STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056198	A. Building B. Wing	08/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Kit Carson Nursing & Rehabilitation Center	811 Court Street Jackson, CA 95642

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observation, interview, and record review, the facility failed to ensure 1 out of 26 sampled residents (Resident 86) with urinary catheters (a thin flexible tube used to empty the bladder and collect urine in a drainage bag) were treated with dignity and their privacy was protected, when Resident 86's urinary catheter bag (a drainage bag attached to a catheter tube that is inside the bladder to collect urine) was exposed and was not placed in a dignity bag (a bag used to the cover and hold the catheter drainage/collection bag so it is not visible). This failure had the potential to negatively effect Resident 86's self-esteem and self-worth. During an observation on 8/11/2025 at 9:16 AM, Resident 86's urinary catheter bag was seen hanging on the side of the bed without a dignity bag. A review of Resident 86's clinical record titled, admission RECORD, indicated Resident 86 was admitted to the facility with diagnoses of, but not limited to, acute cystitis without hematuria (an inflammation of the bladder without blood in the urine), generalized muscle weakness.During an interview on 8/12/2025 at 10:24 AM with Certified Nurse Assistant (CNA) 7, CNA 7 stated the CNAs usually drain the catheter bag and the CNAs place the dignity/privacy bag for the residents but sometimes residents messed it up or it gets removed. CNA 7 acknowledged that there was no privacy cover for Resident 86's urinary catheter bag.During an interview on 8/12/2025 at 12:34 PM with Licensed Nurse (LN) 3, LN 3 stated part of urinary catheter care included the placement of a privacy cover for the catheter bag. LN 3 stated the urinary catheter bag should be hung on the side of the bed with a privacy cover.During an interview on 8/12/2025 at 2:36 PM with LN 5, LN 5 stated she expected the nurses to do daily rounds and assess the flow and color of the urine. LN 5 stated there should be a dignity bag on Resident 86's urinary catheter bag for privacy reasons. LN 5 stated Resident 86's urinary catheter bag would be exposed without the dignity bag and Resident 86 would feel embarrassed. During an interview on 8/13/2025 at 9:58 AM with the Director of Nursing (DON), the DON stated Resident 86 was just admitted to the facility a few days ago and the nursing staff could have forgotten to place the dignity cover. The DON stated there should have been a dignity cover placed on Resident 86's urinary catheter bag. A review of the facility's Policy titled, Resident Rights, revised 1/25, indicated, POLICY Employees shall treat all residents with kindness, respect and dignity.Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to:.privacy and confidentiality.

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 0577 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. Based on observation, interview, and record review, the facility failed to ensure the results of the most recent federal recertification survey were readily accessible to residents, family members, and legal representatives of residents, for a census of 75, when the facility's most recent survey results were not available.This failure violated the residents' right to the examination of the most recent survey results and prevented the residents and family members from accessing the facility's last survey results within in the facility.During the Resident Council Meeting on 8/12/2025 at 10:44 AM, when asked if they knew where to find the most recent survey results, the residents who were in attendance responded that they were not aware of where to find the results of the survey and they were also not aware that survey results were available for the residents to read. During an interview on 8/14/2025 at 11:55 AM with the Infection Preventionist (IP), the IP stated he did not know where the survey results were located, and the results could be with the administrator.During a concurrent observation and interview on 8/14/2025 at 12:01 PM with the administrator (ADM), the ADM stated the last survey results were located by the front door of the facility. With the ADM, the facility front door area where the survey results binder was supposed to be located was observed to be empty. The ADM stated it was updated a few days ago and it was just not there today. During an interview on 8/14/2025 at 12:03 PM with the DON, the DON stated if the survey result binder was not easily available for the residents to read, the residents would not be able to know the results from the last survey, and the residents would not know what the facility was working on (to fix the problems found during the survey). The DON stated she did not know how long the survey result binder had been unavailable.A review of the facility's Policy titled, Resident Rights, revised 1/25, indicated, .Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to.examine survey results.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure that one of twenty-eight sampled residents (Resident 11) end of life wishes, and emergent treatment desires were accurate when Resident 11's POLST (Physician Orders for Life Sustaining Treatment: a medical order signed by both a patient and physician that specifies the types of medical treatment a patient wishes to receive toward the end of life) form and electronic medical record code status (the type of emergent treatment a person would or would not receive if their heart or breathing were to stop) had contradictory code status choices marked.This failure resulted in conflicting code status information for Resident 11 and placed Resident 11 at risk for having emergency treatment wishes not honored. Review of Resident 11's admission RECORD indicated Resident 11 was admitted to the facility with multiple diagnoses including but not limited to cerebral infarction (medical condition that occurs when the blood flow to the brain is disrupted) and vascular dementia (a type of dementia caused by impaired blood flow to the brain, leading to damage and eventual loss of brain cells).Review of Resident 11's POLST form dated [DATE], indicated an X in the box next to Do Not Attempt Resuscitation/DNR [Allow Natural Death], and an X in the box next to Full Treatment - primary goal of prolonging life by all medically effective means. The POLST form was signed by Resident 11's Responsible party on [DATE] and by Resident 11's attending physician on [DATE].Review of Resident 11's electronic physician's order dated [DATE], indicated Resident 11's code status was DNR (Do Not Resuscitate), full Treatment.During a concurrent interview and record review on [DATE] at 3:37 PM with Licensed Nurse (LN) 8, LN 8 stated that Resident 11's treatment options that had been marked with an X on the POLST form and the code status order entered into the electronic medical record contradicted each other. LN 8 stated that Resident 11 could not be a DNR and full treatment at the same time. LN 8 stated that if Resident 11 desired to receive full treatment, then CPR (chest compressions), not DNR should have been checked on the POLST form and the physician's code status order in the electronic medical record should reflect that choice. LN 8 stated that based on the POLST answers she would start CPR. LN 8 stated that the current POLST and physician order were confusing and placed Resident 11 at risk for not receiving end of life, emergency care per his wishes.During a concurrent interview and record review on [DATE] at 11:05 AM with LN 5, LN 5 stated that the definition of full treatment meant that everything possible to keep someone alive would be done, including CPR. LN 5 stated that Resident 11's POLST and physician order for code status contradicted each other and were confusing and could lead to the wrong level of care being administered.During an interview on [DATE] at 10:35 AM with Resident 11's Representative, the Representative stated that if Resident 11 was without a heartbeat or breathing they did not want CPR to be done, nor did they desire Resident 11 to have his life prolonged by any medically effective means. During a concurrent interview and record review on [DATE] at 11:20 AM with the Director of Nurses (DON), the DON confirmed that the POLST for Resident 11 had been completed incorrectly, was contradictory, confusing and needed to be updated. The DON stated that the risk of having a POLST completed incorrectly could lead to Resident 11 receiving care in a manner that Resident 11 had not chosen.Review of a facility policy titled Physician Orders for Life Sustaining Treatment (POLST) or Request Regarding Resuscitative Measures Form with revised date of 01/25 indicated When a POLST.form is completed the admission Coordinator, or other, shall review the documents for validity.

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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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on observation, interview, and record review, for 1 out of 26 sampled residents (Resident 42), the facility failed to ensure: the use of physical restraint was medically indicated;a care plan was developed for the use of restraint;an informed consent was obtained for the use of restraint. This failure resulted in Resident 42 not being able to move freely and potentially exposed Resident 42 to physical and psychological impact related to restraint. Findings: A review of Resident 42's admission RECORD, indicated Resident 42 was admitted to the facility with a diagnosis of, but not limited to, dementia (loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life) with agitation, altered mental status, and generalized muscle weakness. During a concurrent observation and interview on 8/11/25, at 9:41 AM, with Certified Nurse Assistant (CNA) 11, Resident 42 was observed sitting on a Geri chair (a specialized type of recliner designed to provide comfort, support, and positioning for individuals who need to sit for extended periods or have difficulty sitting upright in a traditional wheelchair) which was reclined with the chair footrest placed in an elevated position. Resident 42 was trying to, but could not, get out of the chair. CNA 11 stated Resident 42 was placed in a Geri chair as a fall precaution. During a concurrent interview and record review on 8/12/25, at 2:36 PM, with LN 5, Resident 42's medical record was reviewed. LN 5 stated the resident needed to be assessed by the rehabilitation department (department that helps improve function and reduce disability in people with health conditions so they can interact better with their environment) to check if the resident would be needing a Geri chair or a regular wheelchair. LN 5 confirmed that there was no order, care plan, or informed consent form for Resident 42's Geri chair. LN 5 stated that when Resident 42 was placed on a Geri chair, Resident 42 would be in a reclined position, and he would not fall because his movement would be restricted. LN 5 further stated it was considered a restraint when Resident 42 could not move freely from the Geri chair. LN 5 stated the Geri chair used for Resident 42 should have a doctor's order, an informed consent and a care plan. During a concurrent interview and record review on 8/12/25, at 12:34 PM, with License Nurse (LN) 3, Resident 42's medical record was reviewed. LN 3 stated the Geri chair use needed a doctor's order before the resident could use it because it was a specific need for the resident. LN 3 confirmed that Resident 42 did not have an order for the Geri chair. LN 3 stated Resident 42 was a fall risk and if Resident 42 used the regular chair he would not be able to sit still. LN 3 confirmed that there was no care plan in place for Resident 42's Geri chair use. During a concurrent interview and record review on 8/13/25, at 11:11 AM, with the Director of Nursing (DON), Resident 42's medical record was reviewed. The DON confirmed there was no order for the Geri chair use for Resident 42. The DON further confirmed that there was no informed consent obtained from Resident 42's responsible party regarding the use of the Geri chair. The DON stated there should have been a rehab assessment completed for the Geri chair. The DON stated the Geri chair was used for proper positioning and safety for fall precautions because the resident was not stable. The DON further stated that there was no care plan for the Geri chair, and according to the restraint assessment, a Geri chair had not been documented. The DON stated Resident 42 had 3 falls since admission. A review of the facility's policy titled, Resident Rights, revised 1/25, indicated, .Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to.be free from corporal punishment or involuntary seclusion, and physical or chemical restraints not required to treat the resident's symptoms.be informed of, and participate in, his or her care planning and treatment. A review of the facility's Policy and Procedures titled, POLICY AND PROCEDURE ON RESTRAINT, revised 9/2024, indicated, Physical restraints are defined as any manual method or physical or mechanical device, material, or equipment attached or adjacent to the resident's body that the individual cannot remove easily, which restricts freedom of movement or normal access to one's body.If the restraint is needed, it has to indicate the medical necessity due to resident physical condition or psychosocial problem.Each resident retains the right to accept or refuse the use of restraint. Physical or chemical restraint will never be used for the convenience of the staff.PROCEDURE: 1. Residents are to be evaluated in care conference regarding safety measures, including the use of physical restraint as the protection of the resident from fall or other self-injury. 2. Based on the assessment result if either physical/chemical restraint is needed consent will be obtained by the doctor from the resident/resident representative or both of the use of such restraint. 3. Explain to the resident and/or resident's representative the benefit and adverse side effect to resident ADL function, social and emotional and as well as physical debilities 5. MD's order and consent will be documented in telephone/physician order in the informed consent

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to ensure that three of twenty-six sampled Residents (Resident 5, Resident 11 and Resident 37) were free from the use of chemical restraints (use of medication to restrict a person's freedom or movement) when:1. A gradual dose reduction (GDR: stepwise tapering of a dose to determine if symptoms, conditions, or risks can be managed by a lower dose or if the dose or medication can be discontinued) was not attempted for Resident 5 and Resident 11's antipsychotic medications (a class of medications used to treat a variety of mental health disorders),2. The use of the antipsychotic medication for Resident 5, Resident 11, and Resident 37 did not have an appropriate clinical indication, and3. The behaviors identified for Resident 5, Resident 11, and Resident 37's psychotropic medications (medications that affect the mind, emotions and behaviors that are used to treat various mental health conditions) use were not monitored every shift as ordered in June, July and August 2025.These deficient practices increased Resident 5, Resident 11, and Resident 37's risk of experiencing psychotropic medications' adverse effects (unwanted or dangerous medication-related side effects) such as drowsiness, dizziness, constipation, an increased risk of a fall or declines in their mental and physical condition and psychosocial well-being.1A. Review of Resident 5's admission RECORD indicated that Resident 5 was admitted to the facility with diagnoses that included but not limited to unspecified dementia severe with psychotic disturbance (a condition where person has a progressive decline in cognitive functions like memory, thinking, language, judgment, and see or hear things those are not there or has false beliefs), unspecified mood disorder (diagnosis used when a person experiences mood symptoms that cause significant distress or impairment), and unspecified psychosis not due to a substance or known physiological condition (a mental health condition characterized by a loss of contact with reality but the cause isn't clear, and it's not linked to substance use or a known medical condition). Review of Resident 5's Psychotropic Drug Assessment dated 6/6/2024, indicated that Resident 5 was receiving Seroquel (brand name of quetiapine fumarate, an antipsychotic medication) 50 mg (milligram) one tablet by mouth twice a day since 11/23/23 for restlessness and aggressive behaviors. The assessment did not indicate a reason to continue the medication or a contraindication to reduce the medication. Further review of Resident 5's medical record indicated that no other Psychotropic Drug Use Assessment had been completed since June of 2024.Review of Resident 5's Minimum Data Set (MDS - a federally mandated resident assessment tool) dated 5/14/25, indicated in section N that Resident 5 had received an antipsychotic daily since admission. The MDS assessment further indicated that a GDR had not been attempted and there was no documentation that indicated a reduction was clinically contraindicated.During a concurrent interview and record review on 8/13/2025, at 9:10 AM with Licensed Nurse (LN) 9, LN 9 confirmed that Resident 5 had been taking Seroquel 50mg two times a day for restlessness and aggressive behaviors. LN 9 stated that Resident 5 had not exhibited aggressive behaviors.During a concurrent interview and record review on 8/14/25, at 4:50 PM, the DON stated that the Psychotropic Drug Use assessment was used to review a resident's psychotropic medication use to determine the need to continue the medication or attempt a dose reduction. Resident 5's Psychotropic Drug Use Assessment was reviewed with the DON. The DON verified that Resident 5 had been receiving Seroquel 50 mg twice a day since 11/28/23. The DON confirmed that a GDR was not attempted for Resident 5's Seroquel use and there were no clinical contraindications for reduction documented. The DON stated that a GDR should be attempted quarterly unless clinically contraindicated.1B. Review of Resident 11's admission RECORD indicated that Resident 11 was admitted to the facility with diagnoses that included but not limited to vascular dementia (a type of cognitive decline caused by impaired blood flow to the brain due to damage to the blood vessels in the brain), psychotic disorder with delusions due to known physiological condition (a mental health condition characterized by disruptions in thought processes, perceptions, and emotional responses, often leading to a loss of touch with reality that arise as a direct result of a known medical illness or its physiological effects on the brain), mood disorder due to known physiological condition with mixed features (a mental health condition where a person experiences both depressive and manic symptoms), major depression disorder unspecified (a mood disorder that causes a persistent feeling of sadness and loss of interest), and anxiety disorder unspecified (a mental health condition characterized by ongoing, overwhelming, and disproportionate anxiety and fear that interferes with daily life, going beyond normal temporary worry). Review of Resident 11's Psychotropic Drug Use

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on observation, interview, and record review, the facility failed to ensure 1 of 26 sampled residents (Resident 46) received treatment and care in accordance with professional standards of practice when the care plan for oxygen use for Resident 46, was not developed. This failure had the potential to result in worsening respiratory function, and/or other serious medical complications.Review of Resident 46's admission RECORD, indicated Resident 46 was admitted to the facility in 2023 with diagnoses including chronic combined systolic congestive and diastolic congestive heart failure (the heart struggles to both effectively eject blood and receive blood leading to a range of symptoms such as shortness of breath, fatigue, swelling in legs and ankles, etc.).During a concurrent observation and interview on 8/11/25, at 9:50 AM, Resident 46 was noted to be on oxygen 2 liter/minute (LPM) via nasal cannula (NC, a device providing extra oxygen through a tube and into the nose) via concentrator (a medical device supplying extra oxygen). Resident 46 stated they were on oxygen therapy for a long time, but was unable to recall when it was initiated.During a concurrent observation and interview on 8/11/25, at 9:58 AM, Licensed Nurse (LN) 3 confirmed Resident 46 was on oxygen 2 LPM via NC. LN 3 stated Resident 46 was on oxygen via NC as needed (PRN) for shortness of breath (SOB).During a concurrent interview and record review on 8/13/25, at 8:30 AM, with LN 5, Resident 46's care plans were reviewed. LN 5 confirmed that the care plan for oxygen use was not developed for Resident 46. LN 5 stated that the care plan was a tool to set appropriate goals and to communicate interventions with all staff to provide resident-centered care to Resident 46. LN 5 further stated LNs were responsible for creating care plans for nursing interventions. LN 5 stated not creating a care plan had the potential to affect Resident 46's health and well-being.During a concurrent interview and record review on 8/13/25, at 3:25 PM, with the Director of Nursing (DON), the facility's policy and procedure (P&P) titled, Policy and Procedure - Care plan, revised on 9/2024, and Resident 46's care plans were reviewed. The DON confirmed that the care plan for oxygen use was not created. The DON stated creating a care plan was important and a care plan was a tool to guide nursing staff to provide resident focused care to meet Resident 46's needs. The DON further stated it was a potential to place Resident 46's well-being at risk. The DON stated her expectation from nurses was to create a care plan and implement the interventions. The DON further stated her expectation was not met. Further review of the P&P indicated, .A care plan is the summation of the resident concerns, goals, approaches and interventions in order to meet the goals and help minimize if not totally eradicate residents' problems. Each individual resident has a comprehensive care plan which is objective, measurable and time-framed.PROCEDURE.This individual comprehensive care plan identifies the professional services and the responsible person that evaluates the concerns and carried out the interventions to prevent or reduce re-occurrences of the same problems/concerns.It illustrates how the approaches being provided. The DON confirmed that the facility's P&P was not followed.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on interview and record review the facility failed to provide services that meet professional standards of practice for two of twenty-eight sampled residents (Resident 5 and Resident 11) when Quarterly Abnormal Involuntary Movement Scale (AIMS - a 12-item assessment tool used to evaluate and monitor the severity of involuntary movements in individuals taking an antipsychotic medication [a class of medications use to treat a variety of mental health disorder]) were not completed for Resident 5 and Resident 11.This failure had the potential for Resident 5 and Resident 11 to experience side effects related to the use of antipsychotic medications to go unrecognized and untreated.1. Review of Resident 5's admission RECORD indicated that Resident 5 was admitted to the facility with diagnoses that included but not limited to unspecified dementia severe with psychotic disturbance (a condition where person has a progressive decline in cognitive functions like memory, thinking, language, judgment, and see or hear things those are not there or has false beliefs), unspecified mood disorder (diagnosis used when a person experiences mood symptoms that cause significant distress or impairment), and unspecified psychosis not due to a substance or known physiological condition (a mental health condition characterized by a loss of contact with reality but the cause isn't clear, and it's not linked to substance use or a known medical condition).During a concurrent interview and record review on 8/13/2025, at 9:10 AM, with Licensed Nurse (LN) 9, LN 9 confirmed that Resident 5 had been taking Seroquel (antipsychotic medication) 50mg (milligram) two times a day for restlessness and aggressive behaviors. Review for Resident 5's AIMS assessment initiated on 6/2/24 was completely blank with none of the questions in that assessment answered. Further review of Resident 5's medical record failed to show that any other AIMS assessment had been completed.2. Review of Resident 11's admission RECORD indicated that Resident 11 was admitted to the facility with diagnoses that included but not limited to vascular dementia (a type of cognitive decline caused by impaired blood flow to the brain due to damage to the blood vessels in the brain), psychotic disorder with delusions due to known physiological condition (a mental health condition characterized by disruptions in thought processes, perceptions, and emotional responses, often leading to a loss of touch with reality that arise as a direct result of a known medical illness or its physiological effects on the brain, mood disorder due to known physiological condition with mixed features (a mental health condition where a person experiences both depressive and manic symptoms), major depression disorder unspecified (a mood disorder that causes a persistent feeling of sadness and loss of interest), and anxiety disorder unspecified (a mental health condition characterized by ongoing, overwhelming, and disproportionate anxiety and fear that interferes with daily life, going beyond normal temporary worry).During a concurrent interview and record review on 8/12/25, at 3:46 PM, with LN 8, LN 8 confirmed that Resident 11 had been receiving Olanzapine (antipsychotic medication) 2.5mg one tablet one time a day.Review of Resident 11's AIMS assessment initiated on 8/4/25 was completely blank with none of the questions in that assessment answered. Further review of Resident 11's medical record failed to show that any other AIMS assessment had been completed.During a concurrent interview and record review on 8/14/25, at 4:37 PM, with the DON, the DON confirmed that Resident 5 had been taking an antipsychotic medication since 11/23/23. The DON confirmed the AIMS assessment for Resident 5 dated 6/2/24 was incomplete and there were no other AIMS completed for Resident 5. The DON confirmed that Resident 11 had been taking an antipsychotic medication since 4/28/24. The DON confirmed the AIMS assessment for Resident 11 dated 8/4/25 was incomplete and there were no other AIMS completed for Resident 11. The DON stated that the AIMS assessment should be completed quarterly for every resident who was taking an antipsychotic medication. The DON further stated that not completing the AIMS placed residents at risk for potential side effects related to antipsychotic use going unassessed and untreated and these side effects could permanently affect a resident's ability to complete ADL tasks.Review of a facility policy titled THE USE OF PSYCHOTROPIC MEDICATION revised 6/13 indicated .AIMS will be performed on any resident on an antipsychotic on a quarterly basis and changes will be reported to the physician.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure an environment free of accidents or hazards for 2 of 26 residents (Resident 62 and Resident 46) when: 1. Resident 62's Smoking assessment was not updated and Resident 62 was left smoking and unsupervised; and,2. An oxygen in use sign was not posted at Resident 46's room entrance. These failures had the potential to place Resident 62, Resident 87, Resident 46 and other residents in the facility with a census of 75 residents, at risk of accidental burns and injuries.1. During a concurrent observation and interview on 8/11/2025 at 9:02 AM with Resident 62, Resident 62 stated she smokes cigarettes at scheduled times that were posted on her wall for 10 minutes each time. Resident 62 was observed to have a pack of cigarettes and 2 lighters on the table. A review of Resident 62's clinical record titled, admission RECORD, indicated Resident 62 was admitted to the facility with diagnoses of, but not limited to, generalized muscle weakness, difficulty in walking, cannabis (marijuana) use, and tobacco use. A review of Resident 62’s clinical record titled, “SMOKING RISK ASSESSMENT”, dated 7/11/2025, indicated, “…SMOKING SAFETY ASSESSMENT…nonsmoker at this time but former smoker…Evaluation Resident may not smoke…” During a concurrent observation and interview on 8/13/2025 at 8:47 AM in the courtyard smoking area, maintenance staff left the smoking area with a resident and Resident 62 was left unsupervised and smoking. The Director of Nursing (DON) came to the courtyard and saw Resident 62 was left unattended. The DON stated that there should be at least one staff member supervising the residents during smoking time. During an interview on 8/13/2025 at 9:07 AM with the Social Service Director (SSD) stated that the smoking assessment during admission could be completed by either the nurses or social services. SSD stated the social services department would be the one completing the quarterly and annual smoking reassessment. SSD stated if the resident was evaluated upon admission as a nonsmoker and the resident started smoking, the smoking assessment should have been revised. During a concurrent interview and record review on 8/13/2025 at 9:28 AM, the DON stated the smoking area was located at the courtyard’s gazebo and was supervised by activity staff or any staff member. The DON stated Resident 62 was assessed as a nonsmoker initially during admission. The DON stated Resident 62 does not have an updated smoking assessment. The DON stated that Resident 62 should have been reevaluated for smoking by the social services department. A review of facility’s policy titled, “SMOKING POLICY revised 12/24, indicated, “…Resident who is smoking will be re-evaluated/reassessed at least on admission, quarterly, annually and as needed… 2. Review of Resident 46's record titled, “admission RECORD” indicated, Resident 46 was admitted to the facility with diagnoses including heart failure (the heart’s impaired abilities to pump blood). (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 8/11/25 at 9:50 AM Resident 46 was noted to be on oxygen 2 liters/minute (2L/min, flow rate of oxygen) via Nasal Cannula (NC, two prongs delivering oxygen through the nose) via concentrator (a machine that produces supplemental oxygen). During a concurrent observation and interview on 8/11/25 at 9:58 AM Licensed Nurse (LN) 3 confirmed Resident 46 was on oxygen at 2 liters/minute via NC as needed (PRN) for shortness of breath (SOB). A review of Resident 46’s record titled, “TREATMENT ADMINISTRATION RECORD”, dated 8/1/2025 -8/31/2025, indicated an order for oxygen at 2L/min PRN via NC for SOB, initiated on 8/12/25. During an observation on 8/14/2025 at 3:06 PM oxygen in use signage was not posted at Resident 46’s room entrance to notify other residents, visitors, and staff members that Resident 46 was on oxygen therapy. During a concurrent observation and interview on 8/14/25 at 3:10 PM Certified Nurse Assistant (CNA) 9 confirmed oxygen in use signage was not posted at Resident 46’s room entrance (room [ROOM NUMBER]). CNA 9 stated there was a safety risk when there was no oxygen in use sign posted at the room’s entrance. CNA 9 added oxygen in use signage was a way to warn and notify other residents regarding Resident 46 being on oxygen. CNA 9 further stated in case of fire, oxygen could blow up and place all residents, staff, and visitors’ health and safety at risk. During a concurrent observation and interview on 8/14/25 at 3:19 PM with the Infection Prevention (IP) nurse, the IP confirmed oxygen in use signage was not posted at room [ROOM NUMBER]’s entrance. The IP confirmed that there was an oxygen concentrator next to Resident 46’s bed. IP stated there was a possible risk for fire, and added other residents may not be aware of oxygen being used in Resident 46’s room without signage. IP stated his expectation from licensed nurses was to place the oxygen in use signage at Resident 46’s room entrance, and added his expectation was not met by licensed nurses. During a concurrent interview and record review on 8/14/25 3:28 PM with IP the facility’s Policy and Procedures (P&P) titled,” Oxygen Therapy” revision date 1/2025 was reviewed. The review of P&P indicated, “…PROCEDURES: Equipments…B. One (1) “No smoking/oxygen” signs…3. Place “oxygen in use” sign on outside and inside of room or as State regulations require…” IP confirmed the facility P&P for “Oxygen Therapy” was not followed.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on observation, interview, and record review, the facility failed to ensure adequate hydration (process of providing fluid to the body) for two of 26 sampled residents (Resident 7 and Resident 41), per facility policy and according to each resident's comprehensive plan of care (Care plan- a document detailing an individual's health needs, goals, and the steps needed to achieve those goals) when:1. Resident 7 did not have fluids available to drink at the bedside; and,2. Resident 41 did not have fluids available to drink at the bedside.These failures resulted in Resident 7 having dry mucous membranes (soft tissue that make up the inside the mouth, gums, tongue and lips), chapped lips, and dry and peeling skin on his left leg; in addition, these failures resulted in Resident 41 having dry mucous membranes, chapped and peeling lips and concentrated dark amber colored urine (deep yellow or orange-brown colored urine usually caused by dehydration) (dehydration -a harmful reduction in the amount of water in the body).Findings:1. During a concurrent observation and interview on 8/11/25 at 12:17 PM, in Resident 7's room, Licensed Nurse (LN) 3, confirmed Resident 7 did not have fluids available to drink at the bedside. LN 3 stated Resident 7 did not have any fluid restrictions (limiting the amount of fluids a resident may drink in a day) and should have had fluids available at the bedside. LN 3 further stated the risk to Resident 7 was dehydration.During a concurrent observation and interview on 8/14/25 at 11:36 AM, in Resident 7's room. Certified Nurse Assistant (CNA) 8 and LN 2 confirmed Resident 7 did not have fluids available in reach to drink at the bedside. LN 2 confirmed Resident 7 had dry skin, dry mouth, and chapped and peeling lips and skin on his left leg. LN 2 stated the dry mucous membranes, chapped and peeling lips and dry skin on his left leg, were signs and symptoms (objective, observable indications of a disease or condition that could be detected by someone other than the resident) of dehydration. LN 2 further stated Resident 7 was additionally at risk for a urinary tract infection (UTI -an infection of the urinary system which includes the kidneys, ureters, bladder and urethra) due to dehydration.A review of Resident 7's medical record titled, HYDRATION RISK ASSESSMENT, dated 1/6/25, indicated, .Resident [7] is at risk for Dehydration.POTENTIAL INTERVENTIONS.Place straw in glass so resident can drink independently.Keep fluids in reach.Encourage resident to drink all fluids.A review of Resident 7's Care Plan Report, dated 6/8/21, indicated .RISK FOR DEHYDRATION.Encourage oral fluids.Monitor for s/sx [signs and symptoms] of dehydration: dry mucous membranes.2. During a concurrent observation and interview on 8/12/25 at 9:23 AM, in Resident 41's room, CNA 3, confirmed Resident 41 did not have fluids available at bedside to drink. CNA 3 stated Resident 41 did not have any fluid restrictions, and it was important for Resident 41 to have fluids within reach because he had a catheter (a flexible tube inserted into the bladder to drain urine- hydration decreases the risk of infection by flushing out bacteria) and needed to stay hydrated.During a concurrent observation and interview on 8/12/25 at 11:50 AM, in Resident 41's room, LN 7 confirmed Resident 41 did not have fluids available to drink. LN 7 further confirmed Resident 41's urine was amber, dark in color and concentrated, which could have indicated Resident 41 did not enough fluids in the body. LN 7 further confirmed Resident 41 had dry mucous membranes and lips that were chapped and cracked. LN 7 stated the risk of Resident 41 not having enough fluids was dehydration and UTIs. LN 7 further added that Resident 41 should have always had fluids available.A review of Resident 41's medical record titled, HYDRATION RISK ASSESSMENT., dated 7/20/25, indicated, .Resident [41] is at risk for Dehydration.POTENTIAL INTERVENTIONS.Place straw in glass so resident can drink independently.Keep fluids in reach.Encourage resident to drink all fluids.A review of Resident 41's Care Plan Report, dated 3/30/25, indicated, .RISK FOR DEHYDRATION.Encourage oral fluids.Monitor for s/sx [signs and symptoms] of dehydration: dry mucous membranes.A review of Resident 41's Care Plan Report, dated 5/1/2025, indicated, .At risk for urinary tract infection R/T [related to] indwelling foley catheter use.Encourage fluids.During an interview on 8/14/25 at 1:22 PM, with the Director of Nursing (DON), the DON stated it was her expectation for residents to always have fluids available and within reach of the residents. The DON explained the facility's process was for the CNAs to bring fresh fluids to each resident at the beginning of each shift and with each meal. The DON further explained the fluids were important to prevent UTIs, dehydration and maintain the residents' nutrition and health. The DON stated residents without fluids available or within reach did not meet her expectations.Review of facility policy and procedure titled, Resident Hydration and Prevention of Dehydration, revised 12/2024, indicated, .It is the policy of this facility.to provide adequate hydration.to prevent and treat dehydration.Nursing will assess for signs and symptoms of dehydration during daily care.Nurses' aides will provide and encourage intake of

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on observation, interview, and record review, the facility failed to ensure the provision of routine and emergency medications were provided and/or documented for two of the 26 sampled residents (Resident 66 and Resident 78), based on standards of practice and regulatory requirements when:1. Resident 66 did not receive a physician ordered, as needed (PRN), medication called Ipratropium-Albuterol (inhaled medication used to open the airways and make breathing easier) due to medication unavailability from the pharmacy; and, 2. Resident 78's intravenous antibiotic (IV antibiotics, medications administered directly into the bloodstream through a vein, typically used for serious infections) was removed from the Emergency Kit (E-kit, an emergency supply of medications that are used based on a doctor's order for urgent needs of a residents) without documentation the medication had been removed by facility staff. These failures could have resulted in increased difficulty with breathing for Resident 66 and did result in inaccurate record keeping of medications removed from the E-kit. 1. A review of Resident 66's medical record titled, admission RECORD, indicated Resident 66 was admitted to the facility with diagnoses of, but not limited to, chronic obstructive pulmonary disease (COPD - a progressive lung disease that makes breathing increasingly difficult) and dyspnea (difficulty breathing). A review of Resident 66's medical record titled, Care Plan, dated 7/30/2025, indicated “…Focus: At risk for chronic or intermittent shortness of breath, hypoxia [lack of oxygen] secondary to disease processes…Interventions…Ipratropium-Albuterol Inhalation Aerosol Solution 20-100 MCG/ACT (Ipratropium-Albuterol) as ordered…” During an interview on 8/11/2025 at 10:20 AM, with Resident 66, Resident 66 stated she has had problems with getting access to her inhaler (a portable device for administering medication to the lungs). Resident 66 stated she was admitted to the facility two weeks ago but had never received her Ipratropium-Albuterol inhaler. Resident 66 stated she requested the medication because there were times that she could not breath properly. During a concurrent observation, interview, and record review, on 8/11/2025 at 5:12 PM, with licensed nurse (LN) 4, LN 4 confirmed Resident 66 did not have the Ipratropium-Albuterol inhaler in the medication cart. LN 4 stated based on the Medication Administration Record (MAR- record of medications given and not given) the Albuterol inhaler had never been administered since Resident 66’s admission. LN 4 stated that if Resident 66 did not receive her PRN medication, there could have been problems with her airway, breathing, and circulation (oxygenated blood that circulates through the body). A review of Resident 66's MAR, dated 7/29/25 through 8/11/25, indicated Ipratropium-Albuterol Inhalation Aerosol Solution 20-100 Micrograms per Actuation (MCG/ACT - unit of measurement - amount of medication received per inhalation) (Ipratropium-Albuterol) 1 puff inhale orally every 4 hours as needed for shortness of breath or wheezing (high-pitched, whistling sound made when breathing, caused by a narrowed or airway). (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 8/12/2025 2:36 PM, with LN 5, LN 5 stated the medications that were ordered from the hospital needed to be verified with the doctor upon admission, and the doctor would then approve the medication order. LN 5 stated if the medicine was not delivered from the pharmacy, the nursing staff needed to follow up with the pharmacy. LN 5 stated if the medication was not covered by insurance or there were other reasons why it was not delivered, the nurses needed to ask the pharmacy if there was another approved alternative. LN 5 stated the nurses should have informed the doctor and Resident 66 (or responsible party) for approval of an alternative. LN 5 stated the pharmacy would have sent a fax to the facility to notify them if there were medications that were not available or not covered and the DON would have reviewed it. During an interview on 8/13/2025 at 12:13 PM with the Director of Nursing (DON), the DON stated the facility’s process when ordering medication was to send the order summary to the pharmacy and the pharmacy would send the medication to the facility. The DON stated the pharmacy would contact the facility via fax or email to inform them that a certain medication was not available, or to inform them of other alternatives, and if the medication was not covered by the insurance. The DON confirmed there was no available Ipratropium-Albuterol inhaler for Resident 66 in the medication cart. The DON stated the medication for Resident 66 should have been available for Resident 66 to use. The DON stated she expected the nurses to call the pharmacy to ask for an alternative medication and inform the doctor. The DON stated that the nurses should have informed her and the doctor that the medication was not available. A review of the facility’s policy and procedure titled, “DRUG ORDERING AND RECEIVING”, revised 7/2024, indicated, “…Licensed nurse may transmit orders by fax to the pharmacist; however, all orders must be followed by phone call to the pharmacy…New medication orders: complete telephone order with identical orders to be sent to the prescriber…” 2. During a review of Resident 78's record titled, “admission RECORD”, the record indicated Resident 78 was admitted to the facility in July 2025 with diagnoses that included sepsis (a life-threatening medical emergency caused by the body’s overwhelming response to an infection), cellulitis (a bacterial infection of skin), and a displaced fracture (a bone fracture where the broken pieces of bone have moved out of their normal alignment) of the triquetrum bone (a bone located in the wrist) in the right wrist. A review of Resident 78’s record titled, “HOSPITALIST DISCHARGE SUMMARY”, dated 7/11/25, indicated, “…Sepsis…Right distal radius fracture [broken bone at the end of the arm, near the wrist] …Plan for 6 weeks of IV antibiotics. End date of antibiotic of 08/18/2025…” A review of Resident 78’s record titled, “MEDICATION ADMINISTRATION RECORD”, (MAR) dated 7/1/25 through 7/31/25, indicated Resident 78 was on Cefazoline 2 grams (GM - unit of measurement) IV antibiotics every eight hours for septic arthritis, (infection of the joint). (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 8/13/25 at 1:14 PM, Licensed Nurse (LN) 1 explained the process when a resident was admitted to the facility with IV antibiotic orders. LN 1 stated nurses would enter the medication in the Electronic Health Record (EHR) of the resident and then the LNs would start IV medications as per physician orders. LN 1 further stated that in situations where an IV antibiotic was not available, LNs would take the IV antibiotic from the Emergency Kit (E-kit) and administer the IV antibiotic to the resident. LN 1 stated if an antibiotic dose was missed, there would be a risk to Resident 78 that the antibiotic would not be effective in clearing up the infection. During a concurrent follow up interview, and record review on 8/13/25 at 5:45 PM, with LN 1, Resident 78's progress notes, physician's orders, the medication log, and the pharmacy E-kit slips, were reviewed. LN 2 stated that when a resident was admitted to the facility with IV antibiotics, the facility admission nurse called the Medical Director (MD) and the medications would be reconciled (verified) with the physician's orders. The medication (including IV medication) orders were entered into the EHR, and the medication orders were faxed to the pharmacy. The pharmacy would then deliver the medications, IV pumps (device that administers medication through and IV tube), IV poles (pole that holds up the medication), and tubing (plastic tubing that assists in administering medication via IV). LN 1 stated Resident 78 was on IV Cefazoline 2 GM every 8 hours which was a continued medication order from the hospital. LN 1 added Resident 78 received the first dose in the facility on 7/11/25 at 10:00 PM. LN 1 further stated she pulled the IV antibiotic from the E-kit and administered it to Resident 78, as per physician's order. During a review of the medication log, pharmacy E-kit slips, and progress notes, the records indicated the removal of Cefazoline 2 GM (IV antibiotic) from the E-kit was not documented. LN 1 confirmed no documentation was found related to the removal of the IV antibiotic for Resident 78 from the E-kit. During an interview on 8/14/2025 at 12:35 PM, in the hallway across from the Director of Nursing's (DON) office, with the Director of Staff Development (DSD), the DSD explained the process of pulling out medications from the E-kits. The DSD stated that the LN filled out the pharmacy slips (which were located inside of the E-kits) and faxed the slips to the pharmacy, The DSD stated the LN also filled out the pharmacy log located in medication rooms. The DSD stated that the removal of the medication from the E-kit should have been documented. The DSD further stated filling out the pharmacy slips was an important way to notify the pharmacy to refill the emergency kits supplies and to have medications and supplies available in emergency situations. During a concurrent interview and record review on 8/14/2025 at 2:00 PM, with the DON, the facility’s Policy and Procedure (P&P) titled, “Medication Ordering and Receiving From Pharmacy Provider…3.4 EMERGENCY PHARMACY SERVICE AND EMERGENCY KITS”, dated 01/24, was reviewed, The P&P indicated, “…PROCEDURES…8. Upon removal of any medication or supply item from the emergency kit, the nurse documents the medication or item used on an emergency kit log. One copy of this information should be immediately faxed to the pharmacy or placed within the resealed emergency kit until is scheduled for exchange…The hard copy will be retained in the nursing care center…10. The faxed log sheet will inform the pharmacy of items used from the emergency kit. This will notify the pharmacy to replace the kit or item…” The DON stated antibiotics should be administered within four hours of ordering the medication, and in an emergency, the medications should be pulled out from the Ekits. The DON added the pharmacy log sheet should have been filled upon removing the medications from Ekit and faxed to the pharmacy to get the medication refilled, or Ekit replaced. The DON stated a copy should be kept in the medication room. The DON further stated her expectation from the LNs was to document when any medication was pulled from the Ekit. The DON confirmed that the facility’s P & P was not followed.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident’s drug regimen must be free from unnecessary drugs. Based on interview and record review, the facility failed to ensure safe monitoring and assessment of blood pressure (BP-the force of your blood pushing against the walls of your arteries as your heart pumps blood and was measured as two numbers: systolic [when the heart beats] and diastolic [when the heart rests between beats]) and heart rate (HR-frequency of your heart beats per minute) for a medication used to treat low (hypotension) BP for 1 of 26 sampled residents (Resident 3) when Resident 3's physician prescribed hold parameters (a set of numbers that guide the nursing staff when to not give (hold) a medication) for Midodrine (a medication used to treat low blood pressure) was not followed 7 times between 7/1/25 and 8/14/25.These failures had the potential to put Resident 3 at risk of adverse drug effects including hypertension (HTN -high blood pressure) and increased Resident 3's chance of having a severe medical emergency.Findings:A review of Resident 3's admission RECORD indicated Resident 3 was admitted to the facility early 2024 with diagnoses including but not limited to: Hypertensive heart disease with heart failure, (occurs when chronic high blood pressure damages the heart, leading to its inability to pump blood effectively), and Acute on chronic systolic (congestive) heart failure, (CHF -a sudden worsening of symptoms in a resident with heart failure) (heart failure -a condition where the heart cannot pump enough blood to meet the body's needs).A review of Resident 3's Order Summary dated 5/24/25, indicated Midodrine was ordered by the Medical Director (MD) with parameters to .HOLD Midodrine for SBP [systolic blood pressure] > [greater than] 120 mmHg.During a concurrent interview and record review on 8/14/25 at 11:22 AM, Licensed Nurse (LN) 2, reviewed Resident 3's Medication Administration Record (MAR -a document used in healthcare setting to track and record medication given to residents) for July 2025. LN 2 confirmed Resident 3's ordered medication Midodrine had physician ordered parameters to hold (not give) the medication if Resident 3's systolic BP was greater than 120 mmHg (mmHg -Millimeters of mercury -a unit of pressure). LN 2 further confirmed Resident 3 was given Midodrine on 7/13/25, 7/14/25, 7/16/25, and 7/30/25 when the medication should have been held due to Resident 3's systolic blood pressure being greater than 120 mmHg. LN 2 additionally reviewed Resident 3's MAR for 8/1/25 - 8/14/25 and confirmed Resident 3 had also been given Midodrine in error on 8/3/25, 8/4/25, and 8/10/25. LN 2 explained the medication should not have been given on those 7 dates because Resident 3's blood pressure was already above the physician order parameters. LN 2 further explained that Midodrine was used to increase blood pressure, and they were to not give the medication if the BP was above 120 mmHg. LN 2 stated the facility process was to hold the Midodrine and document it in a note in the MAR. LN 2 stated it was clearly marked on the MAR when they clicked on the medication to hold when SBP was above 120 mmHg. LN 2 stated when a medication error occurs, they were supposed to notify the physician, notify their supervisor, and document it in the Resident's medical record. LN 2 checked Resident 3's medical record and could not find any documentation that 7 medication errors occurred. During an interview on 8/14/25 at 12:57 PM, the Director of Nursing (DON) reviewed Resident 3's MAR and confirmed Midodrine was given 7 times between 7/1/25 and 8/14/25 when it was supposed to be held. The DON confirmed the hold parameters for the Midodrine and stated she had not been made aware of any medication errors.Review of a facility policy and procedure, POLICY AND PROCEDURE IN MEDICATION ADMINISTRATION, revised 01/2025, indicated, .Medication.that requires parameter before administration should be complied with.Resident with this kind of order should be observed and be implemented.

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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. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure medications were stored safely, securely, and properly destroyed (discarding unused or expired medication) in two of three medication carts (a mobile cart containing medication used for administration of medication to residents) for a census of 75 when:1. Two prescription medications (drugs that require a written order from a licensed healthcare professional) of the same brand were found in a basket of over the counter (OTC -medications available without a prescription) medications that were loose in individual blister packs (a form of tamper-evident packaging where a medication is protected by sealed foil) and contained no resident label, expiration date, or indications for use; and,2. An opened multi-use bottle of cough syrup was not labeled with the date opened (date the medication was first opened); and,3. A medication's individual foil package was opened, undated and available for use; An unlabeled, opened and undated single use prescription nose spray was removed from the original box; and,4. A Schedule II controlled substance (a drug with a high potential for abuse leading to addiction) medication was punched through the blister pack and tapped back in; and,5. A Licensed Nurse (LN) did not properly dispose of a medication; and,6. A Licensed Nurse left medications unattended on top of a medication cart.These failures had the potential for medication diversion (medication taken by someone it was not intended for), and unsafe medication use in the facility.Findings:1. During a concurrent medication storage observation and interview on [DATE] at 2:41 PM accompanied by LN 2, the medication cart for Station 1/Wing 2 had loosely stored tablets of Zofran (a prescription only medication used for nausea and vomiting) stored in the top drawer in a basket with other loosely stored medications in individual foil packets for OTC stool softener use. LN 2 confirmed the 2 prescription Zofran tablets were stored improperly and stated they should be in the packaging with the label of the individual resident it belonged to, labeled with its indications for use, expiration date, and not stored with OTC stool softener medications.2. During a concurrent medication storage observation and interview on [DATE] at 2:41 PM accompanied by LN 2, the medication cart for Station 1/Wing 2 was observed to have an opened and undated multi-use bottle of Adult Tussin DM, cough syrup. LN 2 stated it was the facility's policy to write the opened date on the medication. LN 2 stated it was important to label medications with the date opened because some medications have a different expiration date once opened.3. During a concurrent medication storage observation of Station 2/Cart 2 and interview on [DATE] at 3:17 PM, accompanied by LN 4, the following was observed and confirmed by LN 4:a. An opened foil envelope of Budesonide Inhalation Suspension, (medication used to treat a breathing problem) vials was observed in the medication cart without being labeled with an opened date. The label on the container with the manufacturer's instructions for use indicated, .Once the foil envelope is opened, use the vials within 2 weeks.b. An opened bottle of Fluticasone Propionate, (a nasal spray used to treat inflammation of the nose caused by allergies) had and expiration date of 11/2024 and was observed without the packaging indicating its use instructions and without the resident's name and prescription label. LN 4 confirmed the findings and stated he was not aware of the two week expiration date after opening the Budesonisde Inhalation foil envelopes and further stated the expired nose spray should not be in the medication cart. LN 4 further stated using medication beyond its expiration date lowers the medications effectiveness.4. During a concurrent interview and inspection of the facility's medication cart Station 2/Cart 2, on [DATE] at 3:33 PM accompanied by LN 4, the controlled substance drawer was observed. A schedule II-controlled substance medication, Hydrocodone-Acetamin (a narcotic pain reliever with a high potential of abuse and misuse) 5-325 mg (Milligram mg-a unit of measure) was observed to have been punched through the protective foil package in the bubble package and tapped back in. LN 4 confirmed the finding and stated the medication should have been destroyed instead of being tapped back in. LN 4 stated the medication could lose effectiveness since it was no longer sealed and was at risk for diversion.5. During a concurrent observation and interview of medication administration on [DATE] at 9:25 AM, at Station 2, LN 4 was observed throwing a 1/2 tablet of vitamin D3 (a dietary supplemental) in the garbage can. LN 4 stated throwing medication away in the garbage was not part of the facility policy and he should have destroyed it in the facility's medication destroyer bottle. LN 4 stated he used the garbage can because he did not have a destroyer bottle on the medication cart.6. During an observation of medication administration on [DATE] at 9:38 AM at Station 2, the following was observed:a. A half tablet of an OTC vitamin D3 was observed left on top of the medication cart unattended while LN 4 gave medications to a resident on [DATE]

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Based on observation, interview, and record review, the facility failed to ensure the menu, spreadsheet and recipe were followed for the therapeutic diets (the modifications of regular diet, tailored to fit the nutritional needs of the particular person. It could be part of a treatment or medical condition and is normally prescribed by a physician) served during the lunch meals on 8/11/25 and 8/12/25 when:1.Resident 71 with CCHO (Consistent Carbohydrate Diet or Controlled Carbohydrate Diet, this dietary approach focuses on maintaining a consistent intake of carbohydrates throughout the day), 2g Na diet (a low sodium diet, usually to manage high blood pressure and/or heart disease), received a ketchup package instead of no ketchup with meal; and, 2.Eight residents (Resident 4, 11, 14, 42, 51, 52, 57, and 72) with fortified food (food products to which extra nutrients, like vitamins and minerals, have been added during processing to increase their nutritional value) with their diets did not get the fortified food items (1/2 ounce (oz., a unit of weight or volume) of melted margarine on the rice and 1/2 oz. of melted margarine on the peas and onion); and,3.Five residents (Resident 4, 7, 26, 38, and 66) with low fat and low cholesterol diet (diet usually to manage heart disease) received ice cream instead of sherbet and margarine instead of no margarine;4.Resident 2 with mechanical soft texture diet (foods that have been modified in texture to be easier to chew and swallow, often through chopping, grinding, or pureeing) received chopped chicken instead of mechanical soft texture chicken; and,5. Resident 56 with finger food (small, individual portions of food that are eaten out of hand) diet received peas and onions, rice, and an ice cream cup instead of green beans, diced potatoes, and an ice cream bar or popsicle; and,6.Resident 47 with CCHO and Renal diet (a specialized dietary plan designed for individuals with kidney disease) received ice cream instead of 1/2 cup (4oz.) of diet pineapple; and,7.Two Cooks did not follow the recipe while making puree (pureed food should be the texture of mashed potatoes or pudding) and the texture of the puree chicken, puree peas and onion were not appropriate for residents with swallowing problems. (There were eight residents who received puree diet (Resident 7, 11, 57 and 5 unsampled Residents)).These failures had the potential to result in compromising the medical and nutritional status of 21 residents for a census of 75.Findings:1.During an observation and concurrent review of meal tickets (a ticket including resident's diet, date, allergies, specific food and beverage items, dislikes, and likes) from the lunch meal service in the dining room on 8/11/25 at 12:32 p.m., it was noted Resident 71 had a meal tray with ketchup which was already eaten by Resident 71. Resident 71's meal ticket indicated, Diet: CCHO, 2g Na. A review of a document titled, SUMMER MENUS SPREADSHEET, Cooks spreadsheet indicated, Residents on 2g Na diet should not have received ketchup.During an interview with the Registered Dietitian (RD) on 8/14/25 at 8:51 a.m., the RD reviewed the spreadsheet and stated residents with 2g Na diet should not receive ketchup with their meal.2.During an interview with DS on 8/12/25 at 9:54 a.m., DS reviewed the weekly menu guideline and stated the guideline for fortified food for the 8/12/25 lunch meal was 1/2 oz. of melted margarine on the rice and 1/2 oz. of melted margarine on the peas and onions. During an observation of meal distribution on 8/12/25 at 12:50 p.m., it was noted that eight residents (Resident 4, 11, 14, 42, 51, 52, 57 and 72) with fortification with their diets did not get 1/2 oz. of melted margarine on the rice and 1/2 oz of melted margarine on the peas and onion with their meals.During an interview with the RD on 8/14/25 at 8:51 a.m., the RD stated the kitchen staff should have followed the order or menu spreadsheet. The RD further stated residents with an order of fortified food should have received fortified food.A review of the weekly menu guideline titled Weekly Guideline for Summer 2025 - Week 3 indicated TUESDAY.FORTIFIED LUNCH. Rice: 1/2 oz melted margarine, Peas with Onions: 1/2 oz melted margarine.3. During an observation of meal distribution on 8/12/25 at 12:50 p.m., it was noted that five residents (Resident 4,7,26,38 and 66) with low fat and low cholesterol diets received margarine instead of no margarine, and received ice cream instead of sherbet.During an interview with the RD on 8/14/25 at 8:51 a.m., the RD reviewed the spreadsheet and stated residents on the low fat and low cholesterol diet should not have received margarine and should have received sherbet instead of ice-cream per the menu spreadsheet.A review of weekly menu guideline titled, [NAME] Spreadsheet.SUMMER MENUS, dated 8/12/25, indicated .LOW FAT/CHOLESTROL.No Margarine. Sherbet [1/3 cup] .4. During an observation of meal distribution on 8/12/25 at 12:50 p.m., it was noted that Resident 2 with a mechanical soft texture diet received chopped chicken instead of mechanical soft chicken. During an interview with the RD on 8/14/25 at 8:51 a.m., the RD reviewed the spreadsheet and stated there was a specific size for bite size and mechanical soft food. RD stated residents with a mechanical soft texture diet should have received ground chicken or soft texture chicken instead of chopped chicken.A review of

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. Based on observation, interview, and record review, the facility failed to ensure special dietary requirements were implemented for two residents (Resident 53 and Resident 65) during the lunch meal observation on 8/11/25 when Resident 53 did not receive milk with lunch and Resident 65 received corn with lunch which was a documented dislike. This deficient practice had the potential to result in meal dissatisfaction and decreased meal intake that may lead to further complications or Resident 53 and Resident 56's medical status and nutritional status and/or weight loss of both residents.Findings:During an observation of the lunch meal in the dining room with a concurrent review of Resident 53's and Resident 65's meal tickets (a ticket including resident's diet, date, allergies, specific food and beverage items, dislikes, and likes) on 8/11/25, beginning at 12:30 p.m., the following was noted:1. Resident 53's meal ticket indicated, Beverages: 8 ounces (oz., unit of measure) 2% Milk, Resident 53 did not receive 8 oz. 2% milk (1 cup (8 oz.) of milk that contains 2% of fat by weight).2. Resident 65's meal ticket indicated, Dislikes.Corn., Resident 65 received one cup of coleslaw containing corn.During an interview with the Dietary Supervisor (DS) on 8/13/25 at 2:31 p.m., the DS stated the kitchen staff should follow the meal tickets. The DS further stated Resident 53 should have received 8 oz. of 2% milk and Resident 65 should not have received coleslaw with corn. The DS stated residents could get upset when their likes and dislikes were not followed on the meal ticket. During an interview on 8/14/25 at 8:51 a.m. with the Registered Dietitian (RD), the RD stated meal tickets should have been followed, and residents' food preferences should have been honored. The RD stated her expectation was to have accurate meal trays. A review of facility policy and procedure (P&P) titled, JOB DESCRIPTION-Food and Nutrition Service Director (Dietary Supervisor), dated 2023, indicated .DUTIES AND RESPONSIBILITIES.Check trays to ensure diets are served as ordered.Visit residents to determine food acceptance and preferences.A review of facility P&P titled, FOOD PREFERENCES, dated 2023, indicated POLICY.Resident's food preferences will be adhered to within reason.Substitutes for all foods disliked will be given from the appropriate food group.

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F 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide special eating equipment and utensils for residents who need them and appropriate assistance. Based on observation, interview, and record review, the facility failed to provide specialized eating utensils for Resident 14 and Resident 32 for the lunch meal on 8/12/25. This deficient practice may lead to Resident 14 and Resident 32 consuming their meal improperly, cause a lack of self-independence during eating and could be a dignity issue, and may cause weight loss. Findings:A review of Resident 14's admission RECORD indicated Resident 14 was admitted to the facility with diagnoses that included severe protein-calorie malnutrition and dysphagia (a medical condition characterized by difficulty or inability to swallow). A review of Resident 32's admission RECORD indicated Resident 32 was admitted to the facility with diagnoses that included severe protein-calorie malnutrition and muscle weakness. On 8/12/25 at 12:50 p.m., during a meal distribution observation in the kitchen, Resident 14's meal ticket indicated, Devices: Scoop Plate [deeper on one edge than the other to allow the user to easily scoop food onto their eating utensil], Built up utensil [Specialized forks and spoons and other adaptive cutlery have built up handles that are either heavier or lightweight], Resident 14 was observed to have a regular plate and regular utensils for the lunch meal. Also noted was Resident 32 received regular utensils for the lunch meal, but Resident 32's meal ticket indicated, Devices: Built up utensil.On 8/12/25 at 2:35 p.m., during an interview with the Dietary Supervisor (DS), the DS stated the kitchen staff needed to provide assistive devices to Resident 14 and Resident 32 as the meal tickets indicated. The DS further stated kitchen staff needed to follow the meal tickets to provide accurate meals for the residents. On 8/13/25 at 11:38 a.m., a concurrent interview and chart review of Resident 14 and Resident 32's record was conducted with Licensed Nurse (LN) 1. LN 1 confirmed there was no physician order and no care plan for Resident 14 to have special utensils. When reviewing the chart of Resident 32, LN 1 confirmed a physician order dated 12/28/24 indicated, .needs special utensils, poor fine motor skills both hands. LN 1 further stated a care plan dated 12/29/24 indicated .Interventions.Special utensils for eating. LN 1 further stated the risk of Resident 14 and Resident 32 not getting special utensils as ordered could lead to consuming food improperly and might cause choking. LN 1 further stated it might cause poor nutrition for the residents if they needed the special utensils for eating per physician order when the utensils were not provided. LN 1 stated the staff should check the meal trays carefully against the meal tickets before the meals were delivered to the residents. On 8/14/25 at 8:14 a.m., during an interview with the Registered Dietitian (RD), the RD stated the kitchen staff should have followed what was indicated on the meal tickets for the residents. A record review of facility policy, titled SELF-FEEDING DEVICES, dated 2023, indicated, POLICY: Residents will receive self-feeding devices to maintain or improve their ability to eat or drink independently.PROCEDURE.Residents needing devices will receive them with each meal or snack, on their meal trays. Tray cards and diet profile will record which device is needed.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to store, prepare, and distribute food in accordance with professional standards for food service safety when:1. Food items with inconsistent labeling and dating practices were found in the reach-in refrigerators;2. A box of bacon was found to be passed the use by date but was not discarded in the reach-in refrigerator;3. An opened box of Italian sausage which read keep frozen was found in the reach-in refrigerator;4. Two cartons of health shakes (nutritional supplement provides extra calories and protein), and a tray with cartons of health shakes was found in the reach-in and walk-in refrigerators which did not have a date to identify when they were pulled from the freezer and when they were supposed to be used by; 5. Produce items were found not to be fresh in the walk-in refrigerator;6. The metal material of the can opener blade was worn off;7. One dietary aide (DA) with a mustache and beard was not wearing a facial hair restraint or beard net;8. Two residents' food refrigerators/freezers in nursing stations 1 and 2 had conditions:a. Food items found without labeling including residents' names and/or dates,b. Food items found were outdated and were not discarded9. One microwave for the residents located in nursing station 2 was found not clean with dry liquid splashes. These failures had the potential to put residents who consumed food prepared by the facility at risk for foodborne illness for 75 out of 75 residents. Findings:1. During a concurrent observation in the kitchen, interview, and review of the food storage guidelines with Dietary Supervisor (DS) was conducted on 8/11/25 beginning at 8:50 AM. There were food items found in the reach-in refrigerators and walk-in refrigerator with the following:a. A tub of shredded carrots were observed to have dated labels which read 8/02/25 to 9/02/25. The DS confirmed and reviewed the facility document titled, Produce Storage Guideline on the Refrigerator, dated 2023, which indicated the carrots can keep in the refrigerator for 2 weeks. DS stated the carrots should have had a use by date of 8/16/25 and stated the staff had put incorrect dates on the label.b. A tub of chopped ham with a date of 8/6/25 was observed. DS stated he was not sure if 8/6/25 was an open date or used by date. He stated if 8/6/25 was the open date, the used by date should be 8/11/25 per the Refrigerated Storage Guide. The guide indicated that an opened package of ham could be kept in the refrigerator for five days. DS stated he would discard the chopped ham because he did not know what the date of 8/6/25 was for. c. An opened box of bacon with an opened date of 8/6/25 and a use by date of 9/6/25 was observed. The DS confirmed and reviewed the facility document titled Refrigerated Storage Guide, which indicated bacon could be kept refrigerated for five days. He stated 8/11/25 was the last day to keep refrigerated. DS stated he was aware the staff had put use by dates incorrectly and inconsistently. He further stated he had instructed the staff to follow the storage guidelines for labeling and dating. During an interview with Registered Dietitian (RD) on 8/14/25 at 8:51 AM, RD stated the kitchen staff needed more training, and they needed to correct their practice by following the storage guides. RD further stated the opened packaged food items should have opened and use by dates based on the storage guide.A review of facility policy and procedure (P&P) titled, Labeling and Dating of Foods, dated 2023, indicated, .All food items in the.refrigerator.need to be labeled and dated.opened food items will need to be closed and labeled with an open date and used by date that follows the various storage guidelines.2. A follow-up kitchen observation and concurrent interview with DS was conducted on 8/12/25 at 9:54 AM. It was noted there was an opened box of bacon with an open date of 8/6/25 and a use by date of 8/11/25. DS confirmed and stated the bacon was passed the use by date and should have been discarded. During an interview with RD on 8/14/25 at 8:51 a.m., RD stated any food items passed the use by date should be discarded. She further stated that usually the person responsible for receiving orders would check the dates of the food items and rotate the old items out and put the new items in.A review of facility P&P titled, REFERIGERATED STORAGE GUIDELINE dated 2023, indicated .luncheon meats, ham, bacon.Maximum Refrigeration Time.5 days. 3. During a kitchen observation and concurrent interview with DS on 8/11/25 at 9:09 a.m., there was an opened box of raw and ground Italian sausage with a written received date of 7/17/25. There was no indication of a pull date from the freezer or a use by date. The box read that the product should be frozen at 0-degree F (Fahrenheit, a unit of measurement of temperature) or below. DS confirmed and stated the ground Italian sausage should be kept frozen in the freezer. He further stated if the sausage was pulled from the freezer for thawing, it should have a pulled date from the freezer and a use by date. He stated he did not know when the staff pulled out the meat from the freezer and should be discarded.A review of facility P&P titled, Procedure for Freezer Storage, dated 2023

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. (continued on next page)

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Kit Carson Nursing & Rehabilitation Center	811 Court Street Jackson, CA 95642

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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 - Many	Based on observation, interview, and record review, the facility failed to practice appropriate infection prevention and control measures for a census of 75, when:1. The facility did not complete and document a facility-wide assessment of potential Legionella (bacteria that can cause a severe lung infection called Legionnaire's disease) growth areas and did not implement adequate control measures and monitoring protocols.2. Resident 52's urinary catheter bag (a thin flexible tube used to empty the bladder and collect urine in a drainage bag) was touching the floor.3. Nebulizer face mask and tubing (equipment used with a nebulizer machine that delivers liquid medication to the lungs as a fine mist) for Resident 1 and Resident 86 were unlabeled. There was no documentation when Resident 1's nebulizer face mask/tubing was last changed. An order to monitor and change Resident 86's nebulizer mask/ tubing was not initiated.4. Personal Protective Equipment (PPE - specialized clothing and equipment used by healthcare professionals to minimize exposure to infectious agents and hazardous material) was not worn by staff when providing care to residents on Enhanced Barrier Precautions (an infection control strategy used in nursing homes that requires targeted use of gowns and gloves during high-contact resident care activities to reduce the transmission of multidrug-resistant organisms or MDROs).5. Resident 3's oxygen nasal cannula (a medical device used to deliver oxygen consisting of a flexible tube with two small prongs inserted into the nose) was placed on Resident 3 after being picked up off the floor by a Certified Nurse Assistant (CNA). In addition, Resident 3's nasal cannula and humidifier bottle were not changed. Resident 46's oxygen tubing was not dated and had no order to change the tubing. 6. EBP signage for Resident 78 was not posted.7. A CNA performed hand hygiene while wearing a wrist brace/splint.8. Resident 78's peripherally inserted central catheter (PICC, a long, thin, flexible tube inserted into a vein in the upper arm that is threaded into a large vein near the heart. PICC lines are used to deliver medications, fluids, nutrition, and blood products.) line dressing was not changed as per MD order.These failures had the potential to spread infection and cause health problems for the residents in the facility.Findings:1. During an interview on 8/14/25, at 8:46 AM, with the Infection Preventionist, the IP stated the facility reviewed and updated the water management plan annually. The IP further stated they did not have control measures and monitoring protocols to identify legionella growth. The IP stated they did not have a document that described or illustrated the water systems to identify where legionella and other opportunistic waterborne pathogens could grow. The IP further stated the risk of not having a comprehensive water management plan could place all the residents at risk for waterborne diseases. The IP explained they could develop fever, diarrhea (frequent, loose bowel movements), loss of appetite, and develop pneumonia (lung infection). The IP stated most of the residents were considered high risk because they were 80 years and above.A review of the facility's policy and procedures (P&P) titled, Legionella Water Management Program, revised 6/25, indicated, .The water management program include the following elements.A detailed description and diagram of the water system in the facility .The identification of areas in the water system that could encourage the growth and spread of Legionella or other waterborne bacteria.The identification of situations that can lead to Legionella growth. Specific measures to control the introduction and/or spread of legionella.The control limits or parameters that are acceptable and that are monitored.A diagram of where control measures are applied.A system to monitor control limits and the effectiveness of control measures.A plan for when control limits are not met and/or control measures are not effective and Documentation of the program.2. During an observation on 8/11/25, at 9:34 AM, in Resident 52's room, Resident 52's urinary catheter bag was observed hanging on the side of the bed and was touching the floor. During a concurrent observation and interview on 8/12/25, at 12:34 PM, with Licensed Nurse (LN) 3, in Resident 52's room. LN 3 confirmed Resident 52's urinary catheter bag was on the floor beside the bed of Resident 52. LN 3 stated Resident 52's urinary catheter bag should not have touched the floor.During an interview on 8/13/25 at 9:58 AM with the Director of Nursing (DON), the DON stated the urinary catheter should not have been on the floor because there was a risk for infection.A review of the facility's P&P titled, Indwelling/Foley Catheter, revised on 1/2025, indicated, .be sure the catheter tubing and drainage bag are kept off the floor .3a. During a concurrent observation and interview on 8/12/25, at 8:52 AM, in Resident 1's room, LN 5 confirmed Resident 1's nebulizer face mask and tubing was laying on Resident 1's nightstand and not in a protective bag. LN 5 further confirmed the face mask, and tubing was not labeled or dated with when it was last changed. LN 5 stated it was expected that the nebulizer mask and tubing was to be changed every Sunday night. During a subsequent concurrent interview and record review

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. Based on interview, and record review, the facility failed to provide education regarding the benefits and potential side effects for the Pneumococcal (a serious bacterial infection that can cause respiratory illness) vaccine for one out of five sampled residents (Resident 23) when Resident 23's clinical record did not contain documented evidence that education for the pneumococcal vaccine was provided.This deficient practice violated Resident 23's right to make an informed choice to receive or not receive the pneumococcal vaccine.Findings:During an interview on 8/13/25, at 2:46 PM, with the Infection Preventionist (IP), the IP stated the pneumococcal vaccine was offered upon admission. The IP further stated before getting the vaccine, the staff educated or explained to the resident the indication of the vaccine (why a vaccine is recommended), the signs and symptoms or side effects that could occur such as inflammation. The IP stated they also educated those residents with low pain tolerance that the vaccine could be painful, fever could possibly occur, and some adverse reactions such as diarrhea (frequent, loose bowel movements) could occur. The IP further stated if a resident did not have the capacity to make decisions, the facility would get consent from the responsible party (RP). The IP stated the nurses should be documenting in the progress notes when they administered vaccines to the residents.A review of Resident 23's Immunization record indicated Resident 23 was given the PCV20 or Prevnar 20 (pneumococcal vaccine) on 7/8/24. Further review of the document did not indicate if education was provided.During a concurrent interview and record review on 08/14/25, at 8:46 AM, with the IP, Resident 23's Immunization Record was reviewed. The IP confirmed that education was not provided to Resident 23. The IP stated the risks of not providing education prior to vaccine administration would be the lack of resident awareness when and what to report to the staff. The IP further stated that educating residents prior to vaccination helped the residents identify and report signs and symptoms, including potential side effects.A review of the facility's policy titled, Resident Rights, revised 1/25, indicated, .Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to.be informed of, and participate in, his or her care planning and treatment.

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. Based on interview, and record review, the facility failed to provide education regarding the benefits and potential side effects of the COVID-19 vaccine, for three of five sampled residents (Resident 9, Resident 25, and Resident 51) when all three residents' clinical record did not contain documented evidence that education regarding the risk and benefits of the COVID-19 vaccine were provided. This failure had the potential for the residents and resident's responsible parties to not be fully informed about the risks and benefits, and potential side-effects of the COVID-19 vaccination prior to receiving or declining the vaccination. Findings:During an interview on 8/13/25, at 2:46 PM, with the Infection Preventionist (IP), the IP stated the COVID-19 vaccines were offered upon admission. The IP further stated that before getting the vaccine, the staff educated or explained to the resident the indication of the vaccine, the signs and symptoms or side effects that could occur like possible inflammation. The IP stated they also educated those residents with low pain tolerance that the vaccine could be painful, and fever could possibly occur, and some adverse reactions like diarrhea (frequent, loose bowel movements) could occur. The IP further stated if the resident did not have the capacity to make decisions, the facility would get consent from the responsible party (RP). The IP stated the nurses should be documenting in the progress notes when they administered vaccines to the residents.A review of Resident 9's Immunization record indicated Resident 9 was given the COVID-19 vaccine on 7/8/24. Further review of the document did not indicate if education was provided.A review of Resident 25's Immunization record indicated Resident 25 was given the COVID-19 vaccine on 7/8/24. Further review of the document did not indicate if education was provided.A review of Resident 51's Immunization record indicated Resident 51 was given the COVID-19 vaccine on 7/8/24. Further review of the document did not indicate if education was provided.During a concurrent interview and record review on 08/14/25, at 8:46 AM, with the IP, the immunization records for Resident 9, Resident 25, and Resident 51 were reviewed. The IP confirmed education was not provided to Resident 9, Resident 25, and Resident 51. The IP stated the risks of not providing education prior to vaccine administration would be the lack of resident awareness when and what to report to the staff and if a resident feels unwell, they might not report it to the nurse, leaving staff unaware. The IP further stated that educating residents prior to vaccination helped the residents identify and report signs and symptoms, including potential side effects.A review of the facility's policy titled, Resident Rights, revised 1/25, indicated, .Federal and state laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to.be informed of, and participate in, his or her care planning and treatment. A review of the facility's policy and procedure titled, Coronavirus Disease (COVID-19) - Vaccination of Residents, revised January 2025, indicated, .Each resident is offered the COVID-19 vaccine unless the immunization is medically contraindicated or the resident is fully vaccinated . COVID-19 vaccine education, documentation and reporting are overseen by the infection preventionist and coordinated by his or her designee .Before the COVID-19 vaccine is offered, the resident is provided with education regarding the benefits, risks, and potential side effects associated with the vaccine .Residents must sign a consent to vaccinate form prior to receiving the vaccine .The resident's medical record includes documentation that indicates, at a minimum, the following: a. That the resident or resident representative was provided education regarding the benefits and potential risks associated with COVID-19 vaccine, including: (1) samples of the educational materials used; (2) the date the education took place; and (3) the name of the individual who received the education; b. Signed consent; and c. Each dose of COVID-19 vaccine that was administered to the resident.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure that a working call system is available in each resident's bathroom and bathing area. (continued on next page)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, and interview, the facility failed to maintain their resident call light system (system/device used by residents to call staff for assistance) when the call light system did not directly alert staff at Station 1 or a centralized staff work area for 47 of 47 residents.This failure resulted in the residents waiting longer periods of time for assistance and put their physical and emotional needs at risk for being unmet.Findings:During an observation on 8/12/25, at 8:46 AM, in Resident 1's room, Resident 1 pressed the call light to ask for assistance from staff. During an observation on 8/12/25, at 8:49 AM, in front of Resident 1's room, observed the call light outside of the room above the doorway was lit up, and no staff were observed in the hallway to come and answer the call light. During a concurrent observation and interview on 8/12/25, at 8:50 AM, at Nurses Station 1, Licensed Nurse (LN) 2 stated she did not answer the call light because she did not see it and could not hear it. LN 2 further stated the call light system had not been working properly and no longer lit up on a board or alarmed (makes a noise or sound) alerting the staff of an active call light at Station 1. LN 2 stated the staff were supposed to look for call lights lit up above the Resident's door and added if the staff were busy in other rooms, they would not see or know there was a call light on. LN 2 explained the call light system had not been functioning properly for at least one year. LN 2 stated the risk to the residents call lights not being answered when assistance was needed was falls and stated, anything could happen.During an observation and interview on 8/12/25, at 8:52 AM, LN 5 was observed walking past Resident 1's room when the call light was lit up. LN 5 stated she was thinking of something else and did not notice the call light on. LN 5 confirmed there was no box that lit up or alarmed with a resident's room number when a call light was on, so it was important to watch for the call light when the staff walked by the resident's rooms. During an observation on 8/13/25, from 10:16 AM to 10:21 AM, no staff were observed in the hallways of, or at Nurses Station 1. All residents' rooms were observed at Station 1 for a physical bell to ring in case of need, no residents at Station 1 had a bell in their room as an audible source to call for assistance.During a concurrent observation and interview on 8/13/25, at 10:21 AM, at Nurses Station 1, the Administrator (ADM) confirmed there were no staff at Nursing Station 1 to answer call lights. The ADM stated he had been aware the call light board/alarm had not been working since April 2025. The ADM further stated he asked the Maintenance Director (MTD) to look into getting a vendor to fix the issue sometime in July 2025. The ADM stated he did not have the specific date and the MTD was not available for interview due to being out of the country. The ADM explained it was important for residents to be able to call for assistance, so their needs were met. During an observation on 8/14/25, at 11:55 AM, of the Station 1 hallways, a call light was observed lit up above the door to room [ROOM NUMBER]. During this time, 2 staff members walked by and did not answer the call light.During a concurrent observation and interview on 8/14/25, at 12:13 PM, the ADM walked by and answered the call light. The ADM was informed that two staff members walked by and did not answer the call light and that the call light was observed on from 11:55 AM and not answered until he walked by at 12:13 PM, approximately 18 minutes later. The ADM confirmed the facility needed a box that had an audible ring at the nurse's station to alert staff of a resident's need for assistance.During an interview on 8/14/25, at 12:17 PM, in Station 1's hallway, LN 8 stated she did not see the call light. LN 8 further stated they used to have a call box that worked with the call lights at Nurses Station 1, but it had not worked in over a year. LN 8 explained it was important to hear and see the call lights from all over Station 1 in case a resident fell or needed something urgently.During an interview on 8/14/25, at 12:22 PM, the Director of Nursing (DON) stated an audible call alarm was important to alert staff when a resident had needs. The DON further stated that staff walking by and not seeing or answering call lights did not meet her expectations.A review of facility policy and procedure, CALL LIGHT/BELL, revised 01/2025, indicated, .It is the policy of this facility to provide the resident a means of communication with nursing staff.Answer the light within a reasonable time (3-5 minutes).If call light is defective, promptly report this information to the unit supervisor for immediate repair or replacement.