STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056132	A. Building B. Wing	06/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Golden San Andreas Care Center	900 Mountain Ranch Road San Andreas, CA 95249

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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 - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observation, interview, and record review, the facility failed to provide meal service in a dignified manner for 13 Residents during the lunch in the assisted dining room (for residents who need staff assistance to consume their meals/drinks) on 6/9/26 when 13 Residents were served their meals on a food tray (a flat tray utilized to carry plates/bowls/drinks/utensils to a dining area) while 23 Residents in the independent dining room had their meals without the food tray and and the food were set on the dining table.This deficient practice had the potential to negatively affect the 13 Residents' psychosocial (involving mental, emotional, social, an spiritual aspects of a person's life) well-being.Findings:During a concurrent observation and interview on 6/9/26, at 12:36 p.m. with Certified Nurse Assistant (CNA) 5 in the assisted dining room during the lunch, 13 residents were observed seated at tables waiting to be served their lunch meal. Staff who were in the dining room started serving the meals to the 13 Residents at each table and placed their food trays on the table in front of each resident. All 13 Residents received their meals on a food tray. CNA 5, who was assisting the residents in the assisted dining room, stated that it was okay to leave the plates, glasses, and silverware on the tray and that they were instructed to do so. CNA 5 went on to say meals were served like this in just this dining room but not the independent dining room. CNA 5 explained that residents who eat their meals in the independent dining room have their meals removed from the food tray and set on the table. CNA 5 stated meals should not be served on a tray and should have been removed to promote dignity and that everybody should be treated with dignity. CNA 5 also stated there should be no difference between the residents having meals in the independent dining room and the residents having their meals in the assisted dining room.During an observation on 6/9/26, at 12 p.m. in the independent dining room, staff were observed serving meals to the residents by removing their food from the food trays, and setting the plates, glasses, and silverware on the table in front of each resident.During an interview on 6/11/26, at 11:12 a.m. with the Director of Staff Development (DSD), the DSD stated there should be no difference between the residents eating in the independent dining room and the residents eating in the assisted dining room. The DSD also stated the plates, glasses, and silverware should have been removed from the tray to promote dignity and a homelike setting.During an interview on 6/12/26, at 1:30 p.m. with the Administrator (ADM), the ADM stated that meals should be served off the tray for dignity, for homelike environment, and implementing residents' rights.During a review of the list of resident rights from the Social Security Administration (SSA) and Social Services published September 2010 and updated July 2015, the list indicated, .To be treated with consideration, respect and full recognition of dignity and individuality.

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

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

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - 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 kitchen equipment and food-contact surfaces in accordance with professional standards for food safety for 87 residents when:1. Food preparation equipment was not maintained in clean and sanitary conditions in accordance with food safety standards; and,2. The top of the convection oven (a standard oven equipped with a built-in fan and exhaust system) was observed covered with dust and sticky in touch and, the interior surfaces of the convection oven doors were observed to have multiple light brown spots and accumulations of oil/grease residue.3. The top of the dishwasher was observed to be visibly soiled with accumulated debris.These failures had the potential to expose 87 residents to food contamination and foodborne illness (an illness that comes from eating contaminated food. Common signs include nausea, vomiting, watery or bloody diarrhea, abdominal cramps, and fever).Findings: 1a. During a concurrent observation and interview on 6/9/26, during the initial kitchen tour, at 8:15 AM with the Certified Dietary Manager (CDM) in the kitchen, in a shelf, 8 large sheet pans were stored in ready-to-use area with oil/grease buildup that were present throughout the interior surface of the pans, with raised dark brown residue along portions on the inner rims. During a subsequent interview with the CDM, the CDM confirmed the findings, and stated that the sheet pans were not being used for cooking but rather as trays to hold salads and desserts. The CDM further stated that if the sheet pans were used for cooking, the accumulated residue could chip off and potentially fall into the food. However, the sheet pans were stored in the ready-to-use area alongside clean sheet pans, creating the potential for inadvertent use during food preparation and services.During a subsequent observation and interview in the kitchen on 6/10/26, at 10:40 AM with [NAME] (CK) 1, the same 8 large sheet pans previously observed with raised dark brown oil/grease residue were noted to be stored in the ready-to-use area. CK 1 confirmed the findings and stated that those sheet pans should not be stored in the ready-to-use area. CK 1 stated that the residue could chip off and fall into food during use, which could potentially cause residents to become ill. CK 1 further stated that the sheet pans should be thoroughly scrubbed to ensure the cooking surfaces were properly cleaned or, if they could not be adequately cleaned, removed from service and discarded. During an interview on 6/10/26, at 1:43 PM, the Registered Dietitian (RD) stated that 8 sheet pans with oil/grease residue buildup that could not be adequately cleaned should be removed from the ready-to-use shelves in the kitchen when they were not being used as cooking pans. The RD stated that dietary staff should ensure those pans were stored separately to prevent their inadvertent use. The RD further stated using sheet pans with food residue buildup could increase the risk of cross-contamination.2a. During a concurrent observation and interview on 6/9/26, during the initial kitchen tour, at 8:15 AM with the CDM in the kitchen, the interior surfaces of the convection oven doors were observed to have multiple light brown spots and accumulations of oil/grease residue covering the surfaces. The CDM confirmed the findings and stated that the convection oven was old. The CDM began scrubbing the interior door surfaces during the observation and stated that it was unable to remove all the accumulated oil/grease residue due to oven being old. The CDM further stated that dietary staff were responsible for cleaning all food preparation equipment after use and added that continuation of accumulation of food residue might affect sanitary condition of the equipment.During an interview on 6/10/26, at 10:40 AM, CK 1 stated that the interior surfaces of the convection oven doors should be scrubbed thoroughly to remove oil/grease buildup for safety of residents, even though the oven was old. CK 1 further stated that food preparation equipment should be maintained in a sanitary condition.During an interview on 6/10/26, at 1:43 PM, the RD stated that his expectation was for dietary staff to thoroughly clean the interior surfaces of the convection oven doors at the end of each shift. The RD stated that food preparation equipment should be always maintained in a clean and sanitary condition. The RD further stated that accumulated oil/grease residue could dislodge and fall into food items (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	being cooked in the convection oven that could create a risk of cross-contamination and compromising food safety. 2b. During a concurrent observation and interview on 6/9/26, during the initial kitchen tour, at 8:15 AM with the CDM in the kitchen, the top of convection oven observed covered with dust and sticky in touch, the CDM confirmed the findings and stated that dietary staff were responsible for maintaining the cleanliness of food preparation equipment, including the top of the convection oven, and were expected to clean the equipment at the end of each shift. The CDM further stated that dust and food residue could fall into food and potentially cause cross-contamination.During an interview on 6/10/26, at 10:40 AM CK 1 stated that dietary staff were responsible for maintaining the cleanliness of food preparation equipment, including the top of the convection oven. CK 1 stated that exterior surfaces and top of the convection oven should remain free of dust and food residue to prevent those particles from falling into food. CK 1 further stated that dust could contain allergens that might cause residents to become ill.During an interview on 6/10/26, at 1:43 PM, the RD stated that, to remain in compliance with guidelines and adhere to sanitation standards, all food preparation areas and surfaces should be maintained clean and in good condition to prevent contamination of food. The RD stated that dietary staff were expected to maintain the cleanliness of food preparation equipment every day. The RD further stated that the top of the convection oven should be cleaned properly daily to prevent possible cross-contamination.3. During a concurrent observation and interview on 6/9/26, during the initial kitchen tour, at 8:42 AM, a large accumulation of debris was observed on the right side of the top of the dishwasher, where clean dishes exited the dishwasher after washing process. CK 2 confirmed the findings and stated that dietary aides were instructed to clean and remove all food debris and mineral buildup from the top of the dishwasher immediately after completing the dishwashing process. CK 2 further stated that there should not be any visible food debris, food particles, or mineral deposits on the top of the dishwasher, as those materials could fall onto clean dishes and potentially contaminate them.During an interview on 6/9/26, at 8:50 AM, the CDM stated that dietary staff were expected to maintain the cleanliness of the exterior surfaces of the dishwasher during each shift. The CDM further stated that debris and mineral deposits should be removed promptly to prevent them from falling onto clean dishes and potentially causing contamination.During an interview on 6/10/26, at 1:43 PM, the RD stated that dietary staff were expected to wipe down the top of the dishwasher routinely to remove mineral deposits and other debris. The RD further stated that debris and mineral buildup could fall onto clean dishes and potentially cause cross-contamination.During an interview on 6/12/26, at 9:59 AM, the Director of Nursing (DON) stated that some sheet pans and the convection oven were old and had been in use for an extended period, which could result in the accumulation of residue on their inner surfaces over the years. The DON further stated that kitchen and food preparation equipment should be maintained in a clean, sanitary, and good condition to help prevent foodborne illnesses and ensure food safety.During a review of facility's policy and procedure (P&P) titled, Equipment, revised in September 2017, the P&P indicated, .All foodservice equipment will be clean, sanitary, and in proper working order. Procedures. 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.A review of the US FDA 2022 Food Code, section 4-601.11, titled, Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces, and Utensils, January 18, 2023, version, indicated, (A) EQUIPMENT FOOD-CONTACT SURFACES and UTENSILS shall be clean to sight and touch. (B) The FOOD-CONTACT SURFACES of cooking EQUIPMENT and pans shall be kept free of encrusted grease deposits and other soil accumulations. (C) NonFOOD-CONTACT SURFACES of EQUIPMENT shall be kept free of an accumulation of dust, dirt, FOOD residue, and other debris.

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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. Based on observation, interview, and record review the facility failed to ensure safe infection prevention and control practices for census of 87 when:1. Resident 14, Resident 8 and Resident 65's oxygen tubing was not properly stored when not in use,2. Resident 11's indwelling urinary catheter (also known as foley catheter, a flexible, hollow tube inserted into the bladder to continuously drain urine out of the bladder, through the tubing and into an external collection bag) tubing and catheter bag (collects urine drained from the bladder via a catheter, also known as drainage bag) were touching the floor while wheeling herself in the hallway,3. Shared glucometer (a device that measures blood sugar) were not cleaned and sanitized in-between resident care for Resident 98 and Resident 100,4. Pill cutters in the medication cart contained white and yellow medication residue, and5. Medication carts were observed dirty with visible dark specks, debris, fine hairs/fibers, and sticky spills. These failures had the potential to spread infection and cause health problems for the residents in the facility.Findings: 1a. A review of Resident 14's admission RECORD, indicated Resident 14 has a diagnosis of but not limited to dependence on supplemental oxygen. During a concurrent observation and interview with Registered Nurse Supervisor (RNS), on 6/9/26, at 10:51 AM, Resident 14 was observed sleeping in bed with nasal cannula (a flexible plastic device that delivers supplemental oxygen directly into the nostrils) connected to an oxygen concentrator. Resident 14 had a wheelchair on the side of her bed with a nasal cannula wrapped around an oxygen tank that was at the back of the wheelchair. RNS stated when Resident 14 was in the wheelchair, they hook the nasal cannula with the oxygen tank. RNS stated that the nasal cannula should be placed in a plastic bag when not in use. RNS took the nasal cannula and threw it in the trash. A review of Resident 14's physician order dated 4/10/26, indicated, .Change oxygen/nebulizer tubing if it becomes damaged or visible soiled as needed. During a concurrent observation and interview with Resident 14 on 6/11/26, at 2:22 PM, Resident 14's entire oxygen tubing was on the floor while hooked to an oxygen concentrator. Resident 14 was observed pulling her oxygen tubing from the floor and placed it in her nose. Resident 14 stated she had not seen the staff change her oxygen tubing. Resident 14 stated she wanted her oxygen tubing clean because she put it in her nose. During a concurrent observation and interview with License Nurse (LN) 2, on 6/11/26, at 2:25 PM, LN 2 confirmed Resident 14's oxygen tubing was wrapped around the oxygen tank. LN 2 stated it could be contaminated and could be an infection control issue when Resident 14 would use it. LN 2 stated there should be a bag for the oxygen tubing. 1b. A review of Resident 65's admission RECORD, indicated Resident 65 had a diagnosis of, but not limited to dependence on supplemental oxygen, and chronic obstructive pulmonary disease. During an observation on 6/9/26, at 2:20 PM, Resident 65 was observed sitting in a wheelchair and was using oxygen via nasal cannula that was connected to an oxygen tank. During a concurrent observation and interview on 6/9/26, at 2:37 PM, with Certified Nursing Assistant (CNA) 2, CNA 2 confirmed Resident 65's oxygen concentrator at the bedside was on and nasal cannula of the oxygen tubing connected to it was placed inside the drawer of the nightstand. CNA 2 stated the (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	oxygen tubing on the concentrator should not be in the drawer and should be place in the plastic bag when not in use. CNA 2 stated that Resident 65 only used it when he was in bed and he had another one to use while in the wheelchair. A review of Resident 65's physician order dated 5/5/26, indicated, .Change oxygen tubing if it becomes damaged or visibly soiled. as needed . 1c. A review of Resident 8's admission RECORD, indicated Resident 8 had a diagnosis of, but not limited to dependence on supplemental oxygen, and chronic obstructive pulmonary disease (COPD: a progressive, incurable lung disease that restricts airflow and makes it hard to breathe). During an observation on 6/9/26, at 4:40 PM, Resident 8 was observed using oxygen via nasal cannula connected to an oxygen concentrator, and part of the oxygen tubing was on the floor. During a concurrent observation and interview with LN 2, on 6/9/26, at 4:48 PM, Resident 8's oxygen tubing was observed on the floor next to Resident 8's bed while connected to Resident 8's nose. LN 2 stated it should not be on the floor. The DON came into Resident 8's room and instructed LN 2 to replace Resident 8's oxygen tubing. During a concurrent observation and interview with LN 3, on 6/11/26, at 8:38 AM, LN 3 confirmed Resident 8's oxygen tubing was on the floor. LN 3 stated that if the oxygen was being used as needed, it should be coiled and placed inside a bag when not in use. LN 3 stated it was not supposed to be touching the floor because it would become soiled and was not sanitary. The DON came into Resident 8's room and observed Resident 8's tubing on the floor and stated that it should be thrown away and replaced. A review of Resident 8's physician order dated 3/18/26, indicated, .Change oxygen/nebulizer tubing if it becomes damaged or visibly soiled. as needed. During a concurrent interview and record review with Infection Preventionist (IP), on 6/12/26, at 8:33 AM, the IP stated if the oxygen use was for continued use, the staff should transfer the cannula from concentrator to the tank when residents went out of their room. The IP further stated that if the oxygen was used as needed, the cannula should be kept in a bag when not in use. The IP stated if resident was using 2 oxygen tubings, the other one should be place in bag when not in use. The IP stated the oxygen tubing should not be on the floor because it would place the residents at increased risk for infection. The IP stated the oxygen tubing could get contaminated and affect their respiratory system. During an interview on 6/12/2026, at 10:51 AM with the Director of Nursing (DON), the DON stated the oxygen tubing should not be wrapped around the oxygen tank. The DON stated the residents would only need one oxygen tubing. The DON added the oxygen tubing should be stored in a bag when not in use. The DON stated the oxygen tubing should not be on the floor. The DON stated she was not sure if it would pose an infection risk. A review of the facility's policy and procedure titled, Infection Control Policies and Practices, revised 3/19/25, indicated, .Policies and practices are observed to maintaining a safe, sanitary, and comfortable environment and to support infection prevention, identification, and transmission. Policies, protocols, and practices are developed in accordance with the Centers for Disease Control (CDC), Federal and State regulatory requirements, and local health authority guidance. 2. During a review of Resident 11's admission RECORD, dated 6/12/26, the record indicated, Resident (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	11 was admitted to the facility with diagnoses including obstructive and reflux uropathy (conditions where impaired urinary flow or backward leakage causes pressure and damage to the kidneys). During a review of Resident 11's Minimum Data Set (MDS, an assessment tool), dated 5/13/26, the MDS indicated under the Bladder and Bowel section, an indwelling urinary catheter was marked. During a review of Resident 11's Order Summary, dated 5/11/26, the order indicated, .foley cath [catheter] to gravity drainage. Change as needed for clogged or non-functioning related to OBSTRUCTIVE AND REFLUX UROPATHY. During a review of Resident 11's Care Plan Report (a form where you can summarize a person's health conditions, specific care needs, and current treatments), dated 5/11/26, the care plan indicated, .Potential for infection related to indwelling catheter.Monitor placement and positioning of catheter.Provide catheter care Q [every] shift. During a concurrent observation and interview on 6/11/26, at 11:19 a.m. Resident 11 was up in her wheelchair wheeling herself from her room down the hallway, passed by the nurse's station, where several staff members were working, and down the hallway towards the dining room. Resident 11's catheter bag and part of the catheter tubing were hanging under her wheelchair and were touching the floor as Resident 11 was wheeling herself down the hallway. The Infection Preventionist (IP) passed by the hallway while pushing a food cart stopped next to where Resident 11 was. The IP confirmed that Resident 11's catheter tubing and the drainage bag were dragging on the floor from underneath the wheelchair. The IP stated it should not be touching the floor and went on to say, I'll take her to her room and fix it. During an interview on 6/11/26, at 11:36 a.m. with the IP, the IP stated the catheter tubing, and the drainage bag should never touch the ground due to increased risk for bacteria traveling up the tubing that could potentially cause a bladder infection. During an interview on 6/12/26, at 8:15 a.m. with Certified Nurse Assistant (CNA) 3 who was the assigned staff for Resident 11 during the day shift on 6/12/26, CNA 3 stated Resident 11 had limited functioning for Activities of Daily Living (ADLs, tasks we do to stay alive and well such as bathing, dressing, eating, transferring, and toileting) and she needed assistance with catheter care. CNA 3 explained that catheter care involved emptying the drainage bag and placing it in a privacy bag, monitor the tubing if anything was loose, make sure the tubing was not tangled, properly placed the drainage bag below the bladder, and to secure the tubing. CNA 3 stated that usually the CNAs assisted Resident 11 with placing the drainage bag and securing the tubing underneath the wheelchair. CNA 3 did not mention as part of the catheter care to make sure the drainage bag, and tubing should be off the floor. During an interview on 6/12/26, at 10:34 a.m. with Licensed Nurse (LN) 7, LN 7 stated catheter care would include using a privacy bag for the drainage bag, making sure the indwelling catheter was intact, providing proper peri-care (the washing and cleaning of the genital and anal areas), and making sure the catheter bag and the tubing were not touching the floor. During an interview on 6/12/26, at 1:30 p.m. with the Administrator (ADM), the ADM stated that care for the tubing of an indwelling catheter and the drainage bag included that it should not be dragging on the floor. The ADM further stated that there would be increased risk for infection that could affect the health and well-being of the residents. (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 the facility's job description titled, Certified Nursing Assistant, dated March 2025, the job description indicated, .Under general supervision performs a combination of following duties in caring for residents in the Community [facility], consistent with the plan of care and established long-term standards and Community policies and processes. During a review of the facility's In-service Training Program (a professional development and learning activities provided to employees while they are actively employed in their field), a lesson plan titled, Peri Care/Catheter Care given by the DSD on 5/19/26 and again on 5/20/26, the Lesson Plan indicated, .Catheter bags need to be below the level of the bladder and placed in a privacy bag with tubing/bag not on the floor. During a review of the facility's Policy & Procedure (P&P) titled, Infection Control Policies and Practices, dated 3/19/25, the P&P indicated, .Policies and practices are observed to maintaining a safe, sanitary, and comfortable environment and to support infection prevention, identification, and transmission. 3. During a medication administration observation, accompanied by Licensed Nurse 1 (LN 1), on 6/9/26 at 11:38 AM, at C wing hallway, LN 1 gathered blood sugar measurement supplies into Resident 98's room. LN 1 placed the glucometer on tabletop next to Resident 98's bed. LN 1 with gloved hand then used the lancet device (sterile needle used to prick the skin and draw a small drop of blood) to prick the right point finger of Resident 98 to collect the blood sample for testing. LN 1 then soaked the test strip (disposable plastic strip coated with special chemicals to measure blood sugar) attached to glucometer with blood and measured the blood sugar. LN 1 stated insulin (injectable drug to treat high blood sugar) administration was required. When out of Resident 98's room, LN 1 removed the gloves and with bare hands used one bleach wipe to quickly wrap the outer surface of the glucometer. LN 1 kept the glucometer wrapped on top of her cart. During a concurrent observation and interview on 6/9/26 at 11:58 AM, with LN 1, at C wing hallway, LN 1 used a second glucometer and prepared the needed supplies to measure Resident 100's blood sugar and entered the room. LN 1 placed the glucometer on tabletop next to Resident 100's bed. LN 1 with gloved hand then used the lancet device to prick the right middle finger of the resident to collect the blood sample for testing. LN 1 then soaked the test strip attached to glucometer with blood and measured the blood sugar. LN 1 stated insulin administration was required for the measured blood sugar. When out of Resident 100's room, LN 1 removed the gloves and with bare hands used one bleach wipe to quickly wrap the outer surface of the glucometer. LN 1 then kept the glucometer wrapped on top of her cart. LN 1 stated she had been trained on how to clean the shared glucometer in-between resident care by first wiping the front and the back of the device, then using a second wipe to further sanitize the glucometer and then wrapping it for a prolonged wetness for four minutes or more. LN 1 acknowledged that she did not wipe the glucometer as described during her training. LN 1 further acknowledged improper cleaning and sanitizing could pose a risk of spreading infection. During an interview on 6/10/26 at 9:45 AM with the Director of Nursing (DON) and the Registered Nurse Supervisor (RNS), the RNS stated improper cleaning and sanitizing of shared glucometer would be an infection control issue that could have caused spread of infection to the residents and staff. During an interview on 6/10/26 at 12:40 PM with the Infection Preventionist (IP), the IP stated that staff must wipe the glucometer with a bleach wipe, one wipe per side and then wrap it with another sheet of bleach wipe. The IP stated the purpose was to prevent the spread of infection. The IP further stated that failure to follow this education could result in the transmission of infection to staff and (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	residents. The IP stated that staff should handle bleach wipes with gloves. During a review of the facility's policy titled, Disinfecting Glucometer.Machine, dated 4/2011, indicated, .The Center disinfects the multiuse glucometer.between each resident use with Centers for Disease Control (CDC) approved .bleach solution.utilizing infection control practices during the disinfecting process. A review of the manufacturer's instruction titled, Cleaning and Disinfecting the Assure Prism multi Blood Glucose Monitoring System (brand name used by facility), revised 9/2024, last accessed on 6/17/26 via https://arkrayusa.com/support/professional-healthcare/cleaning-disinfecting/ , indicated, .The meter should be cleaned and disinfected after use on each patient.Two wipes are needed; one wipe to clean the meter and a second wipe to disinfect the meter.Always wear the appropriate protective gear, including disposable gloves.Wipe the entire surface of the meter using the towelette at least three times vertically and three times horizontally to clean blood and other body fluids from the meter.Meter surfaces must remain wet according to contact times.Once complete, wipe meter dry. 4. During a concurrent observation and interview, on 6/9/26 at 11:58 AM, with LN 1, during medication cart inspection, on wing C, the medication cart stored two pill cutter devices (device that split the pills) with visible white and yellow medication residues. LN 1 stated the pill cutters were not clean and should have been wiped and clean because it presented a potential risk for infection, cross contamination (spread of germs from cart to residents) and allergic reaction. During an interview on 6/10/26 at 9:45 AM with the DON and the RNS, the DON and RNS stated that residue in the pill cutter would make it impossible to identify the medications present and could result in interactions with other medications, posing a risk for allergic reaction. During an interview on 6/10/26 at 12:40 PM with the IP, the IP stated it was not acceptable for the pill cutter to remain unclean because medications could mix, and some residents could experience an allergic reaction. 5. During a concurrent observation and interview, on 6/9/26 at 11:58 AM, with LN 1, LN 1 confirmed medication cart on wing C had visible dark specks, debris and fine hairs or fibers near the back of the bottom drawer. LN 1 stated that they cleaned the cart recently, but it needed to be wiped more frequently. During a concurrent observation and interview on 6/9/26 at 2:24 PM, with LN 2, LN 2 confirmed medication cart on wing B had visible darkish and sticky spots in the bottom drawer of the medication cart. During an interview on 6/10/26 at 9:45 AM with the RNS, the RNS stated that medication carts should be clean for infection control purposes. During an interview on 6/10/26 at 12:40 PM with the IP, the IP stated the medication carts should have been kept clean to prevent bacterial growth and potential cross-contamination. During a review of the facility's policy titled, Infection Control and Practices dated 3/19/25, indicated, .Policies and practices are observed to maintaining a safe, sanitary and comfortable environment and to support infection prevention, identification, and transmission. Policies, protocols, and practices are (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	developed in accordance with the Centers for Disease Control (CDC), Federal and State regulatory requirements. A review of the Centers for Disease Control (CDC) Guidelines, Recommendations 2.b, 2.b.i and 2.b.ii, titled, Infection Control: Recommendations for Disinfection and Sterilization in Healthcare Facilities, dated 2008, indicated, .Meticulously clean patient-care items with water and detergent, or with water and enzymatic cleaners before high level disinfection or sterilization procedures.Remove visible organic residue.Clean medical devices as soon as practical after use. https://www.cdc.gov/infection-control/hcp/disinfection-sterilization/summary-recommendations.html A review of CDC Guidelines, Healthcare- Associated Infections (HAIs): Medication preparation areas.Appendix B2, Table 2. Cleaning Procedure Summaries for Medication Preparation Areas dated 3/19/24, indicated, .Clean and disinfect: countertops, portable carts used to transport or prepare medications. The CDC identified the frequency for this cleaning and disinfection as between uses. https://www.cdc.gov/healthcare-associated-infections/hcp/cleaning-global/appendix-b2.html

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. Based on interview and record review, the facility failed to ensure informed consent (a process of documenting that a healthcare professional educated a resident about the risks, benefits, and alternatives of a prescribed mental health drug) for psychotropic drug (mind-altering drugs) use followed the facility's policy and resident notification requirements in two (Resident 1 and Resident 3) out of 5 residents reviewed for unnecessary medications.This failed practice may violate residents' rights to be informed of mind-altering medications given to them while in the facility. Findings: 1. A review of Resident 1's electronic medical record, titled admission Record; Diagnosis Information, dated 6/12/26, the record indicated Resident 1 had diagnoses which included depression. The record further indicated Resident 1 had a BIMS score of 13 (BIMS stands for Brief Interview for Mental Status. The test assesses memory and recall, and score is 0 out of 15 points. The total score of 13 to 15 points means resident was cognitively intact with normal thinking and memory.)During an interview with Resident 1, on 6/10/26, at 10:10 AM, Resident 1 stated no one talked to her about medication consent and she did not sign anything. Resident 1 stated she recalled an older guy came to her room and listened to her heart and left without asking any question or giving any comments.2. A review of Resident 3's electronic medical record, titled admission Record; Diagnosis Information, dated 6/12/26, the record indicated Resident 3 had diagnoses which included depression and mood disorder (a category of mental health conditions that primarily affect your emotional state, causing persistent and intense periods of sadness, elation, or both), morbid (severe) obesity, and arthritis among others. The record further indicated Resident 1 had a BIMS score of 15, meaning Resident 3 was cognitively intact with normal thinking and memory.Review of Resident 3's electronic medical record , titled Medication Administration Record or MAR, dated 6/2026, the MAR record indicated Resident 3 was on two mind-altering drugs called Remeron (or Mirtazapine, an anti-depressant) and Cariprazine (or Vraylar, a mood stabilizer).During an interview with Resident 3, on 6/10/26, at 10:21 AM, Resident 3 stated no one talked to her about medication consent and she did not sign anything. Resident 3 stated she had not seen a doctor or anyone explaining anything about her drugs.During a concurrent interview with RNS, on 6/11/26, at 2:12 PM, and review of Resident 3's informed consent form for Remeron and Cariprazine, and Resident 1's informed consent form for Zoloft (or Sertraline, anti-depression drug) the RNS stated the electronic informed consent form was filled out in the computer by a nurse and it did not have an option for the residents to sign it when medication and its side effects were explained to the them. RNS stated the form was printed and given to the doctor or Physician Assistant (PA) for them to sign and talk to residents if needed. RNS stated the nurse was supposed to explain the drug to the resident. RNS stated the form did not have a place for residents to sign the consent even for residents with full mental and physical capacity. RNS acknowledged Resident 3's and Resident 1's informed consents were signed by the PA and the consent form under Prescriber Signature indicated By signing below, I declare that I have personally examined, provided, and discussed with the Resident.the following material information.During an interview with Physician Assistant (PA), on 6/11/26, at 4:27 PM, the PA stated the nursing staff printed the form for him to sign and if needed he would talk to the resident. The PA stated he did not go over side effects, risks or benefits on a regular basis.During a telephone interview with Medical Director (MD), on 6/12/26, at 8:40 AM, the MD stated providers were the ones that give information about drugs as they are more informed of both the drug's effect and the residents medical condition. The MD stated the workflow was that the nurses facilitate the logistics and the providers gave the information and discussed it with the resident. The MD stated the residents should be able to sign the form and acknowledge the information given to them.A review of the facility's policy, titled Psychotropic Medication Use, dated 6/2021, the policy on section 11 indicated .It is the responsibility of attending healthcare practitioner to inform the resident and or resident representative of the initiation, reason for use, and the risk associated with the use of psychotropic medication per facility policy or applicable state regulation. (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Informed consent will be obtained by the prescriber prior to initiation of psychotropic medication .A review of facility's policy, titled Psychoactive Medications, dated 6/2025, the policy indicated .Written consent is obtained/renewed every six months. If the resident or resident representative cannot sign the form, licensed nurse can sign the form and document the name of the person who gave the consent. The prescriber of the medication can sign using remote technology. A copy is offered to the resident or resident representative .

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to implement non-pharmacological interventions (drug-free approaches and/or resident care interventions without use of drugs that may help with mental health issues) for psychotropic drug use (mind-altering medications) in the plan of care for one out of five residents (Resident 6) reviewed for unnecessary medications. This failed practice may discourage use of drug-free approaches to improve residents' quality of life, reduce distress, and psychotropic medication use.Findings: A review of Resident 6's electronic medical record under admission Record and Diagnosis Information, dated 6/12/26, the record indicated Resident 6 was admitted to the facility on [DATE] with principal diagnosis of rheumatoid arthritis (or RA a chronic immune disease in which the immune system mistakenly attacks the lining of the joints), depression, and obesity among others.A review of Resident 6's electronic medical record under Medication Administration Record (or MAR), dated 6/2026, the MAR record indicated the following:-Fluoxetine (or Prozac, anti-depression drug) 20 mg (mg is milligram , a unit of measure); give one capsule daily for .statements of hopelessness related to depression .; Start date 4/21/26.The MAR record indicated that the nursing staff were monitoring the residents' depression behavior and the side effects of Prozac in the MAR every shift. A review of Resident 6's electronic medical record under Care Plan Report, dated 4/21/26, the record under the Problem section indicated Resident 6 was taking fluoxetine for depression and the goal was to reduce and manage behaviors. The Plan of Care under the Interventions section did not address non-drug interventions to help with feelings of depression and hopelessness.In a concurrent interview with Nurse Supervisor (RNS), on 6/12/26, at 9:55 AM, and review of Resident 6's plan of care, RNS stated the non-pharmacological interventions were usually part of the care plan and/or MAR for staff to use and document. RNS stated this may have been missed during Resident 6's care planning documentation.In an interview with Certified Nurse Assistant 1 (CNA 1), on 6/12/26, at 1:23 PM, in the C hallway, CNA 1 stated residents liked to be heard and talked to. CNA 1 stated the residents needed kind gestures and smiles to help them feel good.In an interview with Licensed Nurse 3 (LN 3), on 6/12/26, at 1:30 PM, in the C hallway, LN 3 stated even confused residents needed one on one interaction and eye contact to see what was bothering them. LN 3 stated sometimes just fixing their hair or opening the window or curtain helped them feel better. LN 3 stated she did not look at the care plan, but having a place in the chart to see what interventions worked best for each resident was important and helpful.Review of the facility's policy, titled Psychotropic Medication Use, dated 6/2021, the policy indicated Facility staff should take a holistic approach to behavior management that involves a thorough assessment of underlying causes of behaviors and individualized person-centered nondrug and pharmaceutical interventions. Facility staff should provide the residents with a supportive environment promoting comfort, recognizing individual needs and preferences. Staff should become familiar with the cultural, medical, and psychological information about the resident to identify potential environmental and other triggers to prevent or reduce behavioral symptoms and/or distress, types and the consequences of behavior exhibited by the resident and intervention that may be indicated for specific behavior type. Facility staff should focus on and understanding behavior to enhance communication when the resident is in distress.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. Based on observation, interview, and record review, the facility failed to provide adequate care and services to promote healing and prevent pressure injury (a localized injury to the skin and/or underlying tissue because of prolonged pressure) for two residents (Resident 25 and Resident 56) who used a low-air loss mattress (LAL mattress, a mattress designed to prevent and treat pressure wounds that uses a continuous, gentle flow of air through a surface of tiny holes to reduce pressure helping to prevent and treat skin breakdown and pressure wounds) in a sample of 26 residents, when Resident 25's and Resident 56's LAL was not correctly calibrated according to Resident 25's and Resident 56's current weight.This deficient practice had the potential to place Resident 25 and Resident 56 at increased risk for developing pressure injury and/or skin breakdown.Findings:a. During a review of Resident 25's admission Record, the record indicated Resident 25 was admitted to the facility with multiple diagnoses including personal history of transient ischemic attack (TIA, is a short period of symptoms caused by a brief blockage of blood flow to the brain) and cerebral infarction (the death of brain tissue caused by a prolonged lack of blood flow and oxygen), cellulitis (potentially serious bacterial infection of deep layers of the skin and underlying tissues), and muscle weakness.During a concurrent observation and interview on 6/9/26, at 9:50 AM, Resident 25 was observed lying in bed on a LAL mattress, and the setting was calibrated to over 400 pounds (LBS-a unit of measurement). Resident 25 stated the mattress was in use due to a history of pressure injuries with the purpose of preventing skin breakdown.During a concurrent interview, and record review conducted on 6/9/26 at 10:04 AM with Licensed Nurse (LN) 1, Resident 25's medical record titled, Weights and Vitals Summary, dated 6/7/26 was reviewed. The record indicated Resident 25's most recent weight documented on 6/7/26, was 114 LBS. LN 1 confirmed Resident 25's most recent weight.During a follow-up observation and interview on 6/9/26, at 10:04 AM, with LN 1 in Resident 25's room, LN 1 confirmed that the LAL mattress was not adjusted to reflect Resident 25's current weight because the mattress pump was set for over 400 LBS, which did not correspond to Resident 25's actual weight. LN 1 stated that Resident 25 had a history of a wound to the coccyx (tailbone) area and that the purpose of the LAL mattress was to prevent further skin breakdown due to fragile skin. LN 1 explained that the LAL mattress pump should be adjusted according to Resident 25's current weight. LN 1 stated that Resident 25's skin was fragile and that failure to properly set the LAL mattress pump could result in the development of new pressure injuries. LN 1 further stated that, rather than providing preventative pressure relief, an improperly adjusted mattress could increase the resident's risk for skin breakdown, pressure injuries, and other skin related complications. During review of Resident 25's, BRADEN SCALE FOR PREDICTING PRESSURE SORE RISK (pressure ulcer, areas of damaged skin typically caused by staying in one position for too long) dated 6/7/26, the scale indicated Resident 25 had a score of 18 (at risk, for the development of pressure ulcer).During an interview on 6/11/26, at 4:36 PM, LN 7 explained that the purpose of a LAL mattress was to serve as an intervention and preventative measure to promote wound healing and reduce the risk of pressure injuries. LN 7 stated that nurses were responsible to adjust the mattress pump setting according to the resident's most recent weight. LN 7 further stated that if the pump was not properly adjusted and was set at a pressure that was too high for the resident's weight, the mattress could become too firm, resulting in increased pressure on the skin. LN 7 further added that this could increase the risk of skin breakdown and pressure injuries rather than helping to prevent or heal them.b. During a review of Resident 56's admission Record, the record indicated Resident 56 was admitted to the facility with multiple diagnoses including hemiplegia (complete or total loss of function of one side of the body) and hemiparesis (partial weakness or reduced muscle strength on one side of the body), personal history of transient ischemic attack, and cerebral infarction, and type 2 diabetes mellitus (a chronic condition leading to high levels of sugar in the blood. People with diabetes could develop skin complications and damage to small blood vessels and nerves that keep (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	skin healthy).During an observation on 6/9/26, at 4:22 PM, Resident 56 was observed lying in bed on a LAL mattress, and the setting was calibrated to over 380 LBS.During an observation and interview on 6/9/26, at 4:27 PM, in Resident 56's room, LN 1 confirmed that the LAL mattress was adjusted to 380 LBS.During a concurrent interview and record review on 6/9/26, at 4:35 PM, with LN 1 Resident 56's medical record titled, Weights and Vitals Summary, dated 6/1/26 was reviewed which indicated, Resident 56's most recent weight documented on 6/1/26, was 183.4 LBS. LN 1 explained that the purpose of LAL mattress was as a preventative measure to relieve pressure on the skin, maintain skin integrity, and help prevent pressure injuries. LN 1 stated that due to Resident 56's diagnoses of hemiplegia and diabetes, and because Resident 56 spent most of his time resting in bed, he was at an increased risk for pressure injuries and skin breakdown LN 1 further stated that nurses were responsible for adjusting the LAL mattress pump according to Resident 56's most current weight. She further stated that lying on an LAL mattress that was improperly adjusted to a pressure setting significantly higher than appropriate for Resident 56's weight could increase the risk of developing pressure injuries and skin breakdown rather than providing the intended pressure relieving benefits.During review of Resident 56's, BRADEN SCALE FOR PREDICTING PRESSURE SORE RISK (pressure ulcer, areas of damaged skin typically caused by staying in one position for too long) dated 2/6/26, the scale indicated Resident 65 had a score of 14 (at moderate risk, for the development of pressure ulcer).During an interview on 6/12/26, at 9:59 AM the Director of Nursing (DON) stated that LAL mattress pumps should be adjusted according to the manufacturer's guidelines and the residents' current weight. The DON further stated that when LAL mattress pumps were adjusted for higher weights than were Resident 25 and resident 56 actual weights, the mattresses became firmer than intended, which might increase pressure on the skin. During a review of the facility provided undated LAL mattress operator's manual for [Brand Name], the review indicated, . INDICATIONS. is indicated for the prevention and treatment of any and all stage pressure ulcers [localized damage to the skin and underlying soft tissue, usually over a bony areas of the body]. PRODUCT FUNCTIONS. Pressure-adjust knob (2) Determine the patient's weight and set the control knob to that weight setting on the control unit.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observation, interview, and record review, the facility failed to ensure a safe and hazard free environment for one of twenty-six sampled residents (Resident 19) when Resident 19's cigarettes and lighter were in her possession and not securely stored.This failure had the potential to affect Resident 19's safety, causing a smoking related injury and fire hazard in the facility, and putting the other residents and staff at risk.Findings:During a review of Resident 19's admission RECORD, dated 6/12/26, the record indicated Resident 19 was admitted to the facility with diagnoses including bipolar (a mental health condition that causes extreme mood swings) and schizoaffective (a mental health condition that causes symptoms like hallucinations or delusions and periods of depression or abnormally elevated mood with intense energy) disorder.During a review of Resident 19's Smoking Safety Evaluation, dated 4/8/26, the evaluation indicated answers to each question as followed: Does Resident have cognitive skill and adequate memory recall noted? No. Resident knows how smoking materials are to be stored? No. Resident can demonstrate proper storage of smoking materials? No. RESIDENT NEED FOR ADAPTIVE EQUIPMENT.Supervision. Notes on Safety from IDT [Interdisciplinary Team, a collaborative group of professionals who work together to manage a patient's care].Reviewed and remains appropriate for supervision. Team Decision.Safe to smoke with supervision.During a review of Resident 19's Care Plan Report (a form where you can summarize a person's health conditions, specific care needs, and current treatments), dated 11/20/25, the care plan indicated, .Supervised smoking times.During a concurrent observation and interview on 6/10/26, at 10:55 a.m. with Resident 19 in her room, Resident 19 was holding a red lighter in her right hand. Resident 19 stated that she kept her own cigarettes and lighter with her in her room.During an interview on 6/12/26, at 9:21 a.m. with the Activity Director (AD), the AD stated that residents who were supervised with smoking do not keep their own cigarettes and lighter. The AD stated that Resident 19 needed supervision while smoking and should not keep her own cigarette and lighter due to lack of cognitive functioning. The AD also stated that Resident 19's smoking materials should be kept in a box at the activity office and would only be given during smoking scheduled time.During a concurrent interview and record review on 6/12/26, at 10:03 a.m. with the AD, an undated current residents smoking list was reviewed. The list indicated there were 10 residents who smoked and 4 out of the 10 were independent and 6 out of 10 were supervised for smoking. Resident 19 was included on the list for supervised smoking. The AD confirmed that the list was correct.During an interview on 6/12/26, at 10:07 a.m. with Resident 19 in her room, Resident 19 stated that staff were aware that she kept her own cigarettes and lighter. Resident 19 also stated that she used the lighter to light her cigarette and was able to do it.During an interview on 6/12/26, at 10:17 a.m. with Certified Nurse Assistant (CNA) 4, CNA 4 confirmed Resident 19 had her cigarettes and lighter with her and went on to say that she was not aware and did not know if Resident 19 was allowed to keep her own smoking supplies.During an interview on 6/12/26, at 10:21 a.m. with the Registered Nurse Supervisor (RNS), the RNS stated that per the Administrator (ADM) the smoking supplies should have been kept in a locked box and not with her.During an interview on 6/12/26, at 1:30 p.m. with the ADM, the ADM stated that Resident 19 should not have the cigarette and lighter with her because it would be a safety issue and increased the risk for fire hazards, burns, or even death.During a review of the facility Policy & Procedure (P&P) titled, Resident Smoking Safety Independent and Unsupervised, dated January 2025, the P&P indicted, .It is the policy of the center to provide a safe environment for residents, staff and visitors.Residents who do not meet the established criteria to smoke independently are aided/ supervised during smoking activities.All smoking materials, including cigarettes, electronic cigarettes and lighters are locked up including smoking materials for residents who are assessed to be a supervised smoker.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on observation, interview, and record review, the facility failed to ensure safe pharmaceutical services with census of 87 residents when:1. Prescription and narcotic medication delivery manifest or receipts from provider pharmacy were not signed by licensed staff for accountability.2. Resident 24 and Resident 4's prescribed medications were not available and not refilled in a timely manner3. Hazardous drugs (medications that may pose health hazard when not handled appropriately) stored in the medication carts were not labeled alerting staff for safe use and handling.These deficient practices had the potential for unsafe medication exposure, medication errors, risk of drug diversion (drug loss) and residents not receiving prescribed medications as a result of unavailability and delay in refill process. Findings:1. During a concurrent observation and interview with the Registered Nurse Supervisor (RNS), and record review on 6/9/26 at 9:50 AM, the medication delivery sheets from provider pharmacy were reviewed. The medication delivery sheets were kept in a binder in an unorganized manner with no marking for signature or date the medications were received. The unsigned medication delivery sheets, titled CONSOLIDATED DELIVERY SHEETS, included both narcotic (opioid/controlled drugs-medications strictly regulated by the government because of their potential for abuse, misuse, and dependence) and prescription medications. The signature section at the bottom of each page marked Checked By, Received by Print Name and Date/Time was empty and unmarked. RNS acknowledged the findings and stated the staff signed the delivery driver's records only. RNS stated although they have not had any issues with missing medications there was a risk for drug diversion and accountability for resident's medication orders.During a joint interview with RNS and the Director of Nursing (DON), on 6/10/26 at 9:45 AM, the RNS stated they had instructed nurses during an in-service meeting to sign the physical delivery sheets to ensure accuracy of drug delivery and prevent risk of drug diversion.During a phone interview with the Pharmacist (Pharm) on 6/12/26 at 10:34 AM, the Pharm stated the facility should sign the manifest (consolidated delivery sheets) in addition to signing on the pharmacy driver records. The pharm added that the driver should have waited for the nurses to sign and that the current practice needed improvement for accountability purposes. The pharm confirmed the practice was for the nurses to sign the manifest upon receiving.During a review of the facility's policy titled, MEDICATION ORDERING AND RECEIVING FROM PHARMACY - IC2: PHARMACY DELIVERY, dated 4/2008, indicated .The dispensing pharmacy will transport medication to the facility in a manner that prevents.diversion of medications.pharmacy provided a method of confirmation of receipt of medications by the courier for each delivery that leaves the dispensing pharmacy.upon arrival at the facility, the courier delivers the medication directly to a licensed nurse.the pharmacy provides a method for both parties to confirm delivery.2a. During a concurrent medication administration observation, and interview with Licensed Nurse (LN) 5 , on 6/9/26, at 8:49 AM, LN 5 was not able to find an eye drop called Artificial Tears (a lubricant eye drop) for Resident 4. LN 5 went to the storage room to get a new supply and could not locate one. LN 5 stated they needed to order the product.The next day, during an interview with LN 4, on 6/10/26 at 9 AM, LN 4 went into the medication storage room to look for the eye drop for Resident 4 and found a different product called Clear Eyes (or Visine, eye drop to reduce eye redness). LN 4 stated they ordered the wrong product. LN 4 stated they did not have the Artificial Tears eye drop to give to Resident 4 for the second day in a row and needed to notify the doctor.2b. During a concurrent medication administration observation, and interview with LN 5, on 6/9/26, at 8:55 AM, LN 5 was not able to find a prescription drug called lactulose (a laxative-it stays in the gut to draw water and soften stools) for Resident 24. LN 5 stated she needed to call the pharmacy for a refill of the prescription.During a follow up interview with LN 5, on 6/9/26, at 12:28 PM, LN 5 stated she had not received the lactulose to administer to Resident 24.The next day, during an interview with LN 4, on 6/10/26 at 9 AM, LN 4 stated he did not have the lactulose yet to give to Resident 24 and was not (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Golden San Andreas Care Center	900 Mountain Ranch Road San Andreas, CA 95249

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	sure why it was not delivered.During a joint interview with the DON and the RNS, on 6/10/26 at 9:45 AM, the RNS stated that if a delay occurred in the medication delivery, they would call the pharmacy to determine why the medications were not delivered on time. The DON stated the prescription medication should have been delivered already. The RNS stated that central supply staff had ordered the non-prescription (Over the Counter, OTC) medication and that the facility should have had the medications available for the residents use. RNS stated they may have ordered the wrong eye drop product due to name confusion.During a phone interview on 6/12/26 at 10:34 AM with the Pharm, the Pharm stated the facility ordered medications via computer and that the pharmacy needed extra time to prepare and deliver the orders. The Pharm recommended ordering at least 3-5 days in advance when possible and noted that urgent requests can usually be expedited by making phone calls to the pharmacy. The Pharm stated the pharmacy delivered drugs to facility on daily basis.During a review of the facility's policy titled, ORGANIZATIONAL ASPECTS - IA1: PROVIDER PHARMACY REQUIREMENTS, dated 4/2008, indicated, .Providing routine and timely pharmacy service seven days per week and emergency pharmacy service 24 hours per day, seven days per week.3. During a concurrent observation and interview on 6/9/26 at 2:24 PM with LN 2, during the medication cart inspection, for B wing, two bottles of Megace (primarily uses as an appetite stimulant) were stored at the bottom drawer. One bottle had a sticker indicating HD (hazardous Drugs) while the other bottle did not have a hazardous drug sticker. The two bottles had reddish-brownish sticky spills on the outer surfaces of the product.Further inspection of the B wing medication cart and the bubble packs (plastic sheet with individual bubbles each holding one pill) section stored hazardous drugs with no HD labeling alert on the products including Finasteride (a hormone drug for treatment of prostate) and Depakote (a seizure medications). LN 2 stated she did not know what HD meant and how to handle this product. LN 2 stated she followed the order in the MAR .During an interview on 6/10/26 at 9:45 AM with the DON and the RNS, the RNS stated that the pharmacy was not consistent in labeling medications with HD. The RNS stated she would send an email to the pharmacy because this was a risk for the nurses and the residents. The DON stated it was important to label all HD drugs with an eye-catching sticker that the nurses can see for safe handling instructions.During a phone interview on 6/12/26 at 10:34 AM, with the Pharm, the Pharm stated her drug regimen review often alerted the facility to include safe handling with use of gloves when hazardous drugs were handled.During a review of the facility's policy titled, MEDICATION ORDERING AND RECEIVING FROM PHARMACY - IC8: MEDICATION LABELS, dated 4/2008, indicated .Medications are labeled in accordance with the facility requirements and state and federal laws.Review of the Center for Disease Control's National Institute for Occupational Safety and Health (CDC, and NIOSH, a federal agency sets standard of safety in health care) document, titled Managing Hazardous Drug Exposures: Information for Healthcare Settings, dated 4/2023, last accessed via https://www.cdc.gov/niosh/docs/2023-130/2023-130.pdf?id=10.26616/NIOSHPUB2023130 and https://www.cdc.gov/niosh/docs/2023-130/default.html , the document indicated Many . drugs intended for individual use can be hazardous to healthcare workers with potential occupational exposure to those who handle, prepare, dispense, administer, or dispose of these drugs. Workplace exposure to hazardous drugs can result in negative acute and chronic health effects in healthcare workers including adverse reproductive outcomes. PPE (or Personal Protective Equipment, items like glove or mask) provides worker protection to reduce exposure to hazardous drugs. Efforts should be made to reduce all worker exposures to hazardous drugs. Occupational exposure to hazardous drugs merits serious consideration, as workers may be exposed daily to multiple hazardous drugs over many years. Further review of the document indicated to use single glove for handling intact tablet form and double glove for handling oral liquid form of the hazardous medications as directed.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident?s drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to document and provide clinical justification or expert consultation for switching a blood thinner (rivaroxaban or Xarelto, medication that prevents or slows down the clotting of blood by interfere with the chemical processes that cause blood to clot, helping prevent life-threatening conditions) to an anti-platelet medication (clopidogrel or Plavix, medications that prevent blood cells called platelets from sticking together & primarily used to prevent and treat heart attacks in people with heart disease) for treating recurrent and active blood clot in one out of five residents reviewed for unnecessary drugs (Resident 3). This failure could contribute to ineffective treatment and risk of blood clot formation leading to serious health complications.Findings: Review of Resident 3's clinical record and the admission diagnosis information, dated 6/12/26, the record indicated Resident 3 was admitted with arthritis of the knee with chronic pain, immobility, morbid obesity, history of Pulmonary Embolism (or PE, blood clot in lungs) and recurrent DVT (Deep [NAME] Thrombosis- Blood clot in the legs). The record further indicated Resident 3 was re-admitted to the hospital on [DATE] with another blood clot in left leg and hematoma (localized collection of pooled blood outside of a blood vessel) in her left hip and pelvis area after using enoxaparin injection (a blood thinner in the injection form). Review of Resident 3's clinical record, titled Discharge Summary from the hospital, dated 5/19/26, the record indicated Resident 3 had a nonocclusive thrombus in the left common femoral (an artery in leg) in addition to a left psoas hematoma without evidence of active extravasation (muscle bruise on left side of upper body and hip) and no active bleeding. The record under Discharge Plan indicated to continue rivaroxaban (Xarelto)15 mg twice daily with meals (mg is milligram, a unit of measurement). Review of Resident 3's medical records including the Medication Administration Record (or MAR) and hospital records, dated 5/2026 and 6/2026, the records indicated the following medication and hospitalizations timelines:Xarelto 20 mg once daily from 4/28/26 to 5/6/26emergency room visit on 5/7/26Enoxaparin 100 mg injection (blood thinner in shot/injection form) Twice daily from 5/8/26 to 5/14/26Hospitalization from 5/14 to 5/19/26 (where hematoma and blood clot discovered) Xarelto 15 mg twice daily from 5/19/26 to 5/28/26Xarelto marked OOO (On Order from Pharmacy) for 5/29, 5/30, 5/31 and 6/1/26, 6/2/26 and 6/3/26.Plavix (clopidogrel) 75 mg daily for blood clot prevention related to personal history of pulmonary embolism from 6/1/26 to current. The records did not have any provider, doctor's note or clinical justification for changing Xarelto to Plavix. During a concurrent interview on 6/11/26 at 2:12 PM, with nurse supervisor (RNS) and review of Resident 3's medical records under Nursing Notes, dated 6/3/26, the note indicated PA [redacted, Physician Assistant] gave order for Therapeutic Interchange (means use of a chemically different medication that is therapeutically equivalent and belongs to the same pharmacological class as the originally prescribed drug) for Rivaroxaban to Clopidogrel. Resident notified and agreeable to the change. the RNS stated the order was placed in the computer through a verbal order (taken by a nurse) and later co-signed by PA. In an interview with PA, on 6/11/26 at 4:27 PM, the PA stated he authorized the change from rivaroxaban to clopidogrel. The PA stated both drugs accomplished the same end results with less bleeding based on his experience. PA stated he was aware of hospital discharge orders to continue rivaroxaban and did not document or write any clinical justification for change. The PA stated he was aware the two drugs were not therapeutically equivalent and they served different indications (used or officially approved to treat multiple, distinct medical conditions). In a telephone interview with Medical Director (MD), on 6/12/26 at 8:40 AM, the MD stated two drugs (rivaroxaban and clopidogrel) were very different and risk versus benefits should have been documented. MD stated clinical justification should have been documented and the reasoning behind the change due to high-risk nature of the blood clot and the drugs. In a telephone interview with facility's Consultant Pharmacist (Pharm), on 6/12/26, at 10:36 AM, the Pharm stated the two drugs were two different classes of (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	medications and for an active blood clot and recurrent blood clot, the blood thinner as an anticoagulant was recommended. Pharm stated switching rivaroxaban to clopidogrel was not a therapeutic interchange. Pharm was not sure why the change was ordered.Facility did not provide a policy on medical provider and director's roles and responsibility. Review of DailyMed (drug information site by US National Institutes of Health, NIH, which provides trustworthy information about marketed drugs) drug labeling information on clopidogrel, last accessed on 6/15/26 via https://dailymed.nlm.nih.gov/dailymed/lookup.cfm?setid=86ee71f2-850e-4c8e-87f3-c7a618d59d95, the record indicated the approved indication and usage .INDICATIONS AND USAGE: Acute Coronary Syndrome (ACS, a group of heart conditions-including heart attacks that involve sudden, reduced blood flow to the heart muscle) and Recent MI (heart attack), Recent Stroke, or Established Peripheral Arterial Disease (plaque builds up in the arteries that carry blood) . Review of DailyMed drug labeling information on rivaroxaban, last accessed on 6/15/26, via https://dailymed.nlm.nih.gov/dailymed/lookup.cfm?setid=10db92f9-2300-4a80-836b-673e1ae91610, the record indicated the approved indication usage was treatment and prevention of blood clots during DVT, PE and dangerous blood rhythms (when the heart's electrical system malfunctions, causing it to beat too fast, too slow, or irregularly) among others.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. Based on observation, interview, and record review, the facility failed to ensure that all drugs and biologicals were properly labelled and stored in the medication and treatment carts to ensure they remain effective and safe for use with a resident census of 87 when:1. Medication cart in C wing stored an unlabeled insulin glargine pen (Long-acting insulin in pen shape help reduce blood sugar) for Resident 100 which did not have a pharmacy prescription label. The resident's name was handwritten on the product with a permanent marker.2. Medication cart in B wing stored a box of single use eye drops called Dorzolamide-Timolol ophthalmic solution (eye drop used to treat an eye disease called Glaucoma) and was found in the medication cart out of its foil wrap without an opened date marking. 3. Treatment cart at the main station stored opened bottles of sterile normal saline (germ-free salt solution used for wound care) and an open single-use Soft Foam Dressing (wound care item) in the active storage areas of the treatment cart.These failures had the potential to cause medication errors, reduced medication effectiveness, and increase the risk of infection for the residents in the facility.Findings:1. During a concurrent observation and interview with Licensed Nurse 1 (LN 1), on 6/9/26, at 11:58 AM, in the C wing, the medication cart stored insulin glargine for Resident 100 which did not have a pharmacy label with resident name or direction. The insulin pen was marked with a handwritten marking on the side of the pen with a permanent marker. LN 1 stated she was not sure why the insulin pen did not have a patient label and the Ziplock bag used to store the medication was missing from the cart.During an interview with the Director of Nursing (DON) and the RNS, on 6/10/26 at 9:45 AM, the RNS stated that residents should have their own insulin pen with a pharmacy label. The RNS further stated she would not administer an insulin pen without a label because it posed a risk for medication error and infection control. Both the DON and the RNS acknowledged this practice would increase the risk of medication error during medication administration.During a telephone interview on 6/12/26 at 10:34 AM with the Pharmacist (Pharm), the Pharm stated medications should have a label from the pharmacy, and the label may have fallen off or inadvertently been ripped off of the product. Pharm stated they could always ask for a new product if needed.During a review of the facility's undated policy titled MEDICATION ORDERING AND RECEIVING FROM PHARMACY - IC8: MEDICATION LABELS indicated, .Medications are labeled in accordance with facility requirements and state and federal laws. Only the dispensing pharmacy can modify or change prescription labels.labels are permanently affixed to the outside of the prescription container.the resident's name, at least, must be maintained directly on the actual product container.Medication containers having soiled, damaged, incomplete, illegible, confusing, or makeshift labels are returned to the dispensing pharmacy for relabeling or destroyed in accordance with the medication destruction policy.2. During a concurrent observation and interview, on 6/9/26 at 2:24 PM, with LN 2, medication cart on B wing was inspected. The cart stored an opened box of an eye drop called Dorzolamide -Timolol that was out of the foil wrap and did not have a marking on it to show when it was opened. LN 2 stated she was unsure when the medication pouch was opened. LN 2 reviewed the manufacturer's instructions on the box, which stated to .Throw away any unused single-use containers 15 days after first opening the pouch .During an interview on 6/10/26 at 9:45 AM with the Director of Nursing (DON) and the RNS, the RNS stated she thought the Dorzolamide HCl-Timolol Maleate eye drops were individually packaged. The RNS further stated that using the medication beyond the manufacturer's 15-day beyond-use date after opening the pouch could result in reduced effectiveness.During a review of the facility's policy titled MEDICATION STORAGE IN THE FACILITY under ID1: STORAGE OF MEDICATIONS dated 4/2008 indicated, .Outdated, contaminated, or deteriorated medications. are immediately removed from stock, disposed of according to procedures for medication disposal, and reordered from the pharmacy if a current order exists.3. During a concurrent observation and (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	interview, on 6/9/26 at 2:26 PM, with the Registered Nurse Supervisor (RNS), the Treatment cart stationed at the main nursing station was inspected. The treatment cart stored two open and used bottles of normal saline and an opened sterile single-use Soft Foam Dressing inside the active storage areas of the treatment cart. The label on the normal saline bottle and foam dressing packet indicated they were single use and sterile. The RNS stated that the dressing was sterile and should not be used. RNS stated the saline solution should have been tossed after one time use.During an interview on 6/10/26 at 9:45 AM with the Director of Nursing (DON) and the RNS, the RNS stated they did not know when the normal saline bottle and foam dressing had been opened. The RNS further stated that the normal saline was for single use only and would have been discarded after use for safe practice and infection control. The same applied to the foam dressing because it was no longer sterile once opened.During an interview on 6/10/26 at 12:40 PM with the Infection Preventionist (IP), the IP stated that normal saline bottles and single-use foam dressings found in the treatment cart should have been discarded because they were no longer sterile once opened and could increase the risk of infection.During an interview on 6/10/26 at 12:59 PM with the Treatment Nurse (TN) the TN stated, she did not know why the opened normal saline bottle and opened single-use silicone foam dressing were kept in the treatment cart. The TN further stated that these opened items were not supposed to be kept in the treatment cart because they were no longer sterile and posed a risk of infection. During a review of the facility's policy titled PREPARATION AND GENERAL GUIDELINES - IIA3. VIALS AND AMPULES OF INJECTABLE MEDICATIONS, dated 4/2008, indicated . single-use vials (containing no preservatives) are discarded immediately after use.During a review of the facility's policy titled MEDICATION STORAGE IN THE FACILITY - ID1: STORAGE OF MEDICATIONS, dated 4/2008, indicated .M. Outdated, contaminated, or deteriorated medications and those in containers that are cracked, soiled, or without secure closures are immediately removed from stock, disposed of according to procedures.A review of the Centers for Disease Control (CDC) Guidelines, Recommendations 18.b, 18.e and 18.f titled, Infection Control: Recommendations for Disinfection and Sterilization in Healthcare Facilities, dated 12/7/2023, indicated, .Store sterile items so the packaging is not compromised (e.g., punctured, bent). Evaluate packages before use for loss of integrity (e.g., torn, wet, punctured). The pack can be used unless the integrity of the packaging is compromised. If the integrity of the packaging is compromised (e.g., torn, wet, or punctured), repack and reprocess the pack before use.https://www.cdc.gov/infection-control/hcp/disinfection-sterilization/summary-recommendations.html

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F 0841 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Designate a physician to serve as medical director responsible for implementation of resident care policies and coordination of medical care in the facility. Based on interview and record review the facility failed to carry out physician orders on two (Resident 1 and Resident 3) out of five residents reviewed for unnecessary drugs.These failures could have contributed to unsafe care and not following the physician orders for the treatment of medical problems. Findings: 1. A review of Resident 1's electronic medical record, titled admission Record; Diagnosis Information indicated Resident 1 had diagnosis of anemia (blood condition where body lacks enough healthy red blood cells to carry adequate oxygen to your tissues), low thyroid level, depression, high blood pressure and fracture of thighbone among others.A review of Resident 1's medical record under laboratory work, titled Complete Blood Count . (blood test for anemia and immune system), dated 3/10/26, the paper record indicated low level of hemoglobin (Hemoglobin, an iron-rich protein in red blood cells that carries oxygen to the rest of the body) in addition to abnormal level of other markers for anemia. The paper record had three handwritten orders for Iron pill (a supplement that helped produce red blood cells), Vitamin C (a vitamin that helped increase Iron absorption) and Vitamin B-12 (an essential vitamin for a healthy red blood cell and nervous system). The paper record for laboratory and drug orders was signed by a provider's Physician Assistant (PA).In a concurrent interview with Nurse Supervisor (RNS), on 6/11/26 at 2:12 PM, and review of Resident 1's electronic medical records, RNS stated she could not find any order entered in electronic health record for these three orders. RNS stated she was not sure why these orders were not communicated to nursing staff to get entered into the computer.In an interview with Physician Assistant (PA), on 6/11/26, at 4:27 PM, the PA stated he was not sure why orders were not carried out. The PA stated facility did not have an order sheet form for new orders, and he acknowledged signing the paper sheet and writing the orders on the lab sheet. The PA stated he often brought up any changes or orders to the attention of nursing staff. The PA stated he did not enter orders on a computer and had a program on his phone to approve the orders.In an interview with Medical Director (MD), on 6/12/26, at 8:40 AM, the MD stated the providers had access to facility's computer system and were able to enter orders in the computer system. The MD stated it was a shared responsibility to make sure all orders were entered into medical records on timely manner and he preferred the provider to enter the orders if feasible.2. A review of Resident 3's electronic medical record, titled admission Record; Diagnosis Information indicated Resident 3 had history of blood clots, morbid (severe) obesity, and arthritis among others.A review of electronic medical record, titled History and Physical (H&P), dated 4/29/26, the handwritten paper record by Medical Doctor 2 (MD 2) indicated a new drug order as follow: Start Zepbound 2.5 mg (or tirzepatide, an injectable prescription medication used for chronic weight management; mg is milligram, a unit of measure) weekly. Further review of the electronic records, including nursing notes, medical providers follow-up notes, did not show if this order was addressed or carried out.In a concurrent interview with Director of Nursing (DON) and RNS, on 6/11/26 at 2:12 PM, Resident 3's electronic medical record was reviewed. RNS stated she could not find any notes or documentation if the order for Zepbound was carried out. RNS stated the nursing staff did not see the new order listed at the bottom of the H&P sheet to address and input in the computer. RNS stated the medical doctor should have informed the nursing of the new order.In an interview with Medical Director (MD), on 6/12/26, at 8:40 AM, the MD stated the providers had access to facility's computer system and are able to enter orders in the computer system. The MD stated it was a shared responsibility to make sure all orders were entered into medical records on timely manner and he preferred the provider to enter the orders if feasible.Facility did not provide a policy on medical provider and director's roles and responsibility.Review of the facility policy, titled Medication administration-General Guidelines, dated 10/2017, the policy indicated, Medications are administered as prescribed in accordance with good nursing principles and practices. The policy under administration indicated Medications are administered in accordance with written orders of the attending physician. Medications are administered without unnecessary interruptions.

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on observation, interview, and record review, the facility failed to maintain accurate and complete medical records for 1 of 26 sampled residents (Resident 17) when Resident 17's Documentation Survey Report (form used by Certified Nurse Assistants (CNA) to document patient care and report observations as a proof that required care was provided) did not reflect activities were provided on daily basis from 5/1/26 through 5/31/26.This failure had the potential to not provide sufficient information that reflected Resident 17's activity participation on a daily basis.Findings: During a review of Resident 17's admission RECORD indicated Resident 17 was admitted to the facility with diagnoses including parkinsonism (neurological disorders that cause slowed movement, rigidity, and tremors), difficulty walking, and muscle weakness. During a review of Resident 17's Minimum Data Set (MDS, an assessment tool), dated 5/27/26, the MDS revealed a BIMS (Brief Interview for Mental Status) score of 9 out of 15 indicating a moderate problem with thinking, learning, and memory. During a review of Resident 17's undated Care Plan Report (a form where you can summarize a person's health conditions, specific care needs, and current treatments), the report indicated that Resident 17 needed encouragement and assistance to attend group or social activities. This report also indicated activity staff will visit her to invite, encourage and assist her to group activities she might enjoy. During an observation on 6/10/26, at 10:30 a.m. in Unit A hallway, Resident 17 was taken back to her room and transferred from her wheelchair back to her bed. Resident 17 remained in her room and did not go back to the activities. During a concurrent interview and record review on 6/11/26, at 2:13 p.m. with the Activity Director (AD), Resident 17's Documentation Survey Report, dated from 5/1/26 through 5/31/26 was reviewed. The AD confirmed the report indicated on 5/3/26, 5/4/26, 5/10/26, 5/14/26, 5/20/26, 5/25/26, 5/26/26, and 5/29/26, Resident 17 was recorded to have participated or observed activities. The AD verified all the other days reflected Resident 17 had no activities provided. The AD stated activities were offered every day for 7 days and Resident 17 attended group activities as an observer and seldom as a participant. The AD added that when Resident 17 was not in activities, she spent time with a family member visiting. The AD explained that activities attended, whether in group or family visits, should have been documented on days that it occurred to indicate what Resident 17 did since activities were offered every day. The AD stated there should be activities recorded on those days that reflected with no activity participation because it would mean that no activities were provided which could lead to depression when Resident 17 was left alone, there would be lack of stimulation, and could possibly affect her well-being. The AD stated she expected the activity assistant to record when residents attended activities or offered any kind of activities. During an observation on 6/11/26, at 8:09 a.m. Resident 17 was up in her wheelchair and seated in front of the facility's aviary next to the nurses' station dozing off and did not respond to greetings. During an interview on 6/12/26, at 1:30 p.m. with the Administrator (ADM), the ADM stated there should be documentation or a record of activities on days that activities were offered to give credit to what the activity staff were providing. The ADM further stated that when activities were not documented then activities were not done. During a review of the facility's Policy & Procedure (P&P) titled, Activity Program, dated July 2015, the P&P indicated, .The Center provides an ongoing program of activities designed to meet the interests as well as physical, mental, and psychosocial well-being of each resident.