Summary indicated Resident 64 had a diet order started on 7/8/2024 for a puree diet with pureed texture. During a review of Resident 64's Minimum Data Set (MDS - a resident assessment tool) assessment, dated 4/11/2025, the MDS indicated Resident 64 had severely impaired cognition and was dependent (helper does all the effort and the resident does none of the effort to complete the activity) in eating and required assistance. During a review of Resident 64's Dietary Profile, dated 7/9/2024, the Dietary Profile indicated Resident 64 required total assistance while eating. During an observation on 5/13/2025 at 12:45 p.m. while in Resident 64's room, Resident 64 was sitting up in bed and Certified Nurse Assistant 6 (CNA 6) was standing over Resident 64 while providing feeding assistance during lunch time. During an interview on 5/13/2025 at 12:51 p.m. with CNA 6, CNA 6 stated residents should be fed at eye-level to allow the residents to see who was working with them. CNA 6 adjusted the bed and tray table upward and remained standing over Resident 64. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/16/2025 at 12:26 p.m. with the Director of Nursing (DON), the DON stated when nursing staff are feeding residents they should sit at eye-level with the resident to monitor how the resident was tolerating the feeding. The DON further stated, standing above a resident during feeding assistance was a dignity issue. During a review of the facility's policy and procedure (P&P) titled, Assistance with Meals, last revised 7/2017, the P&P indicated, residents shall receive assistance with meals in a manner that meets the individual needs of each resident. The P&P indicated, for residents requiring full assistance residents who cannot feed themselves will be fed with attention to safety, comfort and dignity, for example, not standing over residents while assisting them with meals.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **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 47) call light was within reach. This failure had the potential to result in Resident 47 not receiving the necessary care or delayed services. Findings: During a review of Resident 47's admission Record (AR), the AR indicated Resident 47 was admitted to the facility on [DATE] with diagnoses that included hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) affecting the right dominant side, muscle weakness (lack of muscle strength), and anxiety (intense, excessive, and persistent worry and fear about everyday situations). During a review of Resident 47's Care Plan (CP), dated 8/14/2023, the CP indicated Resident 47 required assistance with activities of daily living (ADLs). The CP interventions included keeping the call light within the resident's reach. During a review of Resident 47's Minimum Data Set (MDS, a resident assessment tool), dated 2/27/2025, the MDS indicated Resident 47 had intact cognition. The MDS indicated Resident 47 was dependent (helper did all the effort, resident did none of the effort to complete the activity) with oral hygiene, toileting, shower, lower body dressing, and personal hygiene. During an observation, while inside Resident 47's room and a concurrent interview on 5/13/2025 at 9:17 a.m. with Certified Nurse Assistant 3 (CNA 3), Resident 47 was observed in bed, lying on her back with the call light on the floor and on the right side of the bed. Resident 47's right hand was contracted (a stiffening/shortening at any joint, that reduces the joint's range of motion). CNA 3 stated Resident 47 could not reach the call light on the floor. CNA 3 stated the call light should be placed next to the strong arm and hand of Resident 47 where Resident 47 could reach and use the call light when assistance was needed. During an interview on 5/15/2025 at 3:57 p.m. with the Director of Nursing (DON), the DON stated the call light should be placed close and on the good arm and hand of the resident so the resident can be able to use, and the staff could address the resident's needs timely and promptly. During a review of the facility's undated policy and procedures (P&P) titled, Call Light, the P&P indicated, CNAs & Licensed Nurses are trained to ensure the call light is kept within the resident's reach at all times.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the resident's Advance Directive (AD, a legal document indicating a resident's preference for end-of-life treatment decisions) and AD Acknowledgement Form was in the resident's medical record for one of three sampled residents (Resident 16). This failure had the potential to result in the staff providing care and services against the will of Resident 16. Findings: During a review of Resident 16's admission Record (AR), the AR indicated Resident 16 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included malignant neoplasm (cancerous tumor) of the lung, pneumonia (an infection/inflammation in the lungs) and chronic kidney disease (gradual loss of kidney function). During a review of Resident 16's Minimum Data Set (MDS, a resident assessment tool), dated 3/23/2025, the MDS indicated Resident 16 had moderately impaired cognition (ability to understand and process information). The MDS indicated Resident 16 required substantial/maximal assistance (helper did more than half the effort) with eating, upper and lower body dressing and was dependent (helper did all the effort, resident did none of the effort to complete the activity) with oral hygiene, toileting, showering and personal hygiene. During a concurrent interview and record review on 5/13/2025 at 11:38 am with the Registered Nurse Supervisor (RN), Resident 16's medical record (chart) and electronic medical record were reviewed. The RN stated there was no copy of an AD or AD acknowledgement form in Resident 16's chart or electronic medical chart. The RN stated a copy of an AD and ADA form should be updated and, in the chart, and/or uploaded into the electronic medical chart with each admission or readmission for the staff to know the resident's wishes and preferences in case of an emergency and how to care for the resident while residing in the facility. During an interview on 5/15/2025 at 3:48 p.m. with the Director of Nursing (DON), the DON stated, all residents should have an updated copy of an AD and ADA form in the chart and/or uploaded into the electronic medical chart and indicating residents and/or resident's representative were provided with information of their rights to refuse or receive medical treatment and how to formulate an AD upon admission or readmission. The DON stated that an AD and ADA form needs to be filled out and signed with each admission and readmission to honor the resident's wishes, preferences and changes in the plan of care while in the facility. During a review of the facility's undated policy and procedure (P&P) titled, Advance Directives, the P&P indicated, Upon admission, the resident will be provided with written information concerning the right to refuse or accept medical or surgical treatment and to formulate an advance directive if he or she chooses to do so. Information about whether or not the resident has executed an advance directive shall be displayed prominently in the medical record.

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. Based on interview and record review, the facility failed to screen one of two randomly selected employees (Certified Nurse Assistant 2 [CNA 2]) with the Office of Inspector General (OIG - investigates alleged violations of criminal and civil laws) data base prior to hire in accordance with the facility's Policy and Procedure (P&P) titled Abuse, Neglect, Exploitation and Misappropriation Prevention Program. This deficient practice had the potential for employees with a history of abuse get hired, which could lead to possible harm and abuse of the residents. Findings: During a concurrent interview and record review of CNA 2's employee file on 5/15/2025 at 2:08 pm with the Director of Staff and Development (DSD), the DSD stated CNA 2 was hired on 8/1/2024. The DSD stated there was no documented evidence that CNA 2's background check was done prior to hire or recently. The DSD stated that the administrator did the staff background check before hire. The DSD stated it was important to do a background check to ensure employees were safe to work, with no criminal records and residents' well-being were protected. During an interview on 5/15/2025 at 3:31 pm with the facility's Director of Nursing (DON), the DON stated background check needed to be completed prior to hiring for staff and residents' safety. During a review of the facility's undated P&P titled, Abuse, Neglect, Exploitation and Misappropriation Prevention Program, the P&P indicated, The facility will conduct employee background checks and not knowingly employ or otherwise engage any individual who has been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide necessary care and services for a resident with Foley catheter (FC, a medical device that helps drain urine from the bladder) in accordance with the facility's Policy and Procedure (P&P) on catheter care for one of one sampled resident (Resident 257). This failure had the potential to result in catheter-related complications for Resident 257. Findings: During a review of Resident 257's admission Record (AR), the AR indicated Resident 257 was admitted to the facility on [DATE] with diagnoses that included type 2 diabetes mellitus (DM, a disorder characterized by difficulty in blood sugar control), hypertension (HTN, high blood pressure) and chronic kidney disease (CKD- a progressive condition where the kidneys gradually lose their ability to filter waste and excess fluid from the blood.) During a review of Resident 257's Order Summary Report (OSR) dated 5/2/2025, the OSR indicated for licensed staff to check every shift to ensure the FC is in place. During a review of Resident 257's untitled Care Plan (CP) dated 5/2/2025, the CP indicated Resident 257 needed an indwelling Foley catheter due to urinary retention and skin management. The CP interventions included for staff to monitor position of the catheter tubing to ensure descending urine flow to the collection bag. During a review of Resident 257's Minimum Data Set (MDS, as resident assessment tool), dated 5/12/2025, the MDS indicated Resident 257 had intact cognition (ability to understand and process information). The MDS indicated Resident 257 was dependent (helper does all the effort) with toileting hygiene, shower, lower body dressing and putting on /taking off footwear. The MDS indicated Resident 257 needed substantial/maximal assistance (helper did more than half the effort) with oral and personal hygiene. During an observation inside Resident 257's room and interview on 5/13/2025 at 9:05 am, Resident 257 was awake lying in bed with FC tubing not secured on the thigh. During a concurrent observation and interview with Registered Nurse 1 (RN 1) on 5/13/2025 at 9:07 am, Resident 257 was lying in bed with FC tubing not secured on the thigh. RN 1 stated Resident 257's FC tubing was not secured on the thigh, and the securement device was not taped. RN 1 stated the FC tubing should be secured to prevent from tagging and pulling during movement and cause pain to Resident 257. During an interview on 5/15/2025 at 3:28 pm with the facility's Director of Nursing (DON), the DON stated FC tubing needed to be properly secured on the thigh to hold the catheter in place and to prevent pulling and injury during movements. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the undated facility's policy and procedure (P&P) titled, Foley Catheter Care Indication, the P&P indicated to ensues tubing will be attached to resident leg to prevent pulling and injury.

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F 0691 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate colostomy, urostomy, or ileostomy 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 307), who had a biliary drain (biliary drain- allows bile to flow out from a blocked bile duct from the liver into a collection bag outside the body) did not have biliary drainage on the resident's floor. This failure had the potential to result in the transmission of infection from bodily fluids. Findings: During a review of Resident 307's admission Record (AR), the admission Record indicated Resident 307 was readmitted on [DATE] with diagnoses that included bladder cancer and anemia (a condition where the body does not have enough healthy red blood cells). During a review of Resident 307's Minimum Data Set (MDS - a federally mandated resident assessment tool) assessment, dated 2/13/2025, the MDS indicated Resident 307 had intact cognition (ability to understand) and needed substantial/maximal assistance (helper does more than half the effort. Helper lifts or holds trunk or limbs and provides more than half the effort) when moving from the sitting to standing position. During a review of Resident 307's Order Summary Report, dated 5/14/2025, the Order Summary indicated Resident 307 had an order dated 5/7/2025 to monitor and document the biliary drain output three times a day. During a review of Resident 307's Medication Administration Records (MAR - a daily documentation record used by a licensed nurse to document medications and treatments given to a resident), dated 5/1/2025 to 5/31/2025, the MAR indicated Resident 307 had a recorded biliary drain output of 300 milliliters documented on 5/13/2025 at 6:30 a.m. During a concurrent observation and interview on 5/13/2025 at 9:07 a.m. with Licensed Vocational Nurse 6 (LVN 6), Resident 307's right biliary drainage bag had a yellow liquid on the floor beneath it. LVN 6 stated, each LVN empties the drainage bag during their shift, and it should not be dripping onto the floor. During an interview on 5/16/2025 at 12:19 p.m. with the Director of Nursing (DON), the DON stated, Resident 307's biliary fluid should not have been on the floor for infection control reasons. The DON stated organisms in the fluid could be a source of illness or infection and could be transmitted to others by people stepping on the floor. During a review of the facility's undated policy and procedure (P&P) titled, How to Manage Biliary Drain, the P&P indicated, a biliary drain is placed to relieve obstruction of the bile ducts and to allow bile to exit the body. The P&P indicated, proper care helps prevent infection, ensure drainage, and maintain the position of the catheter.

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide for the safe, appropriate administration of IV fluids 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 follow professional standards of practice of infusion therapy for peripheral intravenous catheter (PIV - small flexible tube placed into a vein to administer fluids and/or medications) and total parenteral nutrition (TPN- a medication used to manage and treat malnourishment) care for two of two sampled residents (Resident 55 and 307) by failing to: a. Ensure Resident 55's PIV site was labeled with a date and initials upon insertion. b. Ensure Resident 307's total parenteral nutrition (TPN- a medication used to manage and treat malnourishment) administration set was labeled with a date and time when hung. These failures had the potential to result in infection at Resident 55's IV site, and contamination of Resident 307's TPN and/or TPN tubing that could have led to further infection. Findings: a. During a review of Resident 55's admission Record (AR), the AR indicated Resident 55 was admitted to the facility on [DATE] with diagnoses that included gangrene (condition where tissue dies due to a loss of blood supply) and peripheral vascular disease (PVD - a slow progressive narrowing of the blood flow to the arms and legs.) During a review of Resident 55's Minimum Data Set (MDS, as resident assessment tool), dated 4/8/2025, indicated, Resident 55 had moderately impaired cognition (mental action or process of acquiring knowledge and understanding) for daily decision making. The MDS indicated Resident 55 was dependent (helper does all the effort) with lower body dressing and putting on/taking off footwear. The MDS indicated Resident 55 needed substantial/maximal assistance (helper did more than half the effort) with toileting hygiene, shower, upper body dressing and personal hygiene. During a review of Resident 55's Order Summary Report (OSR) dated 5/6/2025, the OSR indicated to change IV tubing every forty-eight (48) hours (hrs.) During a review of Resident 55's care plan indicated Resident 55 was at risk for infection for IV site on the right hand dated 5/6/2025. The Resident 55 care plan indicated for nursing staff to change dressing every week and as needed. During a concurrent observation and interview on 5/13/2025 at 8:34 am together with Registered Nurse 1 (RN 1), Resident 55 was awake, lying and in bed with peripheral IV site on the right arm was not dated to when the dressing was changed. The RN 1 stated Resident 55's peripheral IV site needed to be labeled with date to know when the dressing was changed for infection control. The RN 1 stated, peripheral IV site needed to be changed every 72 hrs. During an interview with facility's Director of Nursing (DON) on 5/15/2025 at 3:31 pm, the facility DON stated IV site needed to be labeled with date and licensed nurse's initial to know who and when was it change to prevent infection. (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's undated P&P titled, IV Peripheral Line Care and Management, the P&P indicated, to change the dressing every seven (7) days or as needed and dressing to be dated and timed when changed. b. During a review of Resident 307's AR, the AR indicated Resident 307 was readmitted on [DATE] with diagnoses that included bladder cancer and anemia (a condition where the body does not have enough healthy red blood cells). During a review of Resident 307's MDS assessment, dated 2/13/2025, the MDS indicated Resident 307 had intact cognition and needed substantial/maximal assistance (helper does more than half the effort. Helper lifts of holds trunk or limbs and provides more than half the effort) when moving from the sitting to standing position. During a review of Resident 307's OSR, dated 5/14/2025, the OSR indicated Resident 307 had active orders for TPN 1680 milliliters (ml) at 70 ml per hour (hr.) for 24 hours through the right jugular central venous catheter on Tuesday, Thursday, Saturday, and Sunday and TPN at 70 ml/hr. 10ml Multivitamin via the right jugular central venous Cather on Monday, Wednesday, Friday for nutrition supplement. During a review of Resident 307's Medication Administration Records (MAR - a daily documentation record used by a licensed nurse to document medications and treatments given to a resident), dated 5/1/2025 to 5/31/2025, the MAR indicated Resident 307 was receiving TPN at 70 ml/hr. for nutrition that was started on 5/12/2025 at 1800. During a concurrent observation and interview on 5/13/2025 at 9:20 a.m. with Registered Nurse Supervisor 1 (RN 1), while in Resident 307's room, Resident 307's TPN tubing was unlabeled. RN 1 stated, the TPN tubing was unlabeled and should be labeled with date and time when changed, the rate of the drip, the resident's name and the nurse's initials. RN 1 stated, it was necessary to label the tubing to allow the other nurses to know when it was changed for infection control measures. During an interview on 5/16/2025 at 12:20 p.m. with the Director of Nursing (DON), the DON stated, TPN comes with tubing and the nurse should label the tubing with the date when hung. The DON stated, if it's not labeled the nurses cannot prove when it was hung. The DON stated, the TPN could become contaminated and become a source of bacterial infection to the resident. During a review of the facility's untitled and undated policy and procedure (P&P), the P&P indicated, for IV peripheral line care management it should be dated and timed when changed. The P&P indicated, TPN tubing be changed every 24 hours.

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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** c. During a review of Resident 73's AR, the AR indicated the facility admitted to the facility on [DATE] with diagnoses that included pulmonary fibrosis (chronic lung disease), Type 2 diabetes mellitus (body has trouble controlling blood sugar), and major depressive disorder (persistent feeling of sadness or loss). During a review of Resident 73's History & Physical (H&P), dated 2/3/25, the H&P indicated Resident 26 had the capacity to make medical decisions. During a review of Resident 73's MDS, dated [DATE], the MDS indicated Resident 73 was cognitively intact, and was not ambulatory, required partial/moderate assistance with lying to sitting onside of bed, and was dependent on assistance with personal hygiene. The MDS indicated Resident 73 was receiving oxygen therapy. During a record review of Resident 73's Physician Order (PO), dated 3/5/25, the PO indicated to administer oxygen (O2) at 4 liter per minute (LPM) via nasal cannula (gives additional oxygen through your nose) continuously for shortness of breath (SOB). During a concurrent observation and interview, 5/13/25, at 10:35 a.m., Resident 73 was observed lying in bed was receiving oxygen via nasal cannula. Resident 73's oxygen tubing (used to administer oxygen) was observed on the floor and Resident 73's nebulizer (a medical device that converts liquid medication into a fine mist that is inhaled through the lungs) tubing was observed on the floor. During a concurrent observation and interview, on 5/13/25, at 11:14 a.m., with Certified Nurse Assistant (CNA 5), CNA 5 stated Resident 73's oxygen and nebulizer tubings were on the floor. CNA 5 stated the tubings got contaminated because we stepped around on the floor. During an interview, on 5/15/25, at 1:24 p.m., with the Director of Nursing (DON), the DON stated it is important for oxygen, nebulizer, and equipment tubing not to be on the floor because it's infection control. The DON stated once it is on the floor It's contaminated and is another source of infection inhaled by the resident. Based on observation, interview, and record review, the facility failed to provide necessary care and services for residents receiving oxygen therapy (treatment that provides supplemental, or extra oxygen) in accordance with professional standards of practice for four of four sampled residents (Residents 16, 73, 206, and 256) by failing to: a. Ensure Resident 16 received oxygen therapy as ordered by the physician and ensure that the nebulizer face mask (a soft pliable mask that covers the nose and mouth used to deliver liquid medication in the form of a mist directly into the lungs) was stored in a sanitary condition when not in use. b. Ensure a sign Oxygen No Smoking, No Open Flames, was posted outside Resident 206's room in accordance with the facility's policy and procedure. c. Ensure Resident 73's oxygen and nebulizer tubings were not on the floor. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	d. Ensure Resident 256's nasal cannula was not on the floor with the nasal prongs directly touching the floor. These failures had the potential to result in Residents 16, 73, 206, and 256 experiencing serious respiratory complications and infections related to oxygen therapy. Findings: a. During a review of Resident 16's admission Record (AR), the AR indicated Resident 16 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included malignant neoplasm (cancerous tumor) of the lung, pneumonia (an infection/inflammation in the lungs) and chronic kidney disease (gradual loss of kidney function). During a review of Resident 16's Minimum Data Set (MDS, a resident assessment tool), dated 3/23/2025, the MDS indicated Resident 16 had moderately impaired cognition (ability to understand and process information). The MDS indicated Resident 16 required substantial/maximal assistance (helper did more than half the effort) with eating, upper and lower body dressing and dependent (helper did all the effort, resident did none of the effort to complete the activity) with oral hygiene, toileting, shower and personal hygiene. During a review of Resident 16's Care Plan (CP), dated 4/18/2025, the CP indicated Resident 16 had oxygen therapy related to shortness of breath. The CP goal indicated Resident 16, would not have signs and symptoms of poor oxygen absorption. During a review of Resident 16's Order Summary Report (OSR), dated 4/25/2025, the OSR indicated Resident 16 had an order to infuse oxygen (O2) at two (2) liters/minute (L/min, unit of flow rate) via nasal cannula (NC, a medical device used to deliver supplemental oxygen through the nostrils). The OSR indicated Resident 16 had an order for Ipratropium-Albuterol Inhalation Solution (combination medication of bronchodilators) every three hours as needed for shortness of breath and wheezing. During an observation, while inside Resident 16's room and a concurrent interview on 5/13/2025 at 8:48 a.m. with Licensed Vocational Nurse 2 (LVN 2), Resident 16 was observed lying in bed and on her back with oxygen nasal prongs (small, flexible pieces at the end of a nasal cannula inserted into the nostrils to deliver supplemental oxygen) on the left side of the face and a nebulizer face mask on top of the bedside table. LVN 2 stated oxygen nasal prongs should be inside the nostrils to make sure Resident 16 received adequate oxygen to prevent hypoxia (low levels of oxygen) and shortness of breath. LVN 2 stated the nebulizer face mask should be inside the clean, transparent bag when not in use to prevent getting contaminated. During an interview on 5/15/2025 at 3:39 p.m. with the Director of Nursing (DON), the DON stated CNAs and nurses should make sure the nasal oxygen prongs were inside the resident's nostrils to make sure the resident received the desired oxygen as ordered by the physician to prevent shortness of breath. The DON stated the nebulizer face mask should be placed inside the clean transparent bag at bedside intended for the resident's respiratory supplies to prevent contamination and risk of infection. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's undated P&P titled, Oxygen Administration/Respiratory Supply, the P&P indicated, a licensed nurse or nursing staff should initiate to apply oxygen per order of primary care physician either via nasal cannula or mask with appropriate settings and calibration. The P&P indicated inform patient of the procedure and place a sign outside the door indicating No Smoking/Oxygen in Use. The P&P indicated all supplies, including tubing, nasal cannula, masks, nebulizer, and nebulizer tubing should be changed weekly, documenting the date and time. The P&P indicated all supplies not in use should be placed in a bag for infection control.

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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 implement its Policy and Procedure (P&P) on the use of bedrails/siderails (adjustable metal or rigid plastic bars attached to the bed) for two of three sampled residents (Residents 56 and 75). These failures placed Residents 56 and 75 at risk for entrapment (an event in which resident was caught, trapped, or entangled in the tight spaces around the bed), and injury from the use of bedrails/siderails. Findings: a. During a review of Resident 56's admission Record (AR), the AR indicated Resident 56 was admitted to the facility on [DATE] with diagnoses that included dementia (a progressive state of decline in mental abilities), anxiety (intense, excessive, and persistent worry and fear about everyday situations) and Alzheimer's disease (a disease characterized by a progressive decline in mental abilities). During a review of Resident 56's Minimum Data Set (MDS, a resident assessment tool), dated 3/16/2025, the MDS indicated Resident 56 had moderately impaired cognition (ability to understand and process information). The MDS indicated Resident 56 required partial/moderate assistance (helper did less than half the effort) with oral hygiene and upper body dressing; substantial/maximal assistance (helper did more than half the effort) with personal hygiene and dependent (helper did all the effort, resident did none of the effort) with toileting and shower. During a concurrent observation inside Resident 56's room and interview on 5/13/2025 at 9:36 am with Licensed Vocational Nurse 7 (LVN 7), Resident 56 was in bed, on her back with full rails up on both sides of the bed. LVN 7 stated Resident 56 was confused and could not roll on either side of the bed. During a concurrent interview and record review on 5/13/2025 at 3:22 pm with Minimum Data Set Coordinator 2 (MDSC 2), Resident 56's medical record (chart), electronic medical record and hospice binder were reviewed. MDSC 2 stated there was no documented evidence that a bedrail/siderail use assessment was completed, a physician's order was obtained and an informed consent on the use of bedrail/siderail was signed by Resident 56 or his/her representative before the installation of bilateral full bedrails/siderails. MDSC 2 stated Resident 56 should be assessed for potential safety and risk on the use of bedrail/siderail, obtained a physician's order and signed an informed consent before the installation and application of bilateral full bedrails/siderails to make sure that Resident 56 and/or his/her representative understood the risks and benefits on the use of bedrails/siderails to prevent potential entrapment and injury. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's undated Policy and Procedures (P&P) titled, Proper Use of Side Rails, the P&P indicated, An assessment will be made to determine the resident's symptoms or reason for using side rails. When used for mobility or transfer, an assessment will include a review of the resident's bed mobility, and ability to change positions, transfer to and from bed or chair, and to stand and toilet. Consent for using restrictive devices will be obtained from the resident or legal representative per facility protocol. Facility staff in conjunction with the attending physician will assess and document the resident's risk for injury due to neurological disorders or other medical condition. b. During a review of Resident 75's AR, the AR indicated Resident 75 was admitted to the facility on [DATE] with diagnoses that included anxiety disorder (group of mental disorders characterized by feelings of anxiety [an unpleasant state of inner turmoil] and fear) and muscle weakness. During a concurrent observation and interview on 5/13/2025 at 8:22 a.m. with Resident 75 while inside Resident 75's room, Resident 75 was lying in bed on her back and both (bilateral) upper side rails were up. Resident 75 stated the siderails have been up since she got admitted to the facility. Resident 75 stated They never asked me about a consent for the siderails. During a review of Resident 75's dated 4/18/2025, the MDS indicated, Resident 75 had intact cognitive skills (mental action or process of acquiring knowledge and understanding) for daily decision making. The MDS indicated, Resident 75 needed partial/moderate assistance (helper does less than half the effort) by staff for toileting hygiene, lower body dressing, putting on/taking off footwear and personal hygiene. During a concurrent interview and record review on 5/13/2025 at 3:45 p.m. with the facility's Director of Nursing (DON), Resident 75's medical records (chart) were reviewed. The DON stated there was no clinical documentation that appropriate alternatives were attempted before bedrail/siderails were installed. The DON stated, when Resident 33 was re-admitted back to the facility, side rails were placed automatically. The DON stated there was no order from the attending physician and there was no informed consent obtained before side rails were installed for Resident 75. The DON stated, the MD order and a consent needed to be obtained before side rails were installed for residents' safety to avoid injury and entrapment. During a concurrent interview and record review of the facility's undated Policy and Procedure (P&P) titled, Proper Use of Side rails, on 12/19/2024 at 9:19 a.m. with the facility's DON, the DON stated, use of appropriate alternatives should have been attempted before the use of bed rails as indicated in the policy. The facility's DON stated bed rails could cause serious injury such as entrapment to the residents.

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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 ensure medications were administered in a timely manner and as prescribed to meet the therapeutic (treatment, therapy, or drug) needs of the resident for one of one sampled resident (Resident 62). This failure had the potential to increase the risk of adverse drug reactions and potential medical complications for Resident 62. Findings: During a review of Resident 62's admission Record (AR), the AR indicated Resident 62 was admitted to the facility on [DATE] with diagnoses that included paraplegia (loss of movement and/or sensation, to some degree, of the legs), depression (characterized by persistent feelings of sadness, hopelessness, and loss of interest or pleasure in activities), and dementia (a progressive state of decline in mental abilities). During a review of Resident 62's Minimum Data Set (MDS, a resident assessment tool), dated 2/17/2025, the MDS indicated Resident 62 had severely impaired cognition (ability to understand and process information). The MDS indicated Resident 62 was dependent (helper did all the effort, resident did none of the effort) with eating, oral hygiene, toileting, shower, upper and lower body dressing and personal hygiene. The MDS indicated Resident 62 had a feeding tube for nutrition. During an observation while inside Resident 62's room on 5/15/2025 at 7:45 a.m. with Licensed Vocational Nurse 5 (LVN 5), LVN 5 was observed administering medications through Resident 62's gastrostomy tube (GT, a feeding tube surgically placed directly into the stomach through the abdomen). During an interview on 5/15/2025 at 7:54 a.m. with LVN 5, LVN 5 stated a total of five medications were administered to Resident 62 at 7:45 a.m. LVN 5 stated the five medications administered were as follows: 1. Tylenol Extra Strength 1000 milligrams (mg, unit of mass) via GT two times a day for pain management. 2. Ferrous Sulfate Liquid 220 mg/5 milliliters (ml, unit of volume) via GT three times a day for supplement. 3. Folic Acid 400 mg via GT once a day for supplement. 4. Sertraline 50 mg via GT once a day for depression manifested by continuous crying. 5. Docusate Sodium 100 mg via GT two times a day for constipation. LVN 5 stated all 5 medications were scheduled at 9:00 am. LVN 5 stated he administered the 5 medications earlier than the scheduled time. LVN 5 stated administering the medications early or late might change the effectiveness of the medication. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/15/2025 at 3:53 p.m. with the Director of Nursing (DON), the DON stated medications should be given one hour before and after the scheduled prescribed time. The DON stated administering the medications late or early could cause harm to the residents, especially if given late or too close to another scheduled dose. The DON stated all medications should be given in a timely manner to achieve the desired effect of the medications. During a review of the facility's undated Policy and Procedure (P&P) titled, Administration of medications-Medication Passing, the P&P indicated, Medications must be given on a timely basis. A two-hour time span is allowed within one hour either way from the designated time.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to act upon the pharmacist's medication regimen review (MRR, a thorough evaluation of the medication regimen of a resident, with the goal of promoting positive outcomes and minimizing adverse consequences associated with medication) recommendation for one of five sampled residents (Resident 72). This failure had the potential for Resident 72 to receive unnecessary medications and result in undesirable or non-therapeutic effect of the medication to the resident. Findings: During a review of Resident 72's admission Record (AR), the AR indicated Resident 72 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included osteomyelitis (inflammation of bone or bone marrow, usually due to infection), diabetes mellitus (DM, a disorder characterized by difficulty in blood sugar control and poor wound healing), and chronic obstructive pulmonary disease (COPD, a chronic lung disease causing difficulty in breathing). During a review of Resident 72's Order Summary Report, dated 3/25/2025, the OSR indicated Resident 72 had an order for Enoxaparin Sodium Injection (Brand Name Lovenox, an anticoagulant, blood thinner) 30 milligrams/0.3 milliliter (mg/ml, unit of mass and volume), inject subcutaneously (SQ, an injection given into the fatty tissue beneath the skin), for deep vein thrombosis (DVT, blood clot forms in a deep vein, usually in the legs or pelvis) prophylaxis (preventive care). During a review of the Consultant Pharmacist's MRR, dated 4/14/2025, the MRR indicated to provide a duration therapy for the medication Lovenox. During a review of Resident 72's Minimum Data Set (MDS, a resident assessment tool), dated 4/23/2025, the MDS indicated Resident 72 had intact cognition (ability to understand and process information). The MDS indicated Resident 72 required partial/moderate assistance (helper did less than half the effort) with toileting and personal hygiene and required substantial/maximal assistance (helper did more than half the effort) with showers. During a concurrent interview and record review on 5/15/2025 at 2:21 p.m. with Licensed Vocational Nurse 4 (LVN 4), Resident 72's MRR dated 4/14/2025, medical record (chart), and electronic medical record were reviewed. LVN 4 stated there was no documentation indicating Resident 72's attending physician was notified of the pharmacist's recommendation to provide duration therapy on the use of Lovenox. LVN 4 stated the attending physician should have been notified of the pharmacist's recommendation to prevent unnecessary side effects like bleeding. During an interview on 5/15/2025 at 3:37 p.m. with the Director of Nursing (DON), the DON stated the attending physician should be notified after receiving the pharmacist's recommendation to prevent unnecessary medication given that could affect the resident's overall health condition. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's undated Policy and Procedure (P&P) titled, Pharmacists Medication Regimen Review, the P&P indicated, The Consultant Pharmacist review the medication regimen of each resident at least monthly. Findings and recommendations are reported to the Administrator, Director of Nursing, the physician responsible, and the Medical Director, where appropriate. The consultant pharmacist documents potential or actual medication therapy problems and communicates them to the physician responsible and the director of nursing. A written report is provided to the physician within seven working days, with a copy to the facility. In the event of a problem requiring the immediate attention of a physician, the responsible physician or his designee is contacted by the consultant pharmacist or the nurse caring for the resident, and the physician response is documented on the consultant pharmacist review record or elsewhere in the resident's medical record.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to ensure the medication error (any preventable event that may cause or lead to inappropriate medication use or patient harm) rate was five (5) percent (%) or lower during medication administration on 5/15/2025 for one of four sampled residents (Resident 62). This failure resulted in five medications errors out of twenty-eight (28) opportunities for errors, which resulted in medication administration error rate of seventeen and eighty-six hundredths (17.86) %. Findings: During a review of Resident 62's admission Record (AR), the AR indicated Resident 62 was admitted to the facility on [DATE] with diagnoses that included paraplegia (loss of movement and/or sensation, to some degree, of the legs), depression (characterized by persistent feelings of sadness, hopelessness, and loss of interest or pleasure in activities), and dementia (a progressive state of decline in mental abilities). During a review of Resident 62's Minimum Data Set (MDS, a resident assessment tool), dated 2/17/2025, the MDS indicated Resident 62 had severely impaired cognition (ability to understand and process information). The MDS indicated Resident 62 was dependent (helper did all the effort, resident did none of the effort) with eating, oral hygiene, toileting, shower, upper and lower body dressing and personal hygiene. The MDS indicated Resident 62 had a feeding tube for nutrition. During a concurrent observation inside Resident 62's room on 5/15/2025 at 7:45 a.m. with Licensed Vocational Nurse 5 (LVN 5), LVN 5 was observed administering medications through Resident 62's gastrostomy tube (GT, a feeding tube surgically placed directly into the stomach through the abdomen). During an interview on 5/15/2025 at 7:54 a.m. with LVN 5, LVN 5 stated a total of five medications were administered to Resident 62 at 7:45 a.m. LVN 5 stated the five medications administered were as follows: 1. Tylenol Extra Strength 1000 milligrams (mg, unit of mass) via GT two times a day for pain management. 2. Ferrous Sulfate Liquid 220 mg/5 milliliters (ml, unit of volume) via GT three times a day for supplement. 3. Folic Acid 400 mg via GT once a day for supplement. 4. Sertraline 50 mg via GT once a day for depression manifested by continuous crying. 5. Docusate Sodium 100 mg via GT two times a day for constipation. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	LVN 5 stated all five medications were scheduled at 9 a.m. LVN 5 stated he administered the five medications earlier than the scheduled time. LVN 5 stated administering the medications early or late might change the effectiveness of the medication. LVN 5 stated he should make sure to administer the right dose of medications to the right resident at the right time and route to prevent medication error. During an interview on 5/15/2025 at 3:53 p.m. with the Director of Nursing (DON), the DON stated medications should be given one hour before and after the scheduled prescribed time. The DON stated administering the medications late or early could result in a medication error and cause harm to the residents, especially if given late or too close to another scheduled dose. The DON stated all medications should be given in a timely manner to achieve the desired effect of the medications and to prevent medication error. During a review of the facility's undated Policy and Procedure (P&P) titled, Medication Errors, the P&P indicated, To ensure safe medication practices and protect resident health. Follow the five (5) rights of medication administration: right resident, drug, dose, route and time.

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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 and interview, the facility failed to ensure medications were kept secure with limited access by failing to: 1. Ensure to lock the medication cart (Med Cart) that contained residents' medications on North Station when not attended and outside of view. 2. Ensure the Wixela Inhub Inhalation Aerosol Powder Breath (used to control and prevent symptoms (wheezing and shortness of breath) caused by asthma or ongoing lung disease) was in Resident 34's possession. These deficient practices had the potential to result in residents' medications to be accessible to others not authorized to have access to drugs (medications) and biologicals (drugs derived from natural sources) and increased the risk for loss of control, safety, and security of all medications necessary to meet the health care needs of residents. Findings: 1. During a medication Pass Observation on 5/15/2025 at 8:03 a.m. with a Licensed Vocational Nurse 1 (LVN 1) on the North Station, LVN 1 left the medication cart (Med Cart) in the hallway unlocked where the residents and staff passed by. During an interview on 5/15/2025 at 8:06 a.m., with LVN 1 on the North Station, LVN 1 stated, I did not lock my Med Cart when I went to get his (Resident 34) medication from the medication room. I should have locked the Med Cart and not left it unlocked for safety. During an interview on 5/16/2025 at 3:28 p.m. with the facility's Director of Nursing (DON), the DON stated, the Med Cart needed to be locked if it was outside of Licensed Nurse view. 2. During a review of Resident 34's admission Record (AR), the AR indicated Resident 34 was admitted to the facility on [DATE] with diagnoses that included essential hypertension (high blood pressure) and depression (a feeling of severe sadness or hopelessness.) During a review of Resident 34's Order Summary Report (OSR) dated 12/2/2024, the OSR indicated to administer Wixala Inhub Inhalation Aerosol Powder Breath Activated 500 - 50 microgram per actuation (mcg/act) one (1) puff to inhale orally two (2) times a day for chronic obstructive pulmonary disease (COPD, type of obstructive lung disease characterized by long-term poor airflow) to rinse mouth well after use. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 34's dated 4/14/2025, the Minimum Data Set (MDS - a federally mandated resident assessment tool) indicated, Resident 34 had intact (mental action or process of acquiring knowledge and understanding) for daily decision making. The MDS indicated, Resident 34 needed partial/moderate assistance (helper does less than half the effort) from staff for toileting hygiene and shower. The MDS indicated, Resident 34 needed substantial/maximal assistance (helper does more than half the effort) from staff for lower body dressing and putting on and taking off footwear. During an observation on 5/15/2025 at 8:27 a.m., Resident 34 was inside his room sitting in his wheelchair. Resident 34 stated, I have my medication in my drawer. During a concurrent observation and interview on 5/15/2025 at 8:30 a.m., with LVN 1, LVN 1 stated the Wixela Inhub Inhalation Aerosol Powder Breath was inside Resident 34's drawer. LVN 1 stated, medication needed not to be in resident's bedside for safety. During an interview on 5/15/2025 at 3:28 p.m. with the facility's Director of Nursing (DON), the DON stated residents were not allowed to have medication at their bedside unless they were assessed for safe self-administration. During a review of the facility's undated Policy and Procedure titled, Administration of Medications-Medication Passing, the P&P indicated, Absolute security of medications must be maintained. The P&P indicated, The Nurse must lock the medicine cart if it is to be out of sight/control for even a moment. During a review of the facility's undated Policy and Procedure titled, Storage of Medications, the P&P indicated, Medications are stored in locked medication carts and locked in medicine rooms. During a review of the facility's undated P&P titled, Self-Administration of Medication, the facility's P&P indicated, A resident may not be permitted to administer or retain any medication in his/her room unless so ordered, in writing, by the attending physician. During a review of the facility's undated P&P titled, Self-Administration of Medication by Residents, the facility's P&P indicated, The interdisciplinary committee meets to determine if each resident is qualified to self-control and administer medications.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to maintain safe food handling practices by failing to ensure: a. Two of four red sanitization buckets with chemical that used in the kitchen to sanitize kitchen surfaces was maintained at the correct chemical concentration to maintain effectiveness of the disinfectant. b. One of one plastic container of expired red tomato salsa, with an open date of 5/4/25, and one plastic container of green salsa, with an open date of 5/2/25, were inside the walk-in refrigerator. c. One of one bag of open penne pasta noodles and one bag of open spaghetti pasta noodles was in dry storage area and was not labeled with an open date and use by date. These deficient practices had the potential to result in food surfaces not being properly sanitized and foodborne illness (illness caused by contaminated food) due to expired food. Findings: During an observation, on 5/13/25, at 8:33 a.m., with the Dietary Supervisor (DS), one pack of penne pasta noodles and one pack of spaghetti pasta noodles was observed in the dry storage (shelf-stable food) and was not labeled with an open date and a use by date. During an interview, on 5/13/25, at 8:51 a.m., the DS stated labeling food packets with an open date is important to make sure the food is safe to give to the residents. During a concurrent observation and interview, on 5/13/25, 8:52 a.m., one plastic container of tomato sauce was labeled with an open date of 5/4/25 and one plastic container of green salsa was labeled with an open date of 5/2/25. The DS stated, It is important not to serve expired food or serve food after a use by date because we are putting patients at risk for foodborne illness. During a concurrent observation and interview, on 5/13/25, at 8:55 a.m., with the DS, two of four red sanitization buckets tested results were not within the manufacturer's recommended chemical concentration of 200-400 parts per million (ppm). The Quat Sanitizer Spray Bottle/Buckets log (LOG) indicated the red bucket concentration is checked at 8:00 a.m., 10:00 a.m., 2:00 p.m., and 4:00 p.m. The LOG, dated 5/13/25, indicated the red buckets' concentration was not checked at 8:00 a.m. The DS stated the red buckets are used to sanitize the work areas (kitchen surfaces). During a record review of the facility's Policy and Procedure (P&P), titled, Sanitation And Infection Control: Refrigerated Storage, dated, 2018, indicated leftover food or unused portions of packaged foods should be covered, labeled, and dated to assure they will be used first. During a record review of the facility's Policy and Procedure (P&P), titled, Refrigerator Shelf Life, dated 2020, indicated opened salsa expiration date is 3 days and opened tomato sauce expiration date is 5 days. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a record review of the facility's Policy and Procedure (P&P), titled, Directions For Use: Food Contact Sanitizer, indicated use as directed at 200-400ppm.

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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** b. During a review of Resident 16's AR, the AR indicated Resident 16 was initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included malignant neoplasm (cancerous tumor) of the lung, pneumonia (an infection/inflammation in the lungs) and chronic kidney disease (gradual loss of kidney function). During a review of Resident 16's MDS, dated [DATE], the MDS indicated Resident 16 had moderately impaired cognition (ability to understand and process information). The MDS indicated Resident 16 required substantial/maximal assistance (helper did more than half the effort) with eating, upper and lower body dressing and dependent (helper did all the effort, resident did none of the effort to complete the activity) with oral hygiene, toileting, shower and personal hygiene. During a review of Resident 16's Order Summary Report (OSR), dated 5/12/2025, the OSR indicated Resident 16 had an order for Enhanced Barrier Precautions due to Stage 3 pressure injury (full-thickness loss of skin. Dead and black tissue may be visible). During a review of Resident 16's Care Plan (CP), dated 5/12/2025, the CP indicated Resident 16 was on EBP due to Stage 3 pressure injury. The CP interventions included post signage on the door for everyone to see and follow the EBP protocol. During a concurrent observation while outside Resident 16's room and interview on 5/13/2025 at 12:40 p.m. with the Infection Prevention Nurse (IPN), Resident 16 did not have an EBP signage posted and an isolation cart for personal protective equipment (PPE, equipment worn to minimize exposure to hazards) outside Resident 16's room. The IPN stated Resident 16 should have an EBP signage posted and an isolation cart for PPE outside the room for the staff to know and follow the facility's protocol on EBP to prevent the spread of infection. c. During a review of Resident 62's AR, the AR indicated Resident 62 was admitted to the facility on [DATE] with diagnoses that included paraplegia (loss of movement and/or sensation, to some degree, of the legs), depression (characterized by persistent feelings of sadness, hopelessness, and loss of interest or pleasure in activities), and dementia (a progressive state of decline in mental abilities). During a review of Resident 62's OSR, dated 6/24/2024, the OSR indicated Resident 62 had an order for Enhanced Barrier Precautions due to gastrostomy tube (GT, a feeding tube surgically placed directly into the stomach through the abdomen) site. During a review of Resident 62's Minimum Data Set (MDS, a resident assessment tool), dated 2/17/2025, the MDS indicated Resident 62 had severely impaired cognition (ability to understand and process information). The MDS indicated Resident 62 was dependent (helper did all the effort, resident did none of the effort) with eating, oral hygiene, toileting, shower, upper and lower body dressing and personal hygiene. The MDS indicated Resident 62 had a feeding tube for nutrition. During an observation, inside Resident 62's room on 5/15/2025 at 7:45 a.m. with Licensed Vocational Nurse 5 (LVN 5), was observed administering medications through Resident 62's GT without donning a gown. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/15/2025 at 2:03 p.m. with LVN 5, LVN 5 stated Resident 62 was on EBP. LVN 5 stated he should have donned a gown before administering Resident 62's medications to prevent cross-contamination. During the interview on 5/15/2025 at 3:53 p.m. with the Director of Nursing (DON), the DON stated all residents with wounds, indwelling medical devices and history of multidrug-resistant organisms (MDROs) would be placed on EBP to prevent and control the transmission of infection. During a review of the facility's undated P&P titled, Enhanced Barrier Precautions, the P&P indicated, Facility will communicate to the staff which residents require the use of EBP using the following methods: Sign posted outside the room door indicating the use of EBP and for which resident(s) EBP are to be used for, e. g. resident in A bed, resident in B bed, resident in C bed (if applicable), or all residents in the room, indicator in the EMR. Based on observation, interview and record review, the facility failed to implement and follow infection prevention procedures to prevent the transmission of infectious organisms for four of six sampled residents (Residents 55, 16, 62 and 307) and the facility's Water Management, by failing to: a. Ensure a disposable gown was not left hanging on Resident 55's doorknob inside her room, who was on contact isolation (precautions used for infections, diseases, or germs that are spread by touching the patient or items in the room) for multidrug-resistant organisms (MDRO, bacteria that resist treatment with more than one antibiotic). b. Place a personal protective equipment (PPE, equipment that protects people from injury or illness in hazardous environments) cart and post a Contact Isolation Sign outside of Resident 16's door when Resident 16 had physician orders for Contact Precautions. c. Ensure Licensed Vocational Nurse 5 (LVN 5) wore a gown while administering medications through Resident 62's Gastrostomy Tube (GT, a feeding tube surgically placed directly into the stomach through the abdomen). Resident 62 was on Enhanced Barrier Precautions (EBP - precautionary measures that involve using a glove and gown during high-contact resident care activity). d. Post an Enhanced Barrier Precaution Sign outside of Resident 307's door. e. Ensure an infection control program that assesses building water systems using a diagram where Legionella/other waterborne organisms could grow. These deficient practices had the potential to transmit infectious microorganisms and increase the risk of infection for Residents 55, 16, 62 and 307 and had the potential to result in all residents being affected by opportunistic waterborne pathogens. Findings: a. During a review of Resident 55's AR, the AR indicated Resident 55 was admitted to the facility on [DATE] with diagnoses that included gangrene (condition where tissue dies due to a loss of blood supply) and peripheral vascular disease (PVD - a slow progressive narrowing of the blood flow to the arms and legs.) (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 55's Minimum Data Set (MDS, as resident assessment tool), dated 4/8/2025, indicated, Resident 55 had moderately impaired cognition (mental action or process of acquiring knowledge and understanding) for daily decision making. The MDS indicated Resident 55 was dependent (helper does all the effort) with lower body dressing and putting on/taking off footwear. The MDS indicated Resident 55 needed substantial/maximal assistance (helper did more than half the effort) with toileting hygiene, shower, upper body dressing and personal hygiene. During a review of Resident 55's care plan, the care plan indicated Resident 55 was on contact isolation due to MDRO of the urine dated 5/6/2025. Resident 55's care plan indicated to educate staff on proper PPE and Inservice to prevent spread of infection. During a review of Resident 55's Order Summary Report (OSR) dated 5/12/2025, the OSR indicated to place Resident 55 on contact isolation for MDRO. During a concurrent observation and interview on 5/13/2025 at 8:34 a.m. together with Registered Nurse 1 (RN 1), Resident 55 was awake, lying in bed and a disposable gown was hanging on the doorknob inside Resident 55's room. RN 1 stated, there should not be a disposable gown hanging on the doorknob. RN 1 stated, disposable gowns needed to be discarded in the trash bin and should not be left hanging for it might spread infection to residents and staff. During a concurrent observation and interview on 5/15/2025 at 3:35 p.m. the facility Director of Nursing (DON), the facility DON stated, disposable gowns once taken out from the isolation cart needed to be disposed directly and should not be hung anywhere to prevent spread of infection. During a review of the facility's policy and procedure (P&P) titled, Isolation Categories of Transmission - Based Precautions, revised on 10/2010, the P & P indicated, contact precautions are implemented for residents known or suspected to be infected with microorganisms that can be transmitted by direct contact with the resident or indirect contact with environmental surfaces or resident-care items in the resident's environment. The P&P indicated contact precautions are used for residents infected or colonized with MDRO's in the following situations: when a resident has wounds, secretions or excretions that are unable to be covered or contained. d. During a review of Resident 307's admission Record (AR), the admission Record indicated Resident 307 was readmitted on [DATE] with diagnoses that included bladder cancer and anemia (a condition where the body does not have enough healthy red blood cells). During a review of Resident 307's Minimum Data Set (MDS, a resident assessment tool) assessment, dated 2/13/2025, the MDS indicated Resident 307 had intact cognition (ability to understand) and needed substantial/maximal assistance (helper does more than half the effort. Helper lifts of holds trunk or limbs and provides more than half the effort) when moving from the sitting to standing position. During a review of Resident 307's Order Summary Report, the Order Summary indicated Resident 307 had an order to be placed on Enhanced Barrier Precautions (EBP- an infection control intervention designed to reduce transmission of multidrug-resistant organisms (MDROs) that employs targeted gown and glove use during high contact resident care activities and are indicated for residents with infections, wounds, and indwelling medical devices) due to the biliary drain in Resident 307's abdomen, ordered on 5/11/2025. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview on 5/13/2025 at 9:27 am with Registered Nurse Supervisor 1 (RN 1) outside of Resident 307's room, the lack of EBP signage was observed. RN 1 stated, Resident 307 had a central line (or central venous catheter- a longer intravenous (IV) line that could be used to administer medicine, fluids, blood, or nutrition and draw blood), biliary drain, and an order for EBP. RN 1 further stated, all licensed nurses could implement EBP and it should have been done immediately to make staff or visitors aware of infection control measures needed to protect the patient and staff members from spreading any MDROs. During an interview on 5/16/2025 at 12:22 pm with the Director of Nursing (DON), DON stated, EBP should be started upon admission or when the resident meets the criteria. DON stated, an EBP sign should be posted outside the resident's door. DON further stated, EBP was used to prevent the transmission of infection to everyone in the facility and when personal protective equipment (PPE - clothing and equipment that is worn or used to provide protection against hazardous substances and/or environments) was not used, the source of transmission was not being controlled. During a review of the facility's policy and procedure (P&P) titled, Enhanced Barrier Precautions Policy and Procedures, undated, the P&P indicated, the facility strives to reduce the transmission of MDROs by adhering to EBP as clinically indicated during high contact activities for residents with chronic wounds or indwelling medical devices. The P&P indicated, EBP are to be in place for the duration of a resident's stay in the facility or until resolution of the wound or discontinuation of the indwelling medical device that placed them at higher risk with nursing responsible for screening every shift for possible initiation or discontinuation of the care plan for EBP. The P&P indicated, one method the facility will communicate to staff which residents require the use of EBP by posting a sign outside the room door indicating the use of EBP and for which resident(s). e. During a review of the undated Legionella Prevention Weekly QAPI (Quality Assurance and Performance Improvement-a data driven proactive approach to improvement used to ensure services are meeting quality standards) binder, the documentation in the binder did not provide any text and/or flow diagrams to assess where Legionella and other opportunistic waterborne pathogens could grow, spread and were controlled. During an interview on 5/15/2025 at 3:58 p.m. with the Administrator (ADM), the ADM stated the facility did not have any text or flow diagrams to show assessments of where waterborne organisms could grow. During a review of the facility's undated policy and procedure (P&P) titled, Legionella Water Management Program, the P&P indicated, the facility is committed to the prevention, detection, and control of waterborne contaminants, including Legionella. The P&P indicated, as part of the infection prevention and control program, the facility has a water management program which includes the following elements: a detailed description and diagram of the water system in the facility, including the following: 1. Receiving. 2. Cold water distribution. 3. Heating. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. Hot water distribution. 5. Waste. The P&P indicated, the water management program also includes a diagram of where Legionella control measures are applied.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to implement their policy on the use of an antibiotic and a change in condition for one of five sampled residents (Resident 84) for a urinary tract infection (UTI- an infection in the bladder/urinary tract). This failure resulted in Resident 84 receiving antibiotics without meeting facility criteria and had the potential to result in Resident 84 developing antibiotic resistance. Findings: During a review of Resident 84's admission Record (AR), the admission Record indicated Resident 84 was admitted on [DATE] with diagnoses that included Alzheimer's Disease (a disease characterized by a progressive decline in mental abilities), dementia (a progressive state of decline in mental abilities), and depression (a mood disorder that may cause persistent sadness or loss of interest in activities). During a review of Resident 84's Minimum Data Set (MDS - a federally mandated resident assessment tool) assessment, dated 4/11/2025, the MDS indicated Resident 84 had moderately impaired cognition (ability to understand). During a review of Resident 84's Lab Results Report, dated 5/3/2025, the lab result report indicated Resident 84 had an abnormal urinalysis (a test of one's urine used to detect/manage UTI, kidney disease and diabetes). During a review of Resident 84's Physician Orders, the Physician Orders indicated Resident 84 had an order dated 5/5/2025 to administer Cephalexin (antibiotic used for the treatment of bacterial infections) oral tablets 500 milligrams (mg), one tablet by mouth three times a day for a urinary tract infection for 10 days. During a review of Resident 84's Infection Criteria Checklist, dated 5/6/2025, the checklist indicated to meet a symptomatic UTI Resident 84 needed three of the following symptoms when a urinary catheter was not in place: fever, new/increased pain or urination, frequency or urgency with urination, new flank or suprapubic pain or tenderness, or change in urine characteristics that were bloody, foul smell, sediment, pyuria (urine containing white blood cells or pus) and none were documented for Resident 84 (no urinary catheter in place). During a review of Resident 84's Medication Administration Records (MAR - a daily documentation record used by a licensed nurse to document medications and treatments given to a resident), dated 5/1/2025 to 5/31/2025, the MAR indicated Resident 84 was administered Cephalexin oral tablet 500 mg from 5/5/2025 to 5/15/2025. During an interview on 5/15/2025 at 2:41 p.m. with the Infection Preventionist Nurse (IPN), the IPN stated Resident 84's signs and symptoms of UTI were not documented in the medical record. The IPN further stated, it was important to complete the infection criteria for data collection to ensure the right thing was being done, to promote antibiotic stewardship, and prevent antibiotic resistance for the resident. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/16/2025 at 12:11 p.m. with the Director of Nursing (DON), the DON stated, the antibiotic stewardship program was used to confirm residents were receiving an effective and appropriate medication for their condition and to prevent any complications. The DON stated, Resident 84's UTI signs and symptoms were not documented. The DON stated, the facility needed to monitor resident data and complete tracking to meet the criteria to determine if the antibiotic was necessary for treatment. During a review of the facility's policy and procedure (P&P) titled, Doctor Notification, Change Residents Status, undated, the P&P indicated, its purpose was to define the procedures for notifying a physician or licensed practitioner of changes in a resident's condition to promote timely medical intervention and compliance with federal and state regulations. The P&P indicated, a change of condition was a deviation from the resident's baseline and included new or worsening signs or symptoms. The P&P indicated, the licensed nurse will document in the progress notes, summary of the discussion and if a new order is received. During a review of the facility's policy and procedure (P&P) titled, Infection Control Antibiotic Stewardship Program, dated 10/2017, the P&P indicated, the facility implements an Antibiotic Stewardship Program (ASP) to promote appropriate use of antibiotics while optimizing the treatment of infections, at the same time reducing possible adverse events associated with antibiotic use. The P&P indicated, it has the potential to limit antibiotic resistance in the post-acute care setting, while improving treatment efficacy and resident safety, and reducing treatment-related costs. The P&P indicated, ASP activities should, at a minimum, include the basic elements of leadership, accountability, drug expertise, action to implement recommended policies or practices, tracking measures, reporting data .