STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056203	A. Building B. Wing	05/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
City View Post Acute	1359 Pine Street San Francisco, CA 94109

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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. Based on observation, interview, and facility document review, the facility failed to sanitize food contact surfaces, store food, and maintain clean food equipment and kitchen environment in accordance with professional standards for food service safety when:The chemical sanitizing dishmachine was used with low sanitizer strength;Food contact surfaces of food preparation equipment were not sanitized according to sanitizer manufacturer instructions;Refrigerators storing resident food were not clean;Juice machine parts were not clean;The kitchen floor was not maintained clean around the ice machine area;These failures had the potential to result in contamination of food and food utensils with inadequate sanitizing and attraction of pests leading to food related illness for 167 residents who ate food by mouth and received food from the kitchen and/or who could have perishable food brought in by outside sources such as visitors and stored for them in refrigerators. Findings:1.Review of the Policy and Procedure titled Sanitization dated 2001, showed dishmachines are operated according to manufacturer's instructions. General recommendations for chemical sanitization are for low-temperature dishmachines (chemical sanitization) final rinse with 50 parts per million (ppm) chlorine on dish surface.An observation and interview in the kitchen on 4/28/26 at 10:25 a.m., Diet Aide (DA) 4 was washing items such as food plates, and cooking utensils, in the dish machine. DA4 stated the dishmachine was a low temperature machine and demonstrated how to test the sanitizer strength. DA4 ran the machine and pulled out a dish rack onto the clean side of the counter after the machine was finished running. DA4 used a chlorine test strip and dipped it in standing water on the counter of the clean side of the dish machine and compared it to the color chart on the chlorine strip container. The color of the strip was very light and without really changing color. DA4 stated the strip red 10 parts per million (ppm). The Dietary Manager (DM) stated he thought there was a kink from the sanitizer container to the dish machine which blocked the sanitizer getting to the machine.During a consecutive observation and interview in the kitchen on 4/28/26 at 11:40 a.m., the DM retested the sanitizer strength by running the dish machine and touching a chlorine test strip to the surface of a pan after the machine cycle was finished. DM confirmed the sanitizer strength was too low, and the test strip showed 10 ppm when he compared the strip to the color chart on the test strip container. DM stated the sanitizer strength had to be at least 100 ppm. DM confirmed the items that went through the dish machine at 10 ppm were not sanitized adequately. The information plate attached to the side of the dish machine showed for chemical sanitizing the minimum chlorine required was 50 ppm. 2. Review of the Policy and Procedure titled Sanitization dated 2001, showed for manual sanitizing in the three-compartment sink, chemical sanitizing solutions (e.g. quaternary ammonium compound) are used according to manufacturer instructions. During an observation and interview in the kitchen on 4/28/26 at 11:42 a.m., DA1 sanitized items such as food plates and pans in the third compartment of the manual three-compartment dishwashing sink. DA1 stated he was sanitizing items in the sink because the dishmachine was not working. DA1 placed pans in the sanitizer solution in the third sink compartment and removed the pans after 27 seconds. DA1 placed more pans in the sanitizer solution and removed the pans after 28 seconds. During an observation on 4/28/26 at 11:45 p.m., DA4 tested the sanitizer (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	strength in the 3 compartment sink and stated it was 400 ppm when he compared the Quaternary Ammonia (Quat) test strip to the test strip container. During an interview and review of manufacturer instructions on 4/28/26 at12:02 p.m., DM confirmed the sanitizer used to sanitize items in the three compartment sink was Quat. DM provided a container of the Quat for review. The manufacturer's instructions on the container labeled [product brand name] Quat Sanitizer showed to sanitize food contact surfaces with Quat sanitizer at strength from 150 to 400 ppm, expose all surfaces to the sanitizing solution for a period of not less than one minute. 3. Review of the Policy and Procedure titled Sanitation and Infection Control Subject: Cleaning Refrigerators dated 2023, showed reach-in refrigerators will be cleaned and sanitized once a week, or more often as necessary. Messes and spills will be cleaned as they occur. According to the Federal Food Code 2022, food-contact surfaces shall be clean to sight and touch. Nonfood-contact surfaces of equipment shall be kept free of an accumulation of dust, dirt, food residue, and other debris. During an observation on 4/28/26 at 2:42 p.m., two full size refrigerators with a top freezer compartment (refrigerator 1 was to the right and refrigerator 2 was on the left when entering the breakroom) were located in the first floor employee breakroom and held bags of resident food. Refrigerator number 1 had pink residue and scattered black particles over on the entire inside, bottom surface of the freezer compartment. When the surface was wiped with a white paper towel, the residue easily wiped off. In the refrigerator compartment for refrigerator number 1, there were three dead insects on the inside, bottom surface. On the surface of the side shelves inside the refrigerator compartment, there was brownish, and yellow spatters of residue. For refrigerator number 2, there was black residue spread throughout the inside, bottom surface of the freezer compartment. On the inside surface of refrigerator number 2 refrigerator compartment, there was brown residue build-up in the crevices around the center shelving, and under the shelving. During a consecutive observation and interview with HD on 4/28/26 at 2:44 p.m., HD looked at refrigerator 1 and 2 in the first floor employee breakroom. HD confirmed residue in both refrigerators 1 and 2, and stated both refrigerators were not clean. HD stated Housekeeping staff were responsible for cleaning the refrigerators. HD confirmed resident food (Resident 196, Resident 203) were stored in the refrigerators. 4. Review of the Policy and Procedure titled Sanitization dated 2001, showed all kitchen areas are to be kept clean. According to the Federal Food Code 2022, food-contact surfaces shall be clean to sight and touch. Nonfood-contact surfaces of equipment shall be kept free of an accumulation of dust, dirt, food residue, and other debris. An observation in the kitchen on 4/27/26 at 9:40 a.m., showed plastic bags containing juice syrup connected to hoses leading to a juice machine. The plastic connecters between the bags and hoses for seven bags of juice syrup had pink and/or orange colored, sticky residue covering the surface of the connectors. An observation and interview in the kitchen on 4/28/26 at 1:10 p.m., showed the plastic bags containing juice syrup connected to hoses leading to a juice machine. The plastic connecters between the bags and hoses for seven bags of juice syrup had pink and/or orange colored, sticky residue covering the surface of the connectors. [NAME] 2 stated he was responsible for cleaning the juice machine in the evening. [NAME] 2 described how he cleaned the machine, including the juice machine dispenser gun and the outside of the juice machine. [NAME] 2 did not indicate he cleaned the juice machine connectors. During a consecutive observation and interview on 4/28/26 at 1:15 p.m., DM confirmed there was residue build-up on the surfaces of the juice machine syrup bag connecters. DM stated the connecters should be wiped down with warm water each night as part of the cleaning process for the juice machine. 5. Review of the Policy and Procedure titled Sanitization dated 2021, showed all kitchen areas are kept clean. All equipment is kept clean. According to the Federal Food Code 2022, physical facilities shall be cleaned as often as necessary to keep them clean. In addition, nonfood-contact surfaces of equipment shall be kept free of an accumulation of dust, dirt, food residue, and other debris. An observation in the kitchen on 4/27/26 at 10:04 p.m., showed water dripping from a pipe from behind the ice machine onto the floor. On the floor surface behind and under the ice machine there was wet dark brown residue build-up and wet debris such as bits of paper and (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	plastic. An observation in the kitchen on 4/29/26 at 11:40 a.m., the floor behind and under the ice machine appeared the same as in the observation on 4/27/26 at 10:04 a.m., with water dripping from a pipe behind the ice machine onto the floor. On the floor surface behind the ice machine there was wet dark brown residue build-up and wet debris such as bits of paper and plastic. During an interview on 4/29/26 at 3:31 p.m., the Dietary Manager (DM) stated kitchen staff were responsible for cleaning the kitchen floor including behind and under the ice machine. DM stated it was difficult to clean with a mop due to the drainpipes from the ice machine to the floor sink drain under the ice machine. DM reviewed photos taken of the floor under and behind the ice machine on 4/27/26 at 10:04 a.m., and 4/29/26 at 11:40 a.m., and stated it did not appear the floor was cleaned under/behind the ice machine from 4/27/26 to 4/29/26 at 11:40 a.m. DM stated the floors were to be cleaned daily.

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Keep all essential equipment working safely. Based on observation, interview, and record review, the facility failed to ensure adequate maintenance and/or repair of: 1.Two refrigerators used for holding resident food which resulted in low refrigerator temperatures;2.An ice machine drainpipe which resulted in water actively dripping and pooling on the kitchen floor;3. Three drainpipes for an ice machine were not maintained clean; and4.A hotbox (food warming equipment) used to hold food for residents, which resulted in inadequate holding temperatures. The failure to maintain kitchen mechanical and electrical equipment had the potential to result in food and food equipment contamination from pests attracted to a wet environment, as well as not maintaining adequate food temperatures for 167 residents who ate food by mouth and who received food from the kitchen and/or who could have perishable food brought in by outside sources such as visitors and stored for them in refrigerators. Findings:1. Review of the guidelines shown on refrigerator/freezer temperature recording log titled Refrigerator/Freezer Temperature Log showed the refrigerator temperature was to be maintained at 32 to 39 degrees F. The log also showed generally air temperature of 2-3 degrees below the desired internal food temperature (41 degrees or lower for potentially hazardous food) is appropriate (i.e. 39 degrees F or below) to maintain food temperature at 41 degrees F or below.Review of the Policy and Procedure titled Maintenance Policies & Procedures Safety Procedures dated 12/31/15, showed to keep maintenance log in a designated place in the maintenance shop or work area at all times unless it is requested by the administrator or other authorized person. Note and initial all required daily checks. Maintain fixtures and equipment in safe and good repair. Repair, or have repaired, any defect in the defect structure, fixtures, or equipment as soon as possible. If a defect cannot be repaired immediately, post or attach warning signs on or near the defective object. Report to the administrator if a repair job cannot be completed, or a service representative must be called, or a defect in equipment that constitutes a safety hazard.During an interview on 4/28/26 at 2:35 p.m., Certified Nursing Assistant (CNA) 1 stated food belonging to residents brought in from outside by visitors was stored in a refrigerator located in the employee breakroom on the first floor. During an observation on 4/28/26 at 2:42 p.m., two full size refrigerators with a top freezer compartment (refrigerator 1 was to the right and refrigerator 2 was on the left when entering the breakroom) were located in the first floor employee breakroom. Refrigerator 1 contained a bag of food labeled with the name of Resident 196 and contained items including packaged string cheese and an unsealed jar (the jar lid was on the jar but the seal on the jar was broken as it was previously opened) of homemade pickled eggs. Refrigerator 1 had pooled water on the inside bottom surface of the freezer compartment, and on the floor outside of the refrigerator. Refrigerator 2 contained a bag of food labeled with the name of Resident 203. The bag of food for Resident 203 contained packaged fruit salad, including cut melon. The internal dial thermometers in both refrigerators were over 41 degrees F.During a consecutive interview on 4/28/26 at 2:45 p.m., the Housekeeping Director (HD) stated refrigerators 1 and 2 located in the employee breakroom were for staff and residents. A surveyor thermometer was placed in each refrigerator.An observation and interview with HD on 4/28/26 at 4:04 p.m., showed the surveyor's thermometer placed in refrigerator 1 was 50.9 degrees Fahrenheit (F). The facility's internal refrigerator thermometer was just above 50 degrees F. For refrigerator 2, the surveyor thermometer was 47.3 degrees F, and the facility's internal refrigerator thermometer was just under 45 degrees. All temperatures were confirmed by HD.During an interview on 4/29/26 at 11:55 a.m., the Maintenance Director (MM) stated maintenance staff monitored the refrigerator temperatures located in the first floor employee breakroom. MM stated daily logs were maintained for the refrigerators. MM stated yesterday on 4/28/26, he found refrigerator 1 had a bad compressor so the refrigerator temperature was high in the 40 to 50 degrees F range and did not go down. MM stated the thermostat control dial for refrigerator number 2 was turned up when he observed it on 4/28/26 at 10:30 a.m., so he turned the dial down to make the refrigerator colder. MM stated if the food was not stored at an appropriate (continued on next page)

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	temperature, the food could go bad.During an interview on 4/29/26 at 1:25 p.m., MM could not produce the original temperature log for the employee breakroom refrigerators number 1 and 2. MM stated since they were not in the office, they could be in his car. MM checked his car and did not locate the temperature logs. MM stated two temperatures should be documented for the refrigerators daily, AM and PM.During an interview on 4/30/26 at 12 p.m., the Director of Staff Development (DSD) stated storing food belonging to residents in the first floor employee breakroom refrigerators was a standard of practice for the facility and everybody knows resident food is stored there. DSD stated storing food for residents in the employee breakroom refrigerators was done since he started in 2012. During an interview with MM on 4/30/26 at 1:30 p.m., MM stated the Maintenance Assistant (MA) contacted him at 9:30 a.m., on 4/28/26 and reported high temperatures of refrigerators 1 and 2 in the employee breakroom on the first floor. MM stated, at 10:30 a.m. on 4/28/26, when he was on site, he looked at refrigerators 1 and 2 in the employee breakroom. MM stated refrigerator number 1 temperature was high, and he could not fix it because the compressor was broken. MM confirmed he did not place an out of service warning on the refrigerator and he did not take the refrigerator out of service until later in the evening after 5 p.m., on 4/28/26 when refrigerator 1 was replaced. MM also stated he did not report the refrigerator was not working to anyone.In a concurrent interview with MA on 4/30/26 at 1:30 p.m., MA confirmed on 4/28/26 at about 4:30 p.m., when he documented the temperature of refrigerator number 2, it was still above range at 43 degrees F. 2. During a review of the facility's policy and procedure titled Maintenance Polices & Procedures, dated 12/31/2015, indicated, .9. Repair immediately all leaks in the pipes or joints using the proper material and method for the type of pipe.According to the Federal Food Code Annex 3, Grading of the floor to drain allows liquid wastes to be quickly carried away, thereby preventing pooling which could attract pests such as insects and rodents or contribute to problems with certain pathogens such as Listeria monocytogenes. An observation in the kitchen on 4/27/26 at 10:04 p.m., showed water dripping from a pipe from behind the ice machine onto the floor. The end of the pipe was jagged, and had black, slimy in appearance, residue on the outer surface as well and what could be observed of the inner surface.During a concurrent observation and interview in the kitchen on 4/29/2026 at 11:40 AM with the Maintenance Director (MM) and Dietary Manager (DM), the small white pipe, with black, slimy residue, attached to the backside of the ice machine in the kitchen was actively dripping water on the floor. Pools of water were found under the dripping pipe. MM stated the pipe was for the ice storage bin and stated the pipe was broken and should be repaired as soon as possible. MM stated the pipe should have another pipe attached leading to the floor sink drain. 3. Review of the Policy and Procedure titled Maintenance Policy and Procedures Policies dated 12/31/2015, showed the facility was responsible for maintaining fixtures, systems, and equipment in order to ensure the entire facility is clean and free of environmental pollutants. According to the Federal Food Code 2022, physical facilities shall be cleaned as often as necessary to keep them clean.An observation in the kitchen on 4/29/26 at 11:40 p.m., showed three drainpipes attached to the back to the ice machine/ice machine bin. A short drainpipe was jagged at the end and had black, slimy in appearance residue on the entire outside surface and what could be seen of the inside surface. Two more longer drainpipes that lead to a floor sink also had black residue on the outside of the pipe surfaces.In a concurrent interview with the Maintenance Manager (MM) on 4/29/26 at 11:40 p.m., MM stated the short drainpipe was connected to and drained the ice bin. MM stated the short drain was cracked. MM stated the longer drainpipes from the ice machine to the floor sink were from the ice machine condenser and for draining the machine during the cleaning cycle. MM confirmed the drainpipes were not clean and stated they appeared dusty. MM stated maintenance staff were responsible for cleaning the drainpipes and they should be cleaned. 4. During a concurrent observation and interview on 4/27/2026 at 9:52 AM with DM, a Hotbox holding food for the lunch trayline (an assembly line for food service) was observed. The external temperature display showed a temperature of hotbox was108 degrees Fahrenheit (F). DM stated, there was a current work order (provides details for a specific maintenance, repair, or (continued on next page)

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	service task to be done) for the Hotbox to be serviced/fixed. DM verified the soup was heated on stove top, then portioned into bowls and placed in Hotbox prior to being served to the residents on the lunch trayline. DM measured the temperature of the soup stored in the hotbox and the temperatures were as follows: chicken noodle soup 119 degrees F; cream of chicken soup 117 degrees F; and tomato soup 126 degrees F. DM confirmed the temperatures were too low.During a review of a vendor quote titled Warming Cabinet Repair, dated 4/9/2026, it was noted a vendor quote was provided in place of a facility generated work order for the hotbox. The quote from the vendor indicated the DM contacted a service provider (VENDOR 1) and requested a service for the Kitchen Appliance hot Metro C5 insulated holding and proofing cabinet. Vendor 1 indicated, .the unit is not heating, and the temperature gauge is not working.the temperature display is not working due to a crack, and the gasket has a rip affecting temperatures.the temperature display and gasket need to be soured and replaced. The quote also included a monetary amount to repair the hotbox. It noted this quote was not signed by the facility to accept the service outlined in the quote.Review of the facility document titled Proper Temperatures for Meal Preparation and Service dated 2023, showed the minimum acceptable holding temperature for hot food is 140 degrees F.During a record review of MAINTENANCE POLICES & PROCEDURES, dated 12/31/2015, indicated, Maintenance staff safety procedures and responsibilities are as follows:.3. Repair, or have repaired, any defect in the Center's structure, fixtures, or equipment as soon as possible. If a defect cannot be repaired immediately, post or attach warning signs on or near the defective object.According to the 2022 Federal Food Code, standards of practice include equipment is to be maintained in a state of repair.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide necessary care and services for two of 34 sampled residents (Residents 194 and 114) when:1.a. A hand splint was applied without a physician's order; b. The facility failed to identify podiatry needs to maintain level of comfort and care plan was not developed to address resident's mycotic (long, thick and yellowish) toenails; and2. The facility did not follow the physician order for the administration of Tylenol.These deficient practices presented a potential risk of residents not maintaining the highest achievable level of wellbeing which could lead to diminished quality of life. 1.Resident 194 was readmitted on [DATE] with diagnoses that included aphasia (a neurological disorder caused by brain damage that impairs a person's ability to communicate, affecting speech, writing, and comprehension of language), hemiplegia (a severe or complete paralysis of one side of the body) and hemiparesis (weakness, numbness, or reduced motor function on one side of the body), hypertension (high blood pressure), and contracture (permanent tightening of the muscles, tendons, skin, and nearby tissues that causes the joints to shorten and become very stiff). During the initial tour observation on 4/27/2026 at 10:45 AM, Resident 194 was sleeping in bed with blanket covering resident, with a small, white, rolled washcloth placed on contracted left hand. During a concurrent observation and interview on 4/29/26 at 1:50 PM with Certified Nursing Assistant (CNA) 2 and Infection Preventionist (IP), Resident 194 had contractures on both hands and lower extremities and had mycotic toenails. Resident 194 had a blue fabric support device worn on the right hand. CNA 2 concurred with the observation and stated, That's for podiatry (toenails). Furthermore, CNA 2 stated, The RNA (Restorative Nursing Assistant) puts it (support device) in the morning then after one or two hours, they take it off. When asked what the blue fabric support device on Resident 194's right hand was, IP stated, It's a hand splint. During a review of Resident 194's electronic health record (EHR) on 4/29/26 at 2:11 PM, the Orders indicated, no physician's order for the use of hand splint and no referral to podiatry. During a concurrent observation and interview on 4/29/2026 at 2:25 PM, RNA removed Resident 194's hand splint. RNA stated the hand splint was verbally ordered by the physical therapist after evaluation and was applied the day after resident's admission. RNA further stated the splint was applied four hours daily for contracture, and specifically for Resident 194, RNAs put on and take off the splint. During a concurrent interview and record review on 4/29/2026 at 3:46 PM, with the Occupational Therapist (OT), Resident 194's Rehab Screening Form dated 4/15/26 was reviewed. Per OT, Resident 194 had no functional changes, RNA program was re-established for passive range of motion (PROM-movements performed on a patient by a therapist, caregiver, or machine without the patient using their own muscles), and a need for resting hand splint. When queried if a physician's order was required for the splint, OT stated, No. Review of Resident 194's Restorative Nursing Program Referral with effective date 4/15/26 indicated, .A. RNA Program Referral.Range of Motion (ROM) Program.Splinting/Bracing Program (checked).E. Splinting/Bracing Program 1. Splinting/Bracing – Identify Extremity: RUE (right upper extremity) 2. Type of Splint: R (right) resting hand splint 3. Wearing Schedule: At night and during times of rest as tolerated by patient; off for ROM (range of motion), hand hygiene. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Orthosis is the proper term that applies to a custom-fabricated brace/splint. Medicare considers an orthosis a rigid or semi-rigid device that supports a weak or deformed body member or restricts or eliminates motion in a diseased or injured part of the body. Orthoses require a prescription and/or certificate of medical necessity signed by a physician. Orthoses can be provided to the patient in their home, and in other settings such as outpatient centers and SNFs. [https://asht.org/practice/practice-management/orthotics-related/coding] accessed on 5/7/26. During a concurrent observation and interview on 4/30/2026 at 11:17 AM with Registered Nurse (RN) 1, RN 1 described Resident 194's all toenails on the right foot and nails on the big toe and fourth toe on the left foot as long, thickened and yellowish. When asked if the condition of Resident 194's toenails was a concern, RN 1 stated, Yes, because there's fungal infection and the length of the nails can cause damage to her skin. During a concurrent interview and record review on 4/30/2026 at 1:36 PM with Licensed Vocational Nurse (LVN) 2, Resident 194's medical record was reviewed. LVN 2 stated Resident 194 was alert and oriented x 0 (indicates a patient is conscious [alert] but completely disoriented to person, place, time, and situation) and was not able to express care needs. LVN 2 confirmed Resident 194's mycotic nails were not identified in the Nursing Admission/readmission Evaluation Assessment dated 4/14/26 and stated, I don't see it noted. Review of Resident 194's Basic Care Plan (BCP) dated 4/14/26, LVN 2 acknowledged BCP did not mention resident's mycotic nails and stated, None in BCP for nursing. LVN 2 admitted Resident 194's mycotic nails were not addressed in the Progress Notes and stated, None noted. Additionally, LVN 2 acknowledged there was no care plan developed and stated, None. When asked if Resident 194's mycotic nails was a concern, LVN 2 stated, Yes, it is a concern. It can cause pain and distress to the patient. It should have been part of the assessment. During a concurrent observation and interview on 4/30/2026 at 1:46 PM, LVN 2 described Resident 194's toenails on the right foot as long, thick, yellowish on the first to fourth and thick on the fifth. On the left foot, LVN 2 described the first and second toenails as long, thick and yellowish. According to LVN 2, Resident 194's foot condition could have been referred for podiatry services. LVN 2 stated, No order for podiatry service as it was not identified. Furthermore, LVN 2 said he'll check with social services if a referral was made to podiatry. Review of Resident 194's BCP dated 4/14/26 under Social Services indicated, .She is not able to express her care needs or concerns for her health and medical care needs. During an interview on 4/30/2026 at 3:13 PM, Social Services Director (SSD) confirmed Resident 194 did not have a referral for podiatry services. SSD stated, Will refer her now. During an interview on 5/01/2026 at 3:04 PM with the Director of Nursing (DON), the DON stated on residents' admission/readmission, licensed nurses are expected to perform a full assessment that included head-to-toe assessment, skin check, and vital signs (temperature, pulse, respiration, and blood pressure). Regarding Resident 194's mycotic nails, DON stated, It should have been identified in the assessment. Review of facility policy titled Activities of Daily Living (ADL), Supporting dated 2001 indicated, .5. Appropriate care and services are provided for residents who are unable to carry out ADLs independently.including appropriate support and assistance with: a. hygiene (bathing, dressing, grooming, and oral care) .9. The resident's responses to interventions are monitored, evaluated, and revised as appropriate. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of facility policy titled Care Plans, Comprehensive Person-Centered dated 2001 indicated, .1. The interdisciplinary team (IDT).develops and implements a comprehensive person-centered care plan for each resident.3. The care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment.7. The comprehensive, person-centered care plan: a. includes measurable objectives and timeframes; b. describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, including.(3) which professional services are responsible for each element of care. 2. During a review of Resident 114's face sheet (a document completed on admission, a quick reference of essential information including patient demographics and medical condition), the face sheet indicated Resident 114 was admitted with diagnoses including liver cirrhosis (scarring of the liver caused by due to long term liver diseases), stroke and dementia (decline in memory or other thinking skills). Minimum Data Set (a standard assessment tool) dated 4/12/26, Brief Interview of Mental Status (BIMS, a brief memory check to help determine cognitive ability [includes thinking skills, problem solving) score of 11 indicated moderate cognitive impairment (requires supervision and cueing). Functional abilities indicated Resident 114 required partial/moderate assistance (helper does less than half the effort. Helper lifts, holds, or supports trunk, limbs, but provides less than half the effort) to substantial/maximal assistance (helper does more than half the effort. Helper lifts or holds trunk or limbs and provides more than half the effort) during Activity of Daily Living. During a review of Resident 114's physician order dated 11/4/25, the physician order indicated Tylenol 500 milligrams (mg a unit of measurement) two tablets by mouth every six (6) hours as needed for mild pain (1-3/10) not to exceed (NTE) two (2) grams (gm, a unit of measurement) in 24 hours (per day) from all sources. During a review of Resident 114's Medication Administration Record (MAR) for 4/2026, the MAR indicated that Tylenol with a total of three (3) grams was administered to Resident 114 as follows: 4/21/26 at 0225 (2:55 AM), at 0830 (8:30 AM), at 1724 (5:24PM) 4/28/26 at 0128 (1:28 AM), at 0900 (9 AM), at1711 (5:11 PM) During an interview and record review on 5/1/26, at 10:53 AM, the Director of Nursing (DON) reviewed Resident 114's Electronic Health Record (EHR) and acknowledged that the physician order for tylenol not to exceed (NTE) two grams was not followed on 4/21/26 and 4/28/26 resulting in tylenol three grams administered to Resident 114. The DON stated that the nurses were expected to flag when resident's pain does not match the intended parameter and speak to the provider. During a review of Resident 114's most recent Medication Regimen Review (MRR, pharmacist review of the residents' medications) dated 1/2026 and 3/2026, the MRR did not address the tylenol order for Resident 114. During an interview on 5/1/26, at 12:26 PM, the physician stated that the expectation from the facility was that they be notified when the pain medications were ineffective. During a review of the facility Policy and Procedures (P&P) titled, Administering Medications dated 2001, the P&P indicated Medications are administered in a safe and timely manner, and as prescribed.Medications are administered in accordance with prescribed orders including any required (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	time frame.If a dosage believed to be inappropriate or excessive for the resident, or a medication has been identified as having potential adverse consequences for the resident or is suspected of being associated with adverse consequences, the person preparing or administering the medication will contact the prescriber, the resident's attending physician or the facility's medical director to discuss the concerns.The individual administering the medication checks the label. to verify the resident, right medication, right dosage, right time and right method (route) of administration before giving the medications. The following information is checked /verified prior to administering medications: allergies to medications; and vital signs, if necessary.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. Based on observation, interview, and record review, the facility failed to ensure the medication rate did not exceed 5% for 2 of 9 sampled residents (Resident 139 and 199).1. For Resident 139, a Licensed Vocational Nurse (LVN) administered the Resident's Nephro-Vite, a renal-specific multivitamin (vitamin C, B-Complex, & Folic Acid) formulated primarily for individuals with chronic kidney disease, not in accordance with the Physician's Order.2. For Resident 199, the LVN did not administer the Resident's metformin, a medication used to treat high blood sugar levels, as ordered by the physician.3. For Resident 199, the LVN did not administer the Resident's memantine, a medication used to treat memory loss, as ordered by the physician.4. For Resident 199, the LVN administered Resident's metoprolol succinate extended- release, a medication used to treat high blood pressure, after crushing the medication in contradiction to the manufacturer's specification.As a result, 4 errors were identified out of 29 opportunities for error during the observation of medication administration; the facility medication error was 13.79%.1. During an observation of medication administration on 4/27/26 at 9:37 AM, LVN 3 was observed to prepare and administer Resident 139's morning medications which included three-fourths of a 1000 mcg (microgram, unit of measure) folic acid tablet, a component of Nephro Vite.Reconciliation of the observation of medication administration with Resident 139's current Physician Orders indicated an order for Nephro-Vite, dated 3/12/25, give 1 tablet by mouth one time a day.During an interview on 4/27/26 at 2:40 PM with LVN 3, LVN 3 acknowledged that a wrong medication bottle was used. LVN 3 stated she thought the Physician's Order was just for folic acid, and she used the folic acid bottle instead of Nephro-Vite. LVN also stated she had to call the pharmacy to see how she could get the right medication.During an interview on 4/28/26 at 12:17 PM with the Director of Nursing (DON), the DON stated the nurse should have followed the Physician Order and administered the resident's Nephro-Vite as it was prescribed. If the medication was not available for administration, the pharmacy and physician should have been contacted.2. During an observation of medication administration on 4/28/26 at 8:40 AM LVN 2 was observed to prepare and administer Resident 199's morning medications which did not include metformin.Reconciliation of the observation of medication administration with Resident 199's current Physician Orders indicated an order, dated 4/25/26, for metformin 850 mg (milligram, unit of measure), give one tablet by mouth two times a day.A review of Resident 199's Medication Administration Record (MAR) for April 2026 indicated that metformin 850 mg was not administered on 4/28/26.During an interview on 4/28/26 at 8:45 AM with LVN 2, LVN 2 stated metformin 850 mg was not available for administration.During an interview on 4/28/26 at 12:01 PM with the DON, the DON stated the expectation was to have metformin ready in the medication cart at the point of medication administration.3. During an observation of medication administration on 4/28/26 at 8:40 AM LVN 2 was observed to prepare and administer Resident 199's morning medications which did not include memantine.Reconciliation of the observation of medication administration with Resident 199's current Physician Orders indicated an order, dated 4/25/26, for memantine 5 mg, give one tablet by mouth two times a day.A review of Resident 199's Medication Administration Record (MAR) for April 2026 indicated that memantine 5 mg was never administered on 4/28/26.During an interview on 4/28/26 at 8:50 AM with LVN 2, LVN 2 stated memantine 5 mg was not available for administration.During an interview on 4/28/26 at 12:01 PM with the DON, the DON stated the expectation was to have memantine ready in the medication cart at the point of medication administration.4. During an observation of medication administration on 4/28/26 at 8:40 AM, LVN 2 was observed preparing and administering Resident 199's morning medications, which included one half of a metoprolol succinate 25 mg tablet, crushed and mixed with applesauce.Reconciliation of the observation of medication administration with Resident 199's current Physician Orders indicated an order, dated 4/25/26, for metoprolol succinate extended release 24 hours (designed to slowly release medication over 24 hours), 25 mg, 0.5 tablet by mouth in the morning for high blood pressure.During an interview on (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4/28/26 at 8:58 AM with LVN 2, LVN 2 acknowledged that the extended-release formulation of metoprolol should not be crushed. LVN 2 stated the pharmacy label on the medication also said, Do not crush.A review of metoprolol succinate's Prescribing Information (PI), dated 3/2006, the PI indicated, metoprolol succinate extended-release tablets are scored and can be divided; however, the whole or half tablet should be swallowed whole and not chewed or crushed.During an interview on 4/28/26 at 12:05 PM with the DON, the DON stated that metoprolol succinate extended release should not have been crushed. The DON explained that crushing it could make the medication absorb too quickly, causing the resident to get too much of it at once.A review of the facility Policy and Procedures (P&P) titled, Administering Medications, last revised April 2019, the P&P indicated, 4. Medications are administered in accordance with prescriber orders. 10. The individual administering the medication checks the label THREE (3) times to verify the right resident, right medication, right dosage.The director of nursing services supervises and directs all personnel who administer medications.

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. Based on observation, interview, and record review, the facility failed to ensure staff competency when:Two Diet Aides were not competent testing the dishmachine sanitizer;Three staff (one Diet Aide, one Cook, and the Dietary Manager) were not competent in 3-compartment sink procedures including testing the sanitizer strength and length of time for sanitizing items cleaned in the sink; andOne [NAME] was not competent testing the red bucket food contact surface sanitizer The failure to ensure staff competency for 6 out of 27 staff regarding use of the three-compartment sink and sanitizing tasks had the potential to result in contamination of food and/or utensils and equipment leading to illness caused by pathogens (any microorganism that causes disease).Findings:Review of the facility's job summary titled Dietary Supervisor signed on 10/21/2022, showed the Dietary Supervisor was responsible for overseeing the overall operation of the Food Services Department. The supervisor was to manage dietary staff, oversee meal preparation, and ensure compliance with all health and safety regulations. Key responsibilities included but were not limited to: supervising activities of kitchen staff in meal preparation, serving, and clean-up, ensuring that health and safety standards were adhered to; train and mentor kitchen staff on proper food handling, preparation, and dietary regulations and standards. 1A. During a concurrent observation and interview on 4/28/2026 at 10:25 AM with a dietary Aide (DA4), dishes were washed using a low temperature dish machine. DA4 stated, the low temperature dish machine sanitization levels were tested using Chlorine sanitization testing strips. DA4 used a chlorine testing strip provided by the Dietary Manager (DM) and revealed a very slight color change on testing strip. DA4 compared the testing strip to the sanitization chart on the back of the testing strip container and reported the strip showed a 10 parts per million (ppm) Chlorine level. DA4 stated this value was ok.Review of the information plate attached to the dishmachine showed the minimum chlorine required for chemical sanitizing was 50 ppm.Review of the policy and procedure titled Sanitization dated 2001, showed for dish machine chemical sanitization final rinse with 50 ppm chlorine on the dish surface in final rinse. 1B. During a concurrent observation and interview on 4/28/2026 at 11:34 AM with a Dietary Aide (DA2), DA2 was utilized for translation services for another Dietary Aide (DA3), DA3 confirmed he tested the sanitization levels for the dish machine in the morning and documented on the Dishwashing machine Temperature Log. DA3 was asked to demonstrate the sanitization procedure for the dish machine. DA3 ran a dish rack through the dishwasher, at the end of the cycles (wash/rinse) he pulled the dish rack out, and dipped a chlorine sanitizer strip in the standing water on the counter of the clean side of the dish machine. DA3 stated he needed to hold the testing strip in water for 10 seconds.During a concurrent observation and interview on 4/28/2026 at 11:40 AM with DM stated when testing the sanitizer strength of the dish machine, the chlorine test strip had to be touched to the surface of an item in the dish machine after the rinse cycle was complete not dipped in solution for 10 seconds, DM demonstrated testing of the dish machine sanitizer. DM ran a dish rack with a pan through the dish machine; at the end of the cycles (wash/rinse) he pulled the dish rack out. DM placed a chlorine testing strip to the surface of a pan in the dish rack. DM confirmed kitchen staff should not dip the chlorine testing strip in standing water on the counter outside of the dish machine to test the strength of the dish machine sanitizer. Review of the directions on the Chlorine Test Paper container showed to dip and remove quickly.Review of the policy and procedure titled Sanitization dated 2001, showed for dish machine chemical sanitization final rinse with 50 ppm chlorine on the dish surface in final rinse. 2A. During a concurrent observation and interview on 4/28/2026 at 11:42 AM with a Dietary Aide (DA1), DA 1 sanitized various dishes and pans in the three-compartment sink for manual dishwashing with a quaternary ammonia (Quat) solution. DA 1 submerged dishes and pans in the third compartment of the 3-compartment sink. DA1 stated items being manually sanitized using the three-compartment sink had to be submerged in the sanitizer solution for 10 seconds.During a concurrent interview and record (continued on next page)

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	review on 4/28/2026 at 12:02 PM with DM, Oasis 146 Multi- Quat Sanitizer was reviewed. The manufacture guidelines indicated, .TO SANITIZE FOOD CONTACT SURFACES.Expose all surfaces to the sanitizing solution for a period of no less than 1 minute .at 150-400 ppm active quat. Although the DM stated, items only needed to be submerged in sanitizer solution for 20- 30 seconds and did not realize the Quat manufacturer instructions showed one minute Review of the policy and procedure titled Sanitization dated 2001, showed for the three step manual dishwashing procedure, when sanitizing with a chemical solution such as Quat, the chemical is used according to manufacturer's instructions. 2B. During a concurrent observation and interview on 4/28/2026 at 11:45 AM with a Dietary Aide (DA4), a demonstration for testing the sanitizer solution strength in the three-compartment sink was observed. DA4 dipped the sanitizer testing strip into the sanitizer solution and held the strip in the solution for four seconds. When asked how long he should hold the sanitizer testing strip in the sanitizer solution, DA4 stated 10 seconds. When asked to re-test the sanitizer levels with a new testing strip and holding in the sanitizer solution for a full 10 seconds, he held the new strip for only seven seconds.Review of the Quat sanitizer titled test strip container titled Qt-40 showed to dip the test strip in the sanitizer solution for 10 seconds. 3.During a concurrent observation and interview on 4/28/2026 at 1:38 PM with a Dietary Aide (DA 5), a red bucket filled with a Quat sanitizer solution was under a counter near the rear wall of the kitchen. A rag was in the bucket. The DM was used to provide translation services for DA 5 (a Spanish speaking employee). DA 5 stated she changes the solution in the red buckets every day, at the beginning of the shift, and when needed. DA 5 re-tested the solution in the red bucket by dipping a sanitizer testing strip into the solution and removed the strip after several seconds. When asked how long the testing strip should remain in the solution, DA 5 stated, five seconds. DM stated the testing strip was not held in the solution long enough to accurately test sanitizer solution strength. Review of the Quat sanitizer test strip container showed to dip the test strip in the sanitizer solution for 10 seconds.

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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. Based on observation, interview, and record review the facility failed to follow the planned menu when incorrect serving sizes were given to residents on pureed diets. This failure had the potential to result in inadequate and/or inappropriate calories and nutrients served to residents leading to nutrient related medical complications for 20 residents who received pureed food from the kitchen. Findings: During an observation and interview on 4/27/2026 at 11:31 AM., the Dietary Manager (DM) provided a document titled Diet Spreadsheet, when he was asked for a copy of the spreadsheet used for trayline food service to indicate foods and serving sizes to serve for different prescribed diets. During an observation on 4/27/2026 at 11:45 AM, the kitchen staff prepared the trayline (an assembly line for food service) for the resident's lunch. The trayline included regular, pureed, standing and alternate meal selections, and therapeutic modified foods. As food was being plated by a Dietary [NAME] (Cook 3), Pureed (modified to a smooth consistency and holds its shape on a spoon) broccoli and Tater tot casserole was placed on ceramic plates using a number 16 scoop (2 oz; 1/4 c) for each dish. [NAME] 3 also placed a portion of pureed bread (Texas toast) on each plate using a number 6 scoop (5.3 oz; 3/4 c), after reviewing each diet listed on the tray cards (traycards listed the name of the prescribed diet, food preferences, and food allergies). [NAME] 3 verified food being plated with the scoops were for the modified diets such as pureed and minced and moist (soft, finely chopped food that is easy to mash with a tongue or fork and requires very little chewing) diets. During a concurrent observation and interview on 4/27/2026 at 1:11 PM with the DM and Registered Dietician (RD), a photo of the serving utensils (scoops) used during trayline was shown. The DM stated all serving sizes and menu selections needed to match the Diet Spreadsheet during trayline. The spreadsheet was reviewed with the DM and RD, the DM then confirmed pureed serving sizes were incorrect. According to the diet spreadsheet the pureed Tater tot casserole should have been a number 6 scoop (5.3 oz; 3/4 c), and the pureed broccoli and bread should have been a number 12 scoops (2 2/3 oz; 1/3 c). The DM verified the serving sizes did not match the spreadsheet and were incorrect serving sizes given. During a review of the Diet Spreadsheet dated, Monday Day 16, the spreadsheet indicated food items and respective serving sizes for the Regular and therapeutic diets. The spreadsheet showed pureed diets received a number 6 scoop (5.3 oz) of Tater tot casserole (a number 16 scoop [2 oz] was served),a number 12 scoop (2 2/3 oz) of broccoli florets (a number 16 scoop [2 oz] was served), and a number 12 scoop (2 2/3 oz) of Texas toast (a number 6 scoop [5.3 oz] was served).

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observation, interview, and record review, the facility failed to serve food at a palatable temperature. This failure had the potential for decreased food intake leading to nutrient related complications for 5 residents who received Chicken Noodle Soup from the kitchen. Findings:During an observation on 4/27/2026 at 11:45 AM, multiple individual plastic bowls with plastic lids on top were stored on a metal cart at room temperature prior to being placed on the resident trays.During a concurrent observation and interview on 4/27/2026 at 1:11 PM with the Dietary Manager (DM) and Registered Dietitian (RD), a test tray (the purpose of a test tray audit is to evaluate the quality of a meal during meal service) was conducted immediately after the last lunch tray was served to residents. Pureed and regular foods were tested. The food temperatures were measured with a calibrated (has been adjusted, checked, or marked to ensure it is accurate and matches a known standard) thermometer and the chicken noodle soup was 98 degrees F and did not feel warm in mouth when tested. During the test tray assessment and interviews with the DM and Medical Records Director (MR) on 4/27/2026 at 1:16 PM, the DM stated, the soup was just warm after tasting and MR stated he would want the soup to be warmer following his tasting. During a review of the facility's policy and procedure titled, In- Room Dining, (undated), indicated, .Meals served in rooms may be periodically checked at the point of service for palatable food temperatures. Food temperatures of hot foods on room trays at the point of service are preferred to be at 120 degrees F or greater to promote palatability for the resident.

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. Based on observation, interview, and record review, the facility failed to ensure Gradual Dose Reductions (GDRs) were attempted for psychotropic medications (a group of drugs prescribed to affect the mind, emotions or behavior) for one of 5 sampled residents when Resident 9 continued to receive olanzapine (a type of psychotropic medication indicated for psychosis) and trazodone (a psychotropic medication used to promote sleep) without documented clinical contraindications to not attempting any GDRs. This failure resulted in the potential for unnecessary medication use and avoidable adverse effects.Clinical record review indicated Resident 9 was initially admitted to the facility from the acute care hospital in February 2025.Resident 9's admission diagnoses included schizophrenia, a mental health condition that affects a person's connection to reality, including how they think, feel, and behave.A review of Resident 9's acute hospital transfer documents, dated 2/10/25, indicated a Physician's Order for olanzapine 15 mg (milligram-unit of measure) at bedtime for mood disorder manifested by constant yelling and/or screaming and a Physician's Order for trazodone 50 mg at bedtime for insomnia (having trouble sleeping) manifested by an inability to sleep.A review of Resident 9's monthly Medication Administration Records (MAR) indicated that Resident 9 was receiving 15 mg of olanzapine and 50 mg of trazodone every night since he was admitted to the facility over a year ago.A review of Resident 9's monthly behavioral monitoring records from the beginning of August 2025 through the end of April 2026 indicated that Resident 9 exhibited no signs or symptoms of psychosis. Specifically, there were no documented observations of hallucinations (sensory perceptions of stimuli not actually present), delusions (fixed impressions or beliefs not grounded in reality), or verbal or physical behavioral symptoms directed toward others. During the same review period, documentation noted that Resident 9 demonstrated an inability to sleep on seven occasions out of approximately 270 documented nights.A review of Resident 9's psychiatry appointment chart note, dated 5/14/25, stated, [Resident] has trouble maintaining his attention, nearly falls asleep while I'm trying to talk to him.his behavior is not a problem.A review of trazodone's Prescribing Information (PI), dated 1/2014, indicated that the most common adverse reactions include somnolence/sedation, with somnolence referring to a state of drowsiness or heightened sleepiness, and sedation referring to a calming effect that reduces alertness and slows cognitive or physical activity.A review of olanzapine's PI, updated 3/2026, indicated that somnolence was among the most common adverse reactions observed. A review of Resident 9's psychiatry appointment chart note, dated 7/3/25 also indicated that the resident did not have behavioral problems.A review of Resident 9's psychology note, dated 3/23/26, indicated that Resident 9 did not exhibit anxiety, irritability, agitation, or anger. In addition, the report stated: The following concerns are noted regarding the patient's current psychotropic regimen in the context of the patient's age and medical comorbidities and are offered for the treatment team's and/or prescribing provider's consideration: Use of olanzapine in a patient of advanced age with documented cardiac [heart-related] and vascular [blood vessels] history warrants careful consideration. Olanzapine carries a black box warning [most serious alert on medication labels] for increased mortality in elderly patients with dementia related [memory and thinking skills] behavioral disturbance. Additionally, olanzapine is associated with QTc prolongation [irregular heartbeat], orthostatic hypotension [standing dizziness], and significant metabolic effects, including weight gain and hyperglycemia [elevated blood sugar], which are of particular concern given the patient's diagnosis of T2DM [a chronic condition where the body cannot properly use sugar] and renal [kidney] disease. Of further note, olanzapine has the potential to lower seizure threshold [the level at which the brain becomes overwhelmed enough to have a seizure], which is clinically significant given the patient's seizure disorder. Recommend the prescribing provider review the risk benefit profile and consider whether a lower risk alternative or dose reduction is appropriate.A review of Resident 9's (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interdisciplinary Team (IDT) meeting notes dated 2/11/25, 5/5/25, 7/23/25, 8/10/25, 10/24/25, 1/28/26, and 4/29/26 showed no documentation of behavioral concerns, sleep disturbances, or other symptoms that would contraindicate a GDR of psychotropic medications.During an interview on 4/30/26 at 9 AM with the Director of Nursing (DON), the DON stated that according to the facility's monitoring records, the resident did not have any documented inability to sleep, meaning the resident could easily fall asleep, during the past three months-February, March, and April. In addition, the DON stated that during the same review period, facility records indicated the resident did not exhibit any behaviors.During an interview on 4/30/26 at 5:30 PM with the DON, the DON acknowledged that according to the seven quarterly IDT meeting notes, GDR was not performed for Resident 9.During an interview on 4/30/26 at 11:10 AM with Licensed Vocational Nurse (LVN) 9, LVN 9 stated that she had cared for Resident 9 for over a year and had never observed the resident to be agitated. LVN 9 also stated that she did not believe Resident 9 had any issues with sleeping.During an interview on 4/30/26 at 11:15 AM with Certified Nursing Assistant (CNA) 9, CNA 9 stated that she had never observed the resident to be combative or to pose a threat to himself or other residents. CNA 9 further stated that the resident had never complained of an inability to sleep.A review of the facility's Consultant Pharmacist (CP) recommendation regarding the GDR for trazodone, dated 9/9/25, indicated that the physician did not evaluate or address the CP's recommendations. The documentation showed that only the CP's pre-populated option to deny the GDR was selected, using the standard language provided by the CP, without any individualized assessment. There was no evidence that the physician provided a clinical contraindication, resident-specific justification, or any rationale explaining why the GDR was contraindicated for Resident 9.A review of the facility's CP recommendation regarding the GDR for olanzapine, dated 9/9/25, indicated that the physician denied the GDR request. The record reflected no physician documented consideration of risks, benefits, or clinical factors unique to the resident.A review of the facility Policy and Procedures (P&P) titled, Psychotropic Medication Use, dated 2001, the P&P indicated, Psychotropic medication may be considered appropriate when: a. a resident's behavioral symptoms present a danger to the resident or others; b. a resident is exhibiting indications of distress that are significant to the resident; d. gradual dose reduction was attempted, but clinical symptoms returned.

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the Minimum Data Set (MDS - a resident assessment tool) was completed for one of 34 sampled residents (Resident 194) after readmission.This failure had the potential for Resident 194 not to receive appropriate treatment and services.Resident 194 was readmitted on [DATE] with diagnoses that included aphasia (a neurological disorder caused by brain damage that impairs a person's ability to communicate, affecting speech, writing, and comprehension of language), hemiplegia (a severe or complete paralysis of one side of the body) and hemiparesis (weakness, numbness, or reduced motor function on one side of the body), hypertension (high blood pressure), and contracture (permanent tightening of the muscles, tendons, skin, and nearby tissues that causes the joints to shorten and become very stiff).During an observation on 4/27/2026 at 10:45 AM, Resident 194 was sleeping in bed with blanket covering resident, receiving tube feeding (provide nutrients directly into the stomach to people who cannot obtain nutrition by mouth, are unable to swallow safely, or need nutritional supplementation), with a small, white, rolled washcloth placed on contracted left hand. By the wall outside of Resident 194's room was a signage that read Enhanced Barrier Precautions (EBP - an infection control intervention designed to reduce the spread of multi-drug-resistant organisms [MDROs] in nursing homes by requiring staff to wear gowns and gloves during high-contact resident care).During a concurrent observation and interview on 4/29/26 at 1:50 PM with Certified Nursing Assistant (CNA) 2, Resident 194 had contractures on both hands and lower extremities, and had long, thick yellowish toenails. CNA 2 concurred with the observations and stated, That's for podiatry (toenails).During a concurrent interview and record review on 4/30/2026 at 1:59 PM with MDS Coordinator (MC) 2, Resident 194's MDS assessments were reviewed. Per MC 2, Resident 194 was readmitted to the facility on [DATE], and the last MDS completed was on 3/8/26, day she left for hospital leave. MC 2 confirmed that MDS was not initiated for Resident 194's re-entry that should be completed within 14 days of readmission. MC 2 stated, That's on 4/28/26. It was missed. It should be done timely.During an interview on 5/01/2026 at 3:04 PM with the Director of Nursing (DON), the DON stated, MDS accurately reflects the clinical situation of the patient and the services we are providing. It is an honest picture of the resident's condition.Review of facility policy titled Accuracy of the Resident Assessment, revised November 2019, indicated, .3. The information captured on the assessment reflects the status of the resident during the observation (look-back) period for that assessment.4. The Resident Assessment Coordinator is responsible for ensuring that an MDS assessment has been completed for each resident. Each assessment is coordinated and certified as complete by the Resident Assessment Coordinator, who is a registered nurse.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure the Minimum Data Set (MDS, a standard resident assessment tool) was accurately completed to reflect two of 34 sampled residents' (Resident 200 and Resident 10) skin condition when:1. Resident 200's Skin Conditions in the MDS was incorrectly coded as having no pressure injury (localized, pressure-related damage to the skin and/or underlying tissue usually over a bony prominence), and2. Resident 10's Skin Conditions in the MDS was coded as having stage 4 pressure injury instead of a surgical wound.This failure resulted in inaccurate data transmitted to the Center for Medicare and Medicaid Services (CMS, a federal agency that administers the nation's major healthcare programs such as Medicare and Medicaid) system for quality measure and billing and had the potential for residents not to receive appropriate treatment and services.1. Resident 200 was admitted on [DATE] with diagnoses that included rhabdomyolysis (a rare muscle injury where the muscles break down), weakness, and severe malnutrition (a condition where the body does not get the right amount of nutrients needed to function properly).During a concurrent observation and interview on 4/28/26 at 11:08 AM, Wound Care Nurse (WCN) 1 and WCN 2 performed wound treatment on Resident 200's sacral area (also known as sacrum, the area immediately above the tailbone area). WCN 1 stated Resident 200 was admitted with an unstageable pressure injury (a wound where the base is completely obscured by dead tissue, making it impossible to determine its true depth and severity).During a concurrent interview and record review on 4/30/26 at 11:27 AM with MDS Coordinator (MC) 1, Resident 200's Nursing-Comprehensive Skin Evaluation/Assessment (Skin Assessment), dated 4/17/26 at 3:45 PM was reviewed. Resident 200's Skin Assessment indicated the presence of an unstageable pressure injury on the sacrum. Resident 200's MDS Assessment, dated 4/18/26, was also reviewed. The Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage section of the MDS was coded as Resident 200 having 0 (zero) pressure injury. MC 1 stated, It was not coded correctly. It should have been coded as having one unstageable (pressure injury). MC 1 stated that the importance of coding the MDS accurately is to get the real picture of the patient (resident) and to do the correct care plan that is needed for the patient. 2. Resident 10 was admitted on [DATE] with diagnoses that included unstageable pressure injury.During a concurrent interview and record review on 4/30/26 at 10:04 AM with WCN 1 and WCN 2, Resident 10's Skin Assessment, dated 2/5/26 at 4:28 PM was reviewed. Resident 10's Skin Assessment indicated the presence of a Surgical Incision (an intentional cut made through the skin, muscle, and tissues by a surgeon during a medical procedure) in the sacrum. WCN 2 stated Resident 10 was admitted with a pressure injury and was surgically repaired by the vascular surgeon (a doctor who did a specialized surgical training program in the diagnosis and treatment of diseases of arteries and veins) in January 2026. WCN 2 added, It is now considered a surgical wound.Review of the Physician Assistant's Progress Note (PANP), dated 2/2/26 at 8:15 AM, indicated Resident 10 had a wound closure procedure on 1/29/26. The PANP indicated Resident 10 had a surgical wound in the sacrum.During a concurrent interview and record review on 04/30/26 at 1:50 PM with MC 1, Resident 10's Skin Conditions in the MDS, dated [DATE], was reviewed. Resident 10's Skin Conditions was coded as having stage 4 pressure injury (involves complete tissue loss with exposure of muscle, tendon, or bone) instead of surgical wound. MC 1 stated, It should not be coded as stage 4, should have been coded as surgical wound. MC 1 also stated that the MDS nurse's responsibility is to make sure they code it (resident's clinical condition in the MDS) correctly . to accurately reflect the status of the patient during the assessment.During an interview on 5/1/26 at 2:59 PM, the Director of Nursing (DON) stated, The MDS should match the assessments and evaluation provided by nursing. The DON stated further, MDS is one of the things reimbursements is based on, we want to accurately capture the resident's clinical condition and make sure correct treatment is provided to address the (resident's) clinical condition.Review of the facility policy, titled Accuracy of the Resident (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assessment, last revised on 11/2019 indicated Policy Interpretation and Implementation. 2. Any person who completes any portion of the MDS assessment, tracking form, or correction request form is required to sign the assessment certifying the accuracy of that portion of that assessment.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to coordinate Pre-admission Screening and Record Review (PASRR) for one of seven sampled residents (Resident 97) with a diagnosis of psychotic disorder (severe mental illness that cause individuals to lose touch with reality, characterized by hallucinations [false perceptions] and delusions [false beliefs]).This deficient practice could potentially result in Resident 97 not receiving specialized care and services appropriate for her condition.According to medicaid.gov, Preadmission Screening and Resident Review (PASRR) is a federal requirement to help ensure that individuals are not inappropriately placed in nursing homes for long term care. PASRR requires that 1) all applicants to a Medicaid-certified nursing facility be evaluated for serious mental illness (SMI) and/or intellectual disability (ID); 2) be offered the most appropriate setting for their needs (in the community, a nursing facility, or acute care settings); and 3) receive the services they need in those settings.Review of Resident 97's Face Sheet indicated, Resident 97 was admitted on [DATE] with diagnoses that included vascular dementia (a progressive decline in thinking skills caused by conditions that block or reduce blood flow to the brain, depriving it of oxygen and nutrients) and urinary retention (the inability to fully or partially empty the bladder, causing urine to remain in the bladder even when one feels the need to urinate). The face sheet also indicated a diagnosis of psychotic disorder with delusions due to known physiological condition with an onset date of 3/12/25, during Resident 97's stay in the facility.During an observation on 4/30/26 at 11:49 AM, Resident 97 was sitting in her wheelchair by the door, telling another resident who was standing in the hallway to move to another area.During an interview on 4/30/26 at 10:15 AM with Certified Nursing Assistant (CNA) 5, CNA 5 stated, Resident 97 is alert but confused at times. When Resident 97 gets agitated, she tries to scratch or bite staff and other residents if they are in the hallway.During record review of Resident 97's electronic health record (EHR) on 4/30/26 at 8:57 AM, the Medication Administration Record (MAR) for April 2026 was reviewed. The MAR indicated, .Seroquel Oral Tablet 25 MG (milligram) (Quetiapine Fumarate - antipsychotic medication) Give 1.5 tablet by mouth one time a day for paranoid delusions m/b (manifested by) ppl (people) following/trying to hurt her.START: 8/27/25. Quetiapine Fumarate Oral Tablet 100 MG.Give 1 tablet by mouth at bedtime for paranoid delusions m/b ppl following/trying to hurt her.START: 3/6/25. Behavior Monitoring - Antipsychotic: Document Number of Episodes per shift of target behavior [Quetiapine] 1.paranoid delusions m/b ppl following/trying to hurt her every shift.Review of Resident 97's Minimum Data Set (MDS - an assessment tool) dated 9/15/25 indicated, Section A-Type of Assessment: Annual Assessment.Section I-Active Diagnoses: Psychiatric/Mood Disorder: Psychotic Disorder.Section N-Medications: Antipsychotic Medication Review: Antipsychotics were received on a routine basis only.Review of Resident 97's MDS dated [DATE] indicated, Section A-Type of Assessment: Quarterly review assessment.Section I-Active Diagnoses: Psychiatric/Mood Disorder: Psychotic Disorder.Section N-Medications: Antipsychotic Medication Review: Antipsychotics were received on a routine basis only.During a concurrent interview and record review on 4/29/2026 at 12:49 PM with Admissions Director (AD), Resident 97's PASRR was reviewed. The AD confirmed that the clinical record indicated one PASRR Level I Screening Document, DHCS Form 6170 for Resident 97 was completed on 9/5/24 by the acute care hospital (initial admission date). AD stated Resident 97 had an initial diagnosis of dementia and was later diagnosed with psychotic disorder with delusions on 4/17/25. AD stated the PASRR is completed on admission, a change of condition or medical diagnosis, and if resident is placed on psychotropic medications. AD further stated, PASRR is completed to see if the facility can manage resident behavior, and that residents are in an appropriate setting with the mental health diagnoses that they have. AD acknowledged that there was no PASRR reassessment for Resident 97 and stated, We (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	should have created a new screening for the new diagnosis (psychotic disorder) and psychotropics as well. I don't see that we have a new one.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide a written summary of the baseline care plan (BCP, an interim written plan implemented within 48 hours of admission that details the resident's immediate health and safety needs) to two of seven sampled residents (Resident 198 and Resident 197) or their representative.This failure could leave residents or their representatives not fully informed of the treatment plan and unable to participate in their care, putting them at risk for errors or unmet needs. 1. Resident 198 was admitted on [DATE] with diagnoses that included urinary tract infection (an infection in the bladder/urinary tract) and Alzheimer's disease (a disease characterized by a progressive decline in mental abilities).During a concurrent observation and interview on 4/27/26 at 10:53 AM with Resident 198's Representative (RR) 1 and RR 2, RR 1 was talking to RR 2 on speakerphone. When asked if they received a written summary of Resident 198's BCP, RR 2 stated, No, nothing was given to me. RR 2 then asked RR 1 if they had received a copy of the BCP. RR 1 stated, No, and shook her head.During a concurrent interview and record review on 5/1/26 at 9:37 AM with Licensed Vocational Nurse (LVN) 2, Resident 198's BCP, dated 4/23/26 was reviewed. The sections indicating whether Resident and/or Resident Representative (RR) participated in the Baseline Care Plan review with a printed/written summary provided and to whom, the date, and the method the BCP was provided were left blank. LVN 2 also reviewed Resident 198's Progress Notes, dated 4/23/26 to 4/25/26 and found no documentation that a written summary of the BCP was given to Resident 198 or their RR.During an interview on 5/1/26 at 11:03 AM, LVN 2 stated, I don't have any documentation or notes that the team has given (Resident 198) a copy of the baseline care plan. 2. Resident 197 was admitted on [DATE] with diagnoses that included spinal stenosis (a narrowing of the spaces within the spine).Review of Resident 197's Minimum Data Set (MDS, a resident assessment tool), dated 4/29/26 indicated Resident 197 is cognitively intact (indicates normal brain functions, and there are no signs of confusion, memory loss or impaired judgment).During an interview on 5/1/26 at 9:30 AM, Resident 197 stated, I make decisions for myself. Resident 197 also stated, No, I did not receive a copy of the BCP.During a concurrent interview and record review on 5/1/26 at 9:52 AM with the LVN 2, Resident 197's BCP, dated 4/20/26 was reviewed. The sections indicating whether Resident and/or Resident Representative (RR) participated in the Baseline Care Plan review with a printed/written summary provided and to whom, the date, and the method the BCP was provided were left blank. LVN 2 also reviewed Resident 197's Progress Notes, dated 4/19/26 to 4/21/26 and found no documentation that a written summary of the BCP was provided to Resident 197.During an interview on 5/1/26 at 11:09 AM, LVN 2 stated, Copy (of the BCP) was not given to Resident 197. LVN 2 added that providing a written copy is important, so that we can clarify and have a clear path of the plan of care. That there is understanding of the plan of care and acknowledgment that they understood what was discussed with them.During an interview on 5/1/26 at 3:03 PM, the Director of Nursing (DON) stated giving residents and/or their representative a written BCP summary allows the patient (resident) and their RP (responsible person or RR) to have a chance to review our assessment and understanding of their clinical situation, plan of care, and reason for admission. The DON stated further, It allows patients to know what to expect, how to proceed with plan of care. It's also an opportunity to correct misunderstandings from incorrect information from the hospital. The DON also stated that facility policy requires documenting whether the BCP summary was provided and that there is a section in the BCP to indicate this.Review of the facility policy, titled Care Plans - Baseline, dated 2001 indicated Policy Statement - A baseline plan of care to meet the resident's immediate health and safety needs is developed for each resident within forty-eight (48) hours of admission. Policy Interpretation and Implementation 1. The baseline care plan includes instructions needed to provide effective, person-centered care of the resident that meet professional standards of (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	quality care and must include the minimum health care information necessary to properly care for the resident including, but not limited to the following: a. Initial goals based on admission orders and discussion with the resident/representative.4. The resident and/or representative are provided a written summary of the baseline care plan (in a language that the resident/representative can understand) that includes, but is not limited to the following: a. The stated goals and objectives of the resident; b. A summary of the resident's medications and dietary instructions; c. Any services and treatments to be administered by the facility and personnel acting on behalf of the facility; and d. Any updated information based on the details of the comprehensive care plan, as necessary. 5. Provision of the summary to the resident and/or resident representative is documented in the medical record.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observation, interview, and record review, the facility failed to maintain a safe resident environment for a census of 173 residents when Resident 147's Over The Counter (OTC) medications were left unsecured in an area accessible to other residents. This failure exposed residents to the risk of accidental ingestion and avoidable harm.During an observation of Resident 147's room on 4/28/26 at 9:46 AM, three bottles of OTC medications were observed on the resident's bedside table, which included folic acid (a synthetic form of vitamin B9), zinc (a mineral that supports immune health), and men's multivitamin (a combination of different vitamins and minerals in one pill). These medications were unsecured and accessible to other residents.During an interview on 4/28/26 at 12:05 PM with the Director of Nursing (DON), the DON stated that the resident had a habit of buying many OTC medications and supplements, and the facility treated them as the resident's personal belongings.During an observation of Resident 147's room on 4/28/26 at 12:10 PM, the DON entered the resident's room and confirmed that OTC medications were accessible near the resident's bed while the resident was asleep and not using them.During an interview on 4/28/26 at 12:11 PM with Licensed Vocational Nurse (LVN) 5, LVN 5 stated that the resident's OTC medications in the room were not used for the resident's daily medication administration and only the medication cart was used to supply his OTC medications.During another observation on 5/1/26 at 10:34 AM in Resident 147's room, the three bottles of OTC medications were still accessible to other residents and remained unsecured. A review of the facility Policy and Procedures (P&P) titled, Hazardous Areas, Devices and Equipment, dated 2001, the P&P indicated, All hazardous areas, devices, and equipment in the facility will be identified and addressed appropriately to ensure resident safety and mitigate accident hazards to the extent possible. A hazard is defined as anything in the environment that has the potential to cause injury or illness. Once identified, the safety committee will document recommendations for areas and equipment that can be changed or adopted to lessen the potential for accidents, such as hazardous areas that are not adequately secured or supervised.interventions will address the specific hazards identified, and may be facility-specific or resident-specific. Resident-specific interventions may include changes to the plan of care and/or increased supervision. Hazardous areas in the facility that cannot be eliminated, adapted or corrected will be marked clearly and identified on floor plans posted throughout the facility.A review of the facility P&P titled, Medication Labeling and Storage, dated 2001, the P&P indicated, The facility stores all medications and biologicals in locked compartments under proper temperature, humidity and light controls. Only authorized personnel have access to keys.

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City View Post Acute	1359 Pine Street San Francisco, CA 94109

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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 pharmacy services were maintained for a census of 173 residents when non-controlled medications (medications with less risk of addiction and harm) were disposed of in a sharps container (a hard, puncture resistant box used to safely throw away items that can cut or poke someone, such as needles and syringes), which resulted in the improper disposal of medications.During an inspection of medication cart 3A on 4/27/26 at 9:43 AM, Licensed Vocational Nurse (LVN) 6 was observed finding and placing two unidentified loose pills in the sharps container which was on the side of the medication cart.During an interview on 4/27/26 at 9:43 AM with the Nursing Unit Manager (NUM), the NUM stated that staff should have checked and properly dispose of unidentified loose tablets to reduce the risk of medication errors and drug diversion.During an interview on 4/29/26 at 10:58 AM with the Director of Nursing (DON), the DON stated that unidentified loose pills should not have been disposed of in the sharps container. The staff should have used the designated pharmaceutical bins to dispose of the loose pills.A review of the facility Policy and Procedures (P&P) titled, Discarding and Destroying Medications, last revised October 2014, the P&P indicated, Both controlled and Non-controlled substances may be disposed of in the collection receptacle.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. Based on interview and record review, the facility failed to ensure the Consultant Pharmacist (CP) identified, recommended, and followed up on necessary medication regimen changes for one of 5 sampled residents (Resident 9) when the facility did not address the need for a Gradual Dose Reduction (GDR) of olanzapine (a type of psychotropic medication indicated for psychosis) and trazodone (a psychotropic medication used to promote sleep) for Resident 9This failure resulted in Resident 9 receiving psychotropic medications (a group of drugs prescribed to affect the mind, emotions, or behavior) for over 14 months.Clinical record review indicated Resident 9 was initially admitted to the facility from the acute care hospital in February 2025.A review of Resident 9's acute hospital transfer documents, dated 2/10/25, indicated a Physician's Order for olanzapine 15 mg (milligram-unit of measure) at bedtime for mood disorder manifested by constant yelling and/or screaming and a Physician's Order for trazodone 50 mg at bedtime for insomnia (having trouble sleeping) manifested by an inability to sleep.A review of Resident 9's monthly Medication Administration Records (MAR) indicated that Resident 9 was receiving 15 mg of olanzapine and 50 mg of trazodone every night since he was admitted to the facility over a year ago.A review of the facility's Consultant Pharmacist (CP) recommendation regarding the GDR for trazodone, dated 9/9/25, indicated that the physician did not evaluate or address the CP's recommendations. The documentation showed that only the CP's pre-populated option to deny the GDR was selected, using the standard language provided by the CP, without any individualized assessment. There was no evidence that the physician provided a clinical contraindication, resident-specific justification, or any rationale explaining why the GDR was contraindicated for Resident 9.A review of the facility's CP recommendation regarding the GDR for olanzapine, dated 9/9/25, indicated that the physician denied the GDR request. The record reflected no physician documented consideration of risks, benefits, or clinical factors unique to the resident.During an interview on 4/30/26 at 11:45 AM with the CP, the CP stated that she had reviewed resident charts at the facility over the past three months and had not made any recommendations for Resident 9. The CP reported that, for Resident 9, she did not identify any significant concerns based on the Interdisciplinary Team (IDT) meetings. The CP further stated that the number of hours of sleep was not documented for resident 9.A review of trazodone's Prescribing Information (PI), dated 1/2014, indicated that the most common adverse reactions include somnolence/sedation, with somnolence referring to a state of drowsiness or heightened sleepiness, and sedation referring to a calming effect that reduces alertness and slows cognitive or physical activity.A review of olanzapine's PI, updated 3/2026, indicated that somnolence was among the most common adverse reactions observed.A review of Resident 9's Interdisciplinary Team (IDT) meeting notes dated 2/11/25, 5/5/25, 7/23/25, 8/10/25, 10/24/25, 1/28/26, and 4/29/26 showed no documentation of behavioral concerns, sleep disturbances, or other symptoms that would contraindicate a GDR of psychotropic medications.A review of the facility Policy and Procedures (P&P) titled, Psychotropic Medication Use, dated 2001, the P&P indicated, Residents on psychotropic medication receive gradual dose reductions (coupled with non-pharmacological interventions), unless clinically contraindicated, to determine whether the continued use of the medication is benefiting the resident, to find an optimal dose, or in an effort to discontinue the medication.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, and record review, the facility failed to ensure medications were stored according to the manufacturers' specifications for a census of 173, when:1. A bottle of brimonidine eye drops, an eye medication used to treat high pressure inside the eye, was stored in the medication refrigerator, which had the potential to result in medication degradation and reduce efficacy.2. An expired vial of insulin glargine, a medication used to lower blood sugar levels, was available for use in the medication cart which put Resident 12 at risk of receiving expired and ineffective medication. 1. During an inspection of the medication room on the third floor on 4/27/26 at 9:49 AM, a 10 ml (milliliter, unit of measure) vial of brimonidine 0.1% (percentage, unit of measure) eye drops was observed stored in the medication refrigerator at 38 degrees F (Fahrenheit, unit of measure).During an interview on 4/27/26 at 9:50 AM with the Nursing Unit Manager (NUM), the NUM stated that the eye drops should have been stored at room temperature. Furthermore, the NUM stated that according to the manufacturer printed storage instructions on the outside of the box, the label indicated store between 68 to 77 degrees F.During an interview on 4/28/26 at 11:48 AM with the Director of Nursing, the DON stated that cold temperature could denature the medication. The eye drops needed to be discarded, and the pharmacy needed to be notified.A review of the facility Policy and Procedures (P&P) titled, Medication Labeling and Storage, dated 2001, the P&P indicated, The facility stores all medications and biologicals in locked compartments under proper temperature, humidity and light controls.2. During an inspection of medication cart Mod #1 on the second floor on 4/27/26 at 11 AM, a 10 ml vial of insulin glargine was observed to have been previously opened on 3/25/26 with an expiration date of 4/22/26.During an interview on 4/28/26 at 11:51 AM with the DON, the DON stated that the expired insulin glargine should have been removed from the medication cart, since expired medications may not be effective. The DON further stated that the expectation was to check expiration dates at the beginning of each shift and remove the expired medications.A review of glargine's Prescribing Information (PI), dated 5/2019, the PI indicated, used vials should be thrown away after 28 days, even if it still has insulin left in it.A review of the facility P&P titled, Medication Labeling and Storage, dated 2001, the P&P indicated, If the facility has discontinued, outdated or deteriorated medications or biologicals, the dispensing pharmacy is contacted for instructions regarding returning or destroying these items.

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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 facility document review, the facility failed to provide: An entree of similar nutritive value to one resident (Resident 111) who chose not to eat the entree listed on the planned menu. The failure to provide substitute food of similar nutritive value to the food on the planned menu had the potential for a resident to receive inadequate nutrients.Meals that reflected Resident 150's preferences and failed to ensure adequate nutritional intake to reduce the resident's dependence on enteral feedings for one of one sampled residents (Resident 150). This failure resulted in ongoing inadequate meal consumption and repeated meal refusals, placing Resident 150 at risk for unintentional weight loss, nutritional decline, and continued reliance on tube feeding.1. Review of the Diet Spreadsheet Menu: [facility name] Fall/Winter Menu dated 2025/2026 Week 3 and used for lunch 4/27/26, showed a Regular textured, Consistent Carbohydrate diet (a diet typically prescribed to regulate blood sugar), received 1 square (3 inches by 2.5 inches) of Tater Tot Casserole. During an observation of trayline food service in the kitchen on 4/27/26 at 12:13 p.m., food was placed on a tray for Resident 111. The tray ticket on the tray for Resident 111 showed she was on a Regular, Consistent Carbohydrate, No Added Salt diet. The tray ticket also showed Resident 111 had a standing order for a grilled cheese sandwich as her entrée. During an interview on 4/27/26 at 12:16 p.m., [NAME] 1 confirmed she made the grilled cheese sandwich served to Resident 111. [NAME] 1 stated she used two slices of cheese to make the sandwich. [NAME] 1 showed the package of cheese she used. During a concurrent observation on 4/27/26 at 12:16 p.m., the nutrition facts on the package of cheese labeled [Brand name] Pasteurized Process American Cheese used by [NAME] 1 for Resident 111's grilled cheese sandwich showed the cheese contained three grams of protein for one slice of cheese. During an interview on 4/28/26 at 10:30 a.m., DM stated he did not know the amount of protein in the grilled cheese sandwich. During an interview on 4/28/26 at 10:31 a.m., RD stated she reviewed the grilled cheese recipe and indicated the amount of protein the cheese provided in the grilled cheese sandwich for Resident 111 for lunch on 4/27/26 did not equal the amount of protein content of the cheese shown in the recipe. The nutrient analysis for the recipe titled Grilled Cheese Sandwich showed the cheese used for the recipe provided 15.43 grams of protein, the bread provided 4.96 grams of protein, and the margarine, .01 grams of protein. The total protein content was 20.40 grams. The nutrient analysis for the recipe titled Beef Tater Tot Casserole showed the total protein content equaled 29.61 grams protein. During an interview on 4/28/26 at 2:10 p.m., the grilled cheese recipe and Beef Tater Tot Casserole recipe was reviewed with the Registered Dietitian (RD). RD confirmed the grilled cheese recipe showed the sandwich made following the recipe contained 20 grams of protein. RD stated the grilled cheese sandwich made on 4/27/26 for Resident 111's lunch contained a total of 11 grams of protein. RD confirmed the grilled cheese sandwich served to Resident 111 was not of equal nutritional value to the Beef Tator Tot Casserole entrée served on the menu for lunch on 4/27/26. RD and DM (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	confirmed the generally the entrée contained 3-4 ounces of meat. RD confirmed 3-4 ounces of meat would equal 21 – 28 grams of protein (meat contains approximately 7 grams of protein per ounce). RD stated she did not review the amount of protein in the grilled cheese sandwich or the amount of protein Resident 111 received for her meals. During a concurrent interview on 4/28/26 at 2:10 p.m., the Dietary Manager (DM) stated Resident 111 received a grilled cheese in place of the entrée served for lunch and dinner for about the past 60 days. 2. During a review of admission Record for Resident 150, dated 06/15/2022, the admission Record indicates Resident 150 has a past medical history of cerebral infarction (part of the brain dies because it stops receiving enough blood and oxygen) that has resulted in the diagnosis of hemiplegia (the inability to move one side of the body) and hemiparesis (weakness on one side of the body) of the right side of the body. Resident 150 also has a diagnosis of aphasia (a language disorder affecting the ability to speak, understand speech, read, or write). These conditions impact the resident's ability to move, communicate, and participate in care, requiring the facility to ensure appropriate assessment, monitoring, and interventions. During an observation on 04/27/2026 at 11:39 AM in Resident 150's room, Resident 150's lunch tray was sitting on the table and staff asked Resident 150 if Resident 150 wanted to eat and Resident 150 did not respond. Staff covered Resident 150's food and left the room. During an interview on 04/30/2026 at 9:56 AM with Resident 150's Representative (RR 1), RR 1 stated, the food concerns her at the facility and sometimes they give Resident 150 a huge sausage. RR 1 stated that Resident 150 did not like the food at the facility. RR 1 confirmed that Resident 150 is unable to talk. During an interview on 04/30/2026 at 11:25 AM with Licensed Vocational Nurse 7 (LVN 7), LVN 7 stated, Resident 150 is able to feed self with finger foods. LVN 7 stated Resident 150 is unable to speak and only communicates by nodding yes and no. During an observation on 04/30/2026 at 11:34 AM in Resident 150's room, Resident 150 pulled off the top from the lunch plate with left hand, then two staff walked into the room to pull Resident 150 up on the bed, place pillows behind Resident 150's head, and moved tray table with lunch plate closer to resident. Resident 150 used left hand to start eating the fries that were on the lunch plate. During a concurrent observation and interview on 04/30/2026 at 11:53 AM with Licensed Vocational Nurse 7 (LVN 7) at Resident 150's room, Resident 150's lunch tray showed that the resident had eaten the fries, hot dog bun, chocolate pudding, and fruit, but had left the whole hot dog untouched. LVN 7 entered the room during the observation and offered to cut the hot dog for Resident 150; however, the resident did not respond. LVN 7 did not cut the hot dog and stated that the hot dog was too large for Resident 150 to eat. The facility failed to ensure appropriate assistance and modification of food to support Resident 150's nutritional intake and safety needs. During an interview on 04/30/2026 at 2:45 PM with the Speech Pathologist (SP), the SP stated, an annual dysphagia (trouble swallowing) evaluation is performed for Resident 150 with the last evaluation completed February 2026. SP states that Resident 150 is able to swallow liquids and solid foods and is not at risk for choking on food. SP states that Resident 150 has poor food intake related to mental health issues and not related to a swallow disorder. (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 04/30/2026 at 3:05 PM with the Registered Dietician (RD), the RD stated, Resident 150's food intake is better when family visits. The RD stated that Resident 150 had requested a hot dog and indicated the belief that the resident would not benefit from receiving the hot dog cut into pieces rather than whole. The RD also confirmed that Resident 150 consumes only approximately 25 percent of meals. The facility failed to assess and implement appropriate interventions to address Resident 150's poor intake and potential swallowing or safety concerns related to offering whole food items. During a review of the Follow-Up Question Report for What percentage of the meal was eaten? for Resident 150, dated 01/01/2026 to 01/31/2026, the Follow-Up Question Report indicated Resident 150's percentage of each meal eaten was between 0% to 25% of meals for 36 out of 89 total meals and Resident 150 refused 8 out of 89 total meals between 01/01/2026 and 01/31/2026. Nearly half of all meals were either minimally consumed or refused in January 2026. During a review of the Follow-Up Question Report for What percentage of the meal was eaten? for Resident 150, dated 02/01/2026 to 02/28/2026, the Follow-Up Question Report indicated Resident 150's percentage of each meal eaten was between 0% to 25% of meals for 30 out of 84 total meals and refused 8 out of 84 total meals between 02/01/2026 and 02/28/2026. Nearly half of all meals were either minimally consumed or refused in February 2026. During a review of the Follow-Up Question Report for What percentage of the meal was eaten? for Resident 150, dated 03/01/2026 to 03/31/2026, the Follow-Up Question Report indicated Resident 150's percentage of each meal eaten was between 0% to 25% of meals for 38 out of 93 total meals and refused 29 out of 93 total meals between 03/01/2026 and 03/31/2026. Nearly threeˆquarters of all meals were minimally consumed or refused in March 2026. During a review of the Follow-Up Question Report for What percentage of the meal was eaten? for Resident 150, dated 04/01/2026 to 04/30/2026, the Follow-Up Question Report indicated Resident 150's percentage of each meal eaten was between 0% to 25% of meals for 40 out of 90 total meals and refused 20 out of 90 total meals between 04/01/2026 and 04/30/2026. Two-thirds of all meals in April 2026 were minimally consumed or refused. During a review of four monthly Dietary Notes for Resident 150, dated 01/23/2026, 02/20/2026, 03/14/2026, and 04/17/2026 , the Dietary Notes indicated the same Dietary Note was written for each of the dates with the exception of the following: Dietary Note dated 01/23/2026 indicated Resident 150's intake for the month was 0-50% meals and weight was stable for six months with fluctuation to 205 lbs (pounds). Dietary Note dated 02/20/2026 indicated Resident 150's intake for the month was 0-50% meals and weight was stable for six months with fluctuation to 202 lbs. Dietary Note dated 03/14/2026 indicated Resident 150's intake for the month was 0-25% meals and weight was stable for five months with fluctuation to 205 lbs. Dietary Note dated 04/17/2026 indicated Resident 150's intake for the month was 0-25% meals and weight was stable for six months with fluctuation to 201 lbs. Each of the four monthly Dietary Notes also indicated the following: (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Family or friend is not here all the time to encourage PO intake, which improperly suggests that the responsibility for ensuring adequate oral intake rested with the family or friends. The facility failed to ensure that staff provided the necessary assistance and encouragement with oral intake as required. Will continue POC (plan of care) for now, which demonstrated that the facility failed to reassess Resident 150's nutritional status or develop additional interventions to address the resident's inadequate food intake. The facility did not identify, implement, or explore alternative strategies to improve Resident 150's nutritional outcomes as required. During a review of Dietary Note for Resident 150, dated 03/26/2026 and indicated as a late entry for 03/25/2026, the Dietary Note indicated the Registered Dietician (RD) spoke with resident to encourage food intake during lunch on 03/25/2026 and Resident 150 refused all of her food and push the tray away. The RD documented that other food, supplement, and finger food were offered to Resident 150; however, the RD failed to document the manner in which Resident 150 declined these items, despite Resident 150 being nonverbal and unable to verbally express refusal. During a review of Care Plan for Resident 150, dated 03/17/2026, the Care Plan indicated Resident 150 is at nutritional risk related to Resident 150's diagnosis of aphasia and the intervention to determine Resident 150's food/beverage preferences & eating patterns was initiated on 09/20/2022 and last revised on 06/02/2023. During a review of Diet Orders List for Resident 150, dated 05/01/2026, the Diet Orders List indicated Resident 150 has the following active diet orders: Enteral Feed (giving a person nutrition through a tube that goes directly into the stomach or small intestine) Order one time a day at 8:00 PM with Enteral Nutrition titled Jevity 1.2, last revised on 04/14/2026. Enteral Feed Order three times a day with Jevity 1.2 if Resident 150's intake is less than 25%, last revised on 04/14/2026. Protein Modular Liquid two times a day for supplement to be given with 30 milliliters of water through the PEG tube (a feeding tube placed directly into the stomach through the skin), last revised on 04/14/2026. Regular diet which includes a regular texture and thin liquids consistency, last modified on 04/14/2026. During a review of Speech Therapy Medicare SLP Evaluation & Plan of Treatment for Resident 150, dated 02/09/2026, the Speech Therapy Medicare SLP Evaluation & Plan of Treatment indicated Resident 150 is nonverbal and communicates with head nods. The Speech Therapy Medicare SLP Evaluation & Plan of Treatment also indicated no signs or symptoms of esophageal dysphagia present and that the results of the evaluation did not change the clinical management for Resident 150 emphasizing the following: Continue diet as ordered. No further skilled Speech Therapy treatment warranted or justified at this time. (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Swallow function is unchanged. During a review of Speech Therapy SLP Discharge Summary for Resident 150, dated 03/17/2025, the Speech Therapy SLP Discharge Summary indicated three speech therapy goals including: Short term goal: Resident 150 will positively respond to regular texture 'finger foods' presented during meal times to increase food intake to greater than 25% for most meals. The goals was documented as met on 03/17/2025. Second short term goal: Resident 150 will respond to validation statements and redirection to reduce mealtime behaviors and increase attention to food intake with minimal cues provided. The goal is documented as discontinued on 03/17/2025. Long term goal: Resident 150 will improve efficiency of swallow and self-feeding when presented with regular texture 'finger foods' and will not exhibit signs and symptoms of aspiration or penetration. The goal is documented as met on 03/17/2025. Additionally, the Speech Therapy Medicare SLP Evaluation and Plan of Treatment indicated that when Resident 150 did not flat out refuse oral meal trays, the resident's oral intake improved to more than 25% of the majority of meals provided by the SNF (skilled nursing facility), that the resident inconsistently responds to verbal encouragement, and recommended to continue finger foods. This language placed responsibility on the resident for inadequate intake rather than identifying and addressing the facility's obligation to assess barriers, implement appropriate interventions, and ensure adequate nutritional support. During a review of the Speech Therapy Treatment Encounter for Resident 150, dated 03/17/2025, the Speech Therapy Treatment Encounter indicated that the resident voiced disinterest in the meal items presented—including a hot dog, turkey sandwich, banana, and French fries—and that the resident was not receptive to positive encouragement to try food items. This documentation inappropriately attributed the lack of intake to the resident, despite Resident 150 being nonverbal, and did not identify or address facilityˆlevel barriers or interventions necessary to support adequate nutritional intake. Additionally, Resident 150 continued to be served hot dogs for lunch up to and including the survey observations, demonstrating the facility's failure to revise meal offerings to meet the resident's needs. During a review of the Physician Progress Note for Resident 150, dated 08/08/2025, the Physician Progress Note indicated that the resident's representative stated they feel that Resident 150 always eats when [the resident representative] brings food. The Physician Progress Note also indicated that transitioning from enteral feedings to oral intake was considered unattainable due to Resident 150's inconsistent and unreliable food consumption related to advanced dementia. The plan document is to continue current treatment plan. During a review of the Physician Progress Note for Resident 150, dated 12/12/2025, the Physician Progress Note indicated that the resident was nonverbal at baseline and relied on nonverbal communication, including nodding or shaking the head in response to questions. However, the same note also stated that the patient is alert and able to answer simple questions, which was inconsistent with the documented nonverbal status and the resident's inability to speak. The facility failed to ensure accurate and consistent clinical documentation regarding Resident 150's communication abilities. (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of two Physician Progress Notes for Resident 150, dated 02/25/2026 and 04/24/2026, each note contained identical documentation stating that the resident's representative would come and visit and fed Resident 150 at times. Both notes also indicated that Resident 150 had no difficulty swallowing and that the resident refused to eat. The mental status in each note was documented the same, describing Resident 150 as nonverbal but able to nod the head in response to simple questions. The plan in both notes directed Resident 150 to make use of her fingers for eating, citing observations that the resident did not use utensils during meals, and recommended continuation of a regular solid, thin liquids diet along with finger foods. The plan further stated to continue current treatment plan. The facility failed to ensure accurate, individualized, and updated clinical assessments and failed to revise care interventions to address Resident 150's ongoing nutritional needs and food^refusal behaviors. During a review of the facility's policy and procedure titled Resident Food Preferences, dated 2001, indicated, the following: When possible, staff will interview the resident directly to determine current food preferences based on history and life patterns related to food and mealtimes. The dietician and nursing staff, assisted by the physician, will identify any nutritional issues and dietary recommendations that might be in conflict with the resident's food preferences. If the resident refuses or is unhappy with his or her diet, the staff will create a care plan that the resident is satisfied with. Documenting that a resident is refusing meals due to non-compliance with diet orders is not appropriate.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056203	A. Building B. Wing	05/01/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
City View Post Acute	1359 Pine Street San Francisco, CA 94109

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F 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Inform resident or representatives choice to enter into binding arbitration agreement and right to refuse. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure Resident 133 entered into a legally binding arbitration agreement only after fully understanding its terms. (Resident affected). The facility did not provide the required explanation of the agreement in a form and manner the resident could understand. This failure has the potential to result in residents signing legally binding documents without informed understanding of their rights, including the right to rescind or the fact that signing is not required to receive care.During a concurrent observation and interview on 05/01/2026 at 1:41 PM, in Resident 133's room, Resident 133 and Resident 133's friend (RF 1) were presented with a paper copy of the Arbitration Agreement that Resident 133 had signed on 04/09/2026. At that time, Resident 133 stated to RF 1 that they did not remember signing the Arbitration Agreement and did not know what the document was. RF 1 stated that Resident 133 does not have a good memory.During a concurrent interview and record review on 05/01/2026 at 2:34 PM with the Admissions Assistant (AA), the following two documents were reviewed:The Arbitration Agreement for Resident 133, dated 04/09/2026 was reviewed. The Arbitration Agreement showed that the document was signed by Resident 133 on 04/09/2026 and by the Admissions Assistant (AA) on 04/10/2026. The AA stated that Resident 133 was admitted on [DATE] and that Resident 133's primary language is Vietnamese. The AA reported obtaining two signatures from Resident 133 for the Arbitration Agreement on 04/09/2026 with assistance from a Vietnameseˆspeaking nurse, who helped translate and review the fiveˆpage Arbitration Agreement with Resident 133. There was no witness signature documented.The BIMS for Resident 133, dated 04/23/2026 was reviewed. The BIMS stands for Brief Interview for Mental Status, which is a short and structured questionnaire used in nursing homes and healthcare settings to check a resident's cognitive abilities, how well they can think ,remember, and understand what's going on around them. The BIMS for Resident 133 indicated Resident 133 has a BIMS of 10. A BIMS of 10 means Resident 133 has moderately impaired cognition. During a review of the Marketingˆ Admissions Note for Resident 133, dated 04/09/2026, the the Marketingˆ Admissions Note indicated that the Admissions Assistant (AA) visited Resident 133 at the bedside to review the admission packet and used a Vietnameseˆspeaking nurse to provide translation. The note stated that all questions and concerns were answered and that Resident 133 verbalized understanding about admission packet. The AA documented that a copy of the admission packet was offered and Resident 133 declined. The note did not describe how the extensive and complex admission packet, including the Arbitration Agreement, was reviewed with Resident 133, despite Resident 133 having a Brief Interview for Mental Status (BIMS) score of 10, indicating moderate cognitive impairment.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to implement infection prevention and control measures for one of 34 sampled residents (Resident 195) when Resident 195's urinary catheter tubing and urine drainage bag were touching the floor.This deficient practice placed Resident 195 at risk for transmission of infectious organisms from the floor to the urinary tract.Resident 195 was admitted on [DATE] with diagnoses that included dementia (a progressive decline in mental ability, including memory, reasoning, and behavior, severe enough to interfere with daily life) and urinary retention (the inability to fully or partially empty the bladder, causing urine to remain in the bladder even when one feels the need to urinate).During the initial tour observation on 4/27/2026 at 10:05 AM, Resident 195 was in bed, with a urinary catheter attached to an uncovered urine drainage bag, positioned under the bed and touching the floor.During a subsequent observation on 04/29/2026 at 1:02 PM, Resident 195 was sitting at the edge of her bed eating lunch. The urinary catheter tubing was resting on the floor, the catheter tube clip not anchored on the bed rail.During an interview on 4/29/2026 at 1:13 PM, Certified Nursing Assistant (CNA) 4 acknowledged the urinary catheter tubing clip was not anchored on the bed rail. CNA 4 stated that a catheter tubing clipped on the bed rail prevents the catheter from pulling out and keeps the catheter in place when in bed. CNA 4 further stated, Make sure the (catheter) tubing and (urine drainage) bag is above the floor.During an interview on 4/29/2026 at 1:23 PM, as part of urinary catheter care, Licensed Vocational Nurse (LVN) 4 stated, Make sure that the clip is secured to prevent catheter from being dislodged and to prevent the tubing from touching the floor. For infection control.During an interview on 4/29/2026 at 1:29 PM, with Infection Preventionist (IP), for proper urinary catheter care, the IP stated, ensure that the tubing and urine drainage bag are not touching the floor due to presence of germs on the ground. IP further stated, It's an infection control concern.Review of Resident 195's Order Summary Report, with active orders as of 5/1/26 indicated, .Indwelling urinary (Foley) catheter is in privacy bag and catheter leg strap/leg bag on at all times.Secure indwelling catheter tubing using anchoring device to prevent movement and urethral traction.Review of Resident 195's Care Plan Report indicated, .Focus: Bladder: At risk for complications with urinary system related to (r/t) indwelling catheter.Goal: Will have no complications or infections r/t urinary device.Interventions/Tasks: Indwelling Catheter: Use catheter anchor to secure catheter.Keep catheter anchored for security and to prevent trauma.Privacy cover to catheter bag as indicated to promote dignity. Date Initiated: 04/27/2026.Review of facility policy titled Catheter Care, Urinary dated 2001 indicated, General Guidelines.4. Ensure that the catheter remains secured with a securement device to reduce friction and movement at the insertion site.Infection Control.2. Be sure the catheter tubing and drainage bag are kept off the floor.According to the Centers for Disease Control and Prevention (CDC) Healthcare Infection Control Practices Advisory Committee's (HICPAC) Guideline for Prevention of Catheter-Associated Urinary Tract Infections (CAUTI) 2009 last updated on 6/6/2019, indicated, .II. Summary of Recommendations.II. Proper Techniques for Urinary Catheter Insertion.E. Properly secure indwelling catheters after insertion to prevent movement and urethral traction.III. Proper Techniques for Urinary Catheter Maintenance.B. Maintain unobstructed urine flow.2. Keep the collecting bag below the level of the bladder at all times. Do not rest the bag on the floor. [https://www.cdc.gov/infection-control/hcp/cauti/index.html] accessed on 5/5/26.

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. Based on observation, interview, and facility document review, the facility failed to prevent pests from entering the kitchen when there was a gap between one open window and the window screen. This failure had the potential for pests to enter the kitchen and contaminate food and food equipment and utensils.Findings: Review of the Policy and Procedure titled Maintenance Policies & Procedures Interior General Maintenance dated 12/31/2015, showed to replace or repair defective or bend screens or screens that do not fit securely into the frame. Review of the Policy and Procedure titled Pest Control dated 2001, showed windows are screened at all times. An observation in the kitchen on 4/27/26 at 10:05 a.m., showed a window was open and the window screen was not completely attached to the window frame creating a gap to the outside. During an observation and interview in the kitchen on 4/28/26 at 10:35 a.m., the Dietary Manager (DM) confirmed there was a gap between the open window and the window screen. DM stated he did not put in a work order to fix the screen because he did not notice the gap prior. During an interview on 4/29/26 at 11:04 a.m., the Maintenance Director (MM) stated the window screen might have been broken the last time the screen was removed to clean the windows. MM stated pests could probably fit through the gap between the screen and the open window. During an interview on 4/29/26 at 11:36 a.m., DM stated the gap between the window frame and the broken screen was at least a 1/2 inch.