STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056149	A. Building B. Wing	05/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
California Healthcare and Rehabilitation Center	6700 Sepulveda Blvd. Van Nuys, CA 91411

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47883 2. During a review of Resident 27's Admission record, the Admission record indicated the facility admitted the resident on 9/20/2023, with diagnoses including multiple sclerosis (a chronic disease that damaged the central nervous system), type two(2) diabetes mellitus (a long-term medical condition in which the body does not use insulin [a hormone that lowers the level of sugar in the blood] properly) and dementia (impaired ability to remember, think, or make decisions that interferes with doing everyday activities). During a review of Resident 27's Minimum Data Set (MDS, a standardized assessment and care screening tool), dated 4/4/2024, the MDS indicated the resident was totally dependent on staff with all activities of daily living (ADLs - basic tasks that must be accomplished every day for an individual to thrive). The resident had severe cognitive impairment (problems with the ability to think, learn, remember, use judgement, and make decisions). During a review of Resident 27's Care Plan (a document that outlines the actions and interventions needed to address a resident's health and care needs) revised 1/14/2024, the care plan indicated that the resident has self-care deficits due to cognitive deficit and poor safety awareness. The care plan indicated an intervention to provide a safe environment. During an observation on 5/5/2024, at 1:51 p.m., inside Resident 27's room, there was a broken wall molding, with a piece missing behind the resident's bed. During a concurrent observation and interview on 5/6/2025 at 3:50 p.m., with the Director of Nursing (DON) inside Resident 27's room, the DON confirmed that the wall molding behind the resident's bed is broken, with a piece missing. The DON stated the staff should have reported the broken molding to the Maintenance Department. The DON stated the Maintenance Department is responsible for making sure that the wall molding in the room is not damaged. The DON stated she will report the issue to the Maintenance Department for repairs. The DON stated not reporting the broken wall molding to the Maintenance Department placed Resident 27 at risk for injuries and accidents. During concurrent observation and interview with the MD and Administrator on 5/6/2025 at 3:55p.m. in Resident 27's room, the Administrator concurred that the wall molding behind the resident's bed was broken, with a piece missing. The MD stated that he was responsible for ensuring that any damaged moldings were repaired. (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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's policy and procedure (P&P) titled, Homelike Environment, last reviewed 7/16/2024, the P&P indicated residents are provided with a safe, clean, comfortable, and homelike and encouraged to use their personal belongings to the extent possible. 50033 Based on observation, interview, and record review, the facility failed to provide a homelike environment for four of five sampled residents reviewed under the environment task by failing to: 1.Repair or replace ripped and gouged bed rail padding for Residents 182, 642, and 643. This deficient practice placed Residents 182, 642, and 643 at risk to experience an unsanitary and uncomfortable environment. 2.Ensure the molding on the wall behind Resident 27's bed was repaired. This deficient practice has the potential to make residents feel uncomfortable, place residents at higher risk for accidents, and negatively affect the residents' quality of life. Findings: 1. During a review of Resident 182's Admission Record, the Admission Record indicated the facility originally admitted the resident on 3/29/2025 and readmitted the resident on 4/29/2025 with diagnoses including but not limited to cerebral infarction (an obstruction of blood flow in the brain that leads to tissue damage) and acute respiratory failure (a condition where the lungs cannot release enough oxygen into the blood). During a review of Resident 182's Minimum Data Set (MDS - a resident assessment tool), dated 4/11/2025, the MDS indicated Resident 182 had severely impaired cognitive skills (problems with the ability to think, learn, and remember clearly) for daily decision making and required total assistance from staff with activities of daily living (ADLs- activities such as bathing, dressing and toileting a person performs daily). During a review of Resident 182's Physicians Orders, the Physicians Orders indicated an order for padded siderails to decrease potential injury dated 4/30/2025. During a review of Resident 182's care plan titled Resident is on Padded siderails, dated 3/30/2025, the care plan indicated the resident needs padded bed rails to prevent or reduce incidences of injuries. During a review of Resident 642's Admission Record, the Admission Record indicated the facility admitted the resident on 5/1/2025 with diagnoses including but not limited to acute respiratory failure and intracerebral hemorrhage (bleeding inside the brain tissue). During a review of Resident 642's History and Physical, dated 5/3/2025, the History and Physical indicated Resident 642 was not alert or oriented (a person's awareness of their surroundings, including who they are, where they are, and what time it is) and was unable to move any extremities. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 642's Physicians Orders, the Physicians Orders indicated an order for padded siderails to decrease potential injury dated 5/5/2025. During a review of Resident 642's care plan titled (Resident 642's name) is on low bed, floor mat and padded siderails ., dated 4/11/2025, the care plan indicated the goal was to prevent or reduce incidences of injuries. During a review of Resident 643's Admission Record, the Admission Record indicated the facility admitted the resident on 4/10/2025 diagnoses including but not limited to cerebral infarction and acute respiratory failure. During a review of Resident 643's MDS, dated [DATE], the MDS indicated Resident 643 had severely impaired cognitive skills for daily decision making and required total assistance from staff with ADLs. During a review of Resident 643's Physicians Orders, the Physicians Orders indicated an order for padded siderails to decrease potential injury dated 4/12/2025. During a review of Resident 643's care plan titled .Padded side rails when in bed to decrease potential injury, dated 4/11/2025, the care plan indicated the goal was to prevent or reduce incidences of injuries. During a concurrent observation and interview on 5/8/2025 at 10:51 a.m. with the Subacute Director (SD), Resident 643, 642, and 182's bed rails were observed to be covered with black foam padding in poor repair. The SD stated they change the bed rail padding regularly but do not have a set schedule. The black foam padding on Resident 643's right upper and lower bedrails were observed to have several cracks and gouges exposing porous (has many holes, so liquid or air can pass through) foam surfaces. The black foam padding on Resident 642's right upper bed rail was observed to have a large rip exposing porous foam surfaces. The SD stated the padding on Resident 642's right upper bedrail should be replaced due to the rip. The black foam padding covering the left upper bedrail on Resident 182's bed had a large rip which exposed the bed rail and multiple gouges exposing porous foam surfaces. The SD stated the padding should be replaced due to the rip and because it exposes the bed rail. During a concurrent interview and record review on 5/8/2025 at 2:39 p.m. with the Director of Nursing (DON), the DON stated if the bed rail is exposed the resident could potentially be injured. The DON stated Resident 643, 642 and 182's ripped and gouged bed rail paddings were not in good repair and could potentially harbor bacteria. The DON stated all rooms should have equipment in good repair for safety purposes. During a review of the facility's policy and procedure (P&P) titled Homelike Environment, last reviewed 7/16/2024, the P&P indicated residents are to be provided with a safe, clean, comfortable, environment.

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. 49947 Based on observation, interview, and record review the facility failed to ensure residents were free from any physical restraints (any manual method, physical or mechanical device, material or equipment that is attached or adjacent to the patient's body that he or she cannot easily remove that restricts freedom of movement or normal access to one's body) for two of three sampled residents (Resident 149 and Resident 183) by failing to: 1. Perform a bed rail/side rail (a safety device that can be installed on the side of a bed to help people get in and out of bed, turn in bed, and prevent falls) assessment prior to putting up the residents' lower side rails. 2. Obtain a physician's order on the use of bed rail/side rail. This deficient practicse had the potential to result in the restriction of residents' freedom of movement and physical harm from entrapment. Findings: a. During a review of Resident 149's Admission Record, the Admission Record indicated that the facility admitted Resident 149 on 1/14/2025 with diagnoses including but not limited to metabolic encephalopathy (a condition that affects brain function due to an imbalance in the body's metabolism [chemical processes that convert food into energy]), acute respiratory failure with hypoxia (a sudden, life-threatening condition where the lungs struggle to exchange enough oxygen and carbon dioxide in the blood), and congestive heart failure (a condition where the heart muscle is weakened and cannot pump enough blood to meet the body's needs), and need for assistance with personal care. During a review of Resident 149's History and Physical (H&P), dated 5/8/2025, the H&P indicated Resident 149 did have the capacity to understand and make decisions. During a review of Resident 149's Minimum Data Set (MDS - a federally mandated resident assessment tool), dated 4/29/2025, the MDS indicated that the resident can understand others and make himself understood. The MDS indicated that Resident 149 was dependent on staff with activities of daily living (ADLs - basic tasks that must be accomplished every day for an individual to thrive) such as eating, hygiene. dressing, toileting and bathing. The MDS further indicated the resident was dependent on staff to roll left or right and movements such as sit to lying, sit to stand and walking were not attempted. During a review of Resident 149's Informed Consent dated 3/3/2025, the informed consent indicated a treatment of bilateral upper half siderails for mobility, ADL's (activities of daily living - such as bathing, dressing and toileting a person performs daily) and changing positions. During an observation on 5/5/2025 at 9:52 am in Resident 149's room, Resident 149 was lying in bed with both upper and one lower side rails up. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During concurrent observation and interview on 5/5/2025 at 9:59 am, in Resident 149's room with the Assistant Director of Nursing (ADON), the ADON pointed to the lower side rails and stated that the lower side rail must not be up without a signed consent, and it could be considered a restraint because the resident can get stuck in or between the upper and lower rails. During a concurrent interview and record review on 5/8/2025 at 2:33 pm with the Director of Nursing (DON), the DON stated that according to the facility's policy, the use of bed rails is prohibited unless the criteria for use had been met including the assessment of the resident and a signed informed consent. The DON further stated Resident 149 had a consent for upper side rails only and his lower side rails should never have been up because the resident could have been trapped. During a review of the Policy and Procedure (P&P) named Bed safety and Bed Rails, last reviewed on 7/16/2024, the P&P indicated the use of bed rails is prohibited unless the criteria for use of bed rails have been met, including attempts to use alternatives, interdisciplinary evaluation, resident assessment, and informed consent. The P&P further indicated the resident assessment determines potential risks such as accidents associated with the resident attempting to climb over, around, between or throughout the rails or their body could be caught between the rails and mattress. During a review of the P&P named Use of Restraints, last reviewed on 7/16/2024, the P&P stated restraints shall only be used for the safety and well-being of residents. The P&P defined restraints as any manual method or a physical or mechanical device, material or equipment attached to or adjacent to the resident's body that the individual cannot remove easily, which restricts freedom of movement or restricts normal access to one's body. b. During a review of Resident 183's Admission Record, the Administration Record indicated that the facility admitted Resident 183 on 3/31/2025 with diagnoses including but not limited to adult failure to thrive (when an older adult has a loss of appetite, eats and drinks less than usual, loses weight, and is less active than normal), dysphagia (difficulty swallowing), need for assistance with personal care, stiffness on left ankle, and major depressive disorder (persistent feelings of sadness, hopelessness, and loss of interest in activities previously enjoyed). During a review of Resident 183's History and Physical (H&P), dated 4/2/2025, the H&P indicated Resident 183 did have the capacity to understand and make decisions. During a review of Resident 183's Minimum Data Set (MDS - a federally mandated resident assessment tool), dated 4/12/2025, the MDS indicated that the resident can understand others and make herself understood. The MDS further indicated Resident 183 required substantial assistance from staff for activities such as toileting, hygiene, sit to stand, toilet transfer and walking. During a review of Resident 183's Physician's Order dated 3/31/3035, the order indicated an order for bilateral upper half side rails when in bed for safety and protection. During a review of Resident 183's Informed Consent dated 3/31/2025, the informed consent indicated a treatment of bilateral upper half siderails for mobility, ADL's and changing positions. During an observation on 5/5/2025 at 10:11 am in Resident 183's room, Resident 183 was lying in bed with both upper and one lower side rails up. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During concurrent observation and interview on 5/5/2025 at 10:15 am, in Resident 183's room with the Assistant Director of Staff Development (ADSD), the ADSD stated the lower side rail should not be up and could be dangerous because the resident could get a body part stuck in it. During an interview and record review on 5/8/2025 at 2:37 pm with the Director of Nursing (DON), the DON stated according to the facility's policy, the use of bed rails is prohibited unless the criteria for use had been met including the assessment of the resident and a signed informed consent. The DON further stated Resident 183 had a consent for upper side rails only and his lower side rails should never have been up because the resident could have been trapped. During a review of the Policy and Procedure (P&P) named Bed safety and Bed Rails, last reviewed on 7/16/2024, the P&P indicated the use of bed rails is prohibited unless the criteria for use of bed rails have been met, including attempts to use alternatives, interdisciplinary evaluation, resident assessment, and informed consent. The P&P further indicated the resident assessment determines potential risks such as accidents associated with the resident attempting to climb over, around, between or throughout the rails or their body could be caught between the rails and mattress. During a review of the P&P named Use of Restraints, last reviewed on 7/16/2024, the P&P stated restraints shall only be used for the safety and well-being of residents. The P&P defined restraints as any manual method or a physical or mechanical device, material or equipment attached to or adjacent to the resident's body that the individual cannot remove easily, which restricts freedom of movement or restricts normal access to one's body.

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36943 Based on observation, interview, and record review, the facility failed to complete a comprehensive Minimum Data Set ([MDS] a federally mandated resident assessment tool) for one of 38 sampled residents (Resident 690) after admission on 4/18/2025. This failure had the potential to prevent Resident 690 from receiving services to achieve Resident 690's goal of walking with a single point cane ([SPC] walking device with a curved or bent handle at the top and long shaft that ends in a single tip used to provide support while walking) to return home. Findings: During a review of Resident 690's Admission Record, the Admission Record indicated the facility admitted Resident 690 on 4/18/2025 with diagnoses including neoplasm (abnormal tissue growth) of meninges (three protective layers of connective tissue that surround the brain and spinal cord), nontraumatic intracerebral hemorrhage (bleeding in brain tissue), lack of coordination, muscle weakness, foot drop (condition where the individual experiences difficulty or inability to lift their foot or toes) of both feet, and reduced mobility (ability to move). During a review of Resident 690's Admission Minimum Data Set ([MDS] a federally mandated resident assessment tool), dated 4/29/2025, the Admission MDS indicated Resident 690 had clear speech, expressed ideas and wants, clearly understood verbal content, and had intact cognition (clear ability to think, understand, learn, and remember). The MDS did not include the signature of the Registered Nurse (RN) Assessment Coordinator verifying the completion of Resident 690's Admission MDS. During a concurrent observation and interview on 5/6/2025 at 11:27 a.m. with Resident 690 in the resident's room, Resident 690 was awake, alert, and spoke with clear, fluent speech while lying in bed with the head-of-bed elevated. Resident 690 stated the facility was aware of Resident 690's complaints regarding not receiving rehabilitation (therapy given to restore an individual back to their highest possible level of physical, mental, and psychosocial well-being) services. Resident 690 stated she underwent brain surgery three times and walked with a SPC due to left leg weakness after the second brain surgery and prior to the third surgery in 2/2025. Resident 690 stated the desire to return home after receiving therapy. During a concurrent interview and record review on 5/8/2025 at 10:19 a.m. with the MDS Coordinator RN (MDSC), Resident 690's Admission MDS, dated [DATE], was reviewed. The MDSC stated the MDS (in general) was a thorough assessment to ensure the residents were receiving appropriate care and meeting their goals. The MDSC stated the Admisison MDS should be completed by the 14th day of admission. The MDSC stated the facility admitted Resident 690 on 4/18/2025 and should have completed the Admission MDS on 4/29/2025. The MDSC stated Resident 690's Admission MDS was not completed since all the departments did not complete their assigned section of the MDS. The MDSC stated the facility could fail to address an area of Resident 690's care since the Admission MDS was not completed. During a review of page 2-17 of the Resident Assessment Instrument (RAI) Manual, revised 10/1/2023, the RAI Manual indicated the Admission MDS should be completed no later than the 14th calendar day of the resident's admission.

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Encode each resident's assessment data and transmit these data to the State within 7 days of assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47883 Based on interview and record review, the facility failed to ensure the Minimum Data Set (MDS - a standardized assessment and screening tool) was transmitted timely to the Centers for Medicare and Medicaid Services (CMS) system for one (1) out of one (1) sampled residents (Resident 35). This deficient practice had the potential to result in delayed services for Resident 35. Findings: During a review of the Admission record , the Admission record indicated Resident 35 was admitted to the facility on [DATE] and readmitted on 11 /,d+[DATE] with diagnosis including type 2diabetes (a long-term medical condition in which the body does not use insulin [a hormone that lowers the level of sugar in the blood] properly), urinary tract infection (infection in any part of the urinary system), and essential hypertension (high blood pressure that is not due to another medical condition). During a review of Resident 35's Record of Death dated [DATE], the record of death indicated that the body of Resident 35 was released on [DATE]. During a review of the Transfer/ Discharge Report, dated [DATE], the Transfer/Discharge Report indicated that the resident was DNR. During a review of Resident 35's Discharge Summary Report dated [DATE], the Discharge Summary Report indicated Resident 35 resident expired on [DATE]. During a review of the Minimum Data Set assessment dated [DATE], (MDS, a standardized assessment and care screening tool), the MDS indicated Resident 30 had mildly impaired cognition (a slight decline in mental abilities, memory and completing complex tasks). The MDS indicated Resident 30 required moderate assistance for all activities of daily living (ADL- basic tasks that must be accomplished every day for an individual to thrive). During a concurrent interview and record review on [DATE] at 2:45 p.m., with Minimum Data Set Coordinator 1 (MDSC 1), Resident 35`s MDS assessments were reviewed. MDSC 1 stated that when a resident is being discharged from the facility, they (facility) are required to complete an MDS assessment . MDSC 1 stated, We have 14 days to complete the discharge MDS. MDSC 1 stated Resident 30 was discharged from the facility on [DATE], however, the MDS for discharge was not completed and not submitted to Center for Medicaid Services (CMS). During an interview on [DATE] at 3:15 p.m., with the Director of Nursing (DON) the DON stated the discharge assessment has to be done and submitted to CMS in 14 days following the resident's discharge, by the Minimum Data Set Nurse (MDSC). The DON stated the potential outcome of not completing discharge MDS assessment on time is a delay in care and payment for Resident 30. (continued on next page)

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's Centers for Medicare and Medicaid Services (CMS) Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual, Version 1.19.1 dated [DATE], indicated all Medicare and/or Medicaid-certified nursing homes and swing beds, or agents of those facilities, must transmit required MDS data records to CMS' Internet Quality Improvement and Evaluation System (iQIES). Comprehensive assessments must be transmitted electronically within 14 days of the Care Plan Completion Date. All other MDS assessments must be submitted within 14 days of the MDS completion date.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38549 b. During a review of Resident 163's Admission Record, the Admission Record indicated that the facility admitted the resident on 7/20/2024 with a diagnosis of schizophrenia (a mental illness that is characterized by disturbances in thought). During a review of Resident 163's MDS, dated [DATE], the MDS indicated that the resident was in a persistent vegetative state with no discernible consciousness and was dependent on staff for all activities of daily living (ADLs - activities such as bathing, dressing and toileting a person performs daily). On 5/7/2025 at 12:40 p.m., during a concurrent interview and record review, reviewed Resident 163's MDS records with the Minimum Data Set Coordinator (MDSC). A review of the Admission MDS, dated [DATE], Section I - Active Diagnoses indicated that the resident did not have an active diagnosis of schizophrenia. A review of the Quarterly MDS, dated [DATE], Section I - Active Diagnoses indicated that the resident did have an active diagnosis of schizophrenia. A review of the Quarterly MDS, dated [DATE], Section I - Active Diagnoses indicated that the resident did have an active diagnosis of schizophrenia. Reviewed the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5 - a comprehensive guide used by mental health professionals to diagnose and classify mental disorders) Criteria for Schizophrenia with the MDSC, which indicated that two or more symptoms or behaviors must be present for a significant portion of time during a 1-month period. The MDSC stated that the resident's Admission MDS, dated [DATE], was actually coded correctly because, according to their Centers for Medicare & Medicaid Services (CMS - a federal agency within the Department of Health and Human Services [DHHS]) audit, the resident must have been diagnosed with schizophrenia earlier in life, exhibited at least two behaviors as indicated on the DSM-5 Criteria for Schizophrenia, and have psychiatric progress notes explaining the resident's diagnosis. The MDSC stated that the following Quarterly MDSs should not have been coded for an active diagnosis of schizophrenia because the resident was in a vegetative state and, therefore, did not meet the DSM-5 criteria for a diagnosis of schizophrenia. In addition, the MDSC stated that the resident's diagnosis of schizophrenia was carried over from the hospital, and the facility did not have the documentation to show why the resident was diagnosed with schizophrenia. Reviewed the residents General Acute Care Hospital (GACH) History and Physical (H&P - a comprehensive assessment conducted by a healthcare provider to evaluate a patient's overall health) with the MDSC. The MDSC stated that the only indication from the GACH records that the resident had schizophrenia was from a family interview. The MDSC stated that the staff who completed the Quarterly MDSs should have double checked for the accuracy of information. On 5/8/2025 at 11:18 a.m., during an interview, with the Director of Nursing (DON), the DON stated that the purpose of the MDS was to comprehensively assess residents to guide their plan of care. The DON stated it was important for the MDS to be accurate because it directed what interventions residents may or may not need. The DON stated that if residents' MDS were coded incorrectly, then providers may be giving incorrect care, which can negatively affect the resident. During a review of the facility's policy and procedure titled, Resident Assessments, last reviewed on 7/16/2024, the policy and procedure indicated that all persons who have completed any portion of the MDS resident assessment form sign the document attesting to the accuracy of information. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	49947 Based on observation, interview and record review the facility failed to provide an assessment that accurately reflects the residents' status for two of two residents (Resident 5 and Resident 163) by failing to: a. Accurately assess and document Resident 5's hearing assessment on the Social Services Hearing Assessment Form on 12/12/24, accurately code Resident 5's ability to hear in section B of the MDS and complete a quarterly Social Services Hearing Assessment thereafter for one of one resident (Resident 5) investigated under the communication/sensory area This failure prevented Resident 5 from receiving the services and equipment needed to hear more clearly. b. Accurately code schizophrenia (a mental illness that is characterized by disturbances in thought) in Resident 163's Minimum Data Set (MDS - a resident assessment tool). This deficient practice had the potential to inaccurately depict the resident's needs thus affecting his/her plan of care. Findings: a. During a review of Resident 5's Admission Record, the Admission Record indicated the facility admitted Resident 5 on 2/28/2024 with diagnoses including type 2 diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), heart failure (a condition where the heart muscle is weakened and cannot pump blood effectively enough to meet the body's need), acute kidney failure (a sudden and significant loss of kidney [organ that filters blood] function), and depression (persistent feelings of sadness, hopelessness, and loss of interest in activities previously enjoyed). During a review of Resident 5's Minimum Data Set (MDS, a standardized assessment and care screening tool), dated 3/12/2025, the MDS indicated Resident 5 has some memory issues but is understood and able to understand others. The MDS further indicated Resident 5 had adequate (no difficulty in normal conversation, social interaction, listening to TV) hearing. During a review of Resident 5's Order Summary Report, the Order Summary Report indicated an active order dated 2/28/2024, for an audiology (a branch of science dealing with hearing) consult PRN (as needed) for hearing problems. During a review of Resident 5's Social Service Assessment (Hearing) dated 12/12/2024, the assessment indicated Resident 5 has an impaired hearing pattern and hearing appliances and consultation are not indicated. Further review did not indicate a Social Service Assessment (Hearing) was conducted for the first quarter of 2025. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/5/2025 at 10:50 am with Resident 5 in Resident 5's room, Resident 5 stated he has a hard time hearing and has been waiting for approximately six months for hearing aids. Resident 5 stated about four or five months ago, he went to see the ear doctor but was told because they were late, he could not be seen. Resident 5 stated, and he was told he would be seen at the facility instead, but no one has seen him yet. Resident 5 further stated his favorite activity is watching TV, but it was very hard for him to hear it. During a concurrent interview and record review on 5/7/2025 at 1:35 pm with the Social Service Director (SSD), the SSD stated Resident 5 saw the ENT (ear, nose, throat) doctor on 11/26/24 and recommended an audiology exam for hearing aids. The SSD stated Resident 5 had an audiology appointment on 2/3/2025, but they could not accommodate a gurney and the follow-up audiology appointment on 2/10/2025 was cancelled because the audiology office could not accommodate a gurney. The SSD stated the facility did not offer audiology services in-house. The SSD stated the social worker that completed the Social Service Assessment (Hearing) form on 12/12/2024 no longer works at the facility and should have checked off a hearing consultation is needed. The SSD stated she should have completed a Social Service Assessment (Hearing) by March 2025 to ensure Resident 5 received the services he needed. The SSD further stated six months is too long of a wait for hearing aids and she should have prioritized him. During a concurrent interview and record review on 5/8/2025 with the Minimum Data Set Coordinator (MDSC) at 11:15 am, the MDSC reviewed Resident 5's MDS Section B for hearing dated 3/12/2025 and stated he should have coded moderate difficulty instead of adequate. The MDSC stated it is important to have accurate assessment to make sure residents receive the proper care and services. During a review of the facility's policy and procedure (P&P) titled, Resident Assessments, last reviewed on 7/16/2024, the policy and procedure indicated that all persons who have completed any portion of the MDS resident assessment form sign the document attesting to the accuracy of information. During a review of the facility's P&P titled, Hearing Impaired Resident, Care Of, the P&P indicated staff will assist hearing impaired residents to maintain effective communication with clinicians, caregivers, other residents and visitors. The P&P indicated the facility does not provide comprehensive audiological evaluations or devices to assist with hearing and staff will assist the resident (or representative) with locating available resources, scheduling appointments and arranging transportation to obtain needed services.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44309 Based on interview and record review, the facility failed to develop a complete baseline care plan within 48 hours of a resident`s admission to the facility by failing to address the resident`s indwelling catheter (a hollow tube inserted into the bladder to drain or collect urine) for one of one sampled resident (Resident 99) reviewed under catheter care area. This deficient practice had the potential of Resident 99 to not receive appropriate care and treatment in the facility. Findings: During a review of Resident 99's Admission Record (face sheet), the Admission Record indicated that the facility originally admitted the resident on 9/15/2020 and readmitted on [DATE], with diagnoses including type two (2) diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), obstructive uropathy (a blockage in the urinary tract that prevents urine from draining normally), and reflux uropathy (when urine flows backward into the kidneys). During a review of Resident 99's Minimum Data Set (MDS - a resident assessment tool) dated 4/6/2025, the MDS indicated that the resident`s cognitive skills (brain's ability to think, read, learn, remember, reason, express thoughts, and make decisions) for daily decision making was moderately impaired (decisions poor, cues/supervision required). The MDS indicated that Resident 99 was dependent on staff for showering and bathing. The MDS indicated that Resident 99 required staff partial/moderate assistance (helper does less than half the effort) for toileting hygiene, and upper body dressing. The MDS further indicated that Resident 99 had an indwelling catheter. During a review of Resident 99's physician Order Summary Report (physician orders) dated 4/25/2025, the Order Summary Report indicated an order for indwelling catheter due to neurogenic bladder (a problem in which a person lacks bladder control due to a brain, spinal cord, or nerve condition). The order summary report indicated to provide indwelling catheter care during every day shift for 30 days. During a concurrent interview and record review on 5/7/2025 at 8:30 a.m., with the Assistant Director of Nursing (ADON), Resident 99`s baseline care plan was reviewed. The ADON stated that Resident 99 was readmitted to the facility on [DATE] with an indwelling catheter. The ADON stated that Resident 99`s baseline care plan initiated on 1/22/2025, did not indicate that the resident had an indwelling catheter. The ADON stated that residents` baseline care plans must be completed thoroughly reflecting a problem, initial care plan outcome, and nursing interventions. The ADON stated that the potential outcome of not thoroughly completing a resident`s baseline care plan is the inability to meet the resident`s immediate care needs and lack of care. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/8/2025 at 3:00 p.m., with the Director of Nursing (DON), the DON stated a resident`s baseline care plan is required to be completed within 48 hours of the resident`s admission to the facility. The DON stated upon admission, licensed staff are required to develop a complete and thorough baseline care plan for each resident indicating a problem and all nursing interventions to be done for that problem. The DON stated Resident 99`s baseline care plan developed on 1/22/2025 was not completed thoroughly and it did not indicate anything regarding the resident`s indwelling catheter. The DON stated the potential outcome is the inability to meet the resident`s immediate care needs for the indwelling catheter and the delivery of necessary services to the resident.  During review of the facility`s Policy and Procedure (P&P) titled Care Plans-Baseline, last reviewed on 7/16/2024, the P&P indicated that a baseline plan of care to meet the resident`s immediate health and safety needs is developed for each resident within 48 hours of admission. The baseline care plan includes instructions needed to provide effective, person-centered care of the resident that meet professional standards of quality care and must include minimum healthcare information necessary to properly care for the resident. The resident and/or representative are provided a written summary of the baseline care plan that includes but is not limited to any services and treatment to be administered by the facility and personnel acting on behalf of the facility.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 38549 b. During a review of Resident 59's Admission Record, the Admission Record indicated that the facility admitted the resident on 2/20/2025 with diagnoses including type 2 diabetes mellitus (DM - a disorder characterized by difficulty in blood sugar control and poor wound healing), generalized muscle weakness, and reduced mobility. During a review of Resident 59's Minimum Data Set (MDS - a resident assessment tool), dated 3/4/2025, the MDS indicated that the resident had moderately impaired cognition (thought processes) and was dependent on staff for most activities of daily living (ADLs - activities such as bathing, dressing and toileting a person performs daily). The MDS also indicated that the resident was at risk of developing pressure ulcers/injuries and had one or more unhealed pressure ulcers/injuries. During a review of Resident 59's Admission Reassessment, dated 2/21/2025, the reassessment indicated that the resident had a stage II pressure ulcer/injury on the sacrococcyx. During a review of Resident 59's physician's order, dated 4/23/2025, the order indicated to cleanse the resident's sacrococcyx (the area at the base of the spine where the sacrum and coccyx meet) pressure injury with normal saline (NS - a saltwater solution), pat dry, apply honey to the bed wound, and cover with a dry dressing (DD) every day shift for 30 days. On 5/7/2025 at 12:54 p.m., during a concurrent interview and record review, reviewed Resident 59's care plans (a document that outlines a patient's current health status, diagnoses, treatment goals, and interventions) with the Minimum Data Set Coordinator (MDSC). The MDSC stated there was no care plan addressing the resident's pressure ulcer/injury and treatments. On 5/8/2025 at 11:18 a.m., during an interview with the Director of Nursing (DON), the DON stated that the purpose of resident care plans was to guide all disciplines in what interventions to provide residents so they can reach their goals. The DON stated that, in Resident 59's case, the facility should have developed a care plan to address the resident's pressure ulcer/injury and the prescribed treatments. The DON stated that, without a care plan, the resident may not receive proper care or treatment, which can cause the wound to worsen. During a review of the facility's policy and procedure titled, Care Plans, Comprehensive Person-Centered, last reviewed on 7/16/2024, the policy and procedure indicated that the interdisciplinary team (IDT), in conjunction with the resident and his/her family or legal representative, develops and implements a comprehensive, person-centered care plan for each resident. 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 comprehensive, person-centered care plan: a. includes measurable objectives and timeframes; (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	b. describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being; c. includes the resident's stated goals upon admission and desired outcomes; d. builds on the resident's strengths; and e. reflects currently recognized standards of practice for problem areas and conditions. 49947 Based on interview, and record review the facility failed to develop and implement a comprehensive person-centered care plan (a document that outlines a patient's current health status, diagnoses, treatment goals, and interventions to two of five sampled residents (Resident 185 and 59) when: a. A diet order was changed from twice daily pureed (a medical diet where all foods are ground, pressed, or strained into a soft, pudding-like consistency) meals to three times a day regular mechanical soft textures (foods that are easy to chew and swallow, requiring minimal effort) meals, reviewed under the nutrition care area. This deficient practice had the potential for Resident 185 to not receive the proper and necessary care regarding her new diet order. b. There was no care plan developed and implemented addressing a Resident 59's pressure ulcer/injury (localized damage to the skin and/or underlying tissue usually over a bony prominence) and treatments, reviewed under the care area of pressure ulcer/injury. This deficient practice had the potential to result in a failure to deliver the necessary care and services necessary to treat Resident 59's pressure ulcer/injury. Findings: a. During a review of Resident 185's Admission Record, the Admission Record indicated the facility admitted Resident 185 on 4/2/2025 from the sub-acute unit with diagnoses including diffuse traumatic brain injury (TBI-a widespread disruption in the normal function of the brain that can be caused by a bump, blow, or jolt to the head)) with loss of consciousness (when a person is neither awake or aware of the external environment), gastronomy (a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems) and tracheostomy (a surgical procedure that creates an opening in the trachea [tube from mouth to lungs] to allow air to enter the lungs. During a review of Resident 185's History and Physical (H&P), dated 4/3/2025, the H&P indicated Resident 185 did not have the capacity to understand and make decisions. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 185's Minimum Data Set (MDS - an assessment and care screening tool) dated 5/2/2025, the MDS indicated Resident 185 was able to understand others and make herself understood, but forgetful with poor orientation and recall and dependent on staff for eating. The MDS further indicated Resident 185 had a tube feeding (gastrostomy), received 51% or more of her nutrition from tube feeding and received speech therapy (treatment that improves your ability to talk and use other language skills, also assessment for a patient's ability to swallow safely) During a review of Resident 185's Physician's Order on 5/5/2025, the Physician's Order indicated the following orders: -discontinue oral gratification diet - puree texture, nectar/mildly thick consistency, 1:1 feeding for two (2) portions during lunch and dinner. -start regular diet, mechanical soft texture, thin consistency for 3 meals, 1:1 feeding. During an interview with Certified Nursing Assistant 6 (CNA 6) on 5/6/2025 at 11:25 am, CNA 6 stated Resident 185 had pureed diet for lunch and dinner only with one-to-one supervision. CNA 6 stated she was unaware of the diet order change from 5/5/2025 nor was she notified of the change. During a concurrent interview and record review on 5/6/2025 at 4:03 am with Registered Nurse 1 (RN 1), RN 1 stated she was unaware of Resident 185's diet order change. RN 1 looked through Resident 185's care plan and was not able to locate a care plan with interventions for the new diet order change and stated without a care plan with interventions, staff may not know how to properly assist Resident 185 with her meals. RN 1 further stated it is very important to follow all the speech therapists orders to make sure the resident does not aspirate or choke. During a concurrent interview and record review with the Director of Nursing (DON), the DON stated according to the care plan policy, assessments of the residents are ongoing, and care plans are revised as information about the residents and their condition changes. The DON further stated her staff should have created a new care plan for Resident 185's significant diet order change for other staff members to know how to properly care for the residents. During a review of the facility provided Policy and Procedure (P&P) titled, Care Plans, Comprehensive Person-Centered last reviewed on 7/16/2024, the P&P indicates a comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical psychosocial and functional needs is developed and implemented for each resident. The P&P further indicates assessments of the residents are ongoing, and care plans are revised as information about the residents and their condition changes.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 47883 Based on interview and record review, the facility failed to update and revise a resident's care plan (a document that summarizes a resident's needs, goals, and care/treatment) after the resident's restraint freedom splint (multipurpose soft splints that help restrict elbow and knee movement) was discontinued, for one of two sampled residents (Resident 63). This deficient practice had the potential to result in confusion in the delivery of care and service. Findings: During a review of Resident 63's Admission Record, the Admission Record indicated that the facility admitted the resident on 2/14/2018 and readmitted the resident on 6/17/2024 with diagnoses including acute respiratory failure (a condition in which your blood doesn't have enough oxygen causing shortness of breath and difficulty breathing), encephalopathy (brain disease, damage, or malfunction of brain), chronic respiratory failure (condition in which not enough oxygen passes from your lungs into your blood) with hypoxia (a condition where there is an inadequate supply of oxygen to the body's tissues), and quadriplegia (paralysis [complete or partial loss of muscle function] of all four limbs). During a review of Resident 63's Minimum Data Set (MDS- a resident assessment tool) dated 3/20/2025, the MDS indicated that the resident had severely impaired cognitive skills (mental abilities, including remembering things, making decisions, concentrating, or learning). The MDS indicated that Resident 63 was totally dependent on staff with all activities of daily living (ADLs - activities related to personal care). During a review of the Resident 63's care plan, revised on 3/26/2025, the care plan indicated that Resident 63 had a restraint freedom splint and was at high risk for injury and complications due to pulling life sustaining equipment. During a review of Resident 63's physician order dated 4/17/2025, the physician order indicated to discontinue freedom splint to left upper extremity. During a concurrent interview and record review on 5/7/2025 at 3:51 p.m., with the Subacute Director (SD), reviewed Resident 63's care plans. The SD stated that Resident 63 did not have episodes of pulling their tracheostomy tube (an opening created at the front of the neck so a tube can be inserted into the windpipe [trachea] to help you breathe) for the last three months and the physician discontinued the order for freedom splint on 4/16/2025. The SD stated licensed staff did not revise or update Resident 63's care plan addressing that resident's freedom splint was discontinued. The SD stated licensed staff are required to revise a resident's care plan after a resident's condition changed to ensure the effectiveness of care plan interventions. The SD stated the potential outcome of not updating/revising a resident's care plan is the inability to provide appropriate care and monitoring to the resident. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/8/2025 at 3:15 p.m., with the Director of Nursing (DON), the DON stated that residents' care plans are required to be reviewed and revised after residents' change of condition. The DON stated Resident 63's care plan was not revised or updated after Resident 63's restraints were discontinued. The DON stated the potential outcome of not updating/revising a resident's care plan is the inability to provide appropriate care and services to the resident. During a review of the facility's policy and procedure (P&P) titled, Care Plans, Comprehensive Person-Centered, last reviewed on 7/16/2025, the P&P indicated that care plan interventions are chosen only after data gathering, proper sequencing of events, careful consideration of the relationship between the resident's problem areas and their causes, and relevant clinical decision making. Assessments of resident's are ongoing and care plans are revised as information about the residents and the residents' conditions change.

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44309 Based on observation, interview, and record review, the facility failed to ensure one of one sampled resident (Resident 156) was provided a communication device or board (a tool that includes pictures that help residents communicate their healthcare and every-day needs to facility staff) in her preferred language in order to effectively communicate with staff. This deficient practice prevented Resident 156 from communicating with the staff and receiving care in a timely manner. Findings: During a review of Resident 156's Admission Record (face sheet), the Admission Record indicated that the facility admitted the resident on 3/26/2024, with diagnoses including dysphagia (difficulty swallowing), essential hypertension (HTN-high blood pressure), and need for assistance with personal care. The Admission Record further indicated that Resident 156`s primary language was Chinese.  During a review of Resident 156's Minimum Data Set (MDS - a resident assessment tool) dated 4/8/2025, the MDS indicated that the resident`s cognitive skills (brain's ability to think, read, learn, remember, reason, express thoughts, and make decisions) for daily decision making was moderately impaired (decisions poor, cues/supervision required). The MDS indicated that Resident 156 was dependent on staff (helper does all of the effort) for toileting hygiene, showering/bathing, lower body dressing, putting on/talking off footwear, and personal hygiene. The MDS further indicated that Resident 156`s preferred language was Chinese, and the resident needed or wanted an interpreter to communicate with a doctor or health care staff. During a review of Resident 156's care plan (a document that outlines how a patient's health care needs will be met) for cognitive and communication deficit (a problem or difficulty in the brain's functions, such as memory, attention, problem-solving and speaking) initiated on 4/7/2024, the care plan indicated a goal that the resident`s needs will be anticipated and met daily until the next assessment date. The care plan interventions were to speak clearly and slowly to the residents, explain all procedures and reasons prior to initiating care and treatment and to utilize translator or communication devices as indicated. During a concurrent observation and interview on 5/7/2025 at 11:00 a.m. inside the facility`s activity room, Resident 156 was observed sitting on her wheelchair using her cellphone. The Activity Assistant (AA) was present next to Resident 156 and stated that Resident 156 speaks Chinese and does not understand English well. The AA stated staff are using Resident 156`s cellphone to translate from English to Chinese. The AA stated a communication board with pictures and signs is required for residents who do not speak English. The AA started looking for a communication board/device on Resident 156 wheelchair. However, she did not find one. The AA stated there is no communication board and device inside the activity room either. The AA confirmed that Resident 156 spends a lot of time in the activity room and staff have a hard time communicating with her. (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview on 5/7/2025 at 11:05 p.m., with the Activity Director (AD), inside Resident 156`s room, the AD stated for the residents who are not able to communicate their needs in English, the facility places a communication board/device at the residents` bed side. The AD stated that Resident 156 speaks Chinese and requires a communication board at her bedside to be able to make her needs known. The AD started looking for a communication board/device at Resident 156`s bedside. However, she (AD) was not able to find one. The AD stated that the potential outcome of not having a communication board available and accessible to a resident who is not able to communicate effectively in English is inability to meet the resident's needs. During a concurrent observation and interview on 5/7/2025 at 12:10 p.m., inside the facility`s small dining room, Resident 156 was observed eating lunch and sitting with Responsible Party 1 (RP 1). RP1 stated that Resident 156 is alert and able to express her needs. RP 1 stated that Resident 156 speaks Mandarin (one of the dialects of Chinese). RP 1 did not find a communication [NAME] or device attached to Resident 156`s wheelchair. Resident 156 stated that she often does not have a communication board/device, and she normally uses gestures to make her needs known. Resident 156 stated she wishes she knew how to speak English so that she can express her needs. During an interview on 5/8/2025 at 3:08 p.m., with the Director of Nursing (DON), the DON stated staff are required to provide a communication board or device to the residents who do not speak English in the language that they speak. The DON stated Resident 156 was not provided a communication device/board in Chinese. The DON stated the potential outcome of not providing a communication board/device to the residents who do not speak English is the inability to communicate with residents accurately and understand their needs. During a review of the facility's Policy and Procedure (P&P) titled, Accommodation of Needs Related to Communication Deficits, last reviewed on 7/16/2024, the P&P indicated that communication needs will be identified and appropriate interventions including care planning will be developed in order to accommodate the needs of the resident. The care plan will be developed, updated quarterly and as indicated to reflect accurate, current assessments related to communication needs. During a review of the facility's Policy and Procedure (P&P) titled, Activities of Daily Living (ADLs), Supporting, last reviewed on 7/16/2024, the P&P indicated that appropriate care and services will be provided for residents who are unable to carry out ADLs independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with communication (speech, language, and any functional communication system).

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Assist a resident in gaining access to vision and hearing services. 49947 Based on observation, interview and record review the facility failed to ensure residents receive treatment and assistive devices to maintain hearing abilities for one of one resident (Resident 5) reviewed under the communication/sensory care area when Resident 5 was not provided with an audiology consultation for his impaired hearing. This failure prevented Resident 5 from receiving the services and equipment needed to improve his hearing ability. Findings: During a review of Resident 5's Admission Record, the Admission Record indicated the facility admitted Resident 5 on 2/28/2024 with diagnoses including type 2 diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), heart failure (a condition where the heart muscle is weakened and cannot pump blood effectively enough to meet the body's need), acute kidney failure (a sudden and significant loss of kidney [organ that filters blood] function), and depression (persistent feelings of sadness, hopelessness, and loss of interest in activities previously enjoyed). During a review of Resident 5's Minimum Data Set (MDS, a standardized assessment and care screening tool), dated 3/12/2025, the MDS indicated Resident 5 has some memory issues but is understood and able to understand others. The MDS further indicated Resident 5 had adequate (no difficulty in normal conversation, social interaction, listening to TV) hearing. During a review of Resident 5's Order Summary Report, the Order Summary Report indicated an active order dated 2/28/2024, for an audiology (a branch of science dealing with hearing) consult PRN (as needed) for hearing problems. During a review of Resident 5's Social Service Assessment (Hearing) dated 12/12/2024, the assessment indicates Resident 5 has an impaired hearing pattern and hearing appliances and consultation are not indicated. Further review did not indicate a Social Service Assessment (Hearing) was conducted for the first quarter of 2025. During an interview on 5/5/2025 at 10:50 am with Resident 5 in Resident 5's room, Resident 5 stated he has a hard time hearing and has been waiting for approximately six months for hearing aids. Resident 5 stated about four or five months ago, he went to see the ear doctor but was told because they were late, he could not be seen. Resident 5 stated, and he was told he would be seen at the facility instead, but no one has seen him yet. Resident 5 further stated his favorite activity is watching TV, but it was very hard for him to hear it. (continued on next page)

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 5/7/2025 at 1:35pm with the Social Service Director (SSD), the SSD stated Resident 5 saw the ENT (ear, nose, throat doctor) on 11/26/24 and recommended an audiology exam for hearing aids. The SSD then stated Resident 5 had an audiology appointment on 2/3/2025, but they could not accommodate a gurney and the follow-up audiology appointment on 2/10/2025 was cancelled because the audiology office could not accommodate a gurney. The SSD stated the facility did not offer audiology services in-house. The SSD stated the social services staff that completed the Social Service Assessment (Hearing) form on 12/12/2024 no longer works at the facility and should have checked off a hearing consultation is needed. The SSD stated she should have completed a Social Service Assessment (Hearing) this past quarter to ensure Resident 5 received the services he needed. The SSD further stated six months is too long of a wait for hearing aids and she should have prioritized Resident 5. During a review of the facility's policy and procedure (P&P) titled, Resident Assessments, last reviewed on 7/16/2024, the policy and procedure indicated that all persons who have completed any portion of the MDS resident assessment form sign the document attesting to the accuracy of information. During a review of the facility's P&P titled, Hearing Impaired Resident, Care Of, the P&P indicated staff will assist hearing impaired residents to maintain effective communication with clinicians, caregivers, other residents and visitors. The P&P indicated the facility does not provide comprehensive audiological evaluations or devices to assist with hearing and staff will assist the resident (or representative) with locating available resources, scheduling appointments and arranging transportation to obtain needed services.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 38549 1.b. During a review of Resident 36's Admission Record, the Admission Record indicated that the facility originally admitted the resident on 7/6/2014 and readmitted the resident on 4/29/2025 with diagnoses including metabolic encephalopathy (a condition where brain dysfunction results from a problem with the body's metabolism, causing a change in brain function), legal blindness, and a history of falling. During a review of Resident 36's Minimum Data Set (MDS - a resident assessment tool), dated 3/3/2025, the MDS indicated that the resident had intact cognition (thought processes) and was dependent on staff for most activities of daily living (ADLs - activities such as bathing, dressing and toileting a person performs daily). During a review of Resident 36's Fall Risk Assessment, dated 3/4/2025, the Fall Risk Assessment indicated that the resident was at high risk for falls. During a review of Resident 36's physician's order, dated 5/1/2025, the order indicated to provide the resident with a floor mat to decrease potential injury every shift. On 5/7/2025 at 2:41 p.m., during an observation, observed Resident 36 asleep in bed. No floor mats were observed in the room. On 5/7/2025 at 4:04 p.m., during a concurrent observation and interview, observed Resident 36 in bed. Certified Nursing Assistant 4 (CNA 4) stated she was the assigned CNA for Resident 36. CNA 4 verified that the resident was at high risk for falls and did not currently have floor mats. On 5/8/2025 at 11:18 a.m., during an interview with the Director of Nursing (DON), the DON stated if the resident was not provided with the prescribed floor mats, then the resident could potentially have a fall resulting in injury. During a review of the facility's policy and procedure titled, Falls - Clinical Protocol, last reviewed on 7/16/2024, the policy and procedure indicated that, based on the assessment, the staff and physician will identify pertinent interventions to try to prevent falls and to address risks of serious consequences of falling. 44309 Based on observation, interview, and record review, the facility failed to provide an environment that is free from accident hazards for four (Resident 36, 61, 80 and 182) of six sampled residents reviewed under the accidents care area by: 1. Failing to place floor mats (a floor pad designed to help prevent injury should a person fall) on both sides of the Resident 61 and Resident 36's beds as ordered by the physician. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Failing to ensure Resident 182's bed rail padding was intact and did not have a large rip that exposed the hard bed rail for a resident with an order for padded bed rails to decrease potential injuries. 3. Failing to ensure Resident 80 had accurate fall risk assessments. These deficient practices had the potential to place Residents 36, 61, 80 and 182 at risk for injuries. Findings: 1.a During a review of Resident 61's Admission Record (face sheet), the Admission record indicated that the facility admitted the resident on 4/22/2024, with diagnoses including history of falling, muscle weakness, and seizure (a sudden, uncontrolled electrical disturbance in the brain which can cause uncontrolled jerking, blank stares, and loss of consciousness). During a review of Resident 61's Minimum Data Set (MDS- a resident assessment tool) dated 2/2/2025, the MDS indicated the resident's cognitive skills (the brain's ability to think, read, learn, remember, reason, express thoughts, and make decisions) for daily decision making was moderately impaired (decisions poor, cues/supervision required). The MDS indicated that Resident 61 was dependent on staff (helper does all the effort) for oral hygiene, toileting hygiene, showering/bathing, upper and lower body dressing, putting on/taking off footwear, and personal hygiene. The MDS further indicated that Resident 61 had one fall since his admission/entry to the facility. During a review of Resident 61's Order Summary Report (physician order) dated 10/30/2024, the order summary report indicated to place floor mat on both sides of the resident`s bed to decrease potential injuries due to fall.  During a review of Resident 61's Change of Condition (COC-an improvement or worsening of a patient`s condition which was not anticipated) Interact Assessment form dated 11/30/2024, the COC assessment form indicated that the resident slid off his wheelchair in the dining room. During a review of Resident 61's care plan (a document that outlines how a patient's health care needs will be met) for actual fall initiated on 11/30/2024, and last revised on 12/2/2024, the care plan indicated a goal that the resident will have minimum risk for falls/injury through appropriate interventions until the next assessment. The care plan interventions were to place the resident`s bed in a low position, and to place floor mats at the resident`s bedside. During a concurrent observation and interview on 5/8/2025 at 8:46 a.m., inside Resident 61's room, the resident was observed in his bed. Certified Nursing Assistant 3 (CNA 3) was sitting next to the resident and assisting him with his breakfast. CNA 3 stated there is no floor mat at Resident 61's bedside as a fall precaution. During a concurrent interview and record review on 5/8/2025 at 8:50 a.m., with Registered Nurse 1 (RN 1), Resident 61`s physician orders were reviewed. RN 1 stated Resident 61`s physician ordered to place floor mats at the resident`s bedside to decrease the potential injuries due to a fall. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview on 5/8/2025 at 8:53 a.m., inside Resident 61's room with RN 1, RN 1stated that Resident 61 did not have any floor mats at his bedside as ordered by his physician and the potential outcome is injuries if a fall occurs. During an interview on 5/8/2025 at 3:11 p.m., with the Director of Nursing (DON), the DON stated that Resident 61 is considered a high risk for falling and his physician ordered to place floor mats on both sides of his bed. The DON stated staff did not place floor mats at Resident 61's bedside and the potential outcome is insufficient care and increased risk of injuries after a fall. During a review of the facility's Policy and Procedure (P&P) titled Falls - Clinical Protocol, last reviewed on 7/16/2024, the P&P indicated that based on the proceeding assessment, the staff and physician will identify pertinent interventions to try to prevent subsequent falls and to address risks of serious consequences of falling. The staff and physician will monitor and document the individual`s response to interventions intended to reduce falling or the consequences of falling. During a review of the facility's Policy and Procedure (P&P) titled Low Bed - Floor Mat, not a Restraint, last reviewed on 7/16/2024, the P&P indicated that the facility does not consider the use of low bed and floor mat as a restrain. The use of low bed and floor mat is the least restrictive measure when a resident is in bed. 47883 3. During a review of Resident 80's Admission Record, the Admission Record indicated the facility originally admitted the resident on 9/3/2021 and readmitted the resident on 10/29/2023 with diagnoses including metabolic syncope (fainting, or a sudden temporary loss of consciousness), major depression (a mood disorder that causes a persistent feeling of sadness and loss of interest and can interfere with your daily activities of living), and seizures (a burst of uncontrolled electrical activity between brain cells that caused temporary abnormalities in muscle tone or movements) and history of fall. During a review of Resident 80's Minimum Data Set (MDS - a resident assessment tool), dated 4/25/2025, the MDS indicated the resident had intact cognition (undamaged mental abilities, including remembering things, making decisions, concentrating, or learning) was able to make herself understood and usually understands others. The MDS further indicated Resident 80 required supervision of staff to complete most activities of daily living (ADLs- activities such as bathing, dressing and toileting a person performs daily). During a review of Resident 80's Care plan initiated on 06/03/2023, the Care plan indicated that Resident 80 was on Falling Star Program and was at risk for fall. During a review of Resident 80's Change of Condition (COC) Assessment Form, dated 10/14/2024, the COC Assessment Form indicated Resident 80 was found on the floor in his room. The COC Assessment Form further indicated Resident 80 stated he tried getting up from the bed to go to the bathroom and fell . (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 5/8/2025 at 1:39 p.m. with Director of Nursing (DON), Resident 80's Fall Risk Evaluations, dated 10/14/2024 and 4/15/2025 were reviewed. The D section of the Fall Risk Evaluation dated 10/14/2024 titled Predisposing factors, did not reflect seizures as a predisposing factor. The DON stated that the Fall Risk Evaluation should reflect all predisposing conditions including seizures. The second section of Resident 80's Fall Risk Assessment, dated 4/15/2025 titled History of Falls for past three months was blank. The DON stated it is important to accurately complete the Fall Risk Assessment so staff are aware of Resident 80's risk of falling and staff can effectively care for the resident. During a review of the facility's policy and procedure (P&P) titled, Falls - Clinical Protocol, last revised 7/16/2025, the P&P indicated: The staff will document risk factors for falling in the resident's record and discuss resident's fall risk. 50033 2. During a review of Resident 182's Admission Record, the Admission Record indicated the facility originally admitted the resident on 3/29/2025 and readmitted the resident on 4/29/2025 with diagnoses including but not limited to cerebral infarction (an obstruction of blood flow in the brain that leads to tissue damage) and acute respiratory failure (a condition where the lungs cannot release enough oxygen into the blood). During a review of Resident 182's Minimum Data Set (MDS - a resident assessment tool), dated 4/11/2025, the MDS indicated Resident 182 had severely impaired cognitive skills (problems with the ability to think, learn, and remember clearly) for daily decision making and required total assistance from staff with activities of daily living (ADLs- activities such as bathing, dressing and toileting a person performs daily). During a review of Resident 182's Physicians Orders, the Physicians Orders indicated an order for padded bed rails to decrease potential injury dated 4/30/2025. During a review of Resident 182's care plan titled Resident is on Padded siderails, dated 3/30/2025, the care plan indicated the resident needs padded bed rails to prevent or reduce incidences of injuries. During a concurrent observation and interview on 5/8/2025 at 10:51 a.m. with the Subacute Director (SD), Resident 182's upper left bed rail padding had a large rip which exposed the hard bed rail. The SD stated the padding should be replaced due to the rip. The SD stated that because the bed rail is exposed due to the rip the padding would not protect the resident from injuries. During an interview on 5/8/2025 at 2:39 p.m. with the Director of Nursing (DON), the DON stated the ripped bed rail padding on Resident 182's upper left bed rail could potentially result in injuries to Resident 182. During a review of the facility's policy and procedure (P&P) titled Homelike Environment, last reviewed 7/16/2024, the P&P indicated residents are to be provided with a safe, clean, comfortable, environment. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's P&P titled Bed Safety and Bed Rails, last reviewed 7/16/2024, the P&P indicated potential risks with the use of bed rails are assessed including accident hazards and skin integrity issues.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. 47883 Based on observation, interview, and record review, the facility failed to ensure one of two sampled residents (Resident 540) was provided a toileting program and/or bowel and bladder training (when facility staff assist a resident to the restroom at specific timed intervals) to restore as much bladder function as possible. This deficient practice had the potential to result in continued urinary incontinence (the involuntary leakage or loss of bladder control, resulting in unintended urination), development of urinary tract infection (UTI- an infection in any part of the urinary system), and potential to not achieve or restore normal bowel and bladder function. Findings: During a review of Resident 540's Admission Record, the Admission Record indicated the facility originally admitted the resident on 4/6/2025 with diagnoses including acute and chronic respiratory failure (condition in which not enough oxygen passes from your lungs into your blood), acute kidney failure (a condition in which the kidneys are damaged and cannot filter blood well), and type two (2) diabetes mellitus (a chronic condition that affects the way the body processes blood glucose [sugar]). During a review of Resident 540's Minimum Data Set (MDS - a resident assessment tool) dated 4/18/2025, the MDS indicated the resident had intact cognition (mental abilities, including remembering things, making decisions, concentrating, or learning) and required moderate - to - maximal assistance from staff for most activities of daily living (ADLs - activities related to personal care). During a review of Resident 540's Baseline Care Plan (a document that summarizes a resident's needs, goals, and care/treatment) dated 4/6/2025, the care plan indicated that Resident 540 was admitted with an indwelling catheter (a flexible tube used to empty the bladder and collect urine in a drainage bag) and required catheter care. During a review of Resident 540's Bowel and Bladder Screener dated 4/9/2025, the Bowel and Bladder Screener indicated that Resident 540 was a poor candidate for retraining/scheduled toileting. During a review of Resident 540's physician orders, the physician orders indicated an order to discontinue indwelling catheter, dated 4/18/2025. During a review of Resident 540's Care Plan dated 4/21/2025, the Care Plan indicated that the resident had alteration in elimination patterns related to being always incontinent for bowel and bladder and was not retrainable for bladder and bowel. During a review of Resident 540's Elimination Flowsheet dated 5/7/2025, the Elimination Flowsheet indicated that Resident 540 was continent (the ability to control movements of the bowels and bladder) four times in the last seven days on 5/3/2025, 5/5/2025, 5/6/205 and 5/7/2025. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview on 5/5/2025 at 9:51 a.m., with Resident 540 in Resident 540's room, observed Resident 540 walking to the bathroom independently. Resident 540 stated that he was not provided with any bladder retraining program in the facility and he would like to participate in bladder retraining program because he is able to feel the urge to go to bathroom when he is awake but is not be aware of the need to toilet when he is sleeping. During an interview on 5/7/2025 at 8:34 a.m., with the Assistant Director of Nursing (ADON), the ADON stated that she did Resident 540's Bowel and Bladder Screening on 4/9/2025. The ADON stated that Resident 540 was not a candidate for bladder retraining program due to sleepiness and forgetfulness. The ADON stated that the resident should be screened one more time after he becomes more mobile and alert after his indwelling catheter was removed and put on bladder training program to restore as much bladder function as possible. During an interview on 5/8/2025 at 3:15 p.m., with the Director of Nursing (DON), the DON stated that the licensed nursing staff did not repeat a bowel and bladder program screening when Resident 540 became more alert and independent and did not provide Resident 540 with an individualized bowel and bladder retraining program. During a review of the facility's policy and procedure titled, Bladder and Bowel Assessment, dated 7/16/2024, the policy indicated bladder and bowel assessment will be completed within 14 days from admission/readmission and updated quarterly. And based on the score, the care plan is developed and the care planned.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44309 Based on observation, interview, and record review, the facility failed to ensure that one of one sampled resident (Resident 15), who was receiving nutrition by gastrostomy tube (GT-a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems), received appropriate care and services to prevent complications of enteral feeding (tube feeding, a way of delivering nutrition directly to your stomach or small intestine). This deficient practice had the potential to lead to the inadequate care of Resident 15 and place the resident at an increased risk for complications such as infection. Findings: During a review of Resident 15's Admission Record (face sheet), the Admission record indicated that the facility originally admitted the resident on 11/21/2024 and readmitted on [DATE], with diagnoses including tracheostomy (an opening surgically created through the neck into the windpipe to allow air to fill the lungs), gastrostomy, and dementia (a progressive state of decline in mental abilities). During a review of Resident 15's Minimum Data Set (MDS - a resident assessment tool) dated 4/15/2025, the MDS indicated that the resident`s cognitive skills (brain's ability to think, read, learn, remember, reason, express thoughts, and make decisions) for daily decision making was severely impaired (never/rarely made decisions). The MDS indicated that Resident 15 was dependent on staff (helper does all of the effort) for oral hygiene, toileting hygiene, showering and bathing, upper and lower body dressing, and personal hygiene. The MDS further indicated that Resident 15 was receiving nutrition via gastrostomy tube while a resident in the facility. During a review of Resident 15`s care plan (a document outlining a detailed approach to care customized to an individual resident's need) for GT feeding initiated on 1/14/2025 and last revised on 4/30/2025, the care plan indicated a goal that the resident will have minimum risk of infection at his GT site until the next assessment date. The care plan interventions were to provide GT care daily, and assess the skin for redness, pain, swelling, discharge and report to the physician if any present. During a review of Resident 15`s physician Order Summary Report dated 5/5/2025, the Order Summary Report indicated an order to clean the GT site with normal saline (NS- a saltwater solution), pat dry, and cover with dry dressing during every day shift. During a concurrent observation and interview on 5/7/2025 at 11:17 a.m., with Certified Nursing Assistant 2 (CNA 2), inside Resident 15's room, CNA 2 stated that there is no dressing present on Resident 15`s GT insertion site. CNA 2 stated the facility`s Treatment Nurse (TN) is in charge of providing skin care and dressing to residents` GT sites. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a record review of Resident 15`s Treatment Administration Record (TAR-a daily documentation record used by a licensed nurse to document treatments given to a resident) on 5/7/2025 at 12:40 p.m., the TAR indicated that Treatment Nurse 1 (TN 1) documented that he provided treatment to the resident`s GT site during day shift on 5/7/2025. During a concurrent observation and interview on 5/7/2025 at 1:10 p.m., with CNA 2, inside Resident 15's room, CNA 2 stated that there is no dressing present on Resident 15`s GT insertion site.  During a concurrent observation and interview on 5/7/2025 at 1:20 p.m., with TN 1 inside Resident 15's room, TN 1 confirmed that there was no dressing on Resident 15`s GT insertion site. TN 1 stated that he provided skin care and placed a dressing on Resident 15`s GT insertion site today at around 9.00 a.m. However, TN 1 stated that he documented in the Resident 15`s TAR that he (TN 1) provided care today at 12:32 p.m. TN 1 stated that he (TN 1) is not sure what happened to the dressing and that Resident 15 must have removed it. TN 1 stated that he (TN 1) is required to document in the residents` medical record right after completing his task so that the documentation reflects the correct time wound care had been provided. TN 1 stated that the potential outcome of not performing skin care, and not placing the dressing on the GT site is infection. During an interview on 5/8/2025 at 3:04 p.m., with the Director of Nursing (DON), the DON stated that licensed staff are required to provide skin care to GT insertion site daily and document in the residents` TAR immediately after completion of the task. The DON stated, If the dressing is not there, it is not done. The DON stated the potential outcome of not performing skin care and placing dressing to a resident`s GT site is infection. During a review of the facility`s Policy and Procedure (P&P) titled Enteral Nutrition, last reviewed 7/16/2024, the P&P indicated that staff caring for residents with feeding tubes are trained on how to recognize and report complications associated with the insertion and/or use of feeding tube such as skin breakdown around insertion site.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44309 Based on observation, interview, and record review, the facility failed to 1. Ensure that a resident received oxygen as ordered by the physician for one of two sampled residents (Resident 107) reviewed under Respiratory Care area. 2. Ensure that Resident 107`s oxygen tubing had a label indicating the date and time of when it was last changed.  3. Ensure that Resident 107`s oxygen humidifier (a medical device used to add moisture to supplemental oxygen, making it easier and more comfortable to breathe, especially for patients using oxygen therapy for extended periods) was full. These deficient practices had the potential to place Resident 107 at an increased risk of infection and cause complications associated with oxygen therapy. Findings: During a review of Resident 107's Admission Record (face sheet), the Admission Record indicated that the facility originally admitted the resident on 4/19/2021 and readmitted on [DATE], with diagnoses including acute (appear rapidly) and chronic (a condition that lasts longer than three months) respiratory failure (a serious condition that makes it difficult to breathe on your own) with hypoxia (a medical condition where there is an inadequate supply of oxygen to the body's tissues), type two diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), and history of falling. During a review of Resident 107's Minimum Data Set (MDS- a resident assessment tool) dated 2/2/2025, the MDS indicated the resident`s cognitive skills (the brain's ability to think, read, learn, remember, reason, express thoughts, and make decisions) for daily decision making was intact (decisions consistent/reliable). The MDS indicated that Resident 107 required the staff substantial/maximal assistance (helper does more than half the effort) for oral hygiene, and upper body dressing. The MDS indicated that Resident 107 was dependent on staff (helper does all of the effort) for toileting hygiene, showering and bathing, lower body dressing, putting on/talking off footwear and personal hygiene. The MDS further indicated that Resident 107 was receiving oxygen therapy while a resident in the facility. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 107's physician Order Summary Report (physician orders) dated 11/15/2024, the order summary report indicated to administer oxygen at two liters per minute via nasal cannula (NC-a small plastic tube, which fits into the person's nostrils for providing supplemental oxygen) for shortness of breath (SOB) and chronic respiratory failure. The order summary report indicated to titrate (to carefully adjust the amount of oxygen a patient receives to achieve a specific, target level of oxygen saturation in the blood) the oxygen level up to three liters per minute to keep the resident`s oxygen saturation (a measurement of how much oxygen your blood is carrying compared to its maximum capacity-for healthy adults, normal oxygen saturation is between 95% and 100%) above 90%. The order summary report further indicated to change the oxygen tubing every Sunday during night shift. During a review of Resident 107`s care plan (a document outlining a detailed approach to care customized to an individual resident's need) for oxygen, initiated on 4/30/2021 and last revised on 8/18/2024, the care plan indicated a goal that the resident will be free of adverse effects related to use of oxygen. The care plan interventions were to administer oxygen as per physician order, monitor the resident`s oxygen saturation, change the oxygen tubing weekly or as needed and to check the rate of oxygen flow during every shift.  During a concurrent observation and interview on 5/5/2025 at 10:12 a.m. with Certified Nursing Assistant 1 (CNA1) inside Resident 107`s room, Resident 107 was observed sitting on her bed receiving oxygen. CNA 1 stated that Resident 107 was receiving oxygen at six liters per minute via NC. CNA 1 stated that Resident 107`s oxygen tubing did not have a label including the date and time of when it was last changed. CNA 1 stated that the humidifier connected to Resident 107`s oxygen machine was empty. During a concurrent observation and interview on 5/5/2025 at 10:16 a.m. with Licensed Vocational Nurse 2 (LVN 2) inside Resident 107`s room, LVN 2 stated that Resident 107`s physician ordered to administer oxygen at two liters per minute via NC. However, Resident 107 receives oxygen at six liters per minute via NC. LVN 2 stated that Resident 107`s oxygen tubing did not have a label with the date and time of when it was last changed. LVN 2 stated Resident 107`s oxygen humidifier was empty. LVN 2 stated that the facility staff are required to change oxygen tubing once a week on Sundays. LVN 2 stated the potential outcome of not changing a resident`s oxygen tubing once per week as ordered by the physician is placing the resident at risk for infection. LVN 2 further stated that Resident 107 was receiving oxygen at a greater rate than it was ordered by her physician. LVN 2 stated delivering too much oxygen via NC may be harmful to Resident 107. LVN 2 stated licensed nurses are required to ensure that the oxygen humidifier is full to prevent nostril dryness. LVN 2 stated that he (LVN 2) failed to monitor Resident 107 appropriately to ensure that she is receiving the correct rate of oxygen, that the humidifier is full and the oxygen tubing is dated. During an interview on 5/8/2025 at 3:15 p.m., with the Director of Nursing (DON), the DON stated licensed staff are required to implement physician orders for administration of oxygen to residents. The DON stated that the facility staff are required to change the oxygen tubing once per week as ordered by the physician and label the tubing with the date and time it was changed. The DON stated licensed staff are required to monitor residents` oxygen humidifier to ensure the container is full. The DON stated the potential outcome of not changing and labeling the oxygen tubing and humidifier is the increased risk of infection for the residents. The DON stated the potential outcome of administering oxygen more than the physician`s ordered flow rate via NC is difficulty breathing and harm to the resident. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's Policy and Procedure (P&P) titled Oxygen Administration, last reviewed on 7/16/2024, the P&P indicated that oxygen will be administered to residents as needed per attending physician`s orders by licensed personnel. Review oxygen order(s) for oxygen use. Administer oxygen as per physician`s orders. Oxygen administered at three liters per minutes pr more requires humidifier. The oxygen tubing should be changed weekly and as needed. The date, time, and initials should be noted on oxygen equipment when it is initially used and when changed. Since oxygen is based on a physician`s order, it is considered a licensed staff procedure.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. 50033 Based on interview and record review, the facility failed to ensure non-pharmacological interventions (treatments or therapies that do not involve the use of medications) were attempted prior to administering as needed oxycodone (a drug used to treat moderate to severe pain) for one of two sampled residents (Resident 100). This deficient practice placed Resident 100 at increased risk of experiencing adverse side effects (undesired harmful effect resulting from a medication or other intervention) from oxycodone such as drowsiness, increased risk of falling, or loss of appetite. Findings: During a review of Resident 100's Admission Record, the Admission Record indicated the facility originally admitted the resident on 9/19/2020 and readmitted the resident on 3/29/2025 with diagnoses including but not limited to sarcoma (a group of cancers which start in the bones and connective tissue), pain in the right knee, and aftercare following surgery for a neoplasm (abnormal and excessive growth of tissue). During a review of Resident 100's Minimum Data Set (MDS - a resident assessment tool), dated 4/11/2025, the MDS indicated Resident 100 had intact cognition (can think, learn, and remember clearly) and required total assistance or substantial assistance from staff for most activities of daily living (ADLs- activities such as bathing, dressing and toileting a person performs daily). During a review of Resident 100's physician orders, the physician orders indicated the following: - Oxycodone 5 milligram (mg- unit of measurement) oral tablets: give one tablet by mouth every four hours as needed for severe pain, ordered 4/12/2025. - Non-pharmacological pain interventions: 1- reposition, 2-dim lights, 3-distraction, 4-relaxation techniques, 5-hot/cold applications, 6-music, 7-massage, 8-other. Document result and effectiveness of intervention. If ineffective administer appropriate pain medication as ordered, ordered 2/17/2025. During a concurrent interview and record review on 5/7/2025 at 12:02 p.m., with Licensed Vocational Nurse 5 (LVN 5), reviewed Resident 100's Medication Administration Record (MAR - a daily documentation record used by a licensed nurse to document medications and treatments given to a resident) dated 4/2025. Resident 100's MAR indicated there was no documentation that non-pharmacological pain interventions were attempted prior to administering oxycodone on 4/14/2025 at 9:00 a.m. LVN 5 stated Resident 100 should be offered non-pharmacological pain interventions before giving pain medication because there is an order to try non-pharmacological options first and it is important to follow that protocol. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 5/8/2025 at 12:18 p.m., with Registered Nurse 3 (RN 3), reviewed Resident 100's MAR dated 4/2025. Resident 100's MAR indicated there was no documentation that non-pharmacological pain interventions were attempted prior to administering oxycodone on 4/16/2025 at 11:45 a.m. and 4/24/2025 at 12:50 p.m. RN 3 stated she was not sure why there was no documentation of non-pharmacological pain interventions before she administered oxycodone at those times. RN 3 stated it is important to try non-pharmacological pain interventions first because that might relieve the resident's pain, and the pain medication may be unnecessary. During an interview on 5/8/2025 at 2:39 p.m. with the Director of Nursing (DON), the DON stated non-pharmacological pain interventions should be tried first before giving pain medications. The DON stated they need to see if non-pharmacological pain interventions would relieve the pain before considering pain medication. During a review of the facility's policy and procedure (P&P) titled, Pain Assessment and Management, last reviewed 7/16/2024, the P&P indicated non-pharmacological interventions including adjusting room temperature, repositioning, ice packs, range of motion exercises, and diversions may be appropriate interventions alone or in conjunction with medications. The P&P further indicated pain medications can manage pain but can also have adverse effects including drowsiness, increased risk of falling, or loss of appetite.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44309 Based on observation, interview, and record review, the facility failed to ensure a resident who received dialysis (a treatment to cleanse the blood of wastes and extra fluids artificially through a machine when the kidney(s) have failed) received treatment in accordance with standards of practice for one of four sampled residents reviewed under the dialysis care area (Resident 160) by: 1. Failing to assess the resident`s right upper chest quinton catheter (non-tunneled central line catheters, which are often used as temporary access for hemodialysis) dialysis access site. 2. Failing to implement the physician's order for fluid restriction (limiting the amount of liquid a person consumes daily, often prescribed to manage kidney disease) limited to no water pitcher at the resident`s bedside. These deficient practices had the potential to place Resident 160 at risk for fluid overload (a condition where you have too much fluid volume in your body) and infection. Findings: During a review of Resident 160's Admission Record (face sheet), the Admission Record indicated that the facility originally admitted the resident on 6/7/2024 and readmitted on [DATE] with diagnoses including type two (2) diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), dependence on renal (kidney) dialysis, and end stage renal disease (ESRD-irreversible kidney failure). During a review of Resident 160's Minimum Data Set (MDS - a resident assessment tool) dated 4/1/2025, the MDS indicated that the resident`s cognitive skills (brain's ability to think, read, learn, remember, reason, express thoughts, and make decisions) for daily decision making was moderately impaired (decisions poor, cues/supervision required). The MDS indicated that Resident 160 was dependent on staff (helper does all of the effort) for oral hygiene, toileting hygiene, upper and lower body dressing, showering/bathing, putting on/taking off footwear, and personal hygiene. The MDS further indicated that Resident 160 was undergoing hemodialysis while a resident in the facility. During a review of Resident 160`s care plan (a document that outlines how a patient's health care needs will be met) for hemodialysis initiated on 6/20/2024, the care plan indicated that the resident had right upper chest quinton catheter. The care plan interventions were to monitor dialysis access site for sign and symptoms of infection, bleeding, pain, clotting, swelling, drainage, and discoloration, and notify the physician if it occurs. During a review of Resident 160`s care plan for potential for unavoidable bleeding on the AV shunt site or right upper chest central line initiated on 6/20/2024, the care plan indicated a goal that the risk of occurrence of emergency bleeding will be reduced through interventions daily. The care plan interventions were to document monitoring of dialysis site during every shift and as needed. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 160`s Admission assessment dated [DATE], the admission assessment indicated that the resident had right upper chest quinton catheter for hemodialysis. During a review of Resident 160's physician Order Summary Report (physician orders) dated 3/26/2025, the Order Summary Report indicated to place Resident 160 on fluid restriction and not place any water pitcher at her bedside. During a review of Resident 160`s care plan for fluid restriction initiated on 4/14/2025, the care plan indicated a goal that the resident will not show any signs and symptoms of fluid overload. The care plan interventions were to place no water pitcher at the resident`s bedside. During a review of Resident 160's physician Order Summary Report dated 4/17/2025, the Order Summary report indicated to monitor Resident 160`s right upper arm arteriovenous fistula (AVF- a connection that is made between an artery and a vein for dialysis access) for bleeding, itching, pain, and swelling during every shift.  During a review of Resident 160`s Medication Administration Records (MAR - a daily documentation record used by a licensed nurse to document medications and treatments given to a resident) for 4/1/2025-4/31/2025 and 5/1/2025-5/8/2025, the MARs indicated no documentation of monitoring Resident 160`s right upper chest quinton catheter.  During an observation on 5/5/2025 at 9:20 a.m., inside Resident 160`s room, a written note on the wall on top of the resident`s bed indicated No water pitcher at bedside. However, a full pitcher of water, a full glass of milk and juice were observed on the resident`s side table. Resident 160 stated that she is undergoing hemodialysis on Mondays, Wednesdays, and Fridays at noon. During an observation, a right upper chest quinton catheter was observed with dressing. During a concurrent observation and interview on 5/5/2025 at 9:21 a.m. with Infection Preventionist (IPN) inside Resident 160 `s room, IPN stated that there was a full pitcher of water, a full glass of milk and juice at the resident`s side table. IPN stated Resident 160 is undergoing hemodialysis, and her physician ordered to place no water pitcher at her bedside. IPN stated the staff failed to follow Resident 160`s physician order regarding fluid restrictions. IPN stated that the potential outcome is that Resident 160 may experience a fluid overload.  During a concurrent interview and record review on 5/8/2025 at 11:45 a.m., with Registered Nurse 1 (RN 1), Resident 160`s physician orders, MARs and care plans were reviewed. RN 1 stated Resident 160 is undergoing hemodialysis and her care plan indicated that she has right upper chest quinton catheter and right upper arm AV fistula. However, she (RN 1) cannot find any physician orders for monitoring Resident 160`s right upper chest quinton catheter. RN 1 stated licensed staff did not implement Resident 160`s care plan intervention and did not monitor the resident`s right chest quinton catheter. RN 1 stated licensed staff are required to monitor residents` dialysis access sites. RN 1 stated the potential outcome of not monitoring residents` dialysis access sites is infection and bleeding. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/8/2025 at 3:18 p.m., with the Director of Nursing (DON), the DON stated that staff are required to implement physician orders for the resident`s fluid restriction. The DON stated Resident 160 requires hemodialysis three times a week, and it is necessary to not place a water pitcher at her bedside as ordered by her physician to prevent fluid overload and edema. The DON stated license staff failed to obtain a physician order for monitoring Resident 160`s right chest quinton catheter and failed to monitor the catheter as indicated in her care plan. The DON stated the potential outcome is infection and bleeding.  During a review of the facility`s Policy and Procedures (P&P) titled Care of Resident Receiving Renal Dialysis, last reviewed on 7/16/2024, the P&P indicated that if residents have a central line, assess site for signs and symptoms of complications and notify the physician. The physician orders specific fluids allowed in 24 hours. Fluid restriction limited to no water pitcher at bedside promises improved quality of life. During a review of the facility`s Policy and Procedures (P&P) titled Fluid Restricted-Diet, last reviewed on 7/16/2024, the P&P indicated that when a resident requires fluid restriction, a physician`s order shall be obtained and shall note the parameters of the fluid intake desires. Fluid restricted diet shall be monitored by the nursing department. The nursing department shall remove water pitcher from resident`s bedside.

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. Deficiency Text Not Available

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California Healthcare and Rehabilitation Center	6700 Sepulveda Blvd. Van Nuys, CA 91411

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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 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide medically-related social services to help each resident achieve the highest possible quality of life. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47883 Based on interview and record review, the facility failed to follow its Patient Assessment, policy and procedure for one sampled resident (Resident 18) reviewed under dementia care by failing to conduct a quarterly social service assessment . This deficient practice had the potential for Resident 18 to not attain or maintain the highest practicable physical, mental and psychosocial health. Findings: During a review of Resident 18's Admission Record, the Admission Record indicated that the resident was admitted to the facility on [DATE] and readmitted on [DATE] with diagnosis including pneumonia (is an infection that inflames the air sacs [thin-walled structures composed of simple squamous epithelium] in one or both lungs), Parkinsonism (a clinical syndrome characterized by a group of motor symptoms, including bradykinesia[slowed movement], rigidity[stiffness], and tremor, and often associated with impaired posture and gait), and schizophrenia (a serious mental illness that affects how a person thinks, feels, and behaves). During a review of Resident 18's Minimum Data Set (MDS - a resident assessment tool) dated 4/14/2025, the MDS indicated that the resident had severely impaired cognition (severely damaged mental abilities, including remembering things, making decisions, concentrating, or learning).The MDS indicated that Resident 18 was dependent on staff (helper does all of the effort) for oral hygiene, toileting hygiene, upper and lower body dressing, putting on/talking off footwear, and personal hygiene. During a concurrent interview and record review on 5/8/2025 at 10:12 a.m., with the Social Service Director (SSD), Resident 18`s assessments were reviewed. The SSD stated that social service assessment has to be done quarterly and annually. However, she (SSD) did not conduct a quarterly social service assessment in March 2025. The SSD stated that social service assessment includes psychosocial history, physical, cultural and spiritual factors having impact on the resident`s adjustment and wellbeing in the facility, and the determination of anticipated discharge planning. The SSD stated that the last social service assessment was conducted on 1/13/2025. The SSD stated that the reason she did not conduct a social service assessment for Resident 18 was because she was backed up with assignments for other residents. The SSD stated that the potential outcome of not timely reassessing a resident is the delay in addressing their psychosocial issues. During an interview on 5/8/2025 at 3:15 p.m., with the Director of Nursing (DON), the DON stated the social worker shall conduct a social service assessment every quarter and annually. The DON stated SSD did not conduct quarterly social service assessment for Resident 18 in March 2025 and the potential outcome is the inability to address psychosocial concerns and prevent psychosocial issues. During review of the facility's Policy and Procedure (P&P) titled, Patient Assessments, last reviewed on 7/16/2024, the P&P indicated The resident assessment coordinator is responsible for ensuring that the interdisciplinary team conducts timely and appropriate resident assessments and reviews according to the following requirements: (continued on next page)

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F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	a. OBRA required assessments- conducted for all residents in the facility: 1.Admission Assessment 2.Quaterly Assessments 3.Annual Assessments 4. Significant Change in Status Assessment 5.Significant Correction to prior Comprehensive Assessment 6. Significant Correction to prior Quarterly Assessment 7.Discharge Assessment.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 43455 Based on observation, interview, and record review the facility failed to: 1. Reconcile (the process of comparing transactions and activity to supporting documentation) one (1) medication emergency kit (eKIT-contains certain medications that could be taken if needed immediately) containing controlled medications (CM- medications which have a potential for abuse and may also lead to physical or psychological dependence) for 5/2025, in one (1) of two (2) inspected medication rooms (Medication Room Station 1). 2. Reconcile one (1) medication eKIT containing CMs for 5/2025, in one (1) of five (5) inspected medication carts (Medication Cart Station 2B.) These deficient practices increased the opportunity for CM diversion (the transfer of a controlled medication or other medication from a lawful to an unlawful channel of distribution or use). Findings: During a concurrent observation and interview on 5/5/2025 at 12:50 p.m., with Registered Nurse 1 (RN 1) and in the presence of the Director of Nursing (DON) in Medication Room Station 1, observed one (1) medication eKIT in the refrigerator labeled 109 containing CMs without an accountability log for the reconciliation of CM inventory at every shift for 5/2025. RN 1 stated that all CMs, including medication eKITs containing CMs, should be reconciled at every shift. RN 1 stated that the eKIT labeled 109 containing CMs in Medication Room Station 1 was not reconciled at every shift in 5/2025, and it was important to account for all CMs to ensure accountability, prevent CM diversion, and accidental exposure of harmful substances to residents. The DON stated the eKIT labeled 109 contained CMs and was not reconciled at each shift for 5/2025. The DON stated that the facility will immediately implement an accountability log for reconciliation of eKITs containing CMs at each shift in Medication Room Station 1. During a concurrent observation and interview on 5/5/2025 at 2:15 p.m., with Licensed Vocational Nurse 1 (LVN 1), observed in Medication Cart Station 2B, one (1) medication eKIT labeled 318 containing CMs without an accountability log for the reconciliation of CM inventory at every shift for 5/2025. LVN 1 stated that the eKIT labeled 318 containing CMs in Medication Cart Station 2B was not reconciled at every shift in 5/2025, and it was important to account for all CMs to ensure accountability, prevent CM diversion, and accidental exposure of harmful substances to residents. During an interview on 5/6/2025 at 12:28 p.m., with the DON, the DON stated that medication eKITs containing CMs need to be counted and reconciled at every shift change to ensure accountability and prevent CM diversion. The DON stated one (1) eKIT containing CMs in Medication Cart Station 2B was not reconciled at each shift for 5/2025. The DON stated that the facility will immediately implement an accountability log for reconciliation of eKITs with CMs at each shift change in Medication Cart Station 2B. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's policy and procedure (P&P) titled, Controlled Medication Storage, last reviewed 7/16/2024, the P&P indicated, Medications included in the Drug Enforcement Administration (DEA) classification as controlled substances are subject to special handling, storage, disposal, and recordkeeping in the facility, in accordance with federal and state laws and regulations. The DON and the Consultant Pharmacist maintain the facility's compliance with federal and state laws and regulations in the handling of CMs. At each shift change, a physical inventory of all CMs including the emergency supply is conducted by two (2) licensed nurses and is documented on the CM accountability record.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43455 Based on observation, interview, and record review, the facility failed to ensure that its medication error rate was less than five (5) percent (%). Two (2) medication errors out of 34 total opportunities contributed to an overall medication error rate of 8.82% affecting two (2) of six (6) residents observed for medication administration (Resident 151 and 183.) The medication errors were as follows: 1. Resident 151 received carvedilol (a medication used to for hypertension [HTN - a condition in which the blood vessels have persistently raised pressure]) at a different time than ordered by Resident 151 ' s physician. 2. Resident 183: a. did not receive docusate (a medication used to soften stool) as ordered by Resident 183 ' s physician b. received a form of multivitamin (a medication used as a dietary supplement to provide essential vitamins, minerals, and other nutritional elements) that was different than the one ordered by Resident 183 ' s physician These failures had the potential to result in Resident 151 and 183 receiving suboptimal (less than standard) care, experiencing adverse effects (unwanted, uncomfortable, or dangerous effects that a medication may have) and resulting in Residents 151's and 183's health and well-being negatively impacted. Findings: During an observation on 5/5/2025 at 9:10 a.m., in Medication Cart 1A, Registered Nurse 3(RN 3) was observed administering multivitamin with minerals tablet orally and not administering docusate tablet to Resident 183. Resident 183 was observed swallowing the multivitamin with mineral tablet with a glass of juice. During an interview on 5/5/2025 at 11:55 a.m., with RN 3, RN 3 stated the physician order for Resident 183 indicated to hold the docusate dose for loose stool. RN 3 stated RN 3 did not administer docusate to Resident 183, during the morning medication administration at 9:10 a.m. since Resident 183 had a soft stool that morning. RN 3 stated Resident 183 did not have loose stool, and the dose should not have been held. RN 3 stated that not administering docusate could potentially harm Resident 183 by increasing the risk of having hard stools and constipation. During the same interview, RN 3 stated RN 3 stated the physician order for Resident 183 indicated to give multivitamin not containing minerals. RN 3 stated RN 3 failed to administer the correct multivitamin as prescribed by Resident 183's physician. RN 3 stated administering multivitamin with minerals to Resident 183 may not be beneficial to their health and may cause adverse effects. RN 3 stated these were considered medication errors. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 5/6/2025 at 10:05 a.m., in Medication Cart 2B, Licensed Vocational Nurse 1 (LVN 1) was observed administering carvedilol 6.25 milligram ([mg]-a unit of measure of mass) tablet orally to Resident 151. Resident 151 was observed swallowing the carvedilol tablet with a glass of water. During an interview on 5/6/2025 at 11:40 a.m., with LVN 1, LVN 1 the physician order for Resident 151 indicated to administer carvedilol at 8 a.m. with food to prevent stomach discomfort. LVN 1 stated per facility policy there was a 60-minute window for medication administration and LVN 1 administered carvedilol later than that timeframe. LVN 1 stated LVN 1 failed to administer carvedilol as prescribed by Resident 151's physician placing Resident 151 at risk of receiving the next dose closer in time and experiencing stomach irritation. LVN 1 stated this was considered a medication error. During an interview 5/6/2025 at 12:28 p.m., with the Director of Nursing (DON), the DON stated LVN 1 failed to administer carvedilol 6.25 mg tablet to Resident 151 according to physician orders at 8 a.m. that (5/6/2025) morning. The DON stated RN 3 failed to administer multivitamin without minerals and docusate to Resident 183, according to physician orders on 5/5/2025. The DON stated these were considered medication errors. The DON stated Resident 151 may be at risk for having the next dose given in a shorter timeframe since it was ordered to be given twice a day, and possible stomach irritation. The DON stated Resident 183 may possibly experience constipation or hard stools by not receiving docusate and be at risk of not being able to tolerate the additional minerals from the multivitamin. The DON stated licensed nurses should follow facility medication administration guidelines to ensure physician orders are followed and the right medications are administered at the right time to residents. During a review of Resident 183's Admission Record (a document containing demographic and diagnostic information,) dated 5/5/2025, indicated Resident 183 was originally admitted to the facility on [DATE] with a diagnosis including malnutrition (a condition when the body does not receive enough nutrients,) and failure to thrive (to do well.) During a review of Resident 183's Order Summary Report, dated 5/5/2025, the report indicated Resident 183 was prescribed: 1. docusate 100 mg to give one (1) tablet by mouth twice a day for stool softener [hold for loose bowel movement], starting 4/1/2025 2. multivitamin to give one (1) tablet by mouth once a day for wound regimen, starting 4/9/2025 During a review of Resident 183's Medication Administration Record ([MAR] - a record of mediations administered to residents), for May 2025, the MAR indicated Resident 183 was prescribed: 1. docusate 100 mg one (1) tablet by mouth twice a day for stool softener [hold for loose bowel movement], to give at 9 a.m. and 6 p.m. 2. multivitamin one (1) tablet by mouth once a day for wound regimen, to give at 9 a.m. During a review of Resident 151 ' s Admission Record dated 5/6/2025, indicated Resident 151 was originally admitted to the facility on [DATE] and readmitted on [DATE] with a diagnosis including HTN. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 151's Order Summary Report, dated 5/6/2025, indicated Resident 151 was prescribed carvedilol 6.25 mg to give (1) tablet by mouth twice a day for HTN give with food, starting 4/9/2024. During a review of Resident 151's MAR for May 2025, the MAR indicated Resident 151 was prescribed carvedilol 6.125 mg one (1) tablet by mouth twice a day for HTN give with food, to give at 8 a.m. and p.m. During a review of the facility's policy and procedures (P&P) titled Medication Administration-General Guidelines, last reviewed 7/16/2024, the P&P indicated that Medications are administered as prescribed in accordance with good nursing principles and practices . Preparation 3. Prior to administration, the medication and dosage schedule on the resident's MAR is compared with the medication label. Administration 2. Medications are administered in accordance with written orders of the attending physician. 10. Medications are administered within 60 minutes of scheduled time (1 hour before and 1 hour after), except before or after meals, which are administered based on mealtimes. During a review of the facility's P&P, titled Adverse consequences and Medication Errors, last reviewed 7/16/2024, the P&P indicated: 1. An 'adverse consequence' refers to an unwanted, uncomfortable or dangerous effect that a drug may have . An adverse consequence may include: a. Adverse drug/medication reaction b. Side effect 2. The staff and practitioner shall strive to minimize adverse consequences by: a. Following relevant clinical guidelines and manufacturer ' s specifications for use, dose, administration, duration, and monitoring of the medication; 1. A medication error is defined as the preparation or administration of drugs or biological which is not in accordance with physician ' s orders, manufacturer specifications, or accepted professional standards and principles of the professional(s) providing services. 2. Examples of medication error include: a. Omission - a drug is ordered but not administered; f. Wrong drug (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	g. Wrong time. During a review of the facility ' s document, titled Meals Serving Times, [undated], the document indicated: Breakfast - 7:30 to 8:30 Lunch - 12:30 to 1:30 Dinner - 5:30 to 6:30

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43455 Based on observation, interview, and record review the facility failed to: 1. Remove and discard from use one expired insulin (medication used to regulate blood sugar levels) Aspart (short-acting insulin) Flexpen (an injection device containing insulin) for Resident 6, in accordance with manufacturer ' s requirements and facility policy and procedures in one (1) of two (2) inspected medication rooms (Medication Room Station 1.) 2. Label one (1) insulin Humulin R (long-acting insulin) vial for Resident 12, in accordance with manufacturer's requirements and facility policy and procedures in one (1) of two (2) inspected medication rooms (Medication Room Subacute.) 3. Remove and discard from use one (1) Procrit (brand name medication for epogen used to treat anemia [having low red blood cells) vial for Resident 14, in accordance with manufacturer 's requirements and facility policy and procedures in one (1) of two (2) inspected medication rooms (Medication Room Subacute.) These deficient practices increased the risk that Residents 6, 12, and 14 could have received medication that had become ineffective or toxic due to improper storage or labeling, possibly leading to health complications resulting in hospitalization or death. Findings: During an observation on [DATE] at 12:26 p.m., in Medication Room Subacute, in the presence of Registered Nurse 2 (RN 2), the following medications were found either stored in a manner contrary to their respective manufacturer ' s requirements, not labeled with an open date as required by their respective manufacturer ' s specifications, or stored and labeled contrary to facility policies: 1. One (1) opened insulin Humulin R multi-dose (containing more than one dose) vial for Resident 12 was found stored in the refrigerator and without a label indicating when use first began, and an additional label indicating to discard 31 days after opening According to the manufacturer's product labeling, opened Humulin R vials should be stored at room temperature below 86 degrees Fahrenheit and used or discarded after 31 days of opening. 2. One (1) opened single dose vial of Procrit for Resident 14 was found stored in the refrigerator containing unused volume of medication, with a label indicating Single-dose Discard unused potion. According to manufacturer's product storage and labeling, Procrit single-dose vials should be stored in the refrigerator between 36 and 46 degrees Fahrenheit and once opened to be discarded. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview with RN 2, RN 2 stated the Humulin R vial for Resident 12 opened, not labeled with a date indicating when use began and stored in the refrigerator. RN 2 stated the opened Humulin R vial should be stored at room temperature and once opened good for 31 days, after which the insulin loses potency (effectiveness.) RN 2 stated the Humulin R vial for Resident 12 was considered expired since it was not stored correctly and unaware of the date the vial was opened. RN 2 stated administering expired insulin error to Resident 12 will not be effective in keeping the blood sugar stable and can harm Resident 12 by causing high blood sugar levels leading to coma (a state of deep unconsciousness caused by severe injury or illness), Diabetic Ketoacidosis ([DKA] - a condition that develops when the body doesn ' t have enough insulin resulting in the buildup of acid in the blood to levels that can be life threatening], hospitalization or death. RN 2 stated the Humulin R vial for Resident 12 needed to be removed from the refrigerator, disposed of and replaced with a new one from pharmacy. During the same interview, RN 2 stated the Procrit vial for Resident 14 was used with some volume of medication remining in the vial and continued to be stored in the refrigerator. RN 2 stated the Procrit vial for Resident 14 was considered expired since it was opened and used, and continued storage in the refrigerator created the potential for accidental use. RN 2 stated expired Procrit vial has decreased medication potency and when used in error could be ineffective by not treating or controlling Resident 14's anemia, requiring additional treatments. RN 2 stated the Procrit vial for Resident 14 needed to be removed from the refrigerator and disposed of to prevent accidental use. During an observation on [DATE] at 12:50 p.m., in Medication Room Station 1, in the presence of RN 1, the following medications were found either stored in a manner contrary to their respective manufacturer's requirements, not labeled with an open date as required by their respective manufacturer's specifications, or stored and labeled contrary to facility policies: 1. One (1) open insulin Aspart Flexpen for Resident 6 was found stored in the refrigerator with a label indicating that use began on [DATE], and an additional label indicating to discard 28 days after opening. According to the manufacturer's product labeling, opened Aspart Flexpen should be stored at room temperature below 86 degrees Fahrenheit and used or discarded within 28 days of opening. During a concurrent interview with RN 1, RN 1 stated the insulin Aspart Flexpen for Resident 6 was opened on [DATE] and stored in the refrigerator. RN 1 stated expired insulin has lost its potency and administering expired insulin Aspart to Resident 6 will not be effective in keeping the blood sugar stable and can harm Resident 6 by causing high blood sugar levels leading to DKA and hospitalization . RN 1 stated according to the label the pen expired after 28 days on [DATE] and needed to be removed from the refrigerator and medication room to not be used in error and replaced with a new pen from pharmacy. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on [DATE] at 12:28 p.m., with the Director of Nursing (DON), the DON stated that multi-dose medications like insulin vials and pens should be labeled with a date open label and discarded after 28 days from that date. The DON stated insulin vials with no date open label are considered expired and should not be used, and insulin pens that have expired needed to be removed from use. The DON stated expired insulin has lost its effectiveness and should be discarded to prevent accidental use. The DON stated that administering expired insulin in error will not be effective in controlling blood sugar levels and can harm Residents 6 and 12 by causing high or low blood sugar levels, leading to emergency crisis and requiring hospitalization s. The DON stated that unlabeled and expired insulins needed to be removed from the refrigerator and replaced immediately with new ones from pharmacy. During the same interview, the DON stated single-use vials that have been used immediately expire and should be disposed to prevent accidental use. The DON stated that administering expired Procrit in error will not be effective and can harm Resident 14 by not treating the anemia. The DON stated the Procrit vial needed to be removed from refrigerator and disposed of to prevent accidental use. The DON stated several licensed nurses failed to dispose of single dose Procrit vial from the refrigerator. During a review of facility's policy and procedures (P&P,) titled Storage of Medications, last reviewed on [DATE], the P&P indicated that Medications and biologicals ae stored safely, and properly, following manufacturer ' s recommendations or those of the supplier. J. Medications requiring storage at room temperature are kept at temperatures ranging from 59 degrees Fahrenheit to 86 degrees Fahrenheit. M. Outdated, contaminated, or deteriorated medications .are immediately removed from stock, disposed of according to procedures for medication disposal, and reordered from pharmacy if a current order exist. During a review of facility's P&P titled Procedures for All Medications, last reviewed on [DATE], the P&P indicated: To administer medications in a safe and effective manner. E. Check expiration date on package/container. When opening a multi-dose container, place the date on the container. N. Once removed from the package or container, unused doses should be disposed of in accordance with the medication destruction policy. During a review of facility's P&P titled, Vials and Ampules of Injectable Medications, last reviewed [DATE], the P&P indicated: Vials and ampules of injectable medications are used in accordance with the manufacturer's recommendations or the provider pharmacy's directions for storage, use, and disposal. B. The date opened and the initials of the first person to use the vial are recorded on multi-dose vials. C. Ampules and single-dose vials are discarded immediately after use. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	E. Medication in multi-dose vials may be used until manufacturer ' s expiration date or 6 months after opening unless otherwise specified. Refer to Guide for Special Handling of Medications. During a review of facility's P&P, titled Guide for Special Handling of Medications, last reviewed [DATE], the P&P listed the following: Multiple Dose Vials for injection - Discard 28 days after opening Single Dose vial - Discard after initial use.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 47441 Based on observation, interview, and record review, the facility failed to prepare food by methods that conserved temperature, flavor and appearance when the temperature of the food were as follows: -Zest spinach 121 degrees Fahrenheit (F, a scale of temperature) -Chocolate cake 60 F, -Milk 47 F and 49 F -Puree chocolate cake 57 F. This deficient practice placed 138 of 199 facility residents on regular, therapeutic diets (a meal plan that controls the intake of certain food and nutrients) and puree diets (food with soft pudding like consistency) at risk of unplanned weight loss, a consequence of poor food intake, getting food from the kitchen. Findings: During a review of the facility" daily spreadsheet (a list of food, amount of food that each diet would receive) titled Spring Cycle Menus, dated 5/6/2025, the spreadsheet indicated residents on Regular and therapeutic diet t would include the following foods on the tray: -Meat balls with gravy 2 pieces 1-2 ounces (oz, a unit of measurement) -Gravy 1 oz -Penne with garlic and herbs 1/2 cup (c., household measurement -Zesty spinach 1/2 c. -Fresh green salad with dressing 1/2 c -Chocolate cake 2x2 1/2 inches -Milk 4 oz During a review of the facility's menu spreadsheet titled Spring Cycle Menus, dated 5/6/2025, the spreadsheet indicated residents on puree diet would include the following foods on the tray: -Puree meatballs 2- number 16 scoops (1/2 c total) -Gravy 1 oz -Puree penne with garlic and herbs 1/2 c. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Puree zesty spinach 1/3 c. -Puree fresh green salad with dressing 1/3 c. -Puree chocolate cake 1/3 c. -Milk 4 fluid oz. During a concurrent observation on 5/6/2025 at 11:45 a.m. in the trayline (an area where foods were assembled from the steamtable to resident's plate) area with [NAME] 1, observed [NAME] 1 taking temperatures of the hot and cold food. [NAME] 1 stated the green salad was 54.8 F. [NAME] 1 stated he had to put it back in the freezer before serving. During a concurrent observation on 5/6/2025 at 12:11 p.m. in the trayline area with [NAME] 1, observed [NAME] 1 took the temperature the green salad from the freezer. [NAME] 1 stated the green salad temperature was at 50 F and the chocolate cake with icing was at 54.9 F. During an observation on 5/6/2025 at 12:42 p.m. in the trayline area, observed a rack of chocolate cake and milk were out in room temperature. During an observation on 5/6/2025 at 12:48 p.m. of [NAME] 3, [NAME] 3 cooked extra zesty spinach and directly poured it in the steamtable pans without taking the temperature of the spinach. During a concurrent test tray (a process of tasting, temping, and evaluating the quality of food) observation and interview on 5/6/2025 at 1:29 p.m. of the regular test tray with the Dietary Supervisor (DS), observed and the DS stated zesty spinach was at 121 F, chocolate cake with icing at 60 F and milk was at 49 F when the DS took the temperature of the food using the facility thermometer. During a concurrent test tray observation and interview on 5/6/2025 at 1:35 with the DS, observed the following temperature when the DS took the food temperatures using the facility thermometer: -Milk 49 F -Puree chocolate cake 57 F During an interview on 5/6/2025 at 1:56 p.m. with the DS, the DS stated cold food temperatures could be better as they follow a standard of below 41 F and hot food should be above 135 F. The DS stated hot food should be hot and cold food should be cold. The DS stated zesty spinach at 121 F, chocolate cake of 60 F and milk at 49 F was not okay as the residents expected cold food to be cold and hot food to be hot. The DS stated residents could potentially get food borne illnesses, they might not eat and result in weight loss. During an interview on 5/7/2025 at 12:02 p.m. with [NAME] 3, [NAME] 3 stated she prepared the spinach for yesterday's lunch, and she forgot to take the temperature. [NAME] 3 stated it was important to take the temperature of the food to ensure safety and if it was still cold, it would not be good as bacteria could grow making the residents sick. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's policies and procedures (P&P) titled Food Preparation dated 7/16/2024, the P&P indicated Food is to be prepared in such a manner as to maximize flavor, appearance, and nutritional value. Procedure: (1) All foods will be prepared by methods that preserve nutritive value, flavor and appearance and will be attractively served at the proper temperature and in a form to meet the individual needs of the residents. (9) Food temperatures will be taken to ensure all hot foods are at a proper serving temperature. Food temperature will be recorded daily. (10) Hold foods prior to service for as short time as possible. Food should not be held more than two hours during service. Hot food should be held prior to service at 140 F for above and cold foods at 40 F or below. Keep food covered during holding. During a review of the facility's P&P titled Meal Service reviewed 7/16/2024, the P&P indicated, (2) Food temperatures will be taken to ensure all hot foods are at a proper serving temperature. Food temperature will be recorded daily. Food items: -Vegetables, fruits, grains at least 135 F -Cold beverages, desserts no more than 40 F.

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. 47441 Based on observation, interview, and record review, the facility failed to prepare foods in a form designed to meet individual needs when puree (foods that are smooth with pudding like consistency) when puree pasta was sticky pasta and not smooth pudding like consistency. These failures had the potential to result in difficulty in swallowing, chewing, decreased in food intake and nutrient intake to 18 of 18 residents on puree diet, resulting in unintended (not planned) weight loss and chocking (when food gets stuck in your airway, blocking the flow of air to your lungs). Findings: During a review of the facility's menu spreadsheet (a sheet containing the kind and amount of food each diet would receive) titled Spring Cycle Menus, dated 5/6/2025, the spreadsheet indicated residents on puree diet would include the following foods on the tray: -Puree meatballs 2- number 16 scoops (1/2 c total) -Gravy 1 oz -Puree penne with garlic and herbs 1/2 c. -Puree zesty spinach 1/3 c. -Puree fresh green salad with dressing 1/3 c. -Puree chocolate cake 1/3 c. -Milk 4 fluid oz. During a concurrent observation and interview on 5/6/2025 at 11:15 a.m. of puree pasta preparation with [NAME] 1, observed [NAME] 1 pouring potato flakes to the puree pasta without measuring it. [NAME] 1 stated he used potato flakes as a thickener, and he would know it was in the right consistency by following the recipe and using a spoon tilt test. During a concurrent test tray (a process of tasting, temping, and evaluating the quality of food) observation and interview on 5/6/2025 at 1:35 p.m. with the Dietary Supervisor (DS) and the Registered Dietitian (RD), observed little pasta particles on the puree pasta. The RD stated puree diet should be smooth, no lumps, not sticky but not too watery. The DS stated the puree pasta was sticky and would involve more chewing. The DS stated residents on puree diet could aspirate and had trouble chewing and swallowing as a potential outcome of not achieving correct puree texture and consistency. The DS stated the proper way to prepare puree food was to follow the recipes by measuring the correct ingredients to achieve texture and consistency. (continued on next page)

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's policies and procedures (P&P) titled Diet Orders reviewed 7/16/2024, the P&P indicated POLICY: The physician will prescribe diets in accordance with the approved Diet Manual. During a review of the facility's diet manual (a manual containing different diets descriptions, foods allowed and avoided and sample menus the facility have) titled Regular Pureed Diet reviewed 7/16/2024, the diet manual indicated The pureed diet is a regular diet that has been designed for residents who have difficulty chewing and/or swallowing. The texture of the food should be smooth and moist consistency and able to hold its shape. All foods are prepared in a food processor or blender, with the exception of foods which are normally in a soft, and smooth state such as pudding, ice cream, applesauce, mashed potato, etc. During a review of the facility's P&P titled Menu reviewed 7/16/2024, the P&P indicated, Procedure: Menus are planned to meet the Recommended Dietary Allowances of the Food and Nutrition Board, National Research Council, adjusted to the age, activity and environment of the group involved. (5) The menus will be prepared as written using standardized recipes. During a review of the facility's standardized recipe titled Recipe: Pureed (IDDSI Level 4) Starch (Rice, Pasta, Polenta, Potatoes, etc.), the recipe indicated ingredients: (48 servings) starch per recipe: 48 servings, warm milk 48 to 96 oz, instant potato 1 1/2 - 3 cups). The finished pureed item should be smooth and free of lumps, hold its shape, while not being too firm or sticky, and should not weep. The finished pureed item must pass the IDDSI level 4 testing requirements (i.e. the fork drip, fork pressure and spoon tilt tests). During a review of the IDDSI guideline website titled IDDSI, dated 7/2019, the IDSSI guideline indicated, Level 4 Pureed is usually eaten with spoon, falls off spoon in a single spoonful when tilted and continues to hold shape on the plate, no lumps, not sticky, and liquid must not separate from solid. Food testing method: Spoon tilt test and fork drip test.

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F 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. 44309 Based on observation, interview, and record review, the facility failed to ensure safe and sanitary food storage and food preparation practices in the kitchen when: 1. Opened plastic bags of frozen pancakes and frozen pie crust in the freezer were not labeled and dated. 2. Kitchen equipment and kitchen areas were not cleaned and sanitized. a. The reach-in refrigerator's ceiling had dust and dirt debris. b. The two drawers by the preparation area were dirty to touch and had dust buildup. c. Plate warmer's internal part where the clean plates were stored had food and white dirt debris. d. The two push carts where clean resident's trays, bases and domes were stored had dirt, food and hair debris. e. Condiment containers contain loose sugar, pepper, sweetener particles and dirt residues. 3. Kitchen equipment and utensils were not maintained in their proper condition, smooth and easy to clean. a. Seven (7) of 7 green shelves in the Walk-in Refrigerators 1 and 2 had cracks, chips, and rust with amber discoloration. b. The green chopping board had black and brown stains and scratches. c. The juice rack had rust. 4. Three (3) staff (two cooks and one dietary aide) were wearing wristwatches, a bracelet and a diamond ring while preparing food. 5. Five (5) of 5 dented were stored with non-dented cans. 6. Gray, clear food containers, plates and resident's trays were stacked wet with water particles. 7. There was no separation between the dirty area (trash can in the handwashing area) and the clean bowl storage area. 8. Staff was wearing nail polish while cooking food. 9. The residents' freezer in Station 1 had no thermometer. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	These failures had the potential to result in harmful bacterial growth and cross contamination (transfer of harmful bacteria from one place to another) that could lead to foodborne illness (a disease caused by consuming food or drinks that are contaminated by germs or chemicals) in 138 of 199 medically compromised residents who received food and ice from the kitchen. Findings: 1. During an initial kitchen tour on 5/5/2025 at 8:20 a.m., with the Dietary Supervisor (DS), in the walk-in freezer a bag of opened frozen pancakes containing six individual pancakes and a bag of opened frozen pie crusts containing three pie crusts were observed without a label and date of when they were opened. The DS stated that frozen food taken from original packaging in the freezer should be labeled and dated to ensure they will be used first. The DS stated the potential outcome of not dating the opened packages of food is the inability to determine how long the items were stored in the freezer. During review of the facility`s Policy and Procedure (P&P) titled Refrigerator/Frezer Storage, last reviewed on 7/16/2024, the P&P indicated that leftover food or unused portions of packaged foods should be covered, dated and labeled to ensure they will be used first. All items should be properly covered, dated, and labeled. Food items should have the following appropriate dates: Delivery date (upon receipt), Open date (opened container of PHF) and Thaw date (any frozen item). Frozen food taken from the original packaging should be labeled and dated. Food that has freezer burns should be discarded. During a review of Food Code 2022, dated 1/18/2023, the Food Code 2022 indicated, 3-501.17 Commercially processed food, open and hold cold, (B) except specified in (E) - (G) of this section, refrigerated, ready-to-eat time/temperature control for food safety food prepared and packed by a food processing plant shall be clearly marked, at the time the original container is opened in a food establishment and if the food is held for more than 24 hours, to indicate the date or day by which the food shall be consumed on the premises, sold, or discarded, based on the temperature and time combinations specified in (A) of this section and (1) The day the original container is opened in the food establishment shall be counted as Day 1; and (2) The day or date marked by the food establishment may not exceed a manufacture's use-by- date if the manufacturer determined the use-by date based on food safety. 47441 2. a. During an observation on 5/6/2025 at 8:30 a.m., of the reach-in refrigerator by the handwashing station, observed dust on the ceiling. During an interview on 5/6/2025 at 8:35 a.m. with the DS, the DS stated the refrigerator ceiling was dusty, and staff missed cleaning the ceiling. The DS stated it was not okay that the walk-in refrigerator was dusty due to cross-contamination of dust to food that could potentially get the residents sick of diarrhea, vomiting and stomachache. During a review of the facility's P&P titled Refrigerator and Freezer, reviewed 7/16/2024, the P&P indicated, (17) The refrigerator and freezer area will be clean and dry, well-ventilated at all times. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	b. During an observation on 5/7/2025 at 11:18 a.m. of the preparation area, observed two drawers where food containers and sandwich bags were stored had dust buildup. During an interview on 5/7/2025 at 11:31 a.m. with the DS, the DS stated the drawer was deep cleaned once a week however, staff cleaned it every day. The DS stated the drawers had dust build up and staff did not clean last night. The DS stated it was important to keep the drawers clean to avoid food borne illnesses for the residents. c. During an observation on 5/7/2025 at 11:24 a.m. of the plate warmer, observed the internal parts of the plate warmer had dust and dirt debris. During a concurrent observation and interview on 5/72/2025 at 11:53 a.m. of the plate warmer with the DS, the DS stated the plate warmer internal parts had white spill dirt and it was noticeable. The DS stated it was not okay due to cross-contamination of food. The DS stated the plates had also water particles and were not air dried. d. During an observation on 5/7/2025 at 11:29 a.m. of the pushcart used to store resident's tray, observed the pushcart had dust and dirt debris. During an observation on 5/7/2025 at 11:30 a.m. of the pushcart used to store dome and lids, observed the pushcart had dust and dirt debris. During a concurrent observation and interview on 5/7/2025 at 11:45 a.m. of the two pushcarts by the trayline (an area where foods were assembled from the steamtable to resident's plate) with the DS, the DS stated the two pushcarts used to store resident's tray, domes and base were a clean area, however it had dirt, food and hair debris. The DS stated the pushcarts were not cleaned yesterday and it was not okay as it could potentially contaminate food items in trayline. e. During a concurrent observation and interview on 5/7/2025 at 11:49 a.m. of the condiment container with the DS, observed the condiment containers had loose sugar, pepper, sweetener particles and dirt. The DS stated the condiment containers were not clean yesterday and it needed to be cleaned to prevent cross-contamination of food potentially causing food borne illness to the residents. During a review of the facility's P&P titled Sanitizing Equipment and Surfaces, reviewed 7/16/2024, the P&P indicated, Sanitizing solution will be used to sanitize equipment and surfaces after each use or as often as needed. During a review of the facility's P&P titled Cleaning Schedule, reviewed 7/16/2024, the P&P indicated, All areas and equipment in the kitchen should be cleaned daily. The assigned dietary personnel will deep clean the area equipment assigned for them that day using the dietary cleaning schedule. During a review of Food Code 2022, dated 1/18/2023, the Food Code 2022 indicated, 4-601.11 (A) Equipment Food Contact Surfaces and utensils shall be cleaned: (1) Except as specified in (B) of this section, before use with a different type of raw animal food such as beef, fish, lamb, pork or poultry; (2) Each time there is a change from working with raw foods to working with ready-to-eat food; (3) Between uses with raw fruits and vegetables and with time/temperature control for safety food. (4) Before using or storing a food temperature measuring device, and (5) At the time during the operation when contamination may have occurred. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Food Code 2022, dated 1/18/2023, the Food Code 2022 indicated,4-602.13 Nonfood-Contact Surfaces. Nonfood-contact surfaces of equipment shall be cleaned at a frequency necessary to preclude accumulation of soil residues. 3. a. During an observation on 5/6/2025 at 8:42 a.m. of the green racks in walk-in refrigerator 1, observed three (3) of 3 green racks had cracks and chips. During an observation on 5/6/2025 at 8:49 a.m. of the green racks in the walk-in refrigerator 2, observed four (4) of 4 green racks had cracks, chips with amber discoloration. During an interview on 5/6/2025 at 8:59 a.m. with the DS, the DS stated the green racks in the walk-in refrigerators were rusted and they needed to be in good condition with no hips and rust as it could potentially make the residents sick of food borne illnesses. b. During an observation on 5/7/2025 at 11:14 a.m. of the white chopping board, observed the white chopping board had black dirt stains and scratches. During an interview on 5/7/2025 at 11:37 a.m. with the DS, the DS stated the chopping board should be free from noticeable scratch because it would not be properly washed or sanitized, and food particles could get stuck in it. The DS stated the white chopping boards were considered as green chopping boards and it had black and brown stains and scratches. The DS stated the fruit could potentially be contaminated if the chopping boards had scratches and stains. During a review of the facility's P&P titled Cutting Board Cleaning reviewed 7/16/2024, the P&P indicated, All cutting boards should be clean and in good condition. c. During an observation on 5/7/2025 at 11:26 a.m. of the juice dispenser rack by the trayline, observed rack was rusted. During a concurrent observation and interview on 5/7/2025 at 11:43 a.m. of the juice rack with the DS, the DS stated the juice rack looked rusty and he needed to contact the company to replace it as it was not acceptable in the kitchen due to cross-contamination of the food. During a review of the facility's P&P titled Sanitizing Equipment and Surfaces reviewed 7/16/2024, the P&P indicated (6) Dietary staff should ensure that all equipment, shelves, serving utensils, and surface areas are clean and in good condition. During a review of Food Code 2022, dated 1/18/2023, the Food Code 2022 indicated, 4-202.11 Food-Contact Surfaces. (A) Multiuse Food-contact surfaces shall be (1) Smooth (2) Free of breaks, open seams, cracks, chips, inclusions, pits, and similar imperfections. (3) Free of sharp internal angles, corners, and crevices, (4) Finished to have smooth welds and joints. 4. During an observation on 5/6/2025 at 8:56 a.m., of the trayline, observed [NAME] 1 was wearing a black wristwatch and Dietary Aide 3 (DA 3) was wearing a silver bracelet while dishing out food from the steamtable to the resident's plate. During an observation on 5/6/2025 at 11:00 a.m. of the cold food preparation, observed [NAME] 2 wearing a wristwatch and diamond ring while preparing cold food. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 5/6/2025 at 11:08 a.m. of the cold food preparation, observed DA 3 was wearing a silver bracelet while preparing dessert. During an interview on 5/6/2025 at 12:43 p.m. with the DS, the DS stated jewelry was not allowed in the kitchen due to infection control purposes for the residents. During a review of the facility's P&P titled Sanitation and Infection Control, reviewed 7/16/2024, the P&P indicated (9) No dangling jewelry or earrings should be worn. Only wedding rings are acceptable. During a review of Food Code 2022, dated 1/18/2023, the Food Code 2022 indicated 2-303.11 Prohibition. Except for a plain ring such as wedding band, while preparing food, food employees may not wear jewelry including medical information jewelry on their arms and hands. 5. During an observation on 5/6/2025 at 9:15 a.m. in the dry storeroom, observed two (2) dented cans stored with non-dented cans. During a concurrent observation and interview on 5/6/2025 at 9:23 a.m. of the dry storeroom with the DS, observed three (3) dented cans stored with non-dented cans from the emergency food supply. The DS stated a separate area of dented cans was designated so the staff would not accidentally use them. The DS stated there were four (4) dented cans stored with non-dented cans and it was not okay as it could cause physical contamination of food resulting in potential food borne illnesses to the residents who would consume it. During a review of the facility's P&P titled Storage of Canned and Dry Goods, reviewed 7/16/2024, the P&P indicated (10) Canned items should be inspected for damage such as dented, leaking or bulging cans. These items will be stored separately in the designated area- Dented Cans for return to the vendor or disposed of properly. During a review of Food Code 2022, dated 1/18/2023, the Food Code 2022 indicated, 3-101.11 Safe Unadulterated, and Honestly Presented. Food shall be safe, unadulterated, and, as specified under 3-601. 12, honestly presented. 3-201.11 Compliance with Food Law. A primary line of defense ensuring that food meets the requirements of S3-101.11 is to obtain food from approved sources, the implications of which are discussed below. However, it is also critical to monitor food products to ensure that, after harvesting, processing, they do not fail victims to conditions that endanger their safety, make them adulterated, or compromise their honest presentation. The regulatory community, industry, and consumers should exercise vigilance in controlling the conditions to which foods are subjected and be alert to signs of abuse. FDA considers food in hermetically sealed containers that are swelled or leaking to be adulterated and actionable under the Federal Food, Drug, and Cosmetic Act. Depending on the circumstances, rusted, and pitted or dented cans may also present a serious potential hazard. 6. During an observation on 5/6/2025 at 11:11 a.m. of the food container storage area, gray bins and clear Cambro containers were stacked wet. During an interview on 5/6/2025 at 12:50 p.m. with the DS, the DS stated the process of dishwashing was to wash, rinse, sanitize, then air dry. The DS stated the food containers were staked wet and it was not okay as there were still water particles. The DS stated it was important to airdry dishes to avoid moist that could grow bacteria resulting in food borne illnesses. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's P&P titled Manual Dishwashing-2-3 Compartment Sink, reviewed 7/16/2025, the P&P indicated, (6) Dishes should be allowed to air dry before storage. During a review of Food Code 2022, dated 1/18/2023, the Food Code 2022 indicated, 4-901.11 Equipment and Utensils, air-drying required. After cleaning and sanitizing equipment and utensils: (A) Shall be air-dried or used after adequate draining as specified in the first paragraph of 40 CFR 180.940 tolerance exemptions for active and inert ingredients for use in antimicrobial formulations (food-contact surface sanitizing solutions), before contact with food and; (B) May not be cloth dried except that utensils that have been air-dried may be polished with cloths that are maintained clean and dry. 7. During an observation on 5/6/2025 at 11:36 a.m. of the garbage can by the bowl storage area, water splashes observed from handwashing area to the bowl storage area. During an interview on 5/6/2025 at 12:46 p.m. with the DS, the DS stated the bowl storage was a clean area, but it was near the handwashing sink trash can and it was not okay. The DS stated there was no separation of clean and dirty areas that could cause food contamination. During a review of the facility's P&P titled Sanitizing Equipment and Surfaces, reviewed 7/16/2024, the P&P indicated, To prevent cross-contamination and ensure food safety by maintaining strict separation between clean a dirty area within the dietary department. (8) Dietary staff to ensure clean and dirty areas shall be separated by physical barriers where possible workflows must be designated to ensure that the clean and dirty processes do not overlap in time or space. During a review of Food Code 2022, dated 1/18/2023 the Food Code 2022 indicated, 3-307.11 Miscellaneous Sources of Contamination. Food shall be protected from contamination that may result from a factor or source not specified under subparts 3-391 - 3-306. 8. During an observation on 5/6/2025 at 11:42 a.m. of lunch food preparation, observed [NAME] 3 wearing a turquoise nail polish while cooking food for lunch. During an interview on 5/6/2025 at 1:04 p.m. with the DS, the DS stated staff were not allowed to wear nail polish due to physical contamination as the nail polish could fall in the food. The DS stated [NAME] 3 was wearing nail polish and it was not allowed. During a review of the facility's P&P titled Sanitation and Infection Control, reviewed 7/16/2024, the P&P indicated (3) Fingernails should be clean, clipped and free of nail polish. During a review of Food Code 2022, dated 1/18/2023, the Food Code 2022 indicated, (A) Food employees shall keep their fingernails trimmed, filed, and maintained so the edges and surfaces are cleanable and not rough. (B) Unless wearing intact gloves in good repair, a food employee may not wear fingernail polish or artificial fingernails when working with exposed food. 9. During a concurrent observation and interview on 5/7/2025 at 3:51 p.m. of the resident's freezer in Station 1 with Licensed Vocational Nurse 4 (LVN 4), the resident's freezer had no thermometer to monitor the temperature. LVN 4 stated the freezer was not monitored and the temperature log also did not indicate that they were monitoring the freezer temperatures. LVN 4 stated it was important to monitor the freezer to prevent food spoilage and expiration. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/7/2025 at 4:03 p.m. with the Registered Nurse Supervisor (RNS), the RNS stated it was important to monitor the freezer temperature as they did not want the food items to get bad. The RNS stated residents could potentially get sick of food poisoning when consuming food that was not in acceptable temperatures. During a review of the facility's P&P titled Refrigerator/Freezer Storage, reviewed on 7/16/2024, the P&P indicated Dietary staff will check the inside temperature of refrigerators and freezers to ensure the equipment is within appropriate temperature for food storage and handling. (1) Dietary staff will check and record temperatures of all refrigerators and freezers to ensure the equipment is within appropriate temperature for food storage and handling. (2) Dietary staff will record the initial temperature log at the beginning of the shift. (3) If the temperatures are not within appropriate range, dietary staff will notify the dietary supervisor and or Maintenance Supervisor and Administrator. Freezer temperature: 0-degree Fahrenheit (F, a scale of temperature) or lower. During a review of Food Code 2022, dated 1/18/2023, the Food Code 2022 indicated 4-204.112 Temperature Measuring Devices. (A) In a mechanically refrigerated or hot FOOD storage unit, the sensor of a Temperature Measuring Device shall be located to measure the air temperature or a simulated product temperature in the warmest part of a mechanically refrigerated unit and in the coolest part of a hot food storage unit. (B) Except as specified in (C) of this section, cold or hot holding equipment used for time/temperature control for safety food shall be designed to include and shall be equipped with at least one integral or permanently affixed temperature measuring device that is located to allow easy viewing of the device's temperature display.

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Dispose of garbage and refuse properly. 47441 Based on observation, interview, and record review, the facility failed to dispose garbage and refuse properly when there were soiled gloves, empty plastic bottles, plastic and other trash on the floor and surrounding areas of the dumpster bin (a movable waste container designed to be brought and taken away by a special collection vehicle, or to a bin that a specially designed garbage truck lifts). This failure had potential to attract birds, flies, insects, pests, and possibly spread infection to 138 of 199 facility residents. Findings: During a concurrent observation and interview on 5/7/2025 at 3:10 p.m. of the dumpster with the Dietary Supervisor (DS), observed soiled gloves, empty bottles, plastic and other trash on the ground. The DS stated it was not okay to have trash around the dumpster surroundings because it could attract pests, and could spread sickness to the residents. The DS stated he did not know who maintains the trash area. During an interview on 5/7/2025 at 4:11 p.m. with the Maintenance Director (MD), the MD stated he maintains the dumpster and trash area and it needed to be cleaned to prevent flies, rats and animals around. The MD stated it was not okay that there was trash around the dumpster surroundings. The MD stated this could spread diseases to residents as a potential outcome. During a review of the facility's policies and procedures (P&P) titled Waste Control and Disposal dated 7/16/2024, the P&P indicated All waste will be disposed of daily and as needed throughout the day. (6) Outside garbage bin should be kept closed at all times and surrounding area must be kept clean, During a review of Food Code 2022, dated 1/18/2023, the Food Code 2022 indicated, 5-501.116 Cleaning Receptacles. Proper storage and disposal of garbage and refused are necessary to minimize the development of odors, prevent such waste from becoming an attractant and harborage of breeding place for insects and rodents, and prevent the soiling of food preparation and food service areas. Improperly handled garbage creates nuisance conditions, makes housekeeping difficult, and may be possible source of contamination of food, equipment, and utensils. Outside receptacles must be constructed with tight-fitting lids or covers to prevent the scattering of the garbage or refuse by birds, the breeding of flies, or the entry of rodents. Proper equipment and supplies must be made available to accomplish thorough and proper cleaning of garbage storage areas and receptacles so that unsanitary conditions can be eliminated.

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or get specialized rehabilitative services as required for a resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36943 Based on observation, interview, and record review, the facility failed to provide a Physical Therapy ([PT] profession aimed in the restoration, maintenance, and promotion of optimal physical function) Evaluation to one of seven sampled residents (Resident 690) with range of motion ([ROM] full movement potential of a joint [where two bones meet]) and mobility (ability to move) concerns in accordance with the physician's order, dated 5/1/2025. This deficient practice prevented Resident 690 from receiving a PT Evaluation to assess the possibility of receiving additional therapy to achieve Resident 690's goal of walking with a single point cane ([SPC] walking device with a curved or bent handle at the top and long shaft that ends in a single tip used to provide support while walking) to return home. Findings: During a review of Resident 690's Admission Record, the Admission Record indicated the facility admitted Resident 690 on 4/18/2025 with diagnoses including neoplasm (abnormal tissue growth) of meninges (three protective layers of connective tissue that surround the brain and spinal cord), nontraumatic intracerebral hemorrhage (bleeding in brain tissue), lack of coordination, muscle weakness, foot drop (condition where the individual experiences difficulty or inability to lift their foot or toes) of both feet, and reduced mobility. During a review of Resident 690's Minimum Data Set (MDS- a resident assessment tool), dated 4/29/2025, the MDS indicated Resident 690 had clear speech, expressed ideas and wants, clearly understood verbal content, and had intact cognition (clear ability to think, understand, learn, and remember). The MDS indicated Resident 690 required setup or clean up assistance for eating, partial/moderate assistance (helper does less than half the effort) for rolling to either side in bed, and dependent for toileting, bathing, dressing, and putting on/taking off footwear. (continued on next page)

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 690's PT Evaluation and Plan of Treatment, dated 4/19/2025, the PT Evaluation indicated Resident 690's prior level of function (ability prior to admission to the facility) was independent with rolling to both sides of the bed, transferring from lying to sitting at the edge of the bed, transferring from sitting to standing, and walking using a SPC. The PT Evaluation indicated Resident 690's goal was to return to walking with the SPC. The PT Evaluation indicated Resident 690's current ability (as of 4/19/2025) was dependent (helper does all the effort, resident does none of the effort to complete the activity) with rolling to both sides of the bed and dependent with two-person assistance for transferring from lying to sitting at the edge of the bed. The PT Evaluation also indicated that sit-to-stand transfers were not attempted due to medical conditions or safety concerns. The PT Plan of Treatment included therapeutic activity (tasks that improve the ability to perform activities of daily living [(ADLs- tasks related to personal care including bathing, dressing, hygiene, eating, and mobility]), therapeutic exercises (movement prescribed to correct impairments and restore muscle function), neuromuscular re-education (technique used to restore movement patterns through repetitive motion to retrain the brain), orthotic management (the process of designing, making, fitting, and training patients in the use of orthoses [material used to restrict, protect, or immobilize a part of the body to support function, assist and/or increase range of motion]), and wheelchair management training (training on proper positioning and ability to propel the wheelchair), six times per week for four weeks. The PT Plan of Treatment was signed by Physician 1's (MD 1's) nurse practitioner ([NP] nurse who is qualified to treat certain medical conditions without the direct supervision of a doctor) on 4/21/2025. During a review of Resident 690's PT Discharge Summary, dated 4/21/2025, the PT Discharge Summary indicated Resident 690 was dependent with rolling to both sides and dependent with two-person assistance for transferring from lying to sitting on the side of the bed. Resident 690's PT Discharge Summary indicated the reason for discharge was in accordance with the physician or case manager. The PT Discharge recommendations included restorative nursing assistant (RNA - an ongoing program that focuses on helping individuals, especially those in long-term care, maintain and improve their functional abilities and independence, often following rehabilitation) to provide Resident 690 with active assistive range of motion ([AAROM] use of muscles surrounding the joint to perform the exercise but requires some help from a person or equipment) to both arms and passive range of motion ([PROM] movement of a joint through the ROM with no effort from person) to both legs, seven times per week as tolerated. The PT Discharge recommendations also included RNA to apply both pressure relief ankle foot orthoses ([PRAFO] device worn on the calf and foot to suspend the heel and hold the ankle in neutral [90 degree] position) to Resident 690's ankles for two to four hours or as tolerated, seven times per week. During a review of Resident 690's physician's order, dated 4/22/2025, the physician's order indicated RNA for AAROM to both arms and PROM to both legs. Another physician's order, dated 4/23/2025, indicated for the RNA to apply both PRAFOs for two to four hours or as tolerated, seven times per week. During a review of Resident 690's care plan titled, Self care deficits, initiated 4/29/2025, the care plan interventions included Rehabilitation (therapy given to restore an individual back to their highest possible level of physical, mental, and psychosocial well-being) as ordered. During a review of Resident 690's physician's order, dated 5/1/2025, the physician's order indicated PT Evaluation and Treatment when authorized under Medicare Part B (federal medical insurance for persons at least [AGE] years old that covers certain services). (continued on next page)

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 690's Licensed Nursing Progress Note, dated 5/1/2025 by Registered Nurse 4 (RN 4), the Licensed Nursing Progress Note indicated MD 1 approved the PT Evaluation in accordance with Resident 690's request when authorized under Medicare Part B. The Licensed Nursing Progress Note indicated Resident 690's physician's order was given to the case manager for authorization. During a review of Resident 690's Physical Therapy Note, dated 5/6/2025, the Physical Therapy Note indicated the RNA (unspecified) reported improvement with minimally active movement in the right leg. The Physical Therapy Note indicated the RNA program was changed from PROM to AAROM on the right leg. During a review of Resident 690's physician's order, dated 5/6/2025, the physician's order indicated to discontinue PROM to both legs due to the RNA's reports of improvement in the right leg. The physician's order, dated 5/6/2025, indicated for the RNA to provide Resident 690 AAROM to both arms and the right leg and PROM to the left leg. During an interview on 5/6/2025 at 9:12 a.m., with the Director of Rehabilitation (DOR), the DOR stated the purpose of PT included to improve a resident's mobility, including improving strength, the ability to get out of bed, and the ability to walk, to enhance their independence if possible. During a concurrent observation and interview on 5/6/2025 at 11:27 a.m., with Resident 690 in the resident's room, Resident 690 was awake, alert, and spoke with clear, fluent speech while lying in bed with the head-of-bed elevated. Resident 690 stated she underwent brain surgery three times and walked with a SPC due to left leg weakness after the second brain surgery and prior to the third surgery in 2/2025. Resident 690 stated the hospital discharged Resident 690 to another nursing facility after brain surgery due to Resident 690's inability to move both legs, including the right leg. Resident 690 stated PT and Occupational Therapy ([OT] profession aimed to increase or maintain a person's capability of participating in everyday life activities [occupations]) provided therapy services at the previous nursing facility. Resident 690 stated she was transferred from the previous nursing facility to the current facility due to safety concerns and to receive more therapy services. Resident 690 stated she spoke with the DOR and worked with Physical Therapist 1 (PT 1) on the first Saturday of admission (4/19/2025) but did not receive any PT treatment afterward. Resident 690 stated both arms moved well and movement was starting to return to the right leg. Resident 690 was observed without any ROM limitations in both arms. Resident 690 could slowly lift the right leg upward at the hip joint, slowly bent the right knee, and slightly bent the right ankle toward the body. Resident 690 stated RN 4 asked MD 1 for a PT Evaluation last week and was waiting for the DOR to approve it. Resident 690 expressed feelings of anger and frustration because the facility staff does a disappearing act around here especially when it comes to my therapy. Resident 690 stated she wanted to return home after receiving therapy. Resident 690 stated the RNAs provided exercises daily. Resident 690 stated the staff used a mechanical lift to transfer Resident 690 into a Geri chair (reclining chair that allows someone to get out of bed and sit comfortably in different positions while fully supported) daily since Resident 690 did not have a wheelchair. (continued on next page)

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 5/6/2025 at 1:45 p.m., with Restorative Nursing Assistant 1 (RNA 1) in Resident 690's room, observed Resident 690's RNA session. RNA 1 stood on the left side of Resident 690's bed to perform PROM on the left leg at the hip, knee, and ankle joints. RNA 1 walked to the right side of the bed to perform AAROM of the right leg. Resident 690 was observed lifting the right leg at the hip joint (hip flexion), requiring RNA 1's assistance to lift the right leg higher. Resident 690 was observed moving the right hip into abduction (moving the leg at the hip joint away from the body), requiring RNA 1's assistance to move the right legs further away from the body. Resident 690 slid the right leg at the hip joint back toward the body (hip adduction) without physical assistance. Resident 690 slightly bent and extended the right knee, requiring RNA 1's physical assistance to completely bend and extend the knee. Resident 690 also moved the right ankle toward the body (dorsiflexion) and away from the body (plantarflexion), requiring RNA 1's physical assistance to fully move at the ankle joint. During an interview on 5/6/2025 at 2:18 p.m., with RNA 1, RNA 1 stated Resident 690 was seen for PROM of the left leg and AAROM of both arms and the right leg. RNA 1 stated Resident 690 did ROM exercises to both arms without much physical assistance. RNA 1 stated she reported Resident 690's desire for more therapy services to PT 1. RNA 1 stated PT 1 saw Resident 690 today (5/6/2025) and changed the RNA order from PROM to AAROM on the right leg. During a concurrent interview and record review on 5/7/2025 at 2:47 p.m., with the DOR, reviewed Resident 690's PT Evaluation, dated 4/19/2025, and PT Discharge Summary, dated 4/21/2025. The DOR stated the facility admitted Resident 690 on 4/18/2025 from another nursing facility. The DOR stated the facility was aware Resident 690's health insurance had provided a last covered date (last date the person's health insurance policy covered specific services) of 4/21/2025 for therapy services prior to Resident 690's admission to the facility. The DOR stated PT 1 completed Resident 690's PT Evaluation on 4/19/2025 and recommended treatment six times per week for four weeks. The DOR stated Resident 690 was discharged from PT on 4/21/2025 in accordance with the health insurance's last covered date. The DOR stated the PT Discharge recommendations included an RNA program to provide Resident 690 with PROM to both legs and application of both PRAFOs. During an interview on 5/7/2025 at 3:06 p.m., with PT 1, PT 1 stated RNA 1 reported an improvement in movement to Resident 690's right leg yesterday (5/6/2025). PT 1 stated Resident 690's RNA program was modified from PROM to AAROM exercises to the right leg. During an interview on 5/7/2025 at 3:47 p.m., with the DOR, the DOR stated she did not speak with MD 1 about Resident 690's therapy services. The DOR stated the facility was waiting for authorization from Resident 690's health insurance to provide PT services. During an interview on 5/7/2025 at 3:53 p.m., with the Case Manager (CM), the CM stated the Medicare Managed Health Plan (private company contracted with Medicare to provide health care and services) provided a last covered date for Resident 690's therapy services prior to Resident 690's admission to the facility. The CM stated the previous facility issued Resident 690 a Notice of Medicare Non-Coverage ([NOMNC] form used by Medicare providers to notify beneficiaries when Medicare-covered services are ending) and stated the facility did not receive a copy of Resident 690's issued NOMNC. During an interview on 5/7/2025 at 4:07 p.m., with the CM and Resident 690, Resident 690 stated she did not have a Medicare Managed Health Plan. (continued on next page)

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 5/7/2025 at 4:30 p.m., with Licensed Vocational Nurse 3 (LVN 3) and the DOR, reviewed Resident 690's physician order, dated 5/1/2025. LVN 3 stated the physician was contacted and physician's order was submitted based on the conversation with the physician if a resident (in general) was requesting more therapy services. LVN 3 stated Resident 690's physician order, dated 5/1/2025, indicated PT Evaluation and Treatment when authorized under Medicare Part B. LVN 3 stated the PT was supposed to carry out the physician's order. The DOR stated Resident 690's physician's order for PT Evaluation and Treatment was sent to the CM for authorization. During an interview on 5/7/2025 at 4:37 p.m., with the CM, the CM stated Resident 690 did not have Medicare. The CM stated Resident 690's health insurance provided the last covered date for therapy services. The CM stated Resident 690's physician order, dated 5/1/2025, for PT Evaluation and Treatment was sent to the health insurance for review. During an interview on 5/8/2025 at 10:56 a.m., with the Social Services Director (SSD), the SSD stated Resident 690's discharge plan included receiving therapy and returning home. During an interview on 5/8/2025 at 11:57 a.m., with the CM, the CM stated Resident 609's physician order, dated 5/1/2025, for PT Evaluation was submitted to Resident 690's health insurance on 5/7/2025 at 4:01 p. m. The CM stated Resident 690's physician's order was not submitted to the health insurance on 5/1/2025 because the CM did not work from 5/2/2025 to 5/4/2025 and was catching up on other work from 5/5/2025 to 5/6/2025. During a telephone interview on 5/8/2025 at 12:18 p.m., with MD 1, MD 1 stated Resident 690 had left leg weakness and walked with a cane prior to brain surgery. MD 1 stated Resident 690 requested a PT Evaluation on 5/1/2025 and wrote orders for a PT Evaluation to determine if Resident 690 could benefit from more therapy. During a concurrent interview and record review on 5/8/2025 at 1:52 p.m., with the DOR, reviewed Resident 690's physician's order, dated 5/1/2025, and the facility's policy and procedure (P&P) titled, Rehabilitation Services. The DOR stated Resident 60's physician's order indicated PT Evaluation and Treatment when authorized under Medicare Part B. The DOR stated Resident 690 did not have Medicare and did not receive a PT Evaluation since the health insurance has not authorized the service. The DOR reviewed the facility's P&P and stated the P&P did not indicate to perform the PT Evaluation after receiving authorization from the resident's health insurance. The DOR stated Resident 690 did not receive a PT Evaluation within 48 hours in accordance with the facility's P&P. During a concurrent interview and record review on 5/8/2025 at 2:09 p.m with the Administrator (ADM), reviewed Resident 690's physician's order, dated 5/1/2025, and the facility's P&P titled, Rehabilitation Services. The ADM stated the PT would have evaluated Resident 690 if the physician's order did not specifically indicate when authorized under (Medicare) Part B. The ADM reviewed the facility's P&P titled, Rehabilitation Services, and stated the P&P did not indicate to wait for an authorization prior to performing a PT evaluation. During a review of the facility's undated P&P titled, Rehabilitation Services, the P&P indicated Skilled rehabilitation services shall be made available to resident in order to promote recovery, improve and maintain functional independence, and prevent any further decline. The P&P indicted rehabilitation services require specific orders from the attending physician to be written in the resident's health record. The P&P indicated the therapy evaluation orders shall be address within 48 hours.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 36943 Based on observation, interview, and record review, the facility failed to ensure the Restorative Nursing Aide ([RNA] certified nursing aide program that helps residents to maintain their function and joint mobility) records for one of seven sampled residents (Resident 690) with limitation in range of motion ([ROM] full movement potential of a joint [where two bones meet]) and mobility (ability to move) indicated the provision of passive range of motion ([PROM] movement of a joint through the ROM with no effort from person) to both legs from 4/22/2025 to 5/5/2025 in accordance with the physician's order, dated 4/22/2025. This failure resulted in the inaccurate provision of care recorded in Resident 690's medical records. Findings: During a review of Resident 690's Admission Record, the Admission Record indicated the facility admitted Resident 690 on 4/18/2025 with diagnoses including neoplasm (abnormal tissue growth) of meninges (three protective layers of connective tissue that surround the brain and spinal cord), nontraumatic intracerebral hemorrhage (bleeding in brain tissue), lack of coordination, muscle weakness, foot drop (condition where the individual experiences difficulty or inability to lift their foot or toes) of both feet, and reduced mobility. During a review of Resident 690's physician's order, dated 4/22/2025, the physician's order indicated RNA for active assistive range of motion ([AAROM] use of muscles surrounding the joint to perform the exercise but requires some help from a person or equipment) to both arms and PROM to both legs. During a review of Resident 690's Documentation Survey Report (record of nursing tasks) for 4/2025, the Documentation Survey Report indicated the RNA provided AAROM to both arms and the right leg and PROM to the left leg from 4/22/2025 to 4/30/2025. During a review of the Minimum Data Set ([MDS] a federally mandated resident assessment tool), dated 4/29/2025, the MDS indicated Resident 690 had clear speech, expressed ideas and wants, clearly understood verbal content, and had intact cognition (clear ability to think, understand, learn, and remember). The MDS indicated Resident 690 required setup or clean up assistance for eating, partial/moderate assistance (helper does less than half the effort) for rolling to either side in bed, and dependent for toileting, bathing, dressing, and putting on/taking off footwear. During a review of Resident 690's physician's order, dated 5/6/2025, the physician's order indicated to discontinue PROM to both legs due to the RNA's reports of improvement in the right leg. The physician's order, dated 5/6/2025, indicated for the RNA to provide Resident 690 AAROM to both arms and the right leg and PROM to the left leg. During a review of Resident 690's Documentation Survey Report for 5/2025, the Documentation Survey Report indicated the RNA provided AAROM to both arms and the right leg and PROM to the left leg from 5/1/2025 to 5/7/2025. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 5/6/2025 at 1:45 p.m. in Resident 690's room, Resident 690's RNA session was observed. Restorative Nursing Assistant 1 (RNA 1) stood on the left side of Resident 690's bed to perform PROM on the left leg at the hip, knee, and ankle joints. RNA 1 walked to the right side of the bed to perform AAROM of the right leg. Resident 690 was observed lifting the right leg at the hip joint (hip flexion), requiring RNA 1's assistance to lift the right leg higher. Resident 690 was observed moving the right hip into abduction (moving the leg at the hip joint away from the body), requiring RNA 1's assistance to move the right legs further away from the body. Resident 690 slid the right leg at the hip joint back toward the body (hip adduction) without physical assistance. Resident 690 slightly bent the right knee, requiring RNA 1's physical assistance to completely bend the knee. Resident 690 also moved the right ankle toward the body (dorsiflexion) and away from the body (plantarflexion), requiring RNA 1's physical assistance to fully move at the ankle joint. During an interview on 5/6/2025 at 2:18 p.m. with RNA 1, RNA 1 stated Resident 690 was seen for PROM of the left leg and AAROM of both arms and the right leg. RNA 1 stated Resident 690 did ROM exercises to both arms without much physical assistance. RNA 1 stated she reported Resident 690's desire for more therapy services to Physical Therapist 1 ([PT 1] professional aimed in the restoration, maintenance, and promotion of optimal physical function). RNA 1 stated PT 1 saw Resident 690 today (5/6/2025) and changed the RNA order from PROM to AAROM on the right leg. During an interview on 5/7/2025 at 3:06 p.m. with PT 1, PT 1 stated RNA 1 reported an improvement in movement to Resident 690's right leg yesterday (5/6/2025). PT 1 stated Resident 690's RNA program was modified from PROM to AAROM exercises to the right leg. During a concurrent interview and record review on 5/8/2025 at 1:02 p.m. with the Director of Medical Records (DMR), Resident 690's physician's orders for RNA, dated 4/22/2025 and 5/6/2025, and the Documentation Survey Report, dated 4/2025 and 5/2025, were reviewed. The DMR stated Resident 690's physician's order, dated 4/22/2025, indicated RNA to provide AAROM on both arms and PROM on both legs, seven days per week, and was discontinued on 5/6/2025. The DMR stated Resident 690's physician's order, dated 5/6/2025, indicated RNA to provide AAROM to both arms and the right leg and PROM to the left leg, seven days per week. The DMR stated the Documentation Survey Report for RNA indicated whether Resident 690 received RNA services. The DMR reviewed Resident 690's Documentation Survey Report, dated 4/2025 and 5/2025, and stated the RNA services provided in the Documentation Survey Reports from 4/22/2025 to 5/5/2025 did not reflect Resident 690's physician's order, dated 4/22/2025. The DMR stated the Documentation Survey Report was inaccurate and indicated the RNA did not provide the treatment in accordance with the physician's orders. During an interview on 5/8/2025 at 3:18 p.m. and 5/8/2025 at 3:35 p.m. with the DMR, the DMR stated the facility did not have a policy and procedure for medical record accuracy. 50632

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. 44309 Based on interview and record review, the facility failed to provide appropriate hospice services (a program that gives special care to people who are near the end of life and have stopped treatment to cure or control their disease) to one of one sampled resident (Resident 61) reviewed under Hospice and End of Life care area by failing to: 1. Designate a member of the facility's interdisciplinary team to coordinate care provided to the residents by the facility and the hospice company in their Hospice Program, policy. 2. Honor Resident 61`s Responsible Party 2`s (RP 2) wish to end the resident`s hospice services.  These deficient practices had the potential to negatively affect Resident 61`s physical comfort and psychosocial well-being. Findings: During a review of Resident 61's Admission Record (face sheet), the Admission Record indicated that the facility admitted the resident on 4/22/2024, with diagnoses including history of falling, muscle weakness, cerebrovascular disease (conditions that affect blood flow to your brain), seizure (a sudden, uncontrolled electrical disturbance in the brain which can cause uncontrolled jerking, blank stares, and loss of consciousness) and encounter for palliative care (specialized medical care for individuals with serious illnesses that focuses on relieving symptoms, managing stress, and improving quality of life for both the patient and their family). During a review of Resident 61's Minimum Data Set (MDS- a resident assessment tool) dated 2/2/2025, the MDS indicated the resident`s cognitive skills (the brain's ability to think, read, learn, remember, reason, express thoughts, and make decisions) for daily decision making was moderately impaired (decisions poor, cues/supervision required). The MDS indicated that Resident 61 was dependent on staff (helper does all of the effort) for oral hygiene, toileting hygiene, showering/bathing, upper and lower body dressing, putting on/taking off footwear, and personal hygiene. The MDS further indicated that Resident 61 was receiving hospice care while a resident in the facility. During a review of Resident 61`s physician Order Summary Report (physician order) dated 4/22/2024, the Order Summary Report indicated to admit Resident 61 to Hospice Agency 1 (HA1) with primary diagnosis of cerebrovascular accident (CVA-stroke, loss of blood flow to a part of the brain). The order summary report further indicated to call HA1 for any changes in the resident`s condition.  During a review of Resident 61`s care plan (a document outlining a detailed approach to care customized to an individual resident's need) for expected deterioration (becoming worse) due to terminal illness (a medical condition that is considered incurable and will eventually lead to death) initiated on 5/2/2024, the care plan indicated that Resident 61 was under HA1 care for diagnosis of CVA. The care plan interventions were to respect resident`s and or his family`s wishes, provide support and allow the resident to verbalize his feelings. (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a record review of HA 1`s Attendance Flow Sheet for Registered Nurse (RN), the flow sheet indicated that HA 1`s RN last visited Resident 61 in the facility on 5/5/2025 at 1:00 p.m. During a record review of HA 1`s Attendance Flow Sheet for Licensed Vocational Nurse (LVN), the flow sheet indicated that HA 1`s LVN last visited Resident 61 in the facility on 5/6/2025 at 5:00 p.m. During a record review of HA 1`s Attendance Flow Sheet for Certified Home Health Aide (CHHA), the flow sheet indicated that HA 1`s CHHA last visited Resident 61 in the facility on 5/6/2025 at 2:00 p.m. During a concurrent interview and record review on 5/8/2025 at 9:48 a.m., with the Social Service Director (SSD), Resident 61`s physician orders and SS notes were reviewed. The SSD stated that Resident 61 was discharged from hospice services on 5/4/2025 per his Responsible Party 2`s (RP 2) request. The SSD stated that she (SSD) is not sure why Resident 61 is still under HA 1 services. The SSD stated that she called HA 1 and informed the owner that Resident 61`s RP 2 did not wish for Resident 61 to receive hospice services anymore. The SSD stated that she (SSD) did not document her conversation with RP 2 to discontinue Resident 61`s hospice services in the resident`s medical record. The SSD stated she did not document her conversation with HA 1 to end the hospice services in Resident 61`s medical record. The SSD stated HA1`s RN last visited Resident 61 on 5/5/2025. The SSD stated HA 1`s LVN and CHHA last visited the resident on 5/6/2025 after RP 2 made the request to end the hospice services on 5/4/2025. The SSD stated that she should have documented in Resident 61`s medical record about the conversationsshe had with RP 2. The SSD also stated that she should have informed the physician and the facility`s administration regarding RP 2`s request to end the hospice services for Resident 61. Thge SSD stated Resident 61 is still under HA 1 care and hospice continues to receive payments for services they are providing despite RP 2`s request to end hospice services. The SSD further stated that she is the designated staff member to coordinate the care provided to residents by the facility staff and the hospice staff. The SSD stated the facility`s policy titled Hospice Program, does not indicate her name as a designated member. The SSD stated she failed to perform her responsibility as the coordinator of care between the facility and HA 1. The SSD stated the potential outcome of not coordinating Resident 61's care with the hospice provider is not honoring residents` wishes and not providing appropriate care.  During a telephone interview on 5/8/2025 at 11:56 a.m., with the DON of HA 1 (HDON), HDON stated that they (HA 1) did not receive any calls from the SSD informing them to end Resident 61`s hospice services. During a telephone interview on 5/8/2025 at 12:10 p.m., with Responsible Party 2 (RP 2), RP 2 stated that she does not want Resident 61 to receive hospice care and services in the facility anymore. RP 2 stated that last week on 5/1/2025 and 5/2/2025, she contacted the SSD and requested to discontinue Resident 61`s hospice services. RP 2 stated that she wants to transfer Resident 61 to a facility closer to where she lives. RP 2 stated if Resident 61 continues to receive hospice care, the transfer will not happen. (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/8/2025 at 3:22 p.m., with the Director of Nursing (DON), the DON stated that the SSD is the designated staff member to coordinate care provided to residents under hospice services by the facility staff and the hospice staff. The DON stated the facility`s Hospice Program policy did not indicate the SSD`s name as a designated staff member for coordination, and it should have. The DON stated the SSD did not communicate with HA 1 and the facility staff regarding RP 2's wish to discontinue Resident 61`s hospice services. The DON stated the facility respects all residents and their family members' wishes to receive or discontinue the services the facility provides. The DON stated it is important to honor the resident's wishes to ensure appropriate care.  During a review of the facility`s Policy and Procedures (P&P) titled Hospice Program, last reviewed on 7/16/2024, the P&P did not indicate who is the designated person to coordinate care provided to the resident by the facility staff and the hospice staff. This individual is responsible for the following: Communicating with hospice representatives and other healthcare providers participating in the provision of care for the terminal illness, related conditions to ensure quality of care for the resident and family, ensuring that our facility staff provides orientation on the policies and procedures of the facility, including resident rights, appropriate forms, and record keeping requirements, to hospice staff furnishing care to the residents.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36943 Based on observation, interview, and record review, the facility failed to implement infection control practices by failing to: 1. Implement Enhanced Barrier Precautions ([EBP] an infection control intervention in nursing homes designed to reduce transmission of bacteria and other microorganisms that have developed resistance to antibiotics making infections hard to treat) with Resident 130 and 151 in the therapy gym during high contact activities. This deficient practice had the potential to increase the risk of spreading infection to other residents. 2. Clean two of two cloth gait belts (assistive device placed around a person's waist to assist with safe transferring between surfaces or while walking) used with Resident 151 in accordance with the manufacturer's recommendations for disinfecting wipes (pre-moistened towelettes that contain a sanitizing or disinfecting formula that kill or reduce germs on surfaces). This deficient practice had the potential for cross contamination and placed the residents at risk of acquiring an infection. 3. To ensure a resident's oxygen tubing (a flexible tube that delivers supplemental oxygen from an oxygen concentrator or other oxygen supply to a device like a nasal cannula or mask) was not touching the floor for one (Resident 174) out of six sampled residents investigated under the care area of infection control. This deficient practice had the potential to place the resident at increased risk of developing an infection. 4. Maintain infection control practices by failing to ensure a urine bottle (a container for receiving urine) was not hung and stored on a trash can full of trash for one of one sampled resident (Resident 113) during a random observation. This deficient practice had the potential for cross contamination and placed the residents at risk of acquiring an infection. 5. Ensure foam bed rail padding was free from rips and gouges and could be properly cleaned and disinfected for three of five sampled residents (Residents 182, 642, and 643). This deficient practice had the potential for cross contamination and placed the residents at risk of acquiring an infection. 6. Keep the floor of a storage room clean, ensure employees' personal items were not placed on top of boxes containing medical supplies, and ensure boxes of medical supplies were stored off of the floor. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	These deficient practices had the potential to transmit infectious microorganisms to residents in the facility. Findings: 1. During a review of Resident 130's Admission Record, the Admission Record indicated the facility originally admitted Resident 130 on 11/16/2023 and readmitted on [DATE] with diagnoses including hemiparesis (weakness of the arm, leg, and trunk on the same side of the body) following a cerebral infarction (brain damage due to a loss of oxygen to the area) affecting the right dominant side, attention to tracheostomy (hole fitted with a device through the front of the neck and into the windpipe [trachea] to allow air into the lungs), and attention to gastrostomy ([G-tube] surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems). During a review of Resident 130's care plan titled, Enhanced Barrier Precaution, initiated 6/6/2024, the care plan interventions included to provide EBP with gloves, gowns, and masks. During an observation on 5/6/2025 at 10:09 a.m. in the therapy gym, Resident 130 was seated in a wheelchair with a portable oxygen tank attached to the back of the wheelchair seat. Resident 130 had oxygen flowing into the tracheostomy tube. During an observation on 5/7/2025 at 11:25 a.m. in the therapy gym, Resident 130 walked using a height-adjustable four-wheeled walker (an assistive device with four wheels used for stability when walking) with a padded platform underneath the forearms. The Director of Rehabilitation (DOR) and Certified Occupational Therapy Assistant 1 (COTA 1) were on each side of Resident 130 while walking. The DOR and COTA 1 were not wearing any gowns. During an observation on 5/8/2025 at 9:23 a.m. outside of Resident 130's room, there was a sticker labeled E next to Resident 130's name. During an interview on 5/8/2025 at 9:24 a.m. with Registered Nurse 5 (RN 5) outside of Resident 130's room, RN 5 stated the sticker labeled E next to the resident's name indicated the resident was on Enhanced Barrier Precautions (EBP) because the resident has a tracheostomy tube and prone to infection. RN 5 stated anyone coming into high contact with the residents on EBP needed to wear a gown and gloves to protect the residents from infection and to prevent the spread of infection to the healthcare workers. During an interview on 5/8/2025 at 10:05 a.m. with COTA 1, COTA 1 stated Resident 130's treatment session in the therapy gym yesterday (5/7/2025) included range of motion ([ROM] full movement potential of a joint) exercises. COTA 1 stated Resident 130 required physical assistance of two-persons to perform sit-to-stand transfers during the treatment and walked with assistance while using the height-adjustable four-wheeled walker. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. During a review of Resident 151's Admission Record, the Admission Record indicated the facility admitted Resident 151 on 3/21/2024 with diagnoses including cerebral infarction due to occlusion (blockage) or stenosis (narrowing) of the right anterior cerebral artery (blood vessels delivering oxygen rich blood to the front and middle parts of the brain), attention to tracheostomy, attention to gastrostomy, and contractures (a stiffening/shortening at any joint that reduces the joint's range of motion) of the right elbow, right hand, and both ankles. During a review of Resident 151's care plan titled, Enhanced Barrier Precaution, initiated 4/9/2025, the care plan interventions included to provide EBP with gloves, gowns, and masks. During a concurrent observation and interview on 5/6/2025 at 1:05 p.m. in Resident 151's room, Resident 151 was awake and lying in bed with a bandage over the resident's throat in the front of the neck. During an interview on 5/6/2025 at 3:18 p.m. in the bedroom, Resident 151 stated the tracheostomy tube was removed three weeks ago. During an observation on 5/7/2025 at 10:33 a.m. in the therapy gym, Resident 151's Physical Therapy ([PT] profession aimed in the restoration, maintenance, and promotion of optimal physical function) session was observed. Resident 151's bandage over the throat did not fully cover the hole in the front of Resident 151's neck. Resident 151 was sitting up in a Geri chair (reclining chair that allows someone to get out of bed and sit comfortably in different positions while fully supported). Physical Therapist 1 (PT 1) placed a cloth gait belt around Resident 151's waist and placed a height-adjustable four-wheeled walker in front of Resident 151. PT 1 stood directly next to Resident 151 on the left side while the DOR stood directly on the right side to physically assist Resident 151 with transferring from sitting to standing with the four-wheeled walker. Resident 151 attempted to walk with PT 1 and the DOR while both forearms were supported on a padded platform attached to the four-wheeled walker. PT 1 and the DOR were not wearing any gowns. Resident 151 sat up in a wheelchair at the end of the session. During an observation on 5/7/2025 at 11:13 a.m., PT 1 and Rehabilitation Aide 1 (RA 1) wheeled Resident 151 back to the bedroom. PT 1 and RA 1 put on gowns and gloves prior to entering Resident 151's bedroom. PT 1 placed the cloth gait belt around Resident 151's waist. PT 1 and RA 1 physically assisted Resident 151 to transfer from the wheelchair to the edge of the bed. PT 1 removed the cloth gait belt from around Resident 151's waist and assisted the resident back into the bed. During an observation on 5/8/2025 at 9:28 a.m. outside of Resident 151's room, there was a sticker labeled E next to Resident 151's name. During an interview on 5/8/2025 at 9:29 a.m. with Registered Nurse 1 (RN 1) outside of Resident 151's room, RN 6 stated the sticker labeled E next to the resident's name indicated the resident was on Enhanced Barrier Precautions and stated a gown and gloves needed to be worn while handling Resident 151. RN 1 stated Resident 151 was on EBP because there was an open hole in the throat from Resident 151's recent removal of the tracheostomy tube. (continued on next page)

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/8/2025 at 9:43 a.m. with PT 1, PT 1 stated Resident 151 was on EBP only inside the resident's room. PT 1 stated EBP were extra precautions for residents with G-tubes and oxygen to prevent infection. PT 1 stated it would be better to wear a gown while providing therapy to Resident 151 in the therapy gym. During a concurrent interview and record review on 5/8/2025 at 9:48 a.m. with the Infection Prevention Nurse (IPN), the facility's P&P titled, Enhanced Barrier Precautions, dated 6/5/2024, was reviewed. The IPN stated residents with EBP were at high-risk of infection and included residents with tracheostomy tubes, G-tubes, and open wounds. The IPN stated personal protective equipment ([PPE] clothing and equipment that is worn or used to provide protection against hazardous substances and/or environments) including gowns and gloves were worn during high contact care, including transfers. The IPN stated therapists working with residents while transferring was a high contact activity and should be wearing gowns and gloves. During a review of the Center for Disease Control and Prevention (CDC) Frequently Asked Questions (FAQs) about Enhanced Barrier Precautions in Nursing Homes (https://www.cdc.gov/long-term-care-facilities/hcp/prevent-mdro/faqs.html), dated 6/28/2024, the CDC FAQs indicated EBP should be followed outside resident's rooms when working with residents in the therapy gym, specifically when anticipating close physical contact while assisting with transfers and mobility. 2. During a review of Resident 151's Admission Record, the Admission Record indicated the facility admitted Resident 151 on 3/21/2024 with diagnoses including cerebral infarction due to occlusion (blockage) or stenosis (narrowing) of the right anterior cerebral artery (blood vessels delivering oxygen rich blood to the front and middle parts of the brain), attention to tracheostomy (hole fitted with a device through the front of the neck and into the windpipe [trachea] to allow air into the lungs), attention to gastrostomy ([G-tube] surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems), and contractures (a stiffening/shortening at any joint that reduces the joint's range of motion) of the right elbow, right hand, and both ankles. During an observation on 5/6/2025 at 1:12 p.m., RNA 1 wore a cloth gait belt around the waist with RNA 1's name written in black lettering. During an observation on 5/6/2025 at 2:38 p.m. in Resident 151's room, RNA 1 and RNA 2 physically assisted Resident 151 to transfer from lying in the bed to sitting at the edge of the bed. RNA 1 removed the cloth gait belt from around RNA 1's waist and fastened it around Resident 151's waist. RNA 1 stood directly next to Resident 151's right side while RNA 2 stood on the left side to physically assist Resident 151 from sitting at the edge of the bed to standing using a height-adjustable four-wheeled walker (an assistive device with four wheels used for stability when walking). RNA 2 removed the cloth gait belt from around Resident 151's waist after finishing with sit-to-stand exercises. RNA 1 and RNA 2 assisted Resident 151 back to lying in bed. RNA 2 placed the cloth gait belt on top of Resident 151's dresser drawers. During a concurrent observation and interview on 5/6/2025 at 3:11 p.m., RNA 1 removed the cloth gait from the top of Resident 151's dresser drawers. RNA 1 stated disinfecting wipes were used to clean the cloth gait belt and four-wheeled walker. RNA 1 was observed cleaning the cloth gait belt with disinfecting wipes. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 5/7/2025 at 10:33 a.m. in the therapy gym, Resident 151's Physical Therapy ([PT] profession aimed in the restoration, maintenance, and promotion of optimal physical function) session was observed. Resident 151 was sitting up in a Geri chair (reclining chair that allows someone to get out of bed and sit comfortably in different positions while fully supported). Physical Therapist 1 (PT 1) placed a cloth gait belt with PT 1's name in black lettering around Resident 151's waist. PT 1 also placed a height-adjustable four-wheeled walker in front of Resident 151. PT 1 stood directly on Resident 151's left side while the Director of Rehabilitation (DOR) stood on the right side to assist Resident 151 with transferring from sitting to standing with the four-wheeled walker. Resident 151 attempted to walk with PT 1 and the DOR while both forearms were supported on a padded platform attached to the four-wheeled walker. Resident 151 sat up in a wheelchair at the end of the session. PT 1 removed the cloth gait belt from around Resident 151's waist, rolled it up, and placed it in PT 1's left coat pocket. During an observation on 5/7/2025 at 11:13 a.m., PT 1 and Rehabilitation Aide 1 (RA 1) wheeled Resident 151 back to the bedroom. PT 1 placed the cloth gait belt around Resident 151's waist. PT 1 and RA 1 physically assisted Resident 151 to transfer from the wheelchair to the edge of the bed. PT 1 removed the cloth gait belt from around Resident 151's waist and assisted the resident back into the bed. During a concurrent observation and interview on 5/7/2025 at 11:18 a.m., PT 1 placed the cloth gait belt inside PT 1's left coat pocket. PT 1 stated disinfecting wipes were used to clean the cloth gait belt. During a review of the undated manufacturer's recommendations of the disinfecting wipes, the manufacturer's recommendations indicated it was a violation of Federal law to use the product inconsistent with its labeling. The manufacturer's recommendations indicated the disinfecting wipes were for use on hard, non-porous surfaces of non-critical medical devices. During a concurrent observation, interview, and review of the disinfectant wipes' manufacturer recommendations on 5/7/2025 at 4:17 p.m. with the Infection Prevention Nurse (IPN), the IPN stated the disinfectant wipes' manufacture recommendations indicated for use on hard, non-porous surfaces. IPN stated cloth was an example of a porous surface. The IPN observed PT 1's gait belt and stated it was made of thick cloth. The IPN stated the disinfecting wipes were not effective in cleaning cloth gait belts. The IPN stated there was a possibility of bacteria and germs spreading without proper cleaning of cloth gait belts. During a review of the facility Policy and Procedure (P&P) titled, Cleaning and Disinfecting Non-Critical Resident-Care Items, revised 4/2023, the P&P indicated the manufacturer's instructions will be followed for proper use of disinfecting products, including material compatibility (ability of two or more materials to perform effectively together). During a review the facility's Policy and Procedure (P&P) titled, Enhanced Barrier Precautions, dated 6/5/2024, the P&P indicated EBP was utilized to prevent the spread of multi-drug-resistant organisms ([MDROs] bacteria and other microorganisms that have developed resistance to antibiotics making infections hard to treat) to residents. The P&P indicated EBP employed targeted gown and glove use during high contact resident care activities, including during transfers. 38549 (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. During a review of Resident 174's Admission Record, the Admission Record indicated the facility admitted the resident on 1/11/2025 with diagnoses including acute respiratory failure (occurs when the lungs are unable to efficiently transfer oxygen into the blood, or remove carbon dioxide from the blood, leading to a deficiency in oxygen and/or a buildup of carbon dioxide) and encounter for attention to tracheostomy (a surgical procedure that creates an opening in the front of the neck [trachea] and inserts a tube to provide a direct airway for breathing). During a review of Resident 174's Minimum Data Set (MDS - a resident assessment tool), dated 4/25/2025, the MDS indicated the resident had severely impaired cognition (thought processes) and was dependent on staff for most activities of daily living (ADLs - activities such as bathing, dressing and toileting a person performs daily). On 5/6/2025 at 9:30 a.m., during an observation, observed Resident 174 asleep in bed. The resident's oxygen tubing was touching the floor. On 5/6/2025 at 9:38 a.m., during a concurrent observation and interview with the Subacute Director (SD), the SD verified that Resident 174's oxygen tubing was touching the floor. The SD stated that residents' oxygen tubing should be kept off the floor. On 5/8/2025 at 11:18 a.m., during an interview with the Director of Nursing (DON), the DON stated if a resident's oxygen tubing was touching the floor, then the resident can potentially develop an infection. During a review of the facility's policy and procedure titled, Oxygen Administration, last reviewed on 7/16/2024, the policy and procedure indicated that oxygen tubing should be used in a manner that prevents it from touching the floor. 49947 4. During a review of Resident 113's Admission Record, the Admission Record indicated that the facility initially admitted Resident 113 on 12/7/2023 and readmitted on [DATE] with diagnoses including but not limited to encephalopathy (a group of conditions that cause brain dysfunction), type 2 diabetes (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), history of falling and weakness. During a review of Resident 113's History and Physical (H&P), dated 6/9/2024, the H&P indicated Resident 113 did have the capacity to understand and make decisions. During a review of Resident 113's Minimum Data Set (MDS - a federally mandated resident assessment tool), dated 2/21/2025, the MDS indicated that the resident had intact cognition (undamaged mental abilities, including remembering things, making decisions, concentrating, or learning). The MDS further indicated that Resident 113 was dependent on staff with oral hygiene and required set-up assistance for other activities of daily living (ADLs - basic tasks that must be accomplished every day for an individual to thrive). (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During concurrent observation and interview on 5/5/2025 at 10:43 am, in Resident 113's room, Resident 113 was lying in bed and had his urinal hanging inside his trash can and the trash can had food and paper trash in it. Resident 113 stated he hangs it there because he does not have another place to hang it. During concurrent observation and interview on 5/5/2025 at 10:45 am, in Resident 113's room with Certified Nursing Assistant 5 (CNA 5), CNA 5 stated Resident 113 should not have his urinal in the trash because the trash is dirty and the resident can get an infection. CNA 5 then asked Resident 113 if he had a urinal holder and that she will get him one if he did not. During an interview on 5/8/2025 at 1:48 pm with the Director of Nursing (DON), the DON stated staff must empty the urinals as soon as they can and hang it in the urinal holders. The DON stated urinals must never be stored on or in the trash can because it is an infection control issue and the urinal can transmit diseases from the trash to the resident. During a review of the Policy and Procedure (P&P) named Policy: Infection Control, last reviewed on 7/16/2024, the P&P indicated the facility will maintain an infection control program designed to provide a safe, sanitary and comfortable environment and help prevent the development and transmission of disease and infection. During a review of the P&P named Bedpan/Urinal, Offering/Removing, last reviewed on 7/16/2024, the P&P stated to store the urinal clean, dry and per facility policy. 50033 5. During a review of Resident 182's Admission Record, the Admission Record indicated the facility originally admitted the resident on 3/29/2025 and readmitted the resident on 4/29/2025 with diagnoses including but not limited to cerebral infarction (an obstruction of blood flow in the brain that leads to tissue damage) and acute respiratory failure (a condition where the lungs cannot release enough oxygen into the blood). During a review of Resident 182's Minimum Data Set (MDS - a resident assessment tool), dated 4/11/2025, the MDS indicated Resident 182 had severely impaired cognitive skills (problems with the ability to think, learn, and remember clearly) for daily decision making and required total assistance from staff with activities of daily living (ADLs- activities such as bathing, dressing and toileting a person performs daily). During a review of Resident 182's Physicians Orders, the Physicians Orders indicated an order for padded siderails to decrease potential injury dated 4/30/2025. During a review of Resident 642's Admission Record, the Admission Record indicated the facility admitted the resident on 5/1/2025 with diagnoses including but not limited to acute respiratory failure and intracerebral hemorrhage (bleeding inside the brain tissue). During a review of Resident 642's History and Physical, dated 5/3/2025, the History and Physical indicated Resident 642 was not alert or oriented (a person's awareness of their surroundings, including who they are, where they are, and what time it is) and was unable to move any extremities. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 642's Physicians Orders, the Physicians Orders indicated an order for padded siderails to decrease potential injury dated 5/5/2025. During a review of Resident 643's Admission Record, the Admission Record indicated the facility admitted the resident on 4/10/2025 diagnoses including but not limited to cerebral infarction and acute respiratory failure. During a review of Resident 643's MDS, dated [DATE], the MDS indicated Resident 643 had severely impaired cognitive skills for daily decision making and required total assistance from staff with ADLs. During a review of Resident 643's Physicians Orders, the Physicians Orders indicated an order for padded siderails to decrease potential injury dated 4/12/2025. During a concurrent observation and interview on 5/7/2025 at 9:24 a.m. with Environmental Services Worker 1 (ESW 1) and the Infection Preventionist (IPN) in room [ROOM NUMBER], ESW 1 wiped down the hard plastic bed rails but not the black foam bed rail padding covering the bed rail. ESW 1 stated she does not wipe them down because of the type of soft surface they are made of they get too wet when using cleaning products. The IPN stated it is possible for the foam padding to harbor bacteria. The IPN stated they replace the foam padding but she was not sure how often they replace it. The IPN was unable to provide a policy and procedure on cleaning or replacing the foam bed rail padding when requested. During a concurrent interview and record review on 5/7/2025 at 10:13 a.m. with the Maintenance Director (MD), the MD stated the foam should be cleaned with the hydrogen peroxide wipes in the green packaging. During a concurrent interview and record review on 5/8/2025 at 2:39 p.m. with the Director of Nursing (DON), photographs of Resident 182, 642, and 643's padded bed rails were reviewed. The DON stated the ripped and gouged bed rail padding was not in good repair and could potentially harbor bacteria. During a review of the manufacturers instructions for Clorox Healthcare Hydrogen Peroxide Cleaner Disinfectant Wipes, dated 2024, the manufacturers instructions indicated the product cleans, disinfects, and deodorizes hard, nonporous medical surfaces. During a review of the facility's policy and procedure (P&P) titled Homelike Environment, last reviewed 7/16/2024, the P&P indicated residents are to be provided with a safe, clean, comfortable, environment. During a review of the facility's P&P titled, Cleaning and Disinfection of Environmental Surfaces, last reviewed 7/16/2024, the P&P indicated surfaces will be disinfected with a disinfectant registered with the Environmental Protection Agency according to the label's safety precautions and use directions. The P&P further indicates manufacturers instructions will be followed including material compatibility. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	6. During a concurrent observation and interview on 5/8/2025 at 8:05 a.m. with Respiratory Therapist 1 (RT 1) in the storage room next to room [ROOM NUMBER], boxes containing medical supplies were on the floor, the floor had visible dirt, and two personal backpacks and one personal sweatshirt were on top of boxes containing medical supplies. RT 1 stated respiratory therapy supplies used for residents were stored in this storage room. RT 1 stated personal belongings were stored in the storage room as there was not a lot of space to store personal items elsewhere. During a concurrent observation and interview on 5/8/2025 at 10:20 a.m. with Environmental Services Worker 2 (ESW 2), ESW 2 cleaned debris off the storage room floor and scrubbed a stain off with a mop. ESW 2 stated he was unsure when the floor of the storage room was last cleaned, and he does not usually clean storage room floors. During an interview on 5/8/2025 at 1:50 p.m. with IPN, IPN stated she would not say it was okay that the boxes were stored directly on the floor, but that they have been stored that way for a long time and there has never been an issue. The IPN stated the floor of the storage room should be clean to maintain the equipment. During an interview on 5/8/2025 at 2:39 p.m. with DON, the DON stated the floor of the storage room should be clean to prevent contamination. The DON stated storing boxes with medical supplies on the floor and keeping employee personal items on top of the boxes could lead to contamination or possibly spread an infection to a resident. During a review of the facility's P&P titled, Cleaning and Disinfection of Environmental Surfaces, last reviewed 7/16/2024, the P&P indicated floors will be cleaned on a regular basis, when spills occur, and when visibly soiled. During a review of the facility's P&P titled, Storage Areas, Maintenance, last reviewed 7/16/2024, the P&P indicated storage areas shall be maintained in a clean and safe manner. During a review of the facility's P&P titled, Receipt and Storage of Supplies and Equipment last reviewed 7/16/2024, the P&P indicated all supplies and equipment must be stored in accordance with the manufacturer's recommendations.

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F 0907 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough space and equipment to meet each resident's needs **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36943 Based on observation, interview, and record review, the facility failed to ensure the therapy gym had adequate space and equipment to provide therapy services by failing to ensure: 1. One of two therapy mats functioned properly and was accessible for resident care. 2. One of eight hand weights was well-maintained for residents' use. 3. One of one oxygen concentrators (medical device used for delivering oxygen) was serviced. 4. One of one containers of ultrasound (imaging test that uses high-energy sound waves to look at tissues and organs inside the body) gel was not expired. These failures had the potential to place residents receiving therapy services from safe and optimal use of the therapy equipment. Findings: During an observation on [DATE] at 9:43 a.m., in the therapy gym, one combination ultrasound and electrical stimulation (use of mild electrical pulses through the skin to help stimulate injured muscles or manipulate nerves to reduce pain) machine was in the therapy gym. During a concurrent observation and interview on [DATE] at 9:48 a.m., with the Director of Rehabilitation (DOR), the DOR provided the ultrasound gel container which indicated an expiration date of [DATE]. The DOR stated the ultrasound gel was used with the ultrasound machine to address chronic pain and soften soft tissue (non-bony tissues in the body including muscles, tendons, ligaments). The DOR stated the ultrasound gel had been expired for one-and-a-half years and would limit the effectiveness of the ultrasound to address a resident's pain and soft tissue concerns. During an observation on [DATE] at 9:52 a.m., observed one therapy mat was located toward the entrance of the therapy gym. (continued on next page)

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F 0907 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview on [DATE] at 10:00 a.m., with the DOR, observed a second therapy mat (therapy mat #2) was located toward the back of the therapy gym. The therapy mat was unplugged and had therapy equipment scattered over the surface of the therapy mat, including a bean bag toss game, eight hand weights, two arm bicycles, a therapy rainbow arch (plastic tubing in a rainbow shaped used to work on arm range of motion [(ROM)] full movement potential of a joint]). One of the eight hand weights was an eight (8) pound (lbs.- unit of measurement) hand weight with its smooth, protective coating chipped off, exposing the metal. The DOR stated therapy mat #2 was broken and was used as equipment storage for the therapists' convenience. The DOR stated the arm bicycles were broken and were supposed to be thrown out. The DOR stated the 8 lbs. hand weight was used as a paperweight and not for resident care. The DOR stated therapy mats (in general) were used to practice bed mobility (ability to move within the confines of a bed, including activities like rolling, scooting, and transitioning between lying, sitting, and standing positions), perform exercises, and work on balance activities with residents. The DOR stated therapy mat #2 was used as storage and not usable for resident care. During a concurrent observation and interview on [DATE] at 10:09 a.m., with the DOR, observed one oxygen concentrator under a wooden table next to the second therapy mat. The DOR stated the oxygen concentrator did not indicate the date it was last serviced. The DOR stated some residents residing in the facility's subacute area (medical care setting where residents require more complex, round-the-clock care) received therapy in the therapy gym. The DOR stated the oxygen concentrator could ineffectively deliver oxygen since the last service date was unknown. During a review of the facility's undated Policy and Procedure (P&P) titled, Rehabilitation Services, the P&P indicated the therapy gym shall be equipped with necessary equipment, including a treatment table and weights. The P&P also indicated Equipment shall be safe and adequate for resident needs and level of services to be provided.

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. 47441 Based on observation, interview, and record review, the facility failed to maintain sanitary conditions in the food services department when one (1) fly (a type of insect) was observed in the kitchen. This failure had the potential to result in 138 of 199 residents, who received food from the kitchen, to acquire food borne illnesses (illness caused by consuming contaminated foods or beverages) by consuming potentially contaminated food. Findings: During an observation on 5/6/2025 at 11:06 a.m. one (1) fly was flying around the preparation area and landed on the dessert rack. During an observation on 5/6/2025 at 11:13 a.m. one fly was flying around the trayline area (an area where foods were assembled from the steamtable to resident's plate). During an interview on 5/6/2025 at 12:52 p.m. with the Dietary Supervisor (DS), the DS stated the pest control vendor came in the beginning of 4/2025. The DS stated a fly landing on the food rack is not okay as it could transmit diseases through food contact of the residents. During a review of facility's policies and procedures (P&P) titled Pest Control Policy, reviewed 7/16/2024, the P&P indicated, Policy: The facility shall maintain an effective pest control program. Policy Interpretation and Implementation: (1) This facility maintains an on-going pest control program to ensure that the building is kept free from insects and rodents. During a review of Food Code 2022, dated 1/18/2023, the Food Code 2022 indicated 6.501.111 Controlling Pests. The premises shall be maintained free of insects, rodents and other pests shall be controlled to eliminate their presence on the premises by: a. Routinely inspecting incoming shipments of food and supplies. b. Routinely inspecting the premises for evidence of pests. c. Using methods, if pests are found, such as trapping devices or other means of pest control specified under SS 7-202.12, 7-206.12, and 7-206.13. d. Eliminating harborage conditions.