

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

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056136	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/23/2026
NAME OF PROVIDER OR SUPPLIER Villa Mesa Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 867 E. 11th St Upland, CA 91786	
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 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure care and monitoring were maintained for two of two sampled residents (Resident 23 and 4) reviewed for pressure ulcers (injury to skin and underlying tissues that develop because of prolonged pressure, shear (skin tissues slide in opposite directions when sticks to a surface), or friction) when: 1. For Resident 23, there was no documented evidence of wound treatments for Left Iliac Crest (thick, curved bony ridge at the very top of the hip bone), PI (Pressure Injury), change in condition, physician orders for January 7, 2026 through January 16, 2026, IDT meeting (Interdisciplinary Team meeting - a meeting where different professionals come together to discuss a patient's care) and care plan, to address Resident 23's unstageable (when the base of the wound is covered by a layer of dead tissue and it is not possible to determine the stage (classifying wounds)) PI prior to January 21, 2026.2. Resident 4's moisture associated skin damage (MASD- a condition caused by repeated exposure to bodily secretions such as urine resulting in skin breakdown) had no documented evidence of assessments, monitoring, treatments, and interventions. These failures resulted in Resident 23's worsening pressure injury being undetected and Resident 4 MASD left unaddressed, placing both residents at higher risk for infection, development of new pressure ulcers, and delayed wound healing. 1. During a record review of Resident 23's admission Record (contains demographic and medical information), it indicated, Resident 23 was admitted to the facility on [DATE], with diagnoses which included, Parkinson's disease with dyskinesia (a progressive disorder that affects the nervous system, causing involuntary, jerky, or writhing movements) dysphagia (difficulty swallowing), dementia (a condition characterized by the decline mental ability, affecting memory, thinking and language interfering with daily life), heart failure (a condition in which the heart muscle is too weak or stiff to effectively pump enough oxygen). During an observation and interview on January 20, 2026, at 4:00 PM, in Resident 23's room, with Treatment Nurse 1 and 2 (TX 1 and TX 2), Resident 23 was lying on bed with the eyes open. TX 1 and TX 2 positioned Resident 23 to his right side. There was a brown dressing covering his left iliac crest area (top, outer edge of the left hip bone), undated. TX 1 stated, we don't date the dressing when we do treatments, and proceeded to remove the dressing from Resident 23's left iliac crest area. An open wound with black colored edges appeared dry with yellow color slough (a yellowish, soft, stringy, or creamy dead tissue found in wounds) in the center of the wound, was noted. TX 1 stated, Resident 23's wound was unstageable with yellow slough in the center and eschar (a thick, dry, black or brown layer of dead tissue that forms over deep wounds or pressure ulcers). TX 1 and TX 2 stated they were not sure when the last wound treatment was rendered. TX 1 further stated Resident 23's wound treatment was not done today (January 20, 2026). During a record review of facility provided document for Resident 23's titled, physician's orders, a verbal order dated December 31, 2025, it indicated (Treatment) Left iliac Crest, PI (Pressure Injury). (continued on next page)		

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 0686 Level of Harm - Actual harm Residents Affected - Few	The DON acknowledged the policy and stated it had not been followed. ADMIN stated staff should be following the facility policy. The DON acknowledged there were no documented treatments for January 7, 2026, through January 16, 2026, and there was no change in Resident 23's condition, IDT meeting notes and care plan documentation before January 20, 2026. The DON further stated that treatment nurses are responsible for renewing treatment orders and informed the physician about residents' wounds change in condition. 2. During a review of Resident's 4 admission Records (contains demographic and medical information) it indicated, Resident 4 was admitted to the facility on [DATE], with diagnoses which included pressure ulcer of sacral region (at the bottom of the spine), stage 4 (a wound involving full-thickness tissue loss where skin, fat, and deeper tissues are gone, exposing underlying muscle, tendon, or bone), sepsis (a life threatening medical emergency caused by the body's extreme response to an infection), and neuromuscular dysfunction of bladder (a dysfunction of the bladder muscle resulting in an inability to properly store or empty urine). During a review of Resident's 4's clinical records, the Physician Note (contains history and physical information), dated September 24, 2025, it indicated Resident 4 does not have capacity to make and understand medical decisions. During a review of Resident's 4 Braden scale for predicting pressure sore risk (a tool used to assess a patient's risk of developing pressure injuries (bedsores)), dated August 28, 2025, it indicated Resident 4 was at a high risk for developing pressure sore with a score of 11 out of 18 (range for high risk is 10-12). During a concurrent observation and interview on January 22, 2026, at 9:54 AM, with the wound treatment nurse (TX 1) and a Certified Nursing Assistant (CNA 2), Resident 4 was lying in bed. The TX 1 and CNA 2 turned Resident 4 to his left side. Resident 4 had a wound vacuum (tool used to suction drainage from a wound) attached to his sacral region (tailbone). On the left buttock was a foam dressing, the TX 1 removed the dressing and revealed a pink tinged skin wound with dark bruising around the edges. The TX 1 stated it was an MASD and there were wound care orders in place. During a review of Resident 4's clinical records, the document titled Section M-Skin Conditions (resident assessment instrument that gathers information regarding a resident's skin integrity), dated November 28, 2025, the section M-skin conditions indicated . M1040: Other ulcers, Wounds, and Skin Problems. H. Moisture Associated Skin Damage (MASD) (e.g., incontinence-associated dermatitis - (IAD - skin damage, caused by prolonged exposure to urine, feces, or both), perspiration, drainage) was checked. During a review of Resident 4's clinical records, the document Section GG-Functional Abilities- OBRA (Omnibus Budget Reconciliation Act of 1987 - It requires to conduct comprehensive assessments for all residents to ensure quality of care, focusing on resident safety, rights, and proper placement)/Interim, dated November 28, 2025, section GG-functional abilities indicated Resident 4 is dependent on toileting hygiene and transfers. During a review of Resident 4's Skin Observation Tool-V2 dated December 31, 2025, there was no documentation of Resident 4's MASD on the left buttock. (continued on next page)		

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F 0686 Level of Harm - Actual harm Residents Affected - Few	During a review of Resident 4's Skin Observation Tool-V2 dated January 07, 2026, there was no documentation of Resident 4's MASD on the left buttock. During a review of Resident 4's Skin Observation Tool-V2 dated January 12, 2026, there was no documentation of Resident 4's MASD on the left buttock. During a review of Resident 4's Skin Observation Tool-V2 dated January 13, 2026, there was no documentation of Resident 4's MASD on the left buttock. During a concurrent interview and record review on January 23, 2026, at 9:20 AM, with the Assistant Director of Nursing (ADON), Resident 4's Change in Condition- SBAR Communication Form - Situation, Background, Assessment, Recommendation, a structured communication tool used in healthcare to quickly and clearly convey critical patient information), dated January 22, 2026, was reviewed. The SBAR communication form addressing the MASD was started on January 22, 2026. ADON acknowledged the SBAR communication form addressing MASD on Patient 4's left buttock was not initiated prior to January 22, 2026. During a concurrent interview and record review on January 23, 2026, at 9:22 AM, with the ADON, Resident 4's Treatment Administration Record (TAR- document used to record treatments administered to the residents) for the month of December 2025, and January 2026, was reviewed. The TAR indicated a treatment order for left lower buttock MASD: Cleanse w/NS (normal saline-solution used to clean wound), pat dry, apply ointment and cover w/dd (dry dressing), every day shift for wound management for 14 days. The order started on January 22, 2026. The ADON stated there was no treatment order prior to January 22, 2026. During a review of Resident 4's Care Plan dated January 22, 2026, there was no focus, goals, and interventions for Resident 4's MASD. During a review of Resident 4's Order Summary Report, dated January 22, 2026, indicated there was no treatment order for Resident 4's MASD on the left buttock. During a follow-up interview on January 23, 2026, at 11:49 AM, with TX 1, TX 1 stated there was no treatment order addressing Resident 4's MASD on the left buttock, prior to January 22, 2026. TX 1 further stated a change of condition and care plan was created on January 22, 2026. During a concurrent interview and record review on January 23, 2026, at 4:17 PM, with the ADON, the facility's policy and procedure (P&P) titled, Wound Care/Skin Management, revised October 2010, was reviewed. The P&P indicated, .Preparation. 1. Verify that there is a physician's order for this procedure. 2. Review the resident's care plan to assess for any special needs of the patient. The ADON stated the P&P was not followed. During a concurrent interview and record review on January 23, 2026, at 4:19 PM with the ADON, the facility's policy and procedure (P&P) titled, Change in a Resident's Condition or Status, revised February 2021, was reviewed. The P&P indicated, Our facility promptly notifies the resident, his or her attending physician, and the resident representative of changes in the resident's medical/mental condition and/or status. 2. A significant change of condition is a major decline or improvement in the resident's status. 3. Prior to notifying the physician or healthcare provider, the nurse will make detailed observations and gather relevant and pertinent information for the provider, including (for example) information prompted by the Interact SBAR Communication Form. 6. Regardless of the (continued on next page)		

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F 0686 Level of Harm - Actual harm Residents Affected - Few	resident's current mental or physical condition, a nurse or healthcare provider will inform the resident of any changes in his/her medical care or nursing treatments. The ADON stated the P&P was not followed. During a concurrent interview and record review on January 23, 2026, at 4:21 PM with the ADON, the facility's policy and procedure (P&P) titled, Care Plans, Comprehensive Person-Centered, revised March 2022 was reviewed. The P&P indicated, .Assessments of residents are ongoing, and care plans are revised as information about the residents and the residents' conditions change. The ADON stated the P&P was not followed.		

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record reviews, the facility failed to ensure one of one sampled resident (Resident 61) was provided with a dignified experience when the Infection Preventionist (IP) nurse was standing while assisting Resident 61 to eat. This failure has the potential to cause Resident 61 to feel disrespected and negatively affect their psychosocial well-being and individuality. During a review of Resident 61's admission Record (clinical record with demographic information), the admission Record indicated, Resident 61 was admitted to the facility on [DATE], with diagnoses which included, of dysphagia (difficulty swallowing), hemiplegia (paralysis on one side of the body) and dementia (impaired memory, judgment, and ability to understand or communicate needs.) During an observation on January 20, 2026, at 12:24 PM, in the dining area, the facility's Infection Preventionist (IP) nurse assisted Resident 61 with lunch. IP nurse was standing while Resident 61 was seated in a wheelchair at a dining room table. IP nurse was feeding Resident 61 with noodle soup using a spoon while remaining standing. During an interview on January 20, 2026 at 12:29 PM, with the IP nurse, the IP nurse, stated that when providing feeding assistance to a resident, staff should be seated at the resident's level for safety to help prevent aspiration (the possibility that food or liquid may enter the airway instead of the stomach during swallowing, which can cause choking, coughing or breathing problems). During a concurrent interview and record review on January 23, 2026, at 10:13 AM, with the Assistant Director of Nursing (ADON), the facility's policy and procedure (P&P) titled Assistance with Meals, revised March 2022, was reviewed. The P&P indicated, Dining Room Residents. 3. Residents who cannot feed themselves will feed with attention to safety, comfort and dignity, for example: a. not standing over resident while assisting them with meals; The ADON stated staff should not stand over residents while assisting with meals and confirmed that the staff did not follow the facility's policy.		

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to accurately code the Minimum Data Set Assessment (MDS- a computerized assessment instrument) for one resident (Resident 92) reviewed for history of falls. This failure had the potential to cause inaccuracy in identifying Resident 92's care and support needs. During a review of Resident 92's clinical record, the admission Record (contains demographic and clinical data), the admission Record indicated Resident 92 was admitted to the facility on [DATE], with diagnoses which included generalized (overall body) muscle weakness, Dementia (noticeable, worsening loss of brain function, including memory, thinking, language, and judgment, that goes beyond normal aging), and adult failure to thrive (downward spiral of health and ability). During a review of Resident 92's MDS Quarterly Assessment (an assessment for a resident that must be completed every 92 days following the previous assessment), dated January 5, 2026, the MDS Quarterly Assessment under Section J titled Health Conditions indicated Resident 92 had a history of fall with injury (coded 1). During a concurrent interview and record review on January 22, 2026, at 2:25 PM, with the MDS Nurse, Resident 92's MDS Quarterly Assessment, dated January 5, 2026, was reviewed. The MDS's Quarterly Assessment under Section J titled Health Conditions indicated, Resident 92 had a history of fall with injury which was entered as 1 in J1900. The MDS Nurse stated, It [Section J-Health Conditions] was incorrectly coded as a fall. The MDS Nurse further stated, There is no history of fall with this resident in this facility. The MDS Nurse further stated, the facility was supposed to follow the Resident Assessment Instrument (RAI- instruction manual for assessing a nursing home resident's health, needs, and strengths to create a personalized care plan) manual for instructions on how to code the residents correctly in the MDS, but it was not followed. During an interview on January 23, 2026, at 10:50 AM, with the Director of Nursing (DON), the DON stated the MDS Nurse did not code Resident 92's fall correctly and should have coded it as no falls. The DON further stated, they do not have a policy, but they follow the RAI manual. During a review of the CMS's (The Centers for Medicare & Medicaid Services) RAI version 3.0 manual revised October 2025 indicated, . J1700: Fall History on Admission/Entry or Reentry (cont.)-Steps for Assessment 1. Ask the resident and family or significant other about a history of falls in the month prior to admission and in the 6 months prior to admission. 2. Review inter-facility transfer information (if the resident is being admitted from another facility) for evidence of falls. 3. Review all relevant medical records received from facilities where the resident resided during the previous 6 months; also review any other medical records received for evidence of one or more falls. Code 0, no. Code 1, yes .		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to develop and implement a comprehensive, person-centered care plan (a summary of a resident's health conditions, specific care needs, and current treatments) addressing identified medical needs for two of two sampled residents (Residents 11 and 14), when: 1. Resident 11's care plan for intravenous (IV) therapy (a method of giving fluids or medications directly into a vein), initiated on January 12, 2026, did not address monitoring, nursing interventions, or measurable goals. 2. Resident 14, admitted on hospice services (specialized care that provides physical comfort and emotional, social and spiritual support for people nearing the end of life) since June 10, 2025, did not have a comprehensive care plan addressing hospice service, including goals of care, palliative interventions, or coordination of services. These failures had the potential to result in inadequate planning, monitoring, and coordination of care, placing residents at risk for unmet medical needs, or complications related to intravenous therapy, unmanaged symptoms, and decreased quality of life consistent with resident's goals, preferences, and current clinical condition. 1. During a review of Resident 11's admission Record (contains demographic and medical information), it indicated Resident 11 was admitted to the facility on [DATE], with diagnoses which included protein-calorie malnutrition (a condition where the body does not receive enough calories or protein to maintain normal body function), metabolic encephalopathy (a brain dysfunction caused by illnesses, chemical imbalances, or toxins resulting in symptoms like confusion, delirium, and coma). During an observation on January 20, 2026, at 1:18 PM, in the hallway outside room [ROOM NUMBER], Resident 11 was sitting in a Geri chair (a specialized chair designed for residents who need support with sitting, positioning and safety), with an IV (intravenous - via vein) fluid labeled 0.9% Normal Saline IV solution, (a sterile salt - water solution with the same salt concentration as the body, commonly used to provide hydration through an IV) 1000 mL (mL - unit of fluid measurement) with instructions to infuse at 50 mL per hour intravenously, continuously. During an interview on January 20, 2026, at 3:29 PM, with the License Vocational Nurse, (LVN 1), LVN 1 stated Resident 11 had poor venous access and nursing staff were unable to obtain IV access in the upper extremities due to veins repeatedly blowing. The LVN 1 further stated that the physician was notified, and an physician order was obtained authorizing placement of the IV in the lower extremity for hydration. The LVN 1 further stated that the lower extremity is uncommon and is performed only when upper - extremity access is not possible and when ordered by the physician. During a concurrent interview and record review on January 23, 2026, at 10:18 AM, with the Assistant Director of Nurses, ADON, the Physician Orders dated, January 12, 2026, at 1:22 PM was reviewed. The physician orders indicated May have IV access to lower extremity. The ADON acknowledged the order was initiated on January 12, 2026. During a concurrent interview and record review on January 23, 2026, at 10:21 AM, with the ADON, Resident 11's care plan, dated January 12, 2026, was reviewed. The care plan indicated, focus (Name of Resident 11) has poor IV access and at risk for poor tissue perfusion r/t (related to) malnutrition. The ADON confirmed that the care plan was initiated on January 12, 2026; however, the care plan was not fully completed and was reviewed on January 21, 2026. The ADON further confirmed that the care plan lacked measurable goals and did not include defined outcomes to evaluate the effectiveness of nursing interventions. The ADON stated that in nursing measurable goals and outcomes are important to guide care and to assess whether interventions are effective for the resident. During a concurrent interview and record review on January 23, 2026, with the ADON, the facility's policy and procedure (P&P) titled Goals and Objectives, Care Plans, revised April 2009, was reviewed. The P&P indicated, Care plans shall incorporate goals and objectives that lead to the resident's highest obtainable level. 3. Care plan goals and objectives are derived from information contained in the resident's comprehensive assessment and: a. are resident oriented; b. are (continued on next page)		

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

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056136	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/23/2026
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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	behaviorally stated; c. are measurable; and d. contain timetables to meet the resident's needs in accordance with the comprehensive assessment. The ADON confirmed that although the care plan for Resident 11 was initiated on January 12, 2026, the care plan lacked measurable goals and outcomes. The ADON further stated that measurable goals are important in nursing to evaluate the effectiveness of interventions and resident outcomes to address Resident 11's IV care needs. 2. During a review of Resident 14's admission Record (contains demographic and medical information), it indicated Resident 14 was admitted to the facility on [DATE], with the diagnoses which included encounter palliative care (care focused on comfort, pain relief, and quality of life rather than curing illness), dementia (a condition causing severe memory loss and inability to think communicate, or care for oneself) and protein-calorie malnutrition (not getting enough calories or nutrients, leading to weight loss, weakness, and poor healing).During a review of the Resident 14's Physician Orders, dated June 10, 2025, the physician orders indicated, Admit to (name of hospice) under RC (resident condition) DX (diagnosis): Alzheimer's Disease (a progressive brain disease that causes worsening memory loss, confusion, inability to communicate, and loss of ability to perform daily activities).During a concurrent interview and record review on January 23, 2026, at 10:26 AM, with the ADON, the ADON reviewed Resident 14's clinical records. The ADON acknowledged that no comprehensive care plan addressing hospice care was found in the electronic records. The ADON stated hospice residents are expected to have a care plan addressing the comfort measures and coordination with the hospice services.During a concurrent interview and record review on January 23, 2026, at 10:31 AM, with the ADON the facility's policy and procedure (P&P) titled, Care Plans, Comprehensive Person-Centered, Revised March 2022. The P&P indicated, . 2. The comprehensive, person-centered care plan is developed within seven (7) days of the completion of the required MDS assessment (Admission, Annual or Significant change in Status(and no more than 21 days after admission. The ADON confirmed that this expectation was not met for the resident.		

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure nutritional status was monitored for one of eight sampled residents (Resident 47) reviewed for weight loss, when Resident 47's weight loss was not addressed from November 6, 2025, through January 19, 2026. This failure had the potential to result in delayed treatment, increased risk for unmet nutritional needs, further weight loss, decline in function status, and compromised overall health and well-being. During a review of Resident 47's admission Record (clinical record with demographic information), the admission Record indicated Resident 47 was admitted to the facility on [DATE], with diagnoses which included cerebral infarction with right - sided hemiplegia (a stroke that caused weakness on the right side of the body), epilepsy (convulsions) and metabolic encephalopathy (a condition affecting brain function that causes confusion, impaired thinking, and reduced ability to safely care for oneself). During a review of Resident 47's MDS (Minimum Data Set - a standardized assessment tool that measures health status in nursing homes) Section C (Cognitive (involving conscious intellectual activity) Patterns, Dated, December 22, 2025, the MDS Section C indicated, Resident 47 had a BIMS (Brief Interview for Mental Status a tool used to screen how a resident is functioning cognitively) Score of 8 (a BMIS score of 8-12: moderately impaired). During a review of Resident 47's MDS Section GG - Functional Abilities, dated December 22, 2025, the MDS Section GG indicated, (GG130A - Eating) was coded as 05 - Set up or clean up assistance, indicating the resident required staff assistance to prepare and set up meals prior to eating. During an observation on January 21, 2026, at 12:35 PM, during lunch time, in Resident 47's room, with Certified Nurse Assistant (CNA 4), Resident 47 was lying in bed with the head of the bed elevated, awake. The lunch tray meal ticket indicated the following: Diet: fortified (meals enhanced with added calories and protein to support nutrition.), consistency: PU4 (Pureed foods with a smooth, uniform texture requiring no chewing), beverages: MT2 (mild thick) (Slightly thickened liquid to reduce aspiration risk), Nectar (nectar-thick liquid with pourable consistency) , 4 oz (oz - unit of measurement), whole milk, 4 oz (regular milk), water 4 oz (plain drinking water), HPN 4 oz (high-protein nutritional supplement). Resident 47 was fed by CNA 4, who was sitting within one arm's reach, and assisting the resident during the meal. During an interview on January 21, 2026, at 12:39 PM, with Certified Nursing Assistant (CNA 5), CNA 5 entered Resident 47's room and stated she was familiar with the resident and reported that residents require assistance with meals. The CNA 5 stated that Resident 47's weight are taken weekly by the Restorative Nursing Assistant (RNA - staff trained to assist with restorative care and monitoring), and that any identified weight loss is reported to the charge nurse. During a concurrent interview and record review on January 21, 2026, at 12:45 PM, with License Vocational Nurse (LVN 1), the LVN 1 reviewed Resident 47's meal percentage, in the clinical records from January 1, 2026, through January 20, 2026. The LVN 1 confirmed that the resident oral intake ranges from 50-100%. The LVN 1 stated the resident is able to feed himself with set- up assistance and that at times requires assistance. During a review of Resident 47 physician orders, dated January 14, 2026, it indicated WEEKLY WEIGHTS X (times) 4. During a concurrent interview and record review on January 21, 2026, at 12:48 PM, with LVN 1, the Resident 47's Vital Weights, dated November 6, 2025, through January 19, 2026, were reviewed. The LVN 1 confirmed that there were no weights recorded on from November 11, 2025, through January 4, 2026. LVN 1 stated that weights are obtained weekly for new admissions and for residents with identified weight loss, according to physicians' orders. LVN 1 further stated significant weight loss is considered a change in condition, which requires notification of the physician and responsible party, and may result in further monitoring or interventions based on physician orders. LVN 1 confirmed that the lack of documented weights during this period was an oversight. During a concurrent interview and record review on January 21, 2025, at 12:51 PM, the Change of Condition from November 1, 2025 - January 21, 2026, was reviewed. The LVN 1, confirmed (continued on next page)		

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Centers for Medicare & Medicaid Services

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Form Approved OMB
No. 0938-0391

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	that two change of conditions were recorded in the system: one dated November 24, 2025 related to skin tear and the second change of condition dated January 8, 2026 related to skin discoloration. LVN 1 confirmed that no change of condition related to Resident 47's weight loss was documented in the system. During an interview on January 21, 2026, at 4:38 PM, the Registered Dietitian (RD), the RD acknowledged that review of Resident 47's weight history showed an approximately 11 pounds weight loss from November 2025, through December 2025, at the time the RD completed the December 15, 2025, assessment. The RD further acknowledged she was not aware of the weight loss at the time of her assessment. During a review of Resident 47's Vital Weight dated January 21, 2026, at 4:44 PM, the following was indicated: November 6, 2025: 147 Lbs (pounds), (wheelchair) December 1, 2025: 138 Lbs (mechanical lift); (weight was entered on January 21, 2026, and the entry data was confirmed with the DON) December 8, 2025 - January 4, 2026 (No weights were recorded during this period) January 5, 2026: 133 Lbs (Mechanical lift) (used to safely obtain in resident's weight when unable to stand) January 12, 2026: 135 Lbs. (mechanical lift) January 19, 2026: 136 Lbs. (mechanical lift) During an interview on January 22, 2026, at 11:32 AM, with the Restorative Nursing Assistant (RNA 1), the RNA 1 stated weights are documented on paper logs and submitted to the Director of Staff development. The RNA 1 further stated residents with weight loss may be provided nourishments, fortified shakes, assisted dining and one to one feeding assistance, and are monitor weekly. During a concurrent interview and record review on January 22, 2026, at 11:38 AM, with the Director of Staff Development, DSD the Resident 47's January Monthly Weights, dated January 1, 2026, and the Weekly Weights dated January 21, 2026, was reviewed. The monthly weighs for Resident 47's indicated, November 2025: 147 Lbs. December 2025: 138 Lbs. During the concurrent interview and record review on January 22, 2026 at 11:42 AM with the DSD confirmed that December monthly weights dated December 1, 2025 was not recorded in the electronic system at the time, that the weight was obtained and recorded on January 21, 2026. The weekly weights dated January 21, 2026, the Resident 47's weights indicated the following: January 19, 2026: 136 Lbs. January 12, 2026: 135 Lbs. January 5, 2026 : No weight recorded. December 29, 2025: No weight recorded. December 22, 2025: No weight recorded. December 15, 2025: No weight recorded. December 8, 2025 : No weight recorded. The DSD acknowledged Resident 47's weight loss of approximately 11 pounds from November 2025 through January 2026. During a concurrent interview and record review on January 23, 2026, at 10:09 AM, with the Assistant Director for Nursing (ADON), the facility's policy and procedure (P&P) titled Nutrition (Impaired) /Unplanned Weight Loss - Clinical Protocol, Revised September 2017, was reviewed. The P&P indicated, Assessment and Recognition. 1. The nursing staff will monitor and document the weight and dietary intake of the resident in a format with permits comparisons over time. Cause identification. 2. For individuals with recent or rapid wight gain or loss (for example, more than a pound a day), the staff will review for possible fluid and electrolyte imbalance as a cause. The ADON stated that when a significant weight loss is identified, the expected process includes initiating an SBAR (Situation, Background, Assessment, Recommendation - used primarily in healthcare to quickly and effectively convey critical patient information), notifying the physician and family, placing the resident on weekly weights, completing 72 - hours monitoring, and revising the care plan. ADON further stated no weights were documented in the electronic system for the month of December until January 21, 2026, the SBAR dated January 8, 2026, was not completed until January 21, 2026, no 72 -hour monitoring documentation was completed following SBAR initiation, and the resident's care plan did not address the documented 11 - pound weight loss. The ADON acknowledged that staff did not follow the facility's Nutrition (Impaired) / Unplanned Weight Loss - Clinical Protocol.		

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 ensure its intravenous (IV) therapy (a method of giving fluids or medications directly into a vein through a small tube) policy and procedures was followed for one of eight sampled residents (Resident 61) when Resident 61's IV dressing (the bandage place over the IV site to protect it) on the right arm was not labeled to indicate the date when it was changed. This failure prevents staff from properly monitoring the IV site, increasing the risk of infection and infiltration (where fluid leaks into the surrounding tissue causing pain or damage). During a review of Resident 61's admission Record (clinical record with demographic information), the admission Record indicated, Resident 61 was admitted to the facility on [DATE], with diagnoses which included, dysphagia (difficulty swallowing) and dementia (impaired memory, judgment, and ability to understand or communicate needs). During an observation on January 20, 2026, at 11:21 AM, in Resident 61's room, Resident 61 was observed lying on her back with head of the bed slightly elevated. Resident 61 was awake, on the right side of the resident's bed. There was an IV bag of 0.9% Normal Saline (a solution used for intravenous hydration) infusing at a rate of 60 mL (mL- unit of fluid measurement) per hour. Resident 61 had a peripheral (a short, flexible, small-gauge tube inserted through the skin into a peripheral vein) IV catheter (a short, flexible plastic tube placed into a small vein in the arm, hand, or foot to deliver fluids, medications, blood, or nutrition) inserted in the right arm. The IV insertion site was unlabeled. There were no staff initials and date and time of insertion to indicate or when the dressing was applied. During a concurrent observation and interview on January 20, 2026, at 11:31 AM, with the Director of Nurses, DON, inside Resident 61's room, the DON confirmed the IV site dressing should be labeled with the date, time and initials so staff can identify when the IV was inserted and when the dressing was changed. During an interview on January 20, 2026, at 11:36 AM, with Registered Nurse (RN 1), RN 1 stated the IV dressing was not labeled and IV with dressing should include the date it was applied, time, and staff initials for infection control purposes, and to allow staff to track when the IV and dressing need to be changed. During a review of Resident 61' Physician Orders dated January 19, 2026 at 7:00 AM indicated, Sodium Chloride Intravenous Solution 0.9% (Sodium Chloride) use 60 mg/ml Intravenously every shift for dehydration start date January 19, 2026 at 07:00 AM. During a concurrent interview and record review on January 21, 2026, at 5:12 PM, with the ADON, the facility's policy and procedure (P&P) titled Peripheral and Midline IV Dressing Changes, revised March 2022, was reviewed. The P&P indicated, General Guidelines. 4. Change the dressing if it becomes damp, loosened or visible soiled and: . a. at least every 7 days for TSM (Transparent semi-permeable membrane - a thin, clear, adhesive film that allows oxygen and water vapor to pass through while blocking bacteria and liquids) dressing. Steps in the Procedure. 9. Place new dressing (TSM or gauze) over insertion site. Label dressing with the date and time of dressing change, and initials. The ADON stated the policy was not followed.		

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Centers for Medicare & Medicaid Services

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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 accurate records of controlled medications (narcotic medications that are controlled by the government because it may be abused or cause addiction) were maintained in accordance with their own policy and procedure for one of three Medication Carts (Medication Cart B). This failure had the potential to result in inaccurate count of narcotic drugs and drug diversion (illegal distribution of controlled drugs for any illicit use) of controlled medications by the staff in a highly vulnerable population of 93 residents. During a concurrent observation, interview, and record review, on January 1, 2026, at 7:30 AM with a Licensed Vocational Nurse (LVN 3), at Medication Cart B, Medication Cart B's 8-hour Controlled Drugs-Count Record (8 HR CDCR- mandatory, real-time log tracking high-risk medication inventory [Schedules II-V] to prevent theft or misuse), dated January 1, 2026, through January 22, 2026, was reviewed. LVN 3 stated two licensed nurses verify the log during shift change. The 8 HR CDCR indicated there were missing signatures for the following dates: On January 1, 2026, morning shift (7:00 AM -3:00 PM) oncoming nurse. On January 1, 2026, evening shift (3:00 PM to 11:00 PM) off going nurse. On January 3, 2026, evening shift (3:00 to 11:00 PM) oncoming nurse. On January 3, 2026, night shift (11:00 PM to 7:00 AM) off going nurse. On January 4, 2026, morning shift (7:00 AM-3:00 PM) oncoming nurse. On January 4, 2026, evening shift (3:00 PM to 11:00 PM) off going nurse and oncoming nurse. On January 4, 2026, night shift (11:00 PM to 7:00 AM) off going nurse. On January 5, 2026, morning shift (7:00 AM-3:00 PM) oncoming nurse. On January 6, 2026, morning shift (7:00 AM-3:00 PM) oncoming nurse. On January 6, 2026, evening shift (3:00 PM to 11:00 PM) off going nurse. On January 8, 2026, evening shift (3:00 PM to 11:00 PM) oncoming nurse. On January 8, 2026, night shift (11:00 PM to 7:00 AM) off going nurse. On January 11, 2026, evening shift (3:00 PM to 11:00 PM) oncoming nurse. On January 11, 2026, night shift (11:00 PM to 7:00 AM) off going nurse. On January 17, 2026, evening shift (3:00 PM to 11:00 PM) oncoming nurse. On January 17, 2026, night shift (11:00 PM to 7:00 AM) off going nurse. LVN 3 confirmed the 17 missing signatures in the 8 HR CDCR. LVN 3 stated it was important to do a shift narcotic count so there are no discrepancies. During a concurrent interview and record review on January 23, 2026, at 10:46 AM, with the Director of Nursing (DON), the facility's policy and procedure (P&P) titled, Controlled Medication Storage, dated April 2019 was reviewed. The P & P indicated, .At each shift change, a physical inventory of all controlled medications shall be conducted by two licensed nurses and is documented on the controlled substances accountability record. The DON stated the facility did not follow the policy. The DON further stated it was important to do shift to shift narcotic count, to ensure count is accurate, and making each staff accountable for their carts.		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to maintain effective infection prevention and control practices (steps used to prevent the spread of germs, including proper cleaning, storage, and handling of medical equipment) for three of seven sampled residents (Residents 4, 14, and 68) when: 1. For Resident 4, the urinary catheter bag (a medical bag used for collection of urine) was resting on the floor, on January 20, 2026. 2. For Resident 14, an oxygen tubing (a flexible plastic tube to deliver oxygen from the oxygen concentrator to the resident) was hanging from underneath the bed and touching the floor. 3. For Resident 68, a breathing treatment face mask (a medical device that covers the nose and mouth to deliver medication directly to the airways and lungs) was on top of the nightstand, uncovered and unlabeled, while not in use. These failures had the potential to result in cross contamination (when germs are spread from one person, surface, or object to another, making it easier for infections to spread) and transmission of infectious organisms due to improper storage and handling of urinary and respiratory equipment, placing Resident 4, 14, and 68 at risk for infection and harm. 1. During a review of Resident's 4 clinical records the admission Record (contains demographic and medical information) indicated Resident 4 was admitted to the facility on [DATE], with diagnoses which included pressure ulcer (bed sore), sepsis (a life threatening medical emergency caused by the body's extreme response to an infection), and neuromuscular dysfunction of bladder (inability to properly store or empty urine). During a concurrent observation and interview, on January 20, 2026, at 9:50 AM, with a Certified Nursing Assistant (CNA 3), in Resident 4's room. Resident 4 was lying in his bed sleeping, his urinary catheter bag was hanging off the bed frame on the resident's left side of the bed resting on the floor. CNA 3 stated the urinary catheter should not be touching the floor. During a concurrent observation and interview, on January 20, 2026, at 9:58 AM, with a Licensed Vocational Nurse (LVN 1), in Resident 4's room. LVN 1 stated the expectations for urinary catheter is that it should have a dignity bag, should be hanging on lower level, and not touching the floor. During a concurrent interview and record review with the Assistant Director of Nursing (ADON) on January 23, 2025, at 4:16 PM, the facility's policy and procedure (P&P) titled, Catheter Care, Urinary, revised August 2022, was reviewed. The P&P indicated, The purpose of this procedure is to prevent urinary catheter-associated complications, including urinary tract infections. Infection control. 2. Be sure the catheter tubing and drainage bag are kept off the floor. The ADON stated the P&P was not followed. 2. During a review of Resident 14's admission Record (contains demographic and medical information), it indicated Resident 14 was admitted to the facility on [DATE], with the diagnoses that included dysphagia (difficulty swallowing), gastrostomy (a feeding tube, directly to the stomach) and dementia, (loss of memory, language, problem-solving, and other thinking abilities). During a concurrent observation and interview on January 20, 2026, at 10:00 AM, with the Certified Nurse Assistant, (CNA 1), in Resident 14's room, a nebulizer (a small machine that turns liquid medicine into a fine mist so a person can breathe it in through a mask or mouthpiece and helps the medicine go directly into the lungs) was on top of Resident 14's nightstand. A clear bag intended for storage of breathing treatment supplies (mask and oxygen tubing) was hanging from the nightstand. The oxygen tubing was connected to the breathing treatment mask and was downward under Resident 14's bed, touching the floor. The CNA 1 confirmed the oxygen tubing was touching the floor (continued on next page)		

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and stated once the oxygen tubing comes in contact with the floor, it should be discarded because it is considered contaminated. During an interview on January 20, 2026, at 10:20 AM, with the License Vocational Nurse, LVN 1, the LVN 1 acknowledged the oxygen tubing connected to a breathing treatment mask had been found touching the floor and stated, all respiratory equipment must be stored properly inside the plastic bag and should be labeled, to prevent contamination. During a review of Resident 14's Physician Orders, dated January 12, 2026, it indicated, Ipratropium-Albuterol Inhalation Solution (a combination of breathing medication that opens the airway to help the resident breathe easier) 0.5 &ndash; 2.5 (the amount of albuterol in each dose, which helps relieve wheezing and shortness of breath) (ipratropium: the amount of ipratropium in each dose, which keeps relax and open the airways) (3) MG/3ML (the total liquid volume of the medication on one dose) ipratropium-Albuterol) 1 dose inhale orally every 4 (four) hours for Congestion /SOB (shortness of breath). During a concurrent interview and record review on January 21, 2026, at 5:12 PM, with Assistant Director of Nursing (ADON), the facility's policy and procedure (P&P) titled, Departmental Respiratory Therapy &ndash; Prevention of Infection, reviewed 2011, was reviewed. The P&P indicated, Purpose. The purpose of this procedure is to guide prevention of infection associated with respiratory therapy tasks and equipment, among residents and staff. steps in the Procedure. Infection Control Considerations Related to Medication Nebulizer/Continuous Aerosol: .7. Store the circuit in plastic bag, marked with date and resident's name between uses. The ADON Acknowledged, the policy was not followed by staff, as equipment in contact with the floor is considered contaminated and should not be used. 3. During a review of Resident 68's admission Record, it indicated the resident was admitted to the facility on [DATE], with diagnoses which included cerebral infarction affecting the right dominant side (damage to the brain cause by a blockage of blood flow, which can result in weakness on the right side of the body), dysphagia (difficulty swallowing) and hemiplegia and hemiparesis (paralysis of weakness on one side of the body) During a concurrent observation and interview on January 20, 2026, at 10:35 AM, with the License Vocational Nurse (LVN 2), in Resident 68's room, a nebulizer (a medical device that turns liquid medication into a fine mist so it can be breathed into the lungs through a mask or mouthpiece) with an attached tubing and breathing treatment mask (a soft plastic mask place over the nose and mouth that delivers medication or oxygen into the lungs to help the person breathe easier) was located on top of Resident 68's nightstand. The nebulizer equipment was unlabeled and uncovered, improperly stored. The LVN 2 stated the nebulizer equipment, including the tubing and breathing treatment mask, should be stored inside a designated breathing treatment bag, dated and labeled, but it was not. During a concurrent interview and record review on January 21, 2026, at 5:16 PM, with ADON, the facility's policy and procedure (P&P) titled, Departmental Respiratory Therapy &ndash; Prevention of Infection, Revised 2011, was reviewed. The P&P indicated, Purpose. The purpose of this procedure is to guide prevention of infection associated with respiratory therapy tasks and equipment, among residents and staff. steps in the Procedure. Infection Control Considerations Related to Medication Nebulizer/Continuous Aerosol: .7. Store the circuit in plastic bag, marked with date and resident's name between uses. The ADON acknowledged the nebulizer, tubing and breathing treatment mask were found on top on the Residents 68's nightstand unlabeled and not properly stored, the ADON confirmed that the staff did not follow the policy.		