STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056207	A. Building B. Wing	04/24/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pacific Gardens Nursing and Rehabilitation Center	577 S. Peach Ave. Fresno, CA 93727

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to meet professional standards of practice for eight of 21 sampled residents (Resident 1, Resident 55, Resident 72, Resident 102, Resident 127, Resident 150, Resident 155, and Resident 167) when:1. Resident 1's oxygen therapy (a colorless, odorless, tasteless gas essential to living organisms) was set at 2 liters per minute (L/min - a unit of measurement for oxygen flow rate) and not 1 L/min as indicated on the physician order (a set of instructions written by a doctor for clinicians to follow when caring for a resident).2. Resident 55's oxygen flow rate (the quantity of oxygen that is passing through a cross-section of a pipe in a specific period) was being delivered at 4 LPM (liters per minute - a unit of measurement) instead of the ordered 2 LPM.3. Resident 127 was administered 2.5 L/min of oxygen therapy through a nasal cannula (a thin, flexible tube with two prongs that fit into the nostrils and deliver oxygen) without a physician's order.These failure resulted in Resident 1, Resident 55 and Resident 127 not receiving oxygen therapy as ordered which had the potential to result in the administration of unnecessary supplemental oxygen which could lead to nasal dryness, shortness of breath, oxygen toxicity (lung damage that happens from breathing in too much extra oxygen therapy), respiratory distress (difficulty breathing) and serious medical conditions. 4. Resident 155 and Resident 72's oxygen concentrator's (electric, medical air-purifier machine that makes its own pure oxygen) air filter (removes dust, pollen, pet dander and other particles from the room air before the machine turns it into concentrated oxygen) was covered with white dusty looking lint. These failures had the potential to result in Resident 155 and Resident 72 to not receive the oxygen necessary to treat their condition which could lead to more serious respiratory distress. 5. Resident 167's blood sugar level was taken at 5 a.m. and insulin lispro (fast-acting injectable medication that lowers blood glucose (sugar)) was administered an hour before meal.This failure had the potential to result in hypoglycemic (condition where sugar levels in the blood drop too low) episode for Resident 167.6. Resident 102's calcium acetate (medication that helps treat high phosphorus levels in kidney patients) was not given with meals as indicated in the physician's order.This failure had the potential to lead to ineffective treatment of high phosphorus levels and significantly increased the risk of Resident 102 developing hyperphosphatemia (high phosphorus level) due to more phosphorus absorbed into the resident's bloodstream on an empty stomach.7. Resident 102's hydralazine order was implemented with unclear frequency (with meals).This failure had the potential to cause significant, dangerous hypotension (low blood pressure), unpredictable blood pressure spikes, and mismanagement of Resident 102's blood pressure.8. Resident 150's calcium lab result was not communicated to the physician, and there was no evidence of clinical follow-up or intervention.This failure had the potential to place the Resident 150 at risk for complications related to abnormal calcium levels. Findings:1. During an observation on 4/21/2026 at 6:10 a.m. in Resident 1's room, Resident 1 was observed in bed, dressed in a t-shirt, and wearing an oxygen nasal cannula (NC- a small plastic tube, which fits into the person's nostrils to provide supplemental oxygen) with the oxygen rate set at 2 L/min.During a review of Resident 1's admission Record (AR - a summary of information regarding a patient which includes patient identification, past medical history, insurance status, care providers, family contact information and (continued on next page)

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

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

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	other pertinent information), dated 4/23/26, the AR indicated Resident 1 was admitted to the facility from an acute care hospital on 1/30/25 with diagnoses of acute respiratory failure (a serious condition that occurs when the lungs cannot get enough oxygen into the blood or remove enough carbon dioxide [a waste gas] from the blood), obstructive sleep apnea (OSA - when you stop breathing during sleep because of a blockage in the windpipe), cerebral ischemia (insufficient blood flow to the brain resulting in damage to brain tissue), type 2 Diabetes Mellitus (when the blood sugar levels in the body are too high), acquired loss of right limb (surgical removal of finger, toe, hand, foot, arm or leg) below the knee.During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool used to identify cognitive [mental processes] and physical functional level assessment), dated 3/9/26, the MDS section C indicated Resident 1 had a Brief Interview for Mental Status (BIMS - a test given by medical professionals to determine cognitive (involving the process of thinking, learning and understanding) understanding on a scale of 1-15) score of 10 (a score of 0-7 suggests severe cognitive impairment, 8-12 suggests moderately impaired, 13-15 suggests cognitively intact), which suggested Resident 1 was moderately impaired.During a concurrent interview and record review on 4/22/2026 at 2:03 p.m. with Charge Nurse (CRN) 1, Resident 1's Order Review (OR) list, undated was reviewed. The ORL indicated, .oxygen at 1 L/min [LPM] via NC continuous. CRN 1 stated Resident 1's physician orders were to administer oxygen at 1 L/min. CRN 1 stated Resident 1's oxygen rate should have been at 1 L/min and should not have been put at 2 L/min rate. CRN 1 stated oxygen was considered a medication and staff should have followed the physician's orders for resident safety. CRN1 stated if a resident had a complaint of shortness of breath (SOB - occurs when you do not get enough oxygen, difficulty breathing), the nurse completed a change in condition assessment and notified the physician. CRN 1 stated she had not had a complaint from staff or Resident 1 for SOB.During an interview on 4/24/2026 at 10:32 a.m. with the Director of Nursing (DON), the DON stated oxygen was considered a medication and staff needed a physician's order to administer oxygen. The DON stated staff should have followed physician orders. The DON stated staff could have overdosed the resident or gave the resident oxygen when they did not need it. The DON stated if the resident needed a higher rate of oxygen, staff should have assessed the resident to see why he needed a higher rate of oxygen and notified the physician to see if the resident's oxygen rate could have been increased. The DON stated it was not acceptable to give a resident oxygen at 2 L/min when the physician ordered oxygen for 1 L/min.During a review of the facility's P&P titled, Oxygen Administration, dated 2025, the P&P indicated, .oxygen is administered to residents who need it, consistent with professional standards of practice, the comprehensive person-centered care plans, and the resident's goals and preferences.oxygen is administered under orders of a physician.staff shall document the initial and ongoing assessment of the resident's condition warranting oxygen and the response to oxygen therapy.the resident's care plan shall identify the interventions for oxygen therapy, based upon the resident's assessment and orders, such as.equipment setting for the prescribed flow rates.monitoring for complications associated with the use of oxygen.2. During an observation on 4/24/26 at 12:25 p.m. in Resident 55's room during the initial tour, Resident 55 was sitting upright in a wheelchair with a nasal cannula (a small clear plastic tube that delivers oxygen through the nose) in place, connected to an oxygen concentrator (medical device that acts like a specialized air filter). Resident 55's oxygen flow rate was set to 4 LPM.During a review of Resident 55's admission Record (AR), dated 3/30/26, the AR indicated, Resident 55 was admitted to the facility with the diagnoses that included Acute Respiratory Failure with Hypoxia (the body is not getting enough oxygen), Chronic Obstructive Pulmonary Disease (COPD-a disease when lungs are damaged and clogged, making it hard to breathe), and Chronic Pulmonary Edema (fluid keeps building up in the lungs over time, making it harder to breathe). During a review of Resident 55's Order Review Report (ORR), dated 3/31/26, the ORR indicated, . Oxygen at 2LPM via [nasal cannula (NC)] continuous .During a concurrent observation and interview on 4/21/26 at 12:40 p.m. with Licensed Vocational Nurse (LVN) 5 in Resident 55's room, Resident 55 was receiving oxygen at 4 (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	filters were not cleaned or replaced. The DON stated residents would not get better with dirty air filters. The DON stated central supply staff should ensure they were checking oxygen concentrator air filters and replaced them as needed.During a review of facility's [brand name] Oxygen Concentrator Instruction Guide, dated 2022, the instruction guide indicated, .Cabinet Filter. wash with each inspection. Replace if needed. Service and maintenance should only be performed by appropriately trained. personnel and/or service centers. Check to be sure the cabinet air filter (if applicable) and the intake filter area in place. Replace cabinet air filter (when applicable) and follow the Cleaning and Disinfection Instruction. 5. During an observation on 4/21/26 at 6:03 a.m. with Registered Nurse (RN) 4, RN 4 was observed to have documentation of residents' blood sugars on a piece of paper and RN 4 documented administration of insulin lispro for Resident 167 on the electronic health record (EHR)During an interview on 4/21/26 at 7:01 a.m. with RN 4, RN 4 stated breakfast was served around 7 a.m. RN 4 stated insulin lispro should be given about 30 mins before food. RN 4 acknowledged Resident 167 had been administered insulin lispro at approximately 6:00 a.m. and stated Resident 167 could become hypoglycemic if there was long period between insulin given and food served. RN 4 stated the blood sugar for all residents was taken and recorded around 5 a.m. RN 4 stated there would be a difference between blood sugar of residents taken at 5 a.m. and at 6:30 a.m. RN 4 stated the expectation was for nurses to get the reading of resident's blood sugar and administer insulin right away. RN 4 stated breakfast had not been served at 7:08 a.m. RN 4 verified with the kitchen when breakfast would be served and stated breakfast would be served around 7:20 a.m., over 1 hour after Resident 167 had been administered insulin lispro.During a review of Resident 167's admission Record (a summary of important information regarding a patient which includes patient identification, past medical history, insurance status, care providers, family contact information and other pertinent information), the admission record indicated Resident 167 was admitted to the facility on [DATE] with a diagnosis which included type 2 diabetes mellitus (chronic condition where the body does not use insulin properly or make enough insulin, leading to high blood sugar levels, hyperlipidemia (abnormally high fat levels, or lipids, in the blood), chronic kidney disease (a long-term condition where the kidneys are damaged and gradually lose their ability to filter waste, toxins, and excess water from the blood), and long term (current) use of Insulin.During a review of Resident 167's Order Summary Report (OSR), dated 4/8/26, the OSR indicated, Resident 167 had an active order for . Insulin lispro injection solution 100 UNIT/ML [milliliters- metric unit used to measure the volume of a liquid] .inject. Subcutaneously [inject into the fatty tissue] before meals and at bedtime for DM During an interview on 4/22/26 at 3:19 p.m. with the Director of Nursing (DON), the DON stated the expectation from nurses was for insulin lispro should be given when the resident breakfast was available because the medication was short acting and had quick onset. When informed Resident 167's blood sugar level reading was taken at 5 a.m., insulin lispro was administered at 6:30 a.m., and the kitchen expected breakfast for Resident 167 to be served around 7:20 a.m., the DON stated blood sugar should checked right before the insulin was administered and the insulin should be administered no more than 15 mins before meals because there would be a difference in Resident 167's blood sugar within a 30 mins interval and Resident 167 could become hypoglycemic.During a telephone interview on 4/24/26 at 10:14 a.m. with the Consultant Pharmacist (CRPH), the CRPH stated the insulin lispro should be administered 15 mins before the meal or immediately after the meal, so the resident does not become hypoglycemic. The CRPH stated blood sugar level reading should be timed around insulin administration because if Resident 167 was hypoglycemic, the medication would not be administered and physician would be notified.During a professional reference review retrieved from National Library of Medicine/National Institute of Health- Daily Med found at https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=2be14cbb-197a-4da8-82c8-2443594e7f6f, titled, INSULIN LISPRO injection, solution, no dated, the professional reference review indicated .2.2 Administration Instructions for the Approved Routes of Administration-Subcutaneous Injection-Administer the dose of Insulin Lispro within fifteen minutes before a meal or immediately (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	specifications. A provide appropriate amounts of food and fluid. Example guidelines for medication administration (unless otherwise ordered by physician), this list is not all inclusive- medication required administration on an empty stomach, medication requiring administration after food or with food .7. During a review of Resident 102's AR, dated 4/23/26, the AR indicated, Resident 102 was admitted to the facility on [DATE], with diagnoses which included heart failure, type 2 diabetes mellitus, Hypertensive heart and chronic kidney disease with heart failure, hyperlipidemia.During a review of Resident 102's MAR, dated 4/23/26, the MAR indicated, Resident 102 had an active order on 3/27/26 for . Hydralazine HCl oral tablet 100 MG . give one tablet by mouth with meals for HTN During an interview on 4/21/26 at 12:18 p.m. with RN 1, RN 1 stated Resident 102 was supposed to get hydralazine three times a day. When asked if Resident 102 did not eat his meal, will the medication be held, RN 1 stated the medication would still be administered. RN stated the medication is only held based on the blood pressure parameters and not based on the meal. When asked if the order should indicate 3 times a day and not with meals, RN 1 did not response and stated the medication would still be administered even if Resident 102 did not eat his meal.During an interview on 4/22/26 at 3:32 p.m. with the DON, the DON stated Resident 102's hydralazine order was not clear enough. The DON stated an order should have name, route, dosage and frequency. The DON stated the frequency should be stated in the body of the order. The DON stated the order would be clarified.During a telephone interview on 4/24/26 at 10:14 a.m. with the CRPH, the CRPH stated the expectation was for the medication to have frequency. The CRPH stated it was important to have frequency in the medication order, so the nurses know how to give the medication. The CRPH stated frequency should be part of the medication order, and all medication orders should have a frequencyDuring a review of the facility's P&P titled, Medication Administration, undated, the P&P indicated, . Policy: medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice, in a manner to prevent contamination or infection.10. Ensure that the six rights of medication administration are followed: a. right resident b. right drug c. right dosage d. right route e. right time f. right documentation .8. During a review of Resident 150's AR, dated 4/23/26, the AR indicated, Resident 150 was admitted to the facility on [DATE], with diagnoses which included hypothyroidism, Type 2 diabetes mellitus, hyperlipidemia, essential hypertension.During a review of Resident 150's Lab Result Report (LRR), dated 2/17/26, the LRR indicated, Resident 150's blood was drawn on 2/16/26 at 5:49 p.m. The calcium level was reported as 7.2, which was below the reference range of 8.3-10.6. This result indicated a low and out of range value.During a concurrent interview and record review on 4/21/26 at 12:14p.m. with RN 1, Resident 150's EMR, undated was reviewed. RN 1 stated the EMR indicated there was no progress note on the calcium labs. RN 1 stated if labs were low, the supervisor should be informed, the physician should be notified, and it should be documented in the progress notes.During a concurrent interview and record review on 4/22/26 at 3:04 p.m. with the DON, Resident 150's EMR, undated was reviewed. The DON stated the EMR indicated Resident 150's calcium level at 7.2 was low. The DON stated the expectation for abnormal lab level would be for the nurse to notify the physician and the physician would give orders as needed. The DON was unable to provide documentation the physician was notified of low calcium levels. The DON stated it was important for nurses to inform the physician about abnormal levels, because calcium helps keep the bone levels and help prevent fractures in case residents fall.During a telephone interview on 4/24/26 at 10:22 a.m. with the CRPH, the CRPH stated the expectation was there should be a progress note on the lab result, the physician would review the lab result and orders would be given as needed. The CRPH stated it was important to notify the physician of abnormal labs, because abnormal labs could have negative effect on Resident 150During a review of the facility's P&P titled, Diagnostic test result notification, dated 8/2025, the P&P indicated, . Policy: It is the policy of the facil

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pacific Gardens Nursing and Rehabilitation Center	577 S. Peach Ave. Fresno, CA 93727

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to have an adequate system for reconciling controlled drugs (substances that have an accepted medical use and have a potential for abuse and may also lead to physical or psychological dependence), when the facility did not have an effective system in place for the Director of Nursing (DON) to accurately account for all controlled substances awaiting destruction in the facility.This failure had the potential for diversion (the illegal transfer, therft, or misuse of prescription drugs), mismanagement, or unaccounted medication, and the potential not to meet the needs of the residents in the facility.Findings:During an interview on [DATE] at 2:35 p.m. with the DON, the DON stated when controlled medications are discontinued, nursing staff would give the controlled medications to the DON and sign in the controlled medication binder at the nurses' station. The DON stated the discontinued controlled medications would be stored in a locked cabinet in her office until destroyed by the facility's consultant pharmacist (CRPH), during which both her and CPRH would sign a printed log form, accounting for the number of controlled medications destroyed. The DON stated there was no other log indicating how many controlled medications were received from nurses and therefore could not track all the controlled medications received from nursing staff. The DON acknowledged it would be difficult to know if controlled medications were removed from the office cabinet and acknowledged the facility did not have an effective system in place for the reconciliation and destruction of controlled medication. The DON stated it was important to log and track control medications received from the nurses and awaiting destruction to make sure none were missing.During a telephone interview on [DATE] at 10:30 a.m. with the CRPH, the CRPH stated there should be a form of record indicating the quantity of controlled medications the DON received from nursing staff. The CRPH stated this was important for accountability and to make sure there was no theft /diversion of the controlled medication.During a review of the facility's Policy and Procedure (P&P) titled, Inventory Control of Controlled Substances, revised [DATE], the P&P indicated, .5. A facility representative should regularly check the inventory records to reconcile inventory. Facility should regularly reconcile: 5.1 current and discontinued inventory of controlled substances to the log used in facility's controlled medication inventory system; 5.2 current inventory to the controlled medication declining inventory record and to the resident's MAR; And 5.3 unused control substances held in storage awaiting destruction with the declining inventory record.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident?s drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure three of five sampled residents (Resident 3, Resident 79 and Resident 150), were free from unnecessary drugs when:1. Resident 3 was administered magnesium oxide (a mineral supplement used to treat low magnesium levels) medication and magnesium levels were not monitored.2. Resident 79 was administered amiodarone (medication used to treat and prevent severe, life-threatening irregular heartbeats (arrhythmia) by slowing down overactive electrical signals in the heart) and thyroid stimulating hormone (TSH- blood test that measures level of thyroid hormone) levels were not monitored.3. Resident 150 was administered levothyroxine (medication used to treat an underactive thyroid (hypothyroidism) by replacing the missing thyroid hormone) and TSH levels were not monitored.The failure to monitor essential labs work for these medications had the potential to result in adverse consequences and complications which could lead to serious medical condition for Residents 3, 79 and 150.Findings:1. During a review of Resident 3's admission Record (AR- document containing resident personal information), dated 4/24/26, the AR indicated, Resident 3 was admitted to the facility on [DATE], with diagnoses which included, hypomagnesemia (dangerously low level of magnesium in the blood), essential hypertension (high blood pressure), type 2 diabetes mellitus (chronic condition where the body does not use insulin properly or make enough insulin, leading to high blood sugar levels), hyperlipidemia(abnormally high fat levels, or lipids, in the blood.)During a review of Resident 3's Order Summary Report (OSR), dated 12/11/25, the OSR indicated, Resident 3 had an active order for . Magnesium oxide oral tablet 400 MG [milligrams- a measurement of weight of how much medicine is in the tablet] .Give 1 tablet by mouth three times a day for hypomagnesemia During a review of Resident 3's Lab Result Report (LRR), dated 11/18/25, the LRR indicated, Resident 3's blood was drawn on 11/17/25 at 7:14 a.m. The magnesium level was reported as 1.3, which was above the reference range of 1.6-2.6. This result indicated a low and out of range value.During an interview on 4/23/26 at 11:25 a.m. with Registered Nurse (RN) 1, RN 1 stated when a resident is started on magnesium, there should be testing for magnesium levels, usually after 3 months. RN 1 stated that once there was a change in magnesium level, the physician was notified and there would be an order for labs to be completed. RN 1 stated there were no orders for magnesium labs, and no labs were drawn after Resident 3 started taking magnesium oxide.During a review of Resident 3's Medication Administration Record (MAR) dated, 3/26 and 4/26, Resident 3's MAR indicated Resident 3 was administered magnesium oxide 400 mg tablet three times daily.During a concurrent interview and record review on 4/24/26 at 9:45 a.m. with the Director of Nursing (DON), Resident 3's LRR, dated 11/18/26 was reviewed. The DON stated there were no labs completed for Resident 3 to check his magnesium levels after 11/18/26. The DON stated the expectation was for the nurse or pharmacy to recommend a lab follow up to the physician. The DON stated Resident 3's magnesium levels should have been checked since Resident 3 was started on the medication.During a telephone interview on 4/24/26 at 10:26 a.m. with the Consultant Pharmacist (CRPH), the CRPH stated the expectation was there should be a follow up with labs to check if Resident 3's magnesium levels were normal, high or still low.During a professional reference review retrieved from National Library of Medicine/National Institute of Health- Daily Med found at https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=7ccd3733-c3af-4a11-8500-0f99194c1472, titled, AMIODARONE HYDROCHLORIDE tablet, no dated, the professional reference review indicated .Amiodarone hydrochloride tablets can cause either hypothyroidism (reported in up to 10% of patients) or hyperthyroidism (occurring in about 2% of patients). Monitor thyroid function prior to treatment and periodically thereafter, particularly in elderly patients, and in any patient with a history of thyroid nodules, goiter, or other thyroid dysfunction.2. During a review of Resident 79's AR, dated 4/23/26, the AR indicated, Resident 79 was admitted to the facility on [DATE], with diagnoses which included (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	chronic diastolic congestive heart failure (CHF-a heart disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling), unspecified atrial fibrillation(condition where an irregular and often very rapid heart rhythm occurs in the heart), supraventricular tachycardia (where the heart suddenly beats much faster than normal).During a review of Resident 79's OSR, dated 3/27/26, the OSR indicated, Resident 79 had an active order for . Amiodarone HCl oral tablet 200 MG. Give 1 tablet by mouth one time a day for CHF.During a concurrent interview and record review on 4/22/26 at 3:13 p.m. with the DON, Resident 79's OSR, dated 3/28/26 was reviewed. The DON stated Resident 79 was admitted [DATE] and started amiodarone on 3/28/26. The DON stated TSH labs should have been done when Resident 79 was started on amiodarone. The DON stated it was important to monitor the TSH lab so the medication can be adjusted if needed.During a professional reference review retrieved from National Library of Medicine/National Institute of Health- Daily Med found at https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=7ccd3733-c3af-4a11-8500-0f99194c1472, titled, AMIODARONE HYDROCHLORIDE tablet, no dated, the professional reference review indicated .Amiodarone hydrochloride tablets can cause either hypothyroidism (reported in up to 10% of patients) or hyperthyroidism (occurring in about 2% of patients). Monitor thyroid function prior to treatment and periodically thereafter, particularly in elderly patients, and in any patient with a history of thyroid nodules, goiter, or other thyroid dysfunction.3. During a review of Resident 150's AR, dated 4/23/26, the AR indicated, Resident 150 was admitted to the facility on [DATE], with diagnoses which included hypothyroidism (when the thyroid gland does not make enough thyroid hormone), Type 2 diabetes mellitus, hyperlipidemia, essential hypertension.During a review of Resident 150's OSR, dated 7/21/24, the OSR indicated, Resident 150 had an active order for . Levothyroxine sodium tablets 100 MCG. Give 1 tablet by mouth one time a day for hypothyroidism.During a concurrent interview and review on 4/21/26 at 12:04 p.m. with RN 1, Resident 150's Electronic Health Record (EHR), undated was reviewed. RN 1 stated the EHR indicated no labs were completed for TSH monitoring. RN 1 stated Resident 150 had an order for levothyroxine medication to be administered every morning. RN 1 stated Resident 150 was on hospice (specialized, comfort-focused care for individuals with terminal illness).During a review of Resident 150's LRR, dated 2/17/26, the LRR indicated, Resident 150's blood was drawn on 2/16/26 at 5:49 p.m. and there was no TSH level reported.During an interview on 4/22/26 at 3:09 p.m. with the DON, the DON stated Resident 150 was a hospice resident and if labs are done, the facility needed permission from hospice. The DON stated the expectation was for the TSH labs to be completed. The DON stated the therapeutic level should be monitored since Resident 150 was on levothyroxine. The DON stated it was important to monitor level so the medication can be adjusted.During a telephone interview on 4/24/26 at 10:23 a.m. with the CRPH, the CRPH stated there should be TSH baseline labs monitoring done and completed every six months. The CRPH stated it was important to have labs to check medication functions and side effects.During a professional reference review retrieved from National Library of Medicine/National Institute of Health- Daily Med found at https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=4ddcaec1-a58f-340b-9bc1-bbe048b8c885, titled, LEVOTHYROXINE SODIUM tablet, no dated, the professional reference review indicated .2.4 Monitoring TSH and/or Thyroxine (T4) Levels-Assess the adequacy of therapy by periodic assessment of laboratory tests and clinical evaluation. Persistent clinical and laboratory evidence of hypothyroidism despite an apparent adequate replacement dose of Levothyroxine Sodium Tablets may be evidence of inadequate absorption, poor compliance, drug interactions, or a combination of these factors. Adults. In adult patients with primary hypothyroidism, monitor serum TSH levels after an interval of 6 to 8 weeks after any change in dosage. In patients on a stable and appropriate replacement dosage, evaluate clinical and biochemical response every 6 to 12 months and whenever there is a change in the patient's clinical status.During a review of the facility's policy and procedure (P&P) titled, Diagnostic test result notification, dated 8/2025, the P&P indicated, . Policy: It is the (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	policy of the facility to obtain laboratory and radiology services when ordered by a physician . and to promptly notify the ordering provider of test results. Procedure: 1. Laboratory and radiology services will be arranged and completed as ordered 2. Results of laboratory, radiology, and diagnosis tests outside the clinical reference ranges shall be promptly reported to the resident's attending physician . or as specified in the order. 3. Notification of test results will be documented in the resident's clinical records. 4. The results of lab . shall be made a part of the resident's medical records.During a review of the facility's P&P titled, Medication Administration, no date, the P&P indicated, . Refer to drug reference material if unfamiliar with the medication, including its mechanism of action and common side effects.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the medication error rate was less than five percent for five residents (Resident 135, Resident 167, Resident 9, Resident 46 and Resident 117), when:1. Resident 135 was not administered their prescribed dose of levothyroxine (medication used to treat an underactive thyroid by replacing the missing thyroid hormone) and the medication was left with the resident.This failure had the potential to result in Resident 135's thyroid levels dropping, resulting in symptoms like cognitive decline (gradual loss of thinking skills), persistent fatigue (extreme tiredness or lack of energy) and weakness.2. Resident 167's oxycodone-acetaminophen tablet (prescription opioid medication used to treat moderate to severe pain) was administered without a pain assessment.This failure had the potential to lead to a life-threatening respiratory depression, excessive sedation, hypotension, severe constipation, nausea, or accidental overdose.3. Resident 9, Resident 46, and Resident 117's insulin (insulin lispro/ insulin aspart: fast-acting injectable medication that lowers blood glucose (sugar)) were administered an hour before their meal.This failure had the potential to result in hypoglycemic (condition where sugar levels in the blood drop too low) episodes for Resident 9, Resident 46, and Resident 117.The facility's medication error rate was 18.52 percent. There were 27 opportunities for errors.Findings:1. During an observation on 4/21/26 at 6:08 a.m. in Resident 135's room with Registered Nurse (RN) 4, RN 4 was observed trying to administer levothyroxine medication to Resident 135. Resident 135 stated she wanted to use the restroom. RN 4 was observed to have the left the medication with Resident 135 without administering the medication.During an interview on 4/21/26 at 6:22 a.m. with RN 4, RN 4 stated when nurses go into resident's room to administer medication, nurses were expected to monitor the residents and ensure the medications were consumed. RN 4 stated he did not see Resident 135 consume the levothyroxine medication.During a review of Resident 135's admission Record (AR- a summary of important information regarding a patient which includes patient identification, past medical history, insurance status, care providers, family contact information and other pertinent information), dated 4/23/26, the AR indicated Resident 135 was admitted to the facility on [DATE] with a diagnosis which included hypothyroidism (when the thyroid gland does not make enough thyroid hormone), hyperlipidemia (abnormally high fat levels, or lipids, in the blood), and essential hypertension (high blood pressure).During a review of Resident 135's Order Summary Report (OSR), dated 4/5/26, the OSR indicated, Resident 135 had an active order for . Levothyroxine sodium tablets 125 [microgram (MCG)-unit of measure]. Give 1 tablet by mouth one time a day for hypothyroidism During an interview on 4/22/26 at 3:36 p.m. with the Director of Nursing (DON), the DON stated the expectation was for the nurse to wait for Resident 135 to take the medication. The DON stated, If a resident needed to use restroom, the nurse should take medication back and let the resident use the restroom. The DON stated it was important to witness Resident 135 taking medication and to ensure no other resident consumed the medication. The DON stated it was a safety issue and could lead to unnecessary medication.During a telephone interview on 4/24/26 at 10:28 a.m. with the Consultant Pharmacist (CRPH), the CRPH stated the expectation was nurses should not leave medications with the resident because they did not have sight of what was happening with the medication.During a review of the facility's Policy and Procedure (P&P) titled, Medication Administration, undated, the P&P indicated, .Policy: medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice, in a manner to prevent contamination or infection.12a.Refer to drug reference material if unfamiliar with the medication, including its mechanism of action and common side effects . 18. Observe resident consumption of medication.2. During an observation on 4/21/26 at 6:12 a.m. with RN 4 in Resident 167's room, Resident 167 stated she was in pain and wanted pain medication. RN 4 left Resident 167's room, prepared pain medication from the medication cart and administered (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the pain medication to Resident 167 without assessing Resident 167's pain level. During an interview on 4/21/26 at 6:24 a.m. with RN 4, RN 4 stated he did not ask for Resident 167's pain level prior to administering the pain medication. RN 4 stated Resident 167 had acetaminophen tablets (non-opioid medication used for pain relief and fever reduction) and oxycodone- acetaminophen tablets for pain. RN 4 stated it was important to ask for the pain level to know how bad the pain was and how effective the medication administered would be.During a review of Resident 167's AR, dated 4/23/26, the AR indicated Resident 167 was admitted to the facility on [DATE] with a diagnosis which included type 2 diabetes mellitus (DM-chronic condition where the body does not use insulin properly or make enough insulin, leading to high blood sugar levels), hyperlipidemia, chronic kidney disease (a long-term condition where the kidneys are damaged and gradually lose their ability to filter waste, toxins, and excess water from the blood), and history of falling.During a review of Resident 167's OSR, dated 4/06/26, the OSR indicated, Resident 167 had an active order for . oxycodone-acetaminophen tablets 10-325MG [milligrams- a measurement of weight of how much medicine is in the tablet] . Give 1 tablet by mouth every six hours as needed for moderate to severe pain (4 - 10 on pain scale) . During an interview on 4/22/26 at 4:05 p.m. with the DON, the DON stated before medication administration the nurse should ask the resident for their level of pain. The DON stated this was to ensure the right medication was given for severe pain or for moderate pain. The DON stated this failure could lead to ineffective medication, Resident 167 would not benefit from it, and the resident could still be in pain. The DON stated the resident could be lethargic, confused or sleepy if there was too much pain medication.During a telephone interview on 4/24/26 at 10:29 a.m. with the CRPH, the CRPH stated the nurse should have gotten a pain level before administering the pain medication, because there were different orders for pain level and if the pain level was zero, why would pain medication be administered.During a professional reference review retrieved from National Library of Medicine/National Institute of Health- Daily Med found at https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=88d97caf-bcf5-3cde-e053-2995a90acf4a, titled, OXYCODONE AND ACETAMINOPHEN tablet, undated, the professional reference review indicated .Titration [a technique where a solution of known concentration is used to determine the concentration of an unknown solution] and Maintenance of Therapy-Individually titrate oxycodone and acetaminophen tablets to a dose that provides adequate analgesia and minimizes adverse reactions. Continually reevaluate patients receiving oxycodone and acetaminophen tablets to assess the maintenance of pain control, signs and symptoms of opioid withdrawal, and other adverse reactions, as well as reassessing for the development of addiction, abuse, or misuse.During a review of the facility's P&P titled, Medication Administration, undated, the P&P indicated, .Policy: medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice, in a manner to prevent contamination or infection.8. Obtain and record vital signs, and when applicable or per physician orders. When applicable, hold medications for those vital signs outside the physicians prescribed parameters.12a.Refer to drug reference material if unfamiliar with the medication, including its mechanism of action and common side effects .During a review of the facility's P&P titled, Pain Recognition and Management, dated 8/2025, the P&P indicated, .Policy: It is the policy of this facility to ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, our comprehensive and routine assessments . Procedure: the residents will be interviewed and evaluated for pain . with any change in their status. 2. To the extent possible, and staff will .a. recognize when a resident is experiencing pain and identify circumstances when pain can be anticipated b. evaluate existing pain and the causes. 3. Pain will be identified and documented in the electronic health record (EHR) a using a scale of 1-10 is the most common. 5a. monitor pain status every shift using . the numerical pain rating (1- 10) . 3. During a concurrent observation and interview on 4/21/26 at 6:15 a.m. in Resident 9's room, RN 4 was observed administering 10 units Insulin Lispro to Resident 9's to left lower abdomen. No blood sugar (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	level was checked. RN 4 stated the Resident 9's blood sugar was 170. RN 4 stated the blood sugar reading was taken around 5:30 a.m.During an interview on 4/21/26 at 7:01 a.m. with RN 4, RN 4 stated breakfast was usually served around 7 a.m. and insulin for Resident 9 was administered 45 minutes prior. RN 4 stated Resident 9 could become hypoglycemic if there was a long period between the insulin given and the food served. RN 4 stated breakfast had not been served at 7:08 a.m. RN 4 stated and verified with the kitchen when breakfast would be served and stated breakfast would be served around 7:20 a.m.During a review of Resident 9's AR, dated 4/23/26, the AR indicated Resident 9 was admitted to the facility on [DATE] with a diagnosis which included type 2 diabetes mellitus, hyperlipidemia, chronic kidney disease, and long term (current) use of Insulin.During a review of Resident 9's OSR, dated 3/24/26, the OSR indicated, Resident 9 had an active order for . insulin lispro injection solution 100 UNIT/ML [milliliters- metric unit used to measure the volume of a liquid] .inject. Subcutaneously [under the skin] before meals and at bedtime for Type 2 diabetes mellitus with diabetic chronic kidney . During an observation on 4/21/26 at 11:09 a.m. in Resident 46's room, Licensed Vocational Nurse (LVN) 3 was observed administering 6 units of insulin lispro to Resident 46's upper right quadrant. During an observation on 4/21/26 at 11:21 a.m. in Resident 117's room, LVN 3 was observed administering 4 units of insulin lispro to Resident 117's upper left quadrant.During an interview on 4/21/26 at 12:38 p.m. with LVN 3, LVN 3 stated Resident 46 had not had her meal and Resident 117 ate at noon. LVN 3 stated residents should eat food after insulin was administered. LVN 3 stated it was important to eat within a short time because the blood sugar could go down. During a review of Resident 46's AR, dated 4/23/26, the AR indicated Resident 46 was admitted to the facility on [DATE] with a diagnosis which included Type 2 diabetes mellitus, hyperlipidemia, chronic kidney disease, and long term (current) use of Insulin.During a review of Resident 46's OSR, dated 3/30/26, the OSR indicated, Resident 46 had an active order for . insulin aspart injection solution 100 UNIT/ML .inject. Subcutaneously before meals for DM2 During a review of Resident 117's AR, dated 4/23/26, the AR indicated Resident 117 was admitted to the facility on [DATE] with a diagnosis which included Type 2 diabetes mellitus, hyperlipidemia, end stage kidney disease, and long term use of Insulin.During a review of Resident 117's OSR, dated 4/22/26, the OSR indicated, Resident 117 had an active order for . insulin lispro injection solution 100 UNIT/ML .inject. Subcutaneously four times a day for DM, Give 15 minutes before meal and at [bedtime (HS)] . During an interview on 4/22/26 at 3:19 p.m. with the DON, the DON stated the expectation from nurses was for insulin lispro or aspart to be given when the resident breakfast was available to the resident because the medication was short acting and had a quick onset. The DON stated the insulin should be administered no more than 15 mins before meal started. During a telephone interview on 4/24/26 at 10:14 a.m. with the CRPH, the CRPH stated the insulin lispro or aspart should be administered 15 minutes before the meal or immediately after the meal, so the resident does not become hypoglycemic.During a professional reference review retrieved from National Library of Medicine/National Institute of Health- Daily Med found at https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=2be14cbb-197a-4da8-82c8-2443594e7f6f, titled, INSULIN LISPRO injection, solution, undated, the professional reference review indicated .2.2 Administration Instructions for the Approved Routes of Administration-Subcutaneous Injection-Administer the dose of Insulin Lispro within fifteen minutes before a meal or immediately after a meal by injection into the subcutaneous tissue of the abdominal wall, thigh, upper arm, or buttocks.During a professional reference review retrieved from National Library of Medicine/National Institute of Health- Daily Med found at https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=bee5b358-c863-420b-be73-ced2e920c499, titled, INSULIN ASPART injection, solution, undated, the professional reference review indicated .2.2 Preparation and Administration Instructions for the Approved Routes of Administration- Subcutaneous Injection-Inject Insulin Aspart subcutaneously within 5-10 minutes before a meal into the abdominal area, thigh, buttocks or upper arm.During a review of the facility's P&P titled, Medication Administration, undated, the P&P indicated, .Policy: medications are administered by licensed nurses, (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice, in a manner to prevent contamination or infection.12a. Refer to drug reference material if unfamiliar with the medication, including its mechanism of action and common side effects.16. Management of a resident's insulin . will be in compliance with practitioner's orders ., blood glucose checks, and as per manufacturers instruction . for the insulin.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, and record review, the facility failed to ensure drugs and biologicals used in the facility were labeled and stored in accordance with the facility policy and procedures (P&P) when:1. In Station 4 medication room, lorazepam (a Schedule IV controlled medication used for short-term treatment of anxiety (the body's natural response to stress, feeling intense worry, fear, or unease), sleep disorders, acute seizures (a sudden, uncontrolled burst of electrical activity in the brain that temporarily disrupts normal brain function) oral solution was not stored at appropriate fridge temperature per manufacturer's guidelines of 2 to 8 C (C- a scale for measuring temperature) and the medication fridge temperature was 10 C.This failure had the potential to cause degradation (process of something becoming worse, weaker, or less valuable) of the medication, making it ineffective.2. 15 Insulin (injectable medication to help control blood sugar levels) pens for 10 Residents (Residents 46, 117, 170, 67, 148, 42, 76, 107, 30, and 83) were not appropriately labeled. The date open and expiration date labels were on the removable caps of insulin pens and not on the actual pens.This failure had the potential for Residents 46, 117, 170, 67, 148, 42, 76, 107, 30, and 83's pen caps to be swapped between pens which could lead to medication safety error, cross contamination (unintended transfer of bacteria, viruses, or germs from one surface, substance, often leading to illnesses) and infection.3. There were no patient identifiers (name and date of birth) on Resident 164's Insulin Regular 10 milliliter (ml - unit of measure) Multi-Dose Vial (MDV) and four Residents (Residents 115, 182, 149, and 83)'s Inhalers (a small, portable, handheld device used to deliver medication directly into the lungs by breathing it in through the mouth). This failure had the potential for Resident 164 to become hypoglycemic (condition where sugar levels in the blood drop too low) from inability to identify Resident 164's MDV Insulin and for Residents 115, 182, 149, and 83 to use other residents' inhalers which could lead to respiratory distress (state of difficulty breathing or inadequate breathing), cross contamination and infection.4. Three Residents (Residents 140, 164, and 154) had discontinued medication orders and their medications were not separated or removed and were available for use in the medication cart.This failure had the potential for medication errors which could result in significant harm to Residents 140, 164 and 154, including adverse drug reactions (a harmful, unintended reaction to a medication that occurs at regular doses used for treatment), toxicity (a substance can damage, harm, or poison a living being), or the reversal of positive health changes.5. In Station 1 medication room, Vancomycin (antibiotic medication used to treat infections) 1 gram /200 ml (gm/ml - unit of measure) 0.9% Normal Saline (mixture of salt and water used to replenish fluid and electrolytes) premix and lactated ringers (LR- balanced intravenous (IV) fluid used to rapidly replace fluids and electrolytes (minerals in the blood and other body fluids that carry an electric charge), treat severe dehydration, or manage blood loss) 1Liter (L- unit of measure) bags were not stored in an appropriate room according to manufacturer's guidelines. This failure had the potential for therapeutic failure due to degradation, severe adverse infusion reactions, or physical harm from chemical changes. 6. Two 1 ml testosterone (a hormone that sex organs mainly produce) vials control medication for Resident 181 were found in the top drawer of Station 1 medication cart with over the counter (OTC) medications and were not separated and stored with other controlled medications.This failure had the potential for diversion (the illegal transfer, theft, or misuse of prescription medication), mismanagement, or unaccounted medication, and the potential for medication error due to medication mix up for Resident 181.Findings:1. During a concurrent observation and interview on 4/21/26 at 1:42 p.m. with Charge Nurse (CRN) 1 at station 4 medication room, the medication fridge temperature was 10 C, an opened box of lorazepam oral solution 2 milligram/milliliter (mg/ml-unit of measure) was observed in the fridge, the medication was not labeled with date opened or expiration date. CRN 1 stated the expectation was when medications were opened, they should be labeled with opened date (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	and discard date. CRN 1 stated the lorazepam medication was not labeled. CRN 1 stated the fridge thermometer was at 10 C. CRN 1 stated the temperature was too high at 10 C. CRN 1 stated the lorazepam solution should be stored at 2 to 8 C and the medication should be discarded.During an interview on 4/22/26 at 3:45 p.m. with the Director of Nursing (DON), the DON stated if a medication was not stored at the temperature required, it could affect the potency of the medication, and it would not be effective for the residents. During a telephone interview on 4/24/26 at 10:14 a.m. with the Consultant Pharmacist (CRPH), the CRPH stated the facility staff should be checking the fridge temperature, documenting on the log sheet, and when out of range, notify the appropriate personnel, adjust and follow up to ensure the fridge was in range. The CRPH stated if the manufacturer had guidelines for how the lorazepam should be stored, it could affect stability, effectiveness, and how long the medication would be good for.During a review of the facility's document provided on lorazepam, undated, the document indicated, . lorazepam should generally be stored in the refrigerator at 2 C to 8 C (36 F - 46 F) .During a professional reference review retrieved from National Library of Medicine/National Institute of Health- Daily Med found at https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=711b60a3-028d-41d4-aa17-8f976e6df23e, an article titled, LORAZEPAM liquid, undated, the professional reference review indicated .2 mg per mL Lorazepam Oral Concentrate USP NDC 0121-0770-01:1 fl [fluid] [ounce (oz)] (30 mL) with calibrated dropper (graduations of 0.25 mL [0.5 mg], 0.5 mL [1 mg], 0.75 mL [1.5 mg] and 1 mL [2 mg] on the dropper). PROTECT FROM LIGHT. Keep bottles tightly closed. Store at Cold Temperature. Refrigerate 2 - 8 C (36 - 46 F) .During a review of the facility's P&P titled, Medication Administration, undated, the P&P indicated, .Policy: medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice, in a manner to prevent contamination or infection.12a. Refer to drug reference material if unfamiliar with the medication, including its mechanism of action and common side effects .During a review of the facility's P&P titled, Medication Storage, dated 8/1/2025, the P&P indicated, . Policy: it is the policy of this facility to ensure all medications housed on our premises will be stored in the pharmacy and/ or medication rooms according to the manufacturers recommendations and sufficient to ensure proper sanitation, temperature, ventilation, moisture control, segregation, and security.1. General guidelines: a. all drugs and biologicals will be stored in locked compartments (i.e., medication carts, cabinets, drawers, refrigerators, medication rooms) under proper temperature controls.6a. All medications requiring refrigeration are stored in refrigerators located in the pharmacy and at each medication room. B. Temperatures are maintained within 36 - 46 F. Charts are kept on each refrigerator and temperature levels are recorded daily by the child nurse or other designee. c. In the event that a refrigerator is malfunctioning, the person discovering the malfunction must promptly report such findings to the maintenance department for emergency repair. d. In the event that emergency repairs cannot be made timely, temporary or emergency space is available in the pharmacy refrigerator or the refrigerator located at each medication room.2. During a concurrent observation and interview on 4/22/26 at 11:16 a.m. with Licensed Vocational Nurse (LVN) 3 at station 4A medication cart, 6 insulin pens (Insulin lispro (works quickly to control high blood sugar) for Resident 46, Insulin lispro pen for Resident 117, and Insulin glargine (long acting insulin to control high blood sugar) pen for Resident 170) were observed in the medication cart with date opened and expiration date labels on the removable caps of insulin pens. LVN 3 observed the date opened and expiration date labeling on the caps of insulin pens and made no comments.During a concurrent observation and interview on 4/22/26 at 11:19 a.m. with Registered Nurse (RN) 6, at station 2A medication cart, 6 insulin pens (Insulin lispro and Insulin glargine pens for Resident 67, Insulin Regular (short acting insulin to control high blood sugar) pen for Resident 148, and Insulin lispro, Insulin glargine and Insulin aspart pens for Resident 42) were observed in the medication cart with date opened and expiration date labels on the removable caps of insulin pens. RN 6 stated the caps could get mixed up.During a concurrent observation and interview on 4/22/26 at (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	11:44 a.m. with RN 2 at station 1A medication cart, 6 insulin pens (Insulin glargine and human insulin flex pen for Resident 76, Insulin lispro and Insulin glargine pens for Resident 107, human Insulin pen for Resident 30, and Insulin lispro pen for Resident 83) were observed in the medication cart with date opened and expiration date labels on removable caps of insulin pens. RN 2 stated labelled caps could accidentally cause wrong expiration dates to be on another pen if switched. RN 2 stated the nursing staff would not know which pen was for which residents. During an interview on 4/22/26 at 3:49 p.m. with the DON, the DON stated if the pen caps were missing, the nursing staff would not know when the insulin was first used, and the insulin pen would have the wrong expiration date if swapped with another pen cap. The DON stated this failure could cause contamination for use more than the expected expiration date and could affect the potency of medication. During a telephone interview on 4/24/26 at 10:14 a.m. with the CRPH, the CRPH stated the opened and expiration date should be put on the actual product in case the pen caps got switched. During a review of the facility's P&P titled, Medication Administration, undated, the P&P indicated, .Policy: medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice, in a manner to prevent contamination or infection.16. Management of a resident's insulin . will be in compliance with practitioner's orders ., blood glucose checks, and as per manufacturers instruction . for the insulin. 3. During a concurrent observation and interview on 4/22/26 at 11:27 a.m. with RN 6, at station 2A medication cart, Resident 115 and Resident 182's budesonide and formoterol fumarate dihydrate inhaler (medication to treat lung disease) and Resident 149's fluticasone propionate and salmeterol (medication to treat lung disease) 250-50 inhalers were observed in the medication cart with no patient identifier on the actual products. RN 6 stated the expectation was for nursing staff to label the inhalers with the resident's name, so the nursing staff do not mix the inhalers up. During a concurrent observation and interview on 4/22/26 at 11:27 a.m. with RN 2, at station 1A medication cart, Resident 83's umeclidinium and vilanterol (medication to treat lung disease) 62.5/25 microgram (mcg-unit of measure) inhaler was observed in the medication cart with no patient identifier on the actual product. RN 2 stated it was important to always put the resident's name on the inhaler, so that nursing staff would know whose inhaler it was. During a concurrent observation and interview on 4/22/26 at 1:21 p.m. with CRN 1 at station 4B medication cart, Resident 164's Insulin Regular 10 ml mdv were observed in the medication cart with no patient identifier on the actual product. CRN 1 stated the insulin regular needed to be labeled so the nursing staff knew the right patient for the medication. CRN 1 stated if there was no label, there was the potential to accidentally use the medication for the wrong patient. During an interview on 4/22/26 at 3:51 p.m. with the DON, the DON stated the patient identifier should be on the inhaler and the box to ensure the inhaler was for the right resident and to be sure how many puffs to administer to the resident. The DON stated if there was no identifier on the inhaler or MDV, if given to the wrong resident, it could be an infection control issue. During a telephone interview on 4/24/26 at 10:38 a.m. with the CRPH, the CRPH stated the expectation was for nurses to write the name of the residents on the inhalers. The CRPH stated pharmacy should label the Insulin vial with a patient identifier. The CRPH stated it was important that the medications had identifiers because the nursing staff would not know who the medications belonged to once the medications were out of the box package.During a review of the facility's P&P titled, Medication Administration, undated, the P&P indicated, . Policy: medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice, in a manner to prevent contamination or infection.10. Ensure that the six rights of medication administration are followed: a. right resident b. right drug c. right dosage d. right route e. right time f. right documentation .4. During a concurrent observation and interview on 4/22/26 at 11:34 a.m. with RN 6 at station 2A medication cart, Residents 140's discontinued enoxaparin (medication used to prevent blood clots) 40 mg single dose syringes (a medical tool used to inject fluids into or withdraw fluids from the body) containing 6 (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	syringes were observed in the medication cart. The instructions on the box of the medication read Inject 40 mg subcutaneously [beneath the skin] one time a day for [deep vein thrombosis (DVT)-a serious condition where a blood clot forms in a deep vein, usually leg or thigh] prophylaxis [prevent the spread of a disease] for 2 weeks. RN 6 stated the enoxaparin order was discontinued on 4/4/26. RN 6 stated the medication should have been removed and put with the discontinued medications.During a review of Resident 140's Medication Administration Record (MAR) for enoxaparin, dated 3/20/26 , the MAR indicated the order with instructions [Brand name] injection solution prefilled syringe 40mg/0.4ml (enoxaparin sodium). Inject 40 mg subcutaneously one time a day for DVT prophylaxis for 2 weeks. The MAR indicated the medication was administered from 3/20/26 - 4/3/26. During a concurrent observation and interview on 4/22/26 at 1:04 p.m. with CRN 1 at station 4B medication cart, Residents 164 and 154 's discontinued ondansetron (medication used to treat nausea and vomiting) 4 mg medication cards containing 14 tablets and 5 tablets respectively, were observed in the medication cart. Resident 164's ondansetron medication card containing 14 tablets, indicated ondansetron 4 mg, Give 1 tablet by mouth every 8 hours as needed for nausea and vomiting for 14 days, and Resident 154's ondansetron medication card containing 5 tablets, indicated ondansetron 4 mg, Give 1 tablet by mouth every 6 hours as needed for nausea and vomiting for 10 days. CRN 1 stated both Residents 164 and 154's ondansetron orders had been discontinued. CRN 1 stated discontinued medications should be removed from the medication cart, so it was not accidentally given to the residents. During a review of Resident 164's MAR for ondansetron, dated 12/2/26, the MAR indicated the order for ondansetron 4 mg, Give 1 tablet by mouth every 8 hours as needed for nausea and vomiting for 14 days. During a review of Resident 154's MAR for ondansetron, dated 3/26/26, the MAR indicated the order for ondansetron tablet 4 mg Give 1 tablet by mouth every 6 hours as needed for nausea and vomiting for 10 days. During an interview on 4/22/26 at 3:56 p.m. with the DON, the DON stated discontinued medications should be removed from medication cart. The DON stated this was to ensure the medications were not mistakenly given to the residents. During a telephone interview on 4/24/26 at 10:40 a.m. with the CRPH, the CRPH stated the discontinued medications should be removed from active supply and placed in an area for disposal and they should be timely disposed of. During a review of the facility's P&P titled, Medication Storage, dated 8/1/2025, the P&P indicated, . 8 Unused medications: The pharmacy and all medication rooms are routinely inspected by the consultant pharmacy for discontinued, outdated, defective, or deteriorated medications with worn, eligible, or missing labels. These medications are destroyed in accordance with our destruction of unused drugs policy.5. During a concurrent observation and interview on 4/21/26 at 1:54 p.m. with LVN 4 at station 1 medication room, the room thermometer was observed to be at 80 F and vancomycin 1 gm/200 ml NS premix and two lactated ringers 1L bags were observed to be in the room. LVN 4 acknowledged the room temperature was 80 F. LVN 4 stated room temperature should be 71 F. LVN 4 stated the vancomycin 1 gm/200 ml NS premix bag should be stored below 77 F as indicated on the product package. During an interview on 4/22/26 at 3:45 p.m. with the DON, the DON stated if medication was not stored at the temperature required it could affect the potency of the medication, and it would not be effective for the residents. During a telephone interview on 4/24/26 at 10:36 a.m. with the CRPH, the CRPH stated the vancomycin and lactated ringer solutions were being stored outside of the appropriate temperature range. The CRPH stated if outside of range, stability is gone and they need to get stability.During a professional reference review retrieved from National Library of Medicine/National Institute of Health- Daily Med found at https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=60bee69b-be70-412c-9e83-a24a0a8a5e7b, titled, VANCOMYCIN injection, solution, undated, the professional reference review indicated .Vancomycin Injection, USP is supplied as a ready to use clear, colorless to light brown solution in single-dose flexible bags . 16.2 Storage. Store below 25 C (77 F), in original package.During a professional reference review retrieved from National Library of Medicine/National Institute of Health- Daily Med found at (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=dad7735c-709b-40ea-ab7a-15577e24a966, titled, LACTATED RINGERS- sodium chloride, potassium chloride, sodium lactate and calcium chloride injection, solution, no dated, the professional reference review indicated.Lactated Ringer's Injection, USP is supplied as a clear solution in single-dose. as follows: . Code 2B2324- Size (mL)1000.Storage and Handling- Store at room temperature (recommended 25 C/77 F). Exposure to heat should be minimized. Avoid excessive heat .During a review of the facility's P&P titled, Medication Storage, dated 8/1/2025, the P&P indicated, . Policy: it is the policy of this facility to ensure all medications housed on our premises will be stored in the pharmacy and/ or medication rooms according to the manufacturers recommendations and sufficient to ensure proper sanitation, temperature, ventilation, moisture control, segregation, and security.1. General guidelines: a. all drugs and biologicals will be stored in locked compartments (i.e., medication carts, cabinets, drawers, refrigerators, medication rooms) under proper temperature controls.6. During a concurrent observation and interview on 4/22/26 at 11:44 a.m. with RN 2, at station 1A medication cart, 1ml testosterone 200mg/ml vials for Resident 181 were observed in the top drawer of the medication cart with other OTC medications.RN 2 stated the testosterone came from the community hospital; therefore, she was unaware it was a controlled medication. RN 2 stated controlled medications should be stored in a locked drawer and it should be logged to monitor the dose and time given. RN 2 stated the resident had an order for the medication and the medication was family supplied. During an interview on 4/22/26 at 3:57 p.m. with the DON, the DON stated when the resident's own medications were brought in by family, and were being used by the facility, the medication should be verified by the pharmacist. The DON stated the controlled medication should not be in medication cart available for use without being verified. The DON stated controlled medications should be stored in compartments and should have log sheets.During a telephone interview on 4/24/26 at 10:42 a.m. with the CRPH, the CRPH stated the testosterone-controlled medication should be locked up and there should be a count sheet and the medication needed to be verified by the pharmacist. The CRPH stated it was important to verify the product matched the physician's order. The CRPH stated the medication was a controlled drug and needed to be accounted for. During a review of the facility's P&P titled, Medications brought to facility by the resident/ family / physician /prescriber, dated 09/01/12, the P&P indicated, . This policy . set forth procedures relating to medications brought to facility by a resident, a resident responsible party, or a residence physician/ prescriber. 1. Facility staff shall not administer medications, including over the counter medications, naturally occurring of substances, and physician/ prescriber medication samples, and brought to the facility by a resident, a residence family, for a residence physician/ prescriber, unless.1.3. Medications are received: 1.3.3 brought from home. These medications must be verified by a pharmacist before they can be used. 1.3. 3.1 send medications requiring verification to pharmacy. 1.3.3.2 pharmacy will verify medications and label container verified 1.3.3.3 pharmacy will return medication to facility after verification.During a review of the facility's P&P titled, Inventory Control of Controlled Substances, dated 01/01/13, the P&P indicated, . 2. Facility should ensure that facility staff count all scheduled III - V controlled substances in accordance with facility policy and applicable law.

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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, interviews and record review, the facility failed to ensure menus were followed for 20 of 66 sampled residents (Residents 8, 65, 84, 92, 71, 60, 98. 33, 57, 109, 102, 119, 172, 145, 78, 106, 116, 51, 21, and 58) when they were not provided mashed sweet potatoes according to the menu during the lunch meal service on 4/21/26.This failure had the potential to result in not meeting the micronutrients (referred to as vitamins and minerals, are vital to healthy development, growth, disease prevention, and well-being) in the physician's prescribed therapeutic diets which could compromise nutritional and medical status of Residents 8, 65, 84, 92, 71, 60, 98. 33, 57, 109, 102, 119, 172, 145, 78, 106, 116, 51, 21, and 58.During a review of the lunch menu for 4/21/26 indicated, baked honey glaze ham, baked sweet potatoes, and French style green beans for the following diets: regular (House), PU4 (Puree level 4), MM5 (Minced and Moist level 5), SB6 (Soft and Bite Level 6), EC7 (Easy to Chew level 7) and CCHO (Consistent Carbohydrate diet for residents with Diabetes Mellitus- a chronic metabolic disorder characterized by high blood sugar (hyperglycemia) due to insufficient insulin production or ineffective insulin) During an observation of the lunch meal service on 4/21/26 starting at 11:57 a.m., in the kitchen on the steam table (commercial kitchen appliance used for hot-holding prepared food at temperatures above 135 degrees Fahrenheit. It consists of a stainless-steel unit with open wells filled with hot water or heated by steam, designed to hold food pans for buffets or cafeteria-style service), there was a large full hotel pan approximately 12 inches by 20 inches long filled with mashed sweet potatoes. The Dietary [NAME] (DC) would portion out 4 ounces of sweet potatoes on the lunch plates for the residents. During an observation of the lunch meal service on 4/21/26 at 1:00 p.m. in the kitchen, the two pans (1 full and 1 half) of mashed sweet potatoes were emptied. Dietary [NAME] (DC) 1 started using mashed potatoes and pasta for lunch meal trays for the last meal cart for 20 Residents (Residents 8, 65, 84, 92, 71, 60, 98. 33, 57, 109, 102, 119, 172, 145, 78, 106, 116, 51, 21, and 58).During a concurrent observation and record review of Resident 8's lunch meal ticket during the lunch meal service on 4/21/26, Resident 8's lunch meal ticket indicated, Diet Order: Regular CCHO. Resident 8's lunch meal plate contained mashed potato.During a concurrent observation and record review of Resident 65's lunch meal ticket during the lunch meal service on 4/21/26, Resident 65's lunch meal ticket indicated, Diet Order: Regular CCHO. Resident 65's lunch meal plate contained mashed potato.During a concurrent observation and record review of Resident 84's lunch meal ticket during the lunch meal service on 4/21/26, Resident 84's lunch meal ticket indicated, Diet Order: Regular. Resident 84's lunch meal plate contained mashed potato.During a concurrent observation and review of Resident 92's lunch meal ticket during the lunch meal service on 4/21/26, Resident 92's lunch meal ticket indicated, Diet Order: Regular. Resident 92's lunch meal plate contained mashed potato.During a concurrent observation and review of Resident 44's lunch meal ticket during the lunch meal service on 4/21/26, Resident 44's lunch meal ticket indicated, Diet Order: Regular. Resident 44's lunch meal plate contained mashed potato.During a concurrent observation and record review of Resident 71's lunch meal ticket during the lunch meal service on 4/21/26, Resident 71's lunch meal ticket indicated, Diet Order: Regular CCHO. Resident 71's lunch meal plate contained mashed potato.During a concurrent observation and review of Resident 60's lunch meal ticket during the lunch meal service on 4/21/26, Resident 60's lunch meal ticket indicated, Diet Order: Regular. Resident 60's lunch meal plate contained mashed potato.During a concurrent observation and record review of Resident 98's lunch meal ticket during the lunch meal service on 4/21/26, Resident 98's lunch meal ticket indicated, Diet Order: Regular, Large Portions, CCHO. Resident 98's lunch meal plate contained mashed potato.During a concurrent observation and record review of Resident 33's lunch meal ticket during the lunch meal service on 4/21/26, Resident 33's lunch meal ticket indicated, Diet Order: Regular, CCHO. Resident 71's lunch meal plate contained mashed potato.During a concurrent observation and record review of Resident 57's lunch meal ticket (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	during the lunch meal service on 4/21/26, Resident 57's lunch meal ticket indicated, Diet Order: Regular, No Added Salt. Resident 57's lunch meal plate contained mashed potato.During a concurrent observation and record review of Resident 109's lunch meal ticket during the lunch meal service on 4/21/26, Resident 109's lunch meal ticket indicated, Diet Order: Regular, No Added Salt. Resident 109's lunch meal plate contained mashed potato.During a concurrent observation and record review of Resident 102's lunch meal ticket during the lunch meal service on 4/21/26, Resident 102's lunch meal ticket indicated, Diet Order: Regular, CCHO. Resident 102's lunch meal plate contained mashed potato.During a concurrent observation and record review of Resident 119's lunch meal ticket during the lunch meal service on 4/21/26, Resident 119's lunch meal ticket indicated, Diet Order: SB6, Regular . Resident 119's lunch meal plate contained mashed potato.During a concurrent observation and record review of Resident 172's lunch meal ticket during the lunch meal service on 4/21/26, Resident 172's lunch meal ticket indicated, Diet Order: PU4 . Resident 172's lunch meal plate contained mashed potato.During a concurrent observation and record review of Resident 102's lunch meal ticket during the lunch meal service on 4/21/26, Resident 102's lunch meal ticket indicated, Diet Order: Regular, CCHO. Resident 102's lunch meal plate contained mashed potato.During a concurrent observation and record review of Resident 145's lunch meal ticket during the lunch meal service on 4/21/26, Resident 145's lunch meal ticket indicated, Diet Order: Regular, Large Portions. Resident 145's lunch meal plate contained mashed potato.During a concurrent observation and record review of Resident 78's lunch meal ticket during the lunch meal service on 4/21/26, Resident 78's lunch meal ticket indicated, Diet Order: Regular, CCHO. Resident 78's lunch meal plate contained mashed potato.During a concurrent observation and record review of Resident 106's lunch meal ticket during the lunch meal service on 4/21/26, Resident 106's lunch meal ticket indicated, Diet Order: Regular, Large Portions, No Added Salt . Resident 106's lunch meal plate contained mashed potato.During a concurrent observation and record review of Resident 116's lunch meal ticket during the lunch meal service on 4/21/26, Resident 116's lunch meal ticket indicated, Diet Order: Regular, Large Portions, No Added Salt . Resident 116's lunch meal plate contained mashed potato.During a concurrent observation and record review of Resident 51's lunch meal ticket during the lunch meal service on 4/21/26, Resident 51's lunch meal ticket indicated, Diet Order: SB6, Regular . Resident 51's lunch meal plate contained mashed potato.During a concurrent observation and record review of Resident 21's lunch meal ticket during the lunch meal service on 4/21/26 in the kitchen, Resident 21's lunch meal ticket indicated, Diet Order: Regular, CCHO, No Added Salt . Resident 21's lunch meal plate contained pasta.During a concurrent observation and record review of Resident 58's lunch meal ticket during the lunch meal service on 4/21/26, Resident 58's lunch meal ticket indicated, Diet Order: Regular, Small Portions, CCHO . Resident 58's lunch meal plate contained pasta.During a concurrent observation and interview on 4/21/26 at 1:16 p.m. with DC 1, in the kitchen, DC 1 completed serving lunch meal. DC 1 stated the mashed sweet potatoes ran out and needed to use regular mashed potatoes and pasta for the remaining lunch meal trays. DC1 stated he used eight of number 10 cans of sweet potatoes in making mashed sweet potatoes for 167 residents. DC 1 stated that number 10 cans can make 25 servings and he used one of number 10 cans for puree. DC 1 stated he would have enough servings for 167 residents but possibly he was serving too big of a size. DC1 stated he used mashed potatoes and pasta as alternative for mashed sweet potatoes.During an interview on 4/22/26 at 9:57 a.m. with the Dietary Manager (DM), the DM stated mashed sweet potatoes ran out towards the end of lunch meal service yesterday (4/21/26) and she made regular mashed potatoes as alternative. The DM stated there was no available supply of sweet potato on hand yesterday (4/21/26) after using six of number 10 cans for 167 residents. The DM stated she placed an order for cans of sweet potatoes yesterday (4/21/26) at a retail's grocery store and that was used to prepare the sweet potatoes for the residents on a puree diet.During a review of invoice from retail's grocery store, dated 4/21/26, indicated, .7 cans, 40-ounce per can of sweet potatoes cut yam in syrup.During a review of invoice from food vendor, dated 4/16/26, indicated, . potato, sweet cut.pack size: (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure one of seven sampled residents (Resident 12) was informed in advance, by the physician or other practitioner of the risks and benefits of proposed treatment when Resident 12 did not have a signed physician informed consent (a process in which a healthcare professional educates a patient about the risks, benefits, and alternatives of a given procedure or intervention) prior to the use of bed (side) rails (adjustable metal or rigid plastic bars in various sizes that attach to the bed, and can be placed in a guard (raised) or lowered) position.This failure resulted in the violation of Resident 12's Responsible Party's (RP - individual authorized to act on a resident's behalf regarding care) right to be informed, in advance of alternative treatment options and the risks of using side rails, which had the potential to cause entrapment (resident caught, trapped, or entangled in the space in or about the bed and side rail), serious harm, injury, or death to Resident 12.Findings:During an observation on 4/21/2026 at 7:02 a.m. in Resident 12's room, Resident 12 was observed asleep in bed, wearing a gown with side rails up on the left and right side of the bed and a fall mat on the right side of Resident 12's bed.During a review of Resident 12's admission Record (AR - a summary of information regarding a patient which includes patient identification, past medical history, insurance status, care providers, family contact information and other pertinent information), dated 4/23/26, the AR indicated Resident 12 was admitted to the facility from an acute care hospital on [DATE] with diagnoses of cerebral infarction (damage to tissues in the brain due to a loss of oxygen to the area), Alzheimer's disease (a brain disorder that slowly destroys memory and thinking skills, and eventually, the ability to carry out the simplest tasks), dementia (loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life), schizophrenia (a mental illness that affects a person's ability to think, feel, and behave clearly), depression (persistent feelings of sadness, despair, loss of energy, and difficulty dealing with normal daily life), and history of falling.During a review of Resident 12's Minimum Data Set (MDS - a resident assessment tool used to identify cognitive [mental processes] and physical functional level assessment), dated 3/18/26, the MDS section C indicated Resident 12 had a Brief Interview for Mental Status (BIMS - a test given by medical professionals to determine cognitive (involving the process of thinking, learning and understanding) understanding on a scale of 1-15) score of three (a score of 0-7 suggests severe cognitive impairment, 8-12 suggests moderately impaired, 13-15 suggests cognitively intact), which indicated Resident 12 was severely cognitively impaired.During a review of Resident 12's MDS, dated 3/16/26, the MDS section GG (Functional Abilities) indicated Resident 12 had, .impairment on one side.upper extremity [shoulder, elbow, wrist, hand].used in the last 7 days.wheelchair.Dependent [helper does ALL of the effort. Resident does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the resident to complete the activity].chair/bed-to-chair transfer: The ability to transfer to and from a bed to a chair [or wheelchair].During an interview on 4/22/26 at 4:10 p.m. with Certified Nursing Assistant (CNA) 1, CNA 1 stated Resident 12 had her side rails up because she tried to get out of bed and had fallen in the past. During a concurrent interview and record review on 4/22/26 at 4:15 p.m. with Licensed Vocational Nurse (LVN) 1, Resident 12's electronic medical record (EMR), undated was reviewed. LVN 1 stated she was unable to find a consent form or physician order for Resident 12's use of side rails.During a concurrent observation and interview on 4/22/26 at 4:28 p.m. with the Assistant Director of Nursing (ADON), in Resident 12's room, Resident 12 was observed sleeping in her bed with the right and left side rails of her bed in the guard position. The ADON stated it was important to have a consent for the use of side rails, as the rails were a form of restraint. The ADON was unable to provide a signed consent form for Resident 12's use of side rails.During an interview on 4/23/2026 at 10:27 a.m. with LVN 1, LVN 1 stated Resident 12 should have a consent form and physician orders for the use of side rails. LVN 1 stated side rails were considered a restraint. LVN 1 (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stated prior to installing the side rails, staff should have checked on Resident 12 more often, and the physician should have been notified to receive an order for the side rails. LVN 1 stated side rails could have caused an injury to Resident 12, if she tried to climb over the rails to get out of bed or she could have become stuck between the rails. During an interview on 4/24/2026 at 10:32 a.m. with the Director of Nursing (DON), the DON stated Resident 12 should not have had her side rails up on her bed. The DON stated Resident 12 needed a consent and bed assessment before the side rails were applied on her bed. The DON stated the facility was a non-restraint facility and side rails were considered a restrictive device. The DON stated residents could become entrapped or hang themselves on the side rails. The DON stated there needed to be a physician's order for the use of side rails and the resident needed to be assessed prior to the use of side rails to be sure the rails were needed.During a review of the facility's policy and procedure (P&P) titled, Bed Rails, dated 8/2025, the P&P indicated, .it is the policy of this facility to attempt to use appropriate alternatives prior to installing a side or bed rail.if the use of bed rails is recommended by the Interdisciplinary Team [IDT], the facility must obtain informed consent from the resident, or if applicable, the resident representative for the use of bed rails prior to installation or use.During a review of the facility's P&P titled, Restraint Devices, Physical, dated 2006, the P&P indicated, .purpose.to prevent the resident from injuring himself or others.restraints of any type will not be used as punishment or as a substitute for more effective medical and nursing care or for the convenience of the facility staff.physical restraints are defined as any manual method or physical or mechanical device, material, or equipment attached or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body.assess resident's need for restraint device use.obtain informed consent for restraint device use.During a review of the facility's P&P titled, Resident Rights and Responsibilities, Notice of, dated 8/2025, the P&P indicated, .it is the policy of this facility to inform the resident both orally and in writing of their rights as a resident.should a resident be found incompetent by a court of law, the resident's representative shall act on behalf of the resident.During a review of the facility's document titled, California Standard admission Agreement for Skilled Nursing Facilities and Intermediate Care Facilities (AA), undated, the AA section 483.10 indicated, .Resident Rights.a facility must protect and promote the rights of each resident including each of the following rights.be fully informed in advance about care and treatment and of any changes in that care or treatment that may affect the resident's well being.

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. Based on observation, interview, and record review, the facility failed to ensure one of eight sampled residents (Resident 61), was assessed to self-administer and store mediations at bedside when Resident 61 had an expired bottle of [brand name polyethylene glycol 400 0.25% (over the counter eye drop medication used to treat dry eyes)] eye drops stored at bedside for self-administration with no order or Medication Self-Administration Assessment Form (MSA- an assessment form to determine if a resident is clinically appropriate to safely and securely store and self-administer their own medication at bedside).This failure resulted in Resident 61 self-administering and storing expired medication at bedside without oversight which could lead to duplicate therapy, medication interactions, and adverse effects.Findings:During a concurrent observation and interview on 4/21/26 at 7:31 a.m. with Resident 61, in Resident 61's room, Resident 61 was observed lying in bed. Resident 61 was observed with [brand name polyethylene glycol 400 0.25%] eye drops on the center of his bedside table. The expiration date on the eye drops were 10/2018. Resident 61 stated [brand name polyethylene glycol 400 0.25%] eye drops were brought from home when he was admitted , and he had stored them on his bedside table since admission. Resident 61 stated his daughter applied the eye drops to his eyes everyday when she visited.During an observation on 4/21/26 at 7:41 a.m. in Resident 61's room, Certified Nursing Assistant (CNA) 5 was observed delivering Resident 61's breakfast tray. CNA 5 was observed moving Resident 61's eye drops from the center of the bedside table to the corner of the bedside table.During a concurrent interview and record review on 4/22/26 at 10:28 am with Licensed Vocational Nurse (LVN) 5, Resident 61's Medical Record, dated 4/22/26 was reviewed. LVN 5 stated Resident 61 did not have an order for [brand name polyethylene glycol 400 0.25%] eye drops. LVN 5 stated Resident 61 had an as needed order for, polyethylene glycol-propylene glycol eye drops, a different eye drop medication. LVN 5 stated Resident 61 did not have an order to self-administer [brand name polyethylene glycol 400 0.25%] eye drops. LVN 5 stated Resident 61 did not have a Medication Self-Administration Assessment Form (MSA) completed. LVN 5 stated all medications stored and self-administered at bedside were required to have an order and an MSA completed. LVN 5 stated Resident 61 was at risk for unsafe medication storage and self-administration of a medication without an order and MSA completed. LVN 5 stated the eye drops Resident 61 stored at bedside were expired. LVN 5 stated Resident 61 was at risk of side effects, medication interactions, duplicate therapy, unsafe medication storage and access to his expired [brand name polyethylene glycol 400 0.25%] eye drops which were stored at bedside, with no order or MSA. LVN 5 stated all unlicensed and licensed nursing staff were responsible for identifying medications stored and self-administered at bedside to ensure safety.During an interview on 4/22/26 at 10:47 a.m. with Resident 61's Family Member (FM) 1, FM 1 stated she visited Resident 61 on 4/21/26 in the afternoon and administered his eye drops. FM 1 stated Resident 61's eye drops had been stored on his bedside table since admission.During an interview on 4/22/26 at 10:51 a.m. with CNA 5, CNA 5 stated she had observed eye drops on Resident 61's bedside table since his admission. CNA 5 stated licensed nursing staff were responsible for handling medications.During an interview on 4/24/26 at 10:27 a.m. with the Director of Nursing (DON), the DON stated unlicensed and licensed staff were responsible for identifying medications stored and self-administered at bedside. The DON stated residents had the right to store and self-administer medications at bedside, but required an order and an MSA to ensure the resident could safely store and administer their own medications. The DON stated facility policy and procedure was not followed when Resident 61 had expired [brand name polyethylene glycol 400 0.25%] eye drops stored at bedside and was administering them with no physician order or MSA. The DON stated Resident 61 was placed at risk for duplicate therapy, medication interactions, and adverse side effects with no monitoring. During a review of Resident 61's Order Summary Report (OSR), dated 4/22/26, the OSR indicated Resident 61 did not have an order for [brand name polyethylene glycol 400 0.25%] eye drops. The OSR indicated Resident 61 did not have (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	an order to self-administer or store [brand name polyethylene glycol 400 0.25%] eye drops at bedside.During a review of the facility's policy and procedure (P&P) titled, Resident Self-Administration of Medication, undated, the P&P indicated, .a resident may only self-administer medications after the facility's interdisciplinary team has determined which medication may be self-administered safely.when determining is self-administration is clinically appropriate for a resident, the interdisciplinary team should at a minimum consider the following.the medications appropriate and safe for self-administration.the residents physical capacity to.open medication bottles.the residents cognitive status, including their ability to correctly name their medications and know what conditions they are taken for.the residents capability to follow directions and tell time to know when medications need to be taken.the residents comprehension of instructions for the medications they are taking, including the dose, timing, and signs of side effects.the residents ability to ensure that medication is stored safely and securely.the results of the interdisciplinary team assessment are recorded on the Medication Self-Administration Assessment Form, which is placed in the resident's medical record. bedside medication storage is permitted only when it does not present a risk to confused residents who wander into the other resident's rooms or to confused roommates of the resident who self-administers medication.all nurses and aides are required to report to the charge nurse on duty any medication found at the bedside not authorized for bedside storage. Unauthorized medications are given to the charge nurse for return to the family or responsible party. Families or responsible parties are reminded of policy and procedures regarding resident self-administration when necessary. the nursing staff is responsible for proper rotation of bedside stock and removal of expired medications.

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, and record reviews, the facility failed to ensure two of five sampled residents (Resident 3 and Resident 32), were free from unnecessary psychotropic (drugs that affect brain activities with mental processes and behaviors) medications when: a. Resident 3 was prescribed quetiapine fumarate (prescription drugs that alter brain chemistry to affect mood, thoughts, behavior, and perceptions) with inappropriate indication of neurocognitive disorder (decline in mental function-such as memory, attention or language, caused by brain disease, injury or damage). b. There was inadequate monitoring of behaviors for Residents 3's quetiapine fumarate, divalproex sodium (medication used to treat seizures (abnormal electrical activity in the brain) and mood disorders), duloxetine (medication used to treat depression (a serious mood disorder causing persistent sadness, loss of interest, and low energy), anxiety (the body's natural response to stress, feeling intense worry, or unease about the future), and various chronic pain), and trazodone (medication primarily used to treat depression, anxiety, and insomnia (persistent difficulty falling asleep)). c. No gradual dose reductions (GDR-process of slowly lowering the dosage of a medication) were attempted for the use of divalproex sodium, duloxetine, and trazodone. Resident 32 was not adequately monitored for behaviors during the administration of divalproex sodium. These failures resulted in the potential for unnecessary psychotropic medications for Resident 3 and Resident 32 which increased the potential for medication interactions, adverse reactions (unwanted, harmful, or unexpected physical reactions cause by a medication), and unidentified risks associated with the use psychotropic medications including, but not limited to, sedation (use of medication to produce a state of calm, relaxation, or sleepiness), respiratory depression (a serious, potentially fatal condition where breathing becomes shallow, slow or ineffective), memory loss and death. Findings:1a. During a record review of Resident 3's admission Record (AR), dated 4/24/26, the AR indicated Resident 3 was admitted from an acute care hospital on 3/13/25 with diagnosis which included . Alzheimer's Disease [a disease characterized by a progressive decline in mental abilities], Depression, anxiety, and Dementia [a progressive state of decline in mental abilities] . During an observation on 4/22/26 at 9:30 a.m., Resident 3 was observed in his room, sitting in his wheelchair with friend present, and Resident 3 used a whiteboard to communicate.During a record review of Resident 3's Minimum Data Set (MDS- a resident assessment tool used to identify resident cognitive (mental) and physical functional level) assessment, dated 3/6/26, the MDS section C indicated, Resident 3's Brief Interview for Mental Status (BIMS) assessment score was 15 out of 15 (0-6 severe cognitive (pertaining to reasoning memory and judgement) deficit, 7-12 moderate cognitive deficit, 13-15 cognitively intact). The BIMS scores indicated Resident 3 was cognitively intact. During a review of Resident 3's MDS, dated 3/4/26, the MDS indicated in Section E for behavior, under potential indicators of psychosis, none of the above boxes were checked, indicating no hallucinations and delusions. The MDS indicated under Behavioral symptom - Presence and Frequency, all boxes had 0, which indicated for physical behavioral symptoms directed toward others (for example: hitting, kicking, pushing, scratching, grabbing, abusing others sexually), Verbal behavioral symptoms directed toward others (for example: threatening others, screaming at others, cursing at others), Other behavioral symptoms not directed toward others (for example: physical symptoms, such as hitting or scratching self, pacing, rummaging, public sexual acts, disrobing, in public, throwing or smearing food or bodily wastes, or verbal/vocal symptoms like, screaming, disruptive sounds). The MDS indicated, Coding 0 indicated, Behavior not exhibited.During a review of Resident 3's Physician Orders (PO), dated 11/13/25 and 3/15/25, the PO indicated on 11/13/25, Resident 3 was ordered quetiapine fumarate 25 milligram (mg-a measure of weight), give one tablet by mouth at bedtime every other day for neuro cognitive disorder with behavioral disturbance manifested by verbal aggression as evidenced by yelling and (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	screaming toward other. The PO indicated on 3/15/25, Resident 3 was ordered Depakote 125mg, give one tablet by mouth two times a day manifested by increased agitation resulting in physical aggression toward others; trazodone 100mg, given one tablet by mouth at bedtime for depression manifested by inability to sleep; and duloxetine 30 mg give one capsule by mouth one time a day for expression of sadness.During an interview on 4/23/26 at 1:10 p.m. with the Assistant Director of Nursing (ADON), the ADON stated neurocognitive disorder was not an appropriate indication for use of divalproex sodium and quetiapine. The ADON stated she reached out to the physician about the diagnosis, but the physician kept putting neurocognitive disorder. During an interview on 4/24/26 at 9:26 a.m. with the Medical Director (MD), the MD stated Resident 3 uses divalproex sodium as a mood stabilizer, the order should be worded differently, and the diagnosis should be different. The MD stated the indication needed to be updated or changed to something different.During an interview on 4/24/26 at 9:50 a.m. with the Director of Nursing (DON), the DON stated neurocognitive disorder diagnosis was not appropriate. The DON stated she followed up {named hospital} physician and informed the physician the diagnosis and indication should be appropriate, and it was important to follow regulations. During an interview on 4/24/26 at 10:46 a.m. with the Consultant Pharmacist (CRPH), the CRPH stated the neurocognitive disorder diagnosis would be off label, the CRPH stated it was important to have the appropriate indication. The CRPH stated if using any medication for residents, the medications should be used for an indication that has been studied for effectiveness and safety.1b. During an interview on 4/23/26 at 11:07 a.m. with Registered Nurse (RN) 1, RN 1 stated Resident 3's behaviors were normal, he was cooperative with staff, talked easily, followed all instructions, was alert and oriented, was aware of his blood sugar readings, he knew the medications, took all meals, never argued with staff and residents, and he never showed behaviors. RN 1 stated she had worked with Resident 3 on and off for the last 2 years. RN 1 stated Resident 3 checks his pills, asked about his blood sugar, and if his blood sugar was low, he would be concerned.During an observation on 4/23/26 at 11:25 a.m., Resident 3 was observed sitting in his wheelchair on his way to the dining room. Resident 3 stopped and said hello and smiled.During an interview on 4/23/26 at 12 p.m. with the ADON, the ADON stated monthly behavior tallies were completed. During a review of Resident 3's Care Plan (CP), undated, Resident 3's CP indicated, there were no objective goals for the number of episodes for behaviors being monitored for Resident 3's quetiapine, divalproex, duloxetine, and trazodone. During a concurrent interview and record review on 4/23/26 at 1:19 p.m. with the ADON, Resident 3's CP, undated was reviewed. The ADON stated residents have different individualized goals and it was important to monitor behaviors. The ADON stated residents should have measurable goals. The ADON stated the CP indicated there were no measurable goals for the number of behaviors in Resident 3's care plan. The ADON stated this was important, so the facility staff knew when to increase or decrease medications. During an interview on 4/23/26 at 4:08 p.m. with Licensed Vocational Nurse (LVN) 2, LVN 2 stated, Sometimes Resident 3 complained about everything that he saw, if another resident with dementia was passing by with a doll, Resident 3 would be irritated. LVN 2 stated, Resident 3 complained about his insulin injection, he wanted his insulin and his blood sugar checked before he ate eat, even though it was not time yet. LVN 2 stated she considered all these as behaviors and would document them as a total of behaviors on each of the monitoring behavior indicators for quetiapine, divalproex, duloxetine, and trazodone on the MAR.During an interview on 4/24/26 at 10:04 a.m. with the DON, the DON stated there should be monitoring of medications for every resident. The DON stated each medication monitored certain behaviors, and the behaviors were monitored to see if the medication was effective or not, so the medications could be adjusted if needed. The DON stated LVN 2 was not appropriately monitoring the behavioral episodes for Resident 3's quetiapine, duloxetine, divalproex and trazodone. The DON stated it was important to document the number of episodes for each behavior for the medication indicated for that particular behavior. The DON stated it was important for LVN 2 to follow documentation specified, because it helped to know if residents would benefit from the medications or not. The DON stated LVN 2 had (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	received further training on how to appropriately monitor and document behavioral episodes for psychotropic medications.1c. During a review of Resident 3's Consultation Report (CR), dated 3/14/25, the CR indicated, the CRPH recommended a gradual dose reduction, . Resident 3 receives multiple antidepressants for depression concomitantly [at the same time] without documentation in the medical record of an inadequate response to monotherapy: Trazodone . escitalopram . duloxetine . and Trazodone . recommendation: please evaluate the continued need of these orders physician's response- checked box to- I decline the recommendations above and do not wish to implement any changes due to the reasons below. Rationale: Patient is receiving care with mental health doctor as outpatient. Continued treatment- signed and dated 3/17/25.During a review of Resident 3's CR, dated 5/28/25, the CR indicated, the CRPH recommended a gradual dose reduction, .Resident 3 Has received an antidepressant, duloxetine . and [brand name] (escitalopram) . for management of depressive symptoms since 3/25/25. recommendation: please attempt a gradual dose reduction (GDR) of duloxetine and [escitalopram] if indicated at this time Physician's response- checked box to - I decline the recommendations above Because GDR is clinically contraindicated for this individual as indicated below .1 dot checked box to- continued use is in accordance with the current standard of practice and a judiciary attempt at this time is likely to impair this individual's function or cause psychiatric instability by exacerbating an underlying medical condition or psychiatric disorder as documented below. there was no information provided under Please provide CMS required patient specific rationale describing why GDR attempt is likely to impair function or cause psychiatric instability in this individual: document was signed with no date.During a review of Resident 3's CR, dated 8/16/25, the CR indicated, the CRPH recommended a gradual dose reduction, .Resident 3 receives multiple antidepressants for depression concomitantly without documentation in the medical record of an inadequate response to monotherapy: escitalopram . duloxetine . and Trazodone ., recommendation: please evaluate the continued therapy and consider a reduction to one of the antidepressants with goal of discontinuation . Physicians response- checked box to - I decline the recommendations above and do not wish to implement any changes due to the reasons below. Rationale: managed by psych . During a record review of Resident 3's GDR documents, undated the documents indicated there was no GDR for divalproex sodium, duloxetine, and trazodone. During an interview on 4/23/26 at 1:15 p.m. with the ADON, the ADON stated no GDR attempt was completed for Resident 3's divalproex sodium. The ADON stated Resident 3 was being followed by [named hospital] psychiatrist. The ADON stated Resident 3 had been canceling his appointments. The ADON stated Resident 3 had not been to the [named hospital] psychiatrist since admission to facility in 2025. The ADON stated it was important for residents to receive GDR attempts because of irreversible effects like tardive dyskinesia (a neurological movement disorder characterized by uncontrollable, repetitive, and involuntary movements, commonly in the face, mouth, tongue, arms, or legs).During an interview on 4/24/26 at 9:28 a.m. with the MD, the MD stated on Resident 3 followed up with the psychiatrist, the [named hospital] was a separate entity and [named hospital] was fully aware of the regulations. The MD stated he was unable to speak with them; they had their own physicians. The MD further stated since Resident 3 was in the facility, the interdisciplinary team (IDT) had to follow their policy and procedure (P&P). The MD stated the goal was to have Resident 3 at the lowest effective psychotropic medication dose.During an interview on 4/24/26 at 9:56 a.m. with the DON, the DON stated and acknowledged Resident 3 was not going to his psychiatrist appointments and had not seen a psychiatrist since admission to the facility. The DON stated and acknowledged Resident 3 had not received a GDR for his psychotropic medications despite recommendations from the consultant pharmacist. The DON stated GDR was important because medications could make residents sedated, if the medication was effective, there should be an order to switch to other medications. The DON stated medications have black box warning (potentially serious or life-threatening side effects from medications), especially with the elderly population. During an interview on 4/24/26 at 10:48 a.m. with the CRPH, the CRPH stated if Resident 3 was not going to his psychiatrist appointments, the (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	responsibility would fall back to the attending physician if Resident 3 was not seen by a psychiatrist. The CRPH stated GDR was important to find the lowest effective dose, the situation could change over time and if there was no attempted GDR the IDT would not know.2. During a record review of Resident 32's AR, dated 4/24/26, the AR indicated Resident 32 was initially admitted to the facility on [DATE], and was re-admitted from an acute care hospital on 1/28/26 with diagnosis which included . schizoaffective disorder, bipolar type [a chronic mental health condition combining schizophrenia symptoms (hallucinations/delusions) with intense mood shifts, specifically manic episodes and often major depression], depression, personal history of suicidal behavior.During a record review of Resident 32's PO, dated 9/6/25 to 2/15/26, the PO indicated Divalproex Sodium Oral tab 250mg- Give 2 tablets by mouth one time a day for schizophrenia manifested by having auditory hallucination (the perception of sounds, such as voices, noises, or music, that are not actually occurring) and give 4 tablets by mouth in the evening for schizophrenia with start date 9/6/25- ended 2/11/26, start date 2/12/26-ended 2/17/26 and start 2/18/26- present date. During a record review of Resident 32's MDS, dated 3/2/26, the MDS section C indicated Resident 32's BIMS assessment score was 15 out of 15. The BIMS scores indicated Resident 32 was cognitively intact. During a review of Resident 32's MDS, dated 3/2/26, the MDS indicated in Section E for behavior, none exhibited.During a review of Resident 32's CP, undated, the CP indicated there were no objective goal for the number of episodes for behaviors being monitored. During a review of Resident 32's MAR, dated 3/26, the MAR indicated Monitor behavior for anti-convulsant (anti-seizure medication) used as psychoactive (affecting the mind or behavior) divalproex sodium for diagnosis Mood disorder m/b: Auditory Hallucination- Yes/no .During an interview on 4/23/26 at 11:44 a.m. with LVN 1, LVN 1 stated Resident 32 was alert and oriented and sometimes she was emotional. LVN 1 stated on behavior monitoring and side effects, the number in the MAR was the tally to indicate the number of episodes. LVN 1 stated there was no place to document the side effects or behaviors residents were experiencing. LVN 1 stated the care plan was used to help resolve the issues Resident 32 was experiencing. LVN 1 stated it was important the number of times Resident 32 exhibited symptoms or behaviors was documented because it could be used to ensure the appropriate interventions for Resident 32 were used. During a concurrent interview and record review on 4/23/26 at 2:40 p.m. with the ADON, Resident 32's electronic medical record (EMR), undated was reviewed. The ADON stated when documenting behavior monitoring, the numbers meant the resident had that number of behaviors during the shift. The ADON stated no meant zero (0) behaviors . The ADON stated when there was a behavior exhibited, there should be the number of behaviors the resident manifested in a shift indicated in the MAR. The ADON stated and acknowledged Resident 32's Divalproex- yes or no were documented and stated the IDT would not know how many behavior episodes Resident 32 exhibited during the shift. The ADON stated this was important so the IDT could determine through the tallying of behaviors if they needed to make any changes. The ADON stated the monitoring of side effects, the documentation did not reflect what type of side effects Resident 32 had. The ADON stated residents should have individualized care plans according to their needs and goals. The ADON stated Resident 32's care plan was generic and was not individualized. The ADON stated ensuring the care plan was individualized would be a guide on what to do and ensured nursing staff called the physician or could help in adjusting the resident's medication appropriately. During an interview on 4/24/26 at 9:35 a.m. with the MD, the MD stated it was important to document behavior tallies, because it helped to determine whether the medication was effective, and if effective, there could be a reduction in dose or frequency. When informed of LVN 2's understanding of documenting the behavior tallies, the MD stated it was not right to tally behavior medications for different symptoms and indications, it was important that they were differentiated so the IDT knew how severe the behaviors were and the medications could be adjusted appropriately. During an interview on 4/24/26 at 10 a.m. with the DON, the DON stated it was important to monitor behaviors to make sure medication was effective. The DON stated if behaviors were decreasing, a GDR could be attempted, and the medication decreased, if escalated behavior, there would be a need (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	to adjust the medication. The DON stated this was important to have measurable goals when monitoring behaviors, this made it easy to assess if the goals were met and if the goals were not met, then they would be able to determine the next plan.During an interview on 4/24/26 at 10:51 a.m. with the CRPH, the CRPH stated goals helped to analyze if medications were effective or not. The CRPH stated the nursing staff needed to evaluate each behavior separately and when it was time to attempt a GDR, there should be documentation of the correct behaviors to effectively know what medication was working. The CRPH stated there should be a number of episodes to truly measure the number of behaviors residents were exhibiting.During a review of the facility's P&P titled, Medication (Drug) Regimen Review (MRR), dated 8/25, the P&P indicated, . Policy: It is the policy of this facility that the drug regimen of each resident will be refilled at least once a month by a licensed pharmacist. In medication regimen review (MRR) includes a review of the resident's medical chart, identified irregularities will be documented on a separate written report that includes the residents' name, the relevant drug, and the irregularity identified. The report will be sent to the attending physician, the facility's medical director and the director of nursing services (DNS) to be acted upon.During a review of the facility's P&P titled, Comprehensive person centered care planning, dated 8/25, the P&P indicated, . Policy: It is the policy of this facility that the interdisciplinary team (IDT) shall develop a comprehensive person centered care plan for each resident that includes measurable objectives and time frames to meet a residence medical, nursing, mental and psychosocial needs that are identified in the comprehensive assessment. Definition . measurable- is the ability to be evaluated or quantified . objective- is a statement describing the results to be achieved to meet the residents' goals.During a review of the facility's P&P titled, Chemical restraints on psychotropic medication management, dated 8/25, the P&P indicated, . Policy: It is the policy of this facility to ensure that residents are free from chemical restraints imposed for purposes of discipline or convenience or that are not required to treat a specific condition as diagnosed and documented in the clinical record. based on a comprehensive assessment, the facility will ensure that: residents who use psychotropic drugs receive gradual drug reduction (GDR), and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs;. Definitions- gradual dose reduction (GDR) is the stepwise tapering of dose to determine if symptoms, conditions, or risk can be managed by a lower dose or if the dose of medication can be discontinued. a. The medical record must show documentation of the diagnosed condition for which a psychotropic medication is prescribed. 7. The Social Services (SSD) and/or nursing designee will be responsible for initiating the resident's individualized, person-centered psychosocial plan of care, based on their comprehensive initial admission assessment. a. Psychotropic medication was prescribed to treat a specific diagnosed condition, as documented in the clinical record.d. Monitoring for adverse consequences and effectiveness of medications are in place. Informed consent was obtained prior to medication use; g. Review of plan of care shows individualized, person-centered care approaches to manage behavior with non-pharmacological interventions; h. Attempt/consider a GDR (Gradual Dose Reduction), if appropriate.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure a comprehensive person-centered care plan (CP - a detailed approach to care customized to an individual resident's needs) was developed and implemented for four of 14 sampled residents (Resident 12, Resident 15, Resident 120 and Resident 139) when:1. Resident 12 had two bed (side) rails (adjustable metal or rigid plastic bars in various sizes that attach to the bed and can be placed in a guard [raised position that is intended to prevent an individual from inadvertently rolling out of bed] or lowered position) on each side of the bed in the guard position. Resident 12 did not have a plan of care developed and initiated for getting out of bed unassisted and prior to the use of the bed rails. This failure had the potential to result in Resident 12 receiving inadequate person-centered care and placed Resident 12 at risk of not having her needs met and sustaining injury from entrapment (resident caught, trapped, or entangled in the space in or about the bed and side rail), which could cause serious harm, injury, or death.2. Resident 15's care plan was not developed and initiated for refusal of having her nails trimmed.This failure had the potential to result in Resident 15 receiving inadequate person-centered care and placed Resident 15 at risk of not having her needs met and sustaining injury from having long nails. 3. Resident 120 did not have a care plan for the use of antibiotics (medication used to treat bacteria) for peritoneal abscess (pocket of infected fluid or pus that collects inside the belly [abdominal cavity]).This failure had the potential for Resident 120's use of antibiotics to not be monitored for side effects like diarrhea, nausea, and stomach pain.4. Resident 139 did not have a care plan when a right nephrostomy tube (small, flexible tube placed through the skin in the back into the kidney to drain urine directly into an external bag) was inserted and was readmitted to the facility. This failure had the potential for Resident 139 to not receive the care needed for his right nephrostomy tube.Findings: 1. During an observation on 4/21/2026 at 7:02 a.m. in Resident 12's room, Resident 12 was observed asleep in bed, wearing a gown with side rails up on the left and right side of the bed and a fall mat on the right side of Resident 12's bed. During a review of Resident 12's admission Record (AR - a summary of information regarding a patient which includes patient identification, past medical history, insurance status, care providers, family contact information and other pertinent information), dated 4/23/26, the AR indicated Resident 12 was admitted to the facility from an acute care hospital on [DATE] with diagnoses of cerebral infarction (damage to tissues in the brain due to a loss of oxygen to the area), Alzheimer's disease (a brain disorder that slowly destroys memory and thinking skills, and eventually, the ability to carry out the simplest tasks), dementia (loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life), schizophrenia (a mental illness that affects a person's ability to think, feel, and behave clearly), depression (persistent feelings of sadness, despair, loss of energy, and difficulty dealing with normal daily life), and history of falling. During a review of Resident 12's Minimum Data Set (MDS - a resident assessment tool used to identify cognitive [mental processes] and physical functional level assessment), dated 3/18/26, the MDS section C indicated Resident 12 had a Brief Interview for Mental Status (BIMS - a test given by medical professionals to determine cognitive (involving the process of thinking, learning and understanding) understanding on a scale of 1-15) score of three (a score of 0-7 suggests severe cognitive impairment, 8-12 suggests moderately impaired, 13-15 suggests cognitively intact), which indicated Resident 12 was severely cognitively impaired. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 12's MDS, dated 3/16/26, the MDS section GG (Functional Abilities) indicated Resident 12 had, .impairment on one side.upper extremity [shoulder, elbow, wrist, hand].used in the last 7 days.wheelchair.Dependent [helper does ALL of the effort. Resident does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the resident to complete the activity].chair/bed-to-chair transfer: The ability to transfer to and from a bed to a chair [or wheelchair]. During an interview on 4/22/26 at 4:10 p.m. with Certified Nursing Assistant (CNA) 1, CNA 1 stated Resident 12 had her side rails up because she tried to get out of bed and had fallen in the past. During a concurrent interview and record review on 4/23/2026 at 3:51 p.m. with Licensed Vocational Nurse (LVN) 1, Resident 12's Care Plan (CP), undated was reviewed. LVN 1 stated there was no CP for Resident 12 getting out of bed unassisted, or a CP for Resident 12's use of side rails. LVN 1 stated a CP was important for Resident 12's use of side rails and assisting Resident 12 out of bed to prevent Resident 12 from getting injured and to provide resident safety. LVN 1 stated a CP informed staff what level of care Resident 12 required. LVN 1 stated the CP should have been specific for Resident 12's needs. During an interview on 4/24/2026 at 10:32 a.m. with the Director of Nursing (DON), the DON stated Resident 12 should not have her side rails up. The DON stated the facility was a non-restraint facility and side rails were considered a restrictive device. The DON stated side rails could have caused entrapment, or the residents could have hung themselves on the bars. The DON stated Resident 12 should have had a care plan to monitor her, and to make sure the device used to assist her was safe and not loose. The DON stated a care plan gave staff information of the resident's plan of care based on the resident's needs. The DON stated the care plan should have been patient-centered and each resident should have had their own plan of care. The DON stated if the resident had a change of condition, any nurse could have entered a care plan for the change in the resident's condition. During a review of the facility's policy and procedure (P&P) titled, Bed Rails, dated 8/2025, the P&P indicated, .it is the policy of this facility to attempt to use appropriate alternatives prior to installing a side or bed rail.bed rails should be selected and placed to discourage climbing over the rails to get in and out of bed, which may result in falling over bed rails.no gaps wide enough to entrap a resident's head, body, or limbs should be present post-installation or during the course of use.update the resident care plan as needed related to the identified and/or ongoing need or resident choice for the use of bed rails. 2. During an observation on 4/21/2026 at 7:09 a.m. in Resident 15's room, Resident 15 was observed asleep in bed, dressed, wearing an oxygen nasal cannula (a tube that delivers oxygen through the nose to people who have low oxygen levels), and a gauze dressing on her left upper arm. During a review of Resident 15's AR, dated 4/23/26, the AR indicated Resident 15 was initially admitted to the facility from an acute care hospital on [DATE] with a re-admission on [DATE] with diagnoses of arthritis (joint inflammation) due to other bacteria to the right knee, dementia (loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life), dysphagia (difficulty swallowing), congestive heart failure (CHF-a heart disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling), type 2 Diabetes Mellitus (when the blood sugar levels in the body are too high), acquired absence (surgical removal of finger, toe, hand, foot, arm or leg) of right great toe, and depression. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pacific Gardens Nursing and Rehabilitation Center	577 S. Peach Ave. Fresno, CA 93727

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 15's MDS, dated 2/27/26, the MDS section C indicated Resident 15 had a BIMS score of seven, which indicated Resident 15 was severely cognitively impaired. During a review of Resident 15's MDS, dated 2/27/26, the MDS section GG indicated, Resident 15 had, .impairment on both sides.upper extremity.used in the last 7 days.wheelchair.Dependent .personal hygiene: The ability to maintain personal hygiene, including combing hair, shaving, applying makeup, washing/drying face and hands. During a concurrent observation and interview on 4/21/2026 at 1:04 p.m. in Resident 15's room, Resident 15 was observed dressed in bed, and wearing an oxygen nasal cannula. Observed skin tear to the pinky of the right hand, dry/discoloration on left shin, missing toes to right and left foot, right and left hands contracted (a permanent tightening of the muscles, tendons, skin, and nearby tissues that causes the joints to shorten and become very stiff) with long, dark colored right thumb nail. Resident 15 stated she was not sure how she got the skin tear. Observed Resident 15's meal tray delivered, with CNA 3 setting up tray to feed Resident 15. CNA 3 stated Resident 15 needed assistance with meals. Resident 15 did not want to answer any more questions. During a review of Resident 15's electronic medical record (EMR), the EMR indicated there was no CP for refusal of nail care for Resident 15 and no CNA documentation in Resident 15's Tasks of refusal of nail care. During an interview on 4/22/2026 at 3:49 p.m. with Registered Nurse (RN) 1, RN 1 stated there were no paper shower slips the CNAs documented on for Resident's showers, skin or nail assessments. RN 1 stated if a resident refused a shower or bath, or had skin issues, including nail care, the CNA informed the nurse and the nurse documented in the progress notes. RN 1 stated if a resident refused care, the nurse informed the next shift. During a concurrent interview and record review on 4/22/2026 at 3:50 p.m. with LVN 1, Resident 15's CP, undated was reviewed. LVN 1 stated Resident 15 had a care plan initiated yesterday, 4/21/26 for refusing nail care. LVN 1 stated Resident 15 had been refusing nail care. LVN 1 stated if a resident kept refusing care, the nurse should have made a non-compliant care plan, explained the risks and benefits to the resident and/or responsible party (RP), and notified the resident's physician. During a concurrent interview and record review on 4/22/26 at 4:03 p.m. with CNA 1, Resident 15's EMR, undated was reviewed. CNA 1 stated residents received nail care on their shower days. CNA 1 stated Resident 15 had been refusing nail care. CNA 1 stated if a resident refused care, the CNA informed the nurse and during shift report also notified the next shift so they could try to give nail care to the resident. CNA 1 stated the nurse notified the resident's family if a resident refused care. CNA 1 stated the CNAs documented in their point of care (POC) documentation system and it gave an alert to staff regarding the resident's refusals. CNA 1 stated the EMR indicated the POC system and was unable to check past documentation history of Resident 15's care. During an interview on 4/24/2026 at 10:35 a.m. with the DON, the DON stated the refusal of nail care should have been care planned. The DON stated a CP gave staff information of the resident's plan of care based on the resident's needs. The DON stated the CP should have been patient centered and each resident should have their own plan of care. The DON stated if there was a change in the resident's condition any nurse could have entered a CP for the resident's change of condition. The DON stated if a resident refused nail care, they needed to have a CP, and the family needed to be informed. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's P&P titled, Nail Care, dated 2024, the P&P indicated, .the purpose of this procedure is to provide guidelines for the provision of care to a resident's nails for good grooming and health.assessments of resident nails will be conducted on admission and readmission to determine the resident's nail condition, needs, and preferences for nail care.report unusual or abnormal conditions of the nails to the physician and the responsible party [e.g., curling, color changes, separation from the nailbed, redness, bleeding, pain, odor, infection, etc.].identify conditions that increase risk for foot or nail problems, such as diabetes, peripheral vascular disease, heart failure, renal disease, or stroke.routine cleaning and inspection of nails will be provided during Activities of Daily Living [ADL] care on ongoing basis.routine nail care, to include trimming and filing, will be provided on a regular schedule.nail care will be provided between scheduled occasions as the need arises.the resident's plan of care will identify.the frequency of nail care to be provided.the type of nail care to be provided.the person[s] responsible for providing nail care.nails should be kept smooth to avoid skin injury.document completion of task, any complications, or if resident refuses. During a review of the facility's P&P titled, Comprehensive Person-Centered Care Planning, dated 8/2025, the P&P indicated, .it is the policy of this facility that the interdisciplinary team [IDT] shall develop a comprehensive person-centered care plan for each resident that includes measurable objectives and timeframes to meet a resident's medical, nursing, mental and psychosocial needs that are identified in the comprehensive assessment.the resident has the right to refuse or discontinue treatment. In the event that a resident refuses certain services posing a risk to resident's health and safety, the comprehensive care plan will identify care or service declined, the associated risks, IDT's effort to educate the resident and resident representative and any alternate means to address risk. 3. During an observation on 4/21/26 at 6:50 a.m. during initial tour in Resident 120's room. Resident 120 was observed lying in bed, eyes closed and did not answer questions asked. During a review of Resident 120's AR, dated 4/23/26, the AR indicated Resident 120 was admitted to the facility on [DATE] with diagnoses which included fibromyalgia (a chronic [long-lasting] disorder characterized by widespread pain, stiffness, and tenderness throughout the body, accompanied by intense fatigue and sleep issue), pressure ulcer of sacral region (at the bottom of the spine), urinary tract infection (bacterial infection in the bladder), and peripheral vascular disease (a slow circulation problem where blood vessels outside the heart and brain-usually in the legs-become narrowed, blocked, or damaged). During a concurrent interview and record review on 4/23/26 at 10:37 a.m. with LVN 3, Resident 120's EMR, undated was reviewed. LVN 3 stated she was familiar with Resident 120. LVN 3 stated the EMR indicated Resident 120 was sent out to the acute hospital and returned to the facility with an order for an antibiotic. LVN 3 stated she did not find a care plan for the antibiotic order. LVN 3 stated there should have been a care plan initiated and it was the responsibility of all licensed nurses to initiate a care plan. During a concurrent interview and record review on 4/24/26 at 10:50 a.m. with the Assistant Director of Nursing (ADON), Resident 120's EMR, dated 4/10/26 was reviewed. The ADON stated the EMR indicated Resident 120 was sent out to the acute hospital on 4/10/26 and returned to the facility on 4/13/26 with an antibiotic order for peritoneal abscess (infected pus pocket in the belly) to be given for three days. The ADON stated the EMR indicated there was no care plan for the antibiotic. The ADON stated there should have been a care plan initiated but there was none. The ADON stated care plans were important, and it should be patient centered to direct staff to properly care for residents. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	4. During an observation on 4/21/26 at 6:38 a.m. during initial tour in Resident 139's room, Resident 139 was observed lying in bed, eyes closed and did not answer questions asked. During a review of Resident 139's AR, dated 4/23/26, the AR indicated Resident 139 was admitted to the facility on [DATE] with diagnoses which included unspecified hydronephrosis (kidney swelling or a fluid-filled kidney), obstructive (blockage in the urinary system that prevents urine from flowing freely) and reflux uropathy (backward flow of urine from the bladder toward the kidneys). During a concurrent interview and record review on 4/23/26 at 11:05 a.m. with LVN 3, Resident 39's EMR, undated was reviewed. LVN 3 stated she was Resident 139's nurse. LVN 3 stated the EMR indicated Resident 139 was re-admitted to the facility on [DATE]. LVN 3 stated Resident 139 had a cystoscopy (a medical procedure using a thin, lighted tube with camera to look inside the bladder and the tube that drains urine) appointment at the general acute care hospital (GACH) and was kept overnight. LVN 3 stated the EMR indicated Resident 139 was readmitted to the facility with nephrostomy tubes on both the right and left side. LVN 3 stated she was not sure if Resident 139 had nephrostomy tubes on both right and left side prior to admission to the hospital. LVN 3 stated she did not find a care plan for the right nephrostomy tube. During a concurrent interview and record review on 4/24/26 at 9:55 a.m. with the ADON, Resident 139's EMR, dated 12/20/25 was reviewed. The ADON stated the EMR indicated Resident 139 was admitted to the facility with one nephrostomy tube, but she was not sure which side. The ADON stated the EMR indicated the hospital record titled, Discharge Summary, indicated Resident 139 had a nephrostomy tube placed on the right side. The ADON stated she did not find a care plan for the placement of the right nephrostomy tube and there should have been a care plan. The ADON stated care plans were very important to guide staff on how to care for residents. During an interview on 4/24/26 at 11:31 a.m. with the DON, the DON stated care plan was the responsibility of every nurse. The DON stated her expectation was to ensure a care plan was initiated when there was a change in condition, a new order or medication, or a change in medications. The DON stated basic care plans were initiated and completed within 48 hours, and comprehensive care plans were initiated and completed within 21 days of admission. During a review of facility's policy and procedures (P&P) titled, Comprehensive Resident Centered Care Plan, revised date 8/25, the P&P indicated, It is the policy of this facility that the interdisciplinary team (IDT-group of experts from different fields working together closely to solve a complex problem or care for a person, rather than working in isolation) shall develop a comprehensive person-centered care plan for each resident that includes measurable objectives and timeframes to meet resident's medical, nursing, mental and psychosocial needs. The IDT team will also develop and implement a baseline care plan for each resident. to properly care for each resident .

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on observation, interview, and record review, the facility failed to ensure activities of daily living (ADL's- routine activities such as grooming, bathing, dressing and toileting a person performs daily to care for themselves) was not provided for one of three sampled residents (Resident 178), when Resident 178's fingernails on both hands were long, jagged (sharp, uneven edges), and dirty with brownish to blackish dirt built up underneath her nails.This failure had the potential for Resident 178 to obtain skin-related injuries including cuts, scratches, and infections.During a concurrent observation and interview on 4/22/26 at 1:03 p.m. with Resident 178 in Resident 178's room, Resident 178 was observed having a Peripherally Inserted Central Catheter (PICC -a long, thin tube that's inserted through a vein in the arm) line placed to her right upper arm. Resident 178 stated her antibiotic was given through the PICC line. Resident 178 stated she was admitted to the facility since April 19, 2026. Resident 178 stated her nails were long, dirty, and felt like a mess. Resident 178 stated she wanted to have her fingernails cleaned and trimmed.During a review of Resident 178's admission Record (AR), dated 4/19/26, the AR indicated, Resident 178 was admitted to the facility with the diagnosis which included Sepsis (the body's extreme, dangerous response to an infection), Diverticulitis (infected or inflamed pockets in the colon) and Restless leg syndrome (fidgety legs, tingling, pulling, or aching sensation deep in the legs, which is temporarily relieved by movement).During a concurrent observation and interview on 4/22/26 at 1:31 p.m. with Certified Nursing Assistant (CNA) 6, in Resident 178's room, Resident 178 was lying in bed, needed assistance with repositioning and noted that the fingernails on both hands appeared long, jagged, and dirty. CNA 6 stated Resident 178 was unable to reposition independently in bed and needed assistance. CNA 6 stated Resident 178's fingernails were long and dirty. CNA 6 stated nail care was provided during ADL care, on scheduled shower days twice a week, and as needed.During a concurrent observation and interview on 4/22/26 at 1:54 p.m. with Registered Nurse (RN) 6, in Resident 178's room, Resident 178 was lying in bed and noted that fingernails on both hands appeared long, jagged, and dirty. RN 6 stated Resident 178's fingernails were long, uneven with sharp edges and dirty with brownish to blackish buildup underneath the nail bed. RN 6 stated the CNA could have provided nail care, such as trimming and filling fingernails for Resident 178 because the resident was non-diabetic (a person who does not have a problem with high blood sugar). RN 6 stated if a resident was diabetic (a person who has a problem with high blood sugar), only the nurses may provide nail care. RN 6 stated keeping nails short and clean helped prevent Resident 178 from scratching her skin, which could lead to skin breakdown and infection.During an interview on 4/24/26 at 9 a.m. with the Director of Staff Development (DSD), the DSD stated CNA's or nurses were expected to perform and assist with hand hygiene for residents during ADLs, before and after meals, including nail care, and as needed.During an interview on 4/24/26 at 10:05 a.m. with the Director of Nursing (DON), the DON stated nail care was part of ADL's and hand hygiene. The DON stated proper nail care and hand hygiene helped prevent the transmission of infection, bacteria and other microorganisms, such as multi drug-resistant organisms (any living thing), especially if a resident had an intravenous (something that goes directly into a vein) line or PICC line.During a review of the facility's policy and procedures (P&P) titled, Nail Care, dated 2024, the P&P indicated, .Assessments of resident nails will be conducted on admission.Routine cleaning and inspection of nails will be provided during ADL care on an ongoing basis.Nails should be kept smooth to avoid skin injury.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure acceptable parameters of nutritional status were maintained for one resident (Resident 12) when when weekly weights were not implemented to track and monitor the effectiveness of interventions that were put into place such as snacks, nutritional shakes and daily intake.This failure resulted in a weight loss of 4.49 % (percent) in a month from 11/19/25 to 12/17/25, 13.48 % in three months from 11/19/25 to 2/18/26, and 9.14% in three months from 12/17/25 to 3/18/26 for Resident 12. Findings: During an observation on 4/21/26 at 8:19 a.m. with Resident 12, in Resident 12's room, Resident 12 was sitting up in bed with breakfast tray on bedside table, cover off plate with a hard-boiled egg.During an observation on 4/23/26 at 10:08 a.m. with Resident 12, in Resident 12's room, Resident 12 was lying asleep in bed, with bilateral mats (a cushioned floor pad designed to help prevent injury should a person fall) on the floor.During an observation on 4/23/26 at 10:10 a.m., at the nursing station, Resident 12's nutrition shake (health shake - nutrient-dense, blended beverages designed to improve health, manage weight, or supplement diets with protein, vitamins, and minerals) and chocolate pudding were stored in a bucket labeled with Resident 12's name.During an observation on 4/23/26 10:16 a.m. with Resident 12, in Resident 12's room, an unopened health shake and chocolate pudding were on top of her bedside table. Resident 12 was asleep in bed. During an interview on 4/23/26 at 10:19 a.m. with Certified Nursing Assistant (CNA) 4, CNA 4 stated she was distributing residents' supplements and snacks. CNA 4 stated Resident 12 was one of her residents. CNA 4 stated Resident 12's had been sleeping since the beginning of her shift. CNA 4 stated she assisted Resident 12 for breakfast today (4/23/26) in her room. CNA 4 stated Resident 12 did not eat her breakfast. CNA 4 stated Resident 12 drank only one third of the juice and few sips of milk. During a review of Resident 12's Face Sheet (FS - a summary of information regarding a patient which includes patient identification, past medical history, insurance status, care providers, family contact information and other pertinent information), dated 4/23/23, the FS indicated Resident 12 was admitted to the facility on [DATE] with diagnoses of cerebral infarction (damage to tissues in the brain due to a loss of oxygen to the area), Alzheimer's disease (a brain disorder that slowly destroys memory and thinking skills, and eventually, the ability to carry out the simplest tasks), type 2 diabetes mellitus (when the blood sugar levels in the body are too high), and protein calorie malnutrition (a condition resulting from inadequate intake of protein and calories, often due to decreased oral intake). During a review of Resident 12's Minimum Data Set (MDS - a resident assessment tool used to identify cognitive [mental processes] and physical functional level assessment), dated 3/18/26, the MDS section C indicated Resident 12 had a Brief Interview for Mental Status (BIMS - a test given by medical professionals to determine cognitive understanding on a scale of 1-15) score of 3 (a score of 0-7 suggests severe cognitive impairment, 8-12 suggests moderately impaired, 13-15 suggests cognitively intact), which suggested Resident 12 had a severe cognitive impairment.During a review of Resident 12's Electronic Medical Records (EMR) titled Weights, indicated, 11/19/25 155.8 lbs. (pounds - a unit of weight), 12/17/25 148.8 lbs., 2/18/26 134 lbs., 3/18/26 135.2 lbs. Resident 12 had a weight losses of 4.49 % (percent) in a month from 11/19/25 to 12/17/25, 13.48 % in three months from 11/19/25 to 2/18/26, and 9.14% in three months from 12/17/25 to 3/18/26.During a review of physician orders dated 4/23/26 indicated CCHO (Consistent Carbohydrate) NAS (No Added Salt) Regular, Thin Liquids diet. Dated 2/20/26 indicated Health shake twice a day between meals. Dated 10/11/22 indicated snacks two times a day. Dated 10/9/22 indicated CCHO, regular NAS diet. During a review of Resident 12's Order Summary Report, dated 3/31/26, indicated, CCHO, NAS, Regular texture, Thin Liquids, Health shake two times a day 4 oz BID (twice a day) between meals, Snacks two times a day.During a review of Resident 12's medical record titled, Mini Nutritional assessment dated [DATE] and 3/18/26, indicated, . 12/19/25 Weight loss during the last 3 months: weight loss greater than 3 kg (6.6 lbs.) . care planning 1. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Potential for Malnutrition.Goal Resident Intake of Nutrients Will Metabolic Needs.Intervention: Monitor weight closely for gain/loss.3/18/26 Weight loss during the last 3 months: weight loss between 1 and 3 kg (2.2 and 6.6 lbs.) .During a review of the Clinical Interdisciplinary Team (IDT) assessment dated [DATE], indicated Resident 12's po (oral) intake had decreased meal intake and was at 54%; Recommendations: change to weekly weights.Review Date: 2/18/26 indicated Resident 12 with poor po intake meal intake at 27% .Weight change: -7.4 lbs. x 1 month. Recommendations indicated to change to weekly weights, implement four-ounce health shake twice a day and MD (Doctor of Medicine) to follow up with RP (responsible party) regarding weight loss. Review Date: 2/25/26 indicated Resident 12 with poor po intake meal intake at 25%. Started on Mirtazapine (medication to treat major depressive disorder with a common side effect of weight gain). Weight: -12.2 lbs. x 9 weeks. Recommendations: continue weekly weights, snacks and health shake twice a day. Review Date: 3/4/26 indicated poor po intake decline in condition, meal intake 33% Weight change: -13.6 lbs. x 9 weeks, started Mirtazapine on 2/21/26 and monitoring weekly weights. During an interview with the Registered Dietitian (RD), in the kitchen, on 4/22/26 at 3:02 p.m., the RD stated she works full time at the facility. The RD stated she will see residents for weight variance that trigger five pounds in one week and one month, 5% in one month, 7.5% in three months and 10% in six months. During a concurrent interview and clinical record review on 4/23/26 at 10:33 a.m. with the RD, Resident 12's weights (11/19/25 to 3/18/26), and Clinical Interdisciplinary (IDT) Assessments (1/21/26 to 3/18/26), Nutrition notes and physician orders were reviewed. The weights indicated, 3/18/26 135.2 lbs,3/11/26 137.4 lbs., 3/4/26 135.2 bs, 2/25/26 136.6 lbs., 2/18/26 134.8 lbs.,1/21/2026 142.2 lbs.,12/17/25 148.8 lbs.,12/17/25 148.8 lbs., and 11/19/25 155.8 lbs. The RD indicated Resident 12's had been losing weight and had a significant weight loss which triggered in 12/2025. The RD acknowledged that it should have triggered her to see the resident in December and that did not happen. The RD stated there was only a mini assessment in December and no interventions. The RD stated Resident 12's son and friends visit and brings variety of foods regularly but stopped in 11/2025. The RD stated Resident 12's oral intake continuously declined which resulted in significant weight losses on weekly and monthly weights. The RD stated physicians were always in agreement with RD recommendations and should be followed to address further weight changes. The RD stated Resident 12's monthly weight was changed to weekly weights as the only intervention when declined in oral intake and significant weight loss were identified on 1/22/26. The RD acknowledged Resident 12's weekly weights were not done at that time. The RD stated Resident 12's weekly weights should be completed to closely monitor her weight and implement necessary nutrition interventions and services to prevent further weight loss. The RD stated they do not have physician orders for weights at the facility. The RD stated nutritional interventions such as supplements (nutrition shake) and snacks consumption should be documented to accurately reflect the actual percentage of consumption to assess the effectiveness of the interventions. The RD stated the goal is to achieve Resident 12's usual desirable weight. During a concurrent interview and record review on 4/23/26 at 11:14 a.m. with Licensed Vocational Nurse (LVN) 1, Resident 12's electronic medication administration record (EMAR- a daily digital documentation record used by a licensed nurse to document medications and treatments given to a resident), dated 4/2026 was reviewed. The EMAR indicated, Health shake two times a day 4 oz BID (twice a day) between meals and snacks two times a day 10:00 a.m. and 1400 (2:00 p.m.) showing check marks with Licensed Nurses' initials. LVN 1 stated green check marks in Resident 12's EMAR for snacks and health shake indicated it was given and does not mean consumption. LVN 1 stated Resident 12's health shake and snack were given by the CNAs. During an interview on 4/23/26 at 11:29 a.m. with CNA 4, CNA 4 stated Resident 12 refused her health shake and snacks. CNA 4 stated she put some chocolate pudding to Resident 12's lips and used a straw for the health shake but Resident 12 was not participating and started to close her mouth. CNA 4 stated Resident 12 remained sleepy. During a concurrent interview and record review on 4/23/26 at 12:07 p.m. with Restorative Nurse Assistant (RNA) 1, Resident 12's weekly weights dated (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1/28/26, 2/11/26, and 2/18/26 were reviewed. The weekly weights indicated, 1/28/26 Resident 12 refused two times. On 2/11/26, and 2/18/26 Resident 12's name was not written. RNA 1 stated Resident 12 refused weight on 1/28/26 and was not listed for weekly weights in the succeeding weeks of 2/11/26 and 2/18/26. RNA 1 stated Resident 12's one time refusal of weight does not mean taking her off the weekly weights. RNA 1 stated Resident 12's weekly weights were not done and should be completed. RNA 1 should continue weighing Resident 12 weekly until a notification from the RD to discontinue her weekly weights. RNA stated they were responsible in weighing residents on admission for 3 days (to establish the baseline), weekly weights and monthly weights. RNA 1 stated the RD gave them a list of residents of needing weights and RNAs handwritten residents' names in their weekly weights paper form. During an observation on 4/24/26 at 8:34 a.m. with Resident 12, in Resident 12's room, Resident 12 was awake shouting with LVN 1 and CNA 4. During an interview on 4/24/2026 at 8:36 a.m. with CNA 4, CNA 4 stated Resident12 refused her breakfast and pushed away her breakfast tray. During a concurrent interview and record review on 4/24/26 at 8:50 a.m. with the Assistant Director of Nursing (ADON), Resident 12's EMAR dated 4/23/26 was reviewed. The EMAR indicated, Health shake two times a day 4 oz BID (twice a day) between meals two times a day -10:00 a.m. and 1400 (2:00 p.m.) showing check mark with LVN 1's initial. The ADON stated Resident 12's EMAR with a check mark for health shake indicating heath shake was given and consumed by Resident 12. The ADON stated if Resident 12 refused the health shake on 4/23/26, LVN 1 should document refused. The ADON acknowledged Resident 12's EMAR for health shake and snacks does not indicate percentage of consumption. The ADON stated Licensed Nurses and CNAs should document percentage of consumption to determine if the nutritional interventions were effective. The ADON stated RD recommendations such as weekly weights should be followed and completed to determine a weight change (gain or loss) to implement appropriate additional interventions.During a concurrent interview and record review on 4/24/26 at 9:15 a.m. with the ADON, Resident 12's amount eaten from the last 30 days (3/26/26 -4/23/26), indicated, there were 21 meals of 0-25% and 24 meals of refusals. Resident 12 refused or ate 25% or less 45 out of 87 meals (50% of the month). The ADON stated Resident 12 had a poor oral intake and should be closely monitored for further weight loss and decline in health.During an interview on 4/24/26 at 10:50 a.m. with the Director of Nursing (DON), the DON stated significant weight changes including loss and gain applies to 5% in 1 month, 7.5% in three months, and 10% in six months. The DON stated the facility also addresses a five pounds weight loss in a week and in a month. The DON stated RD recommendations include weekly weights and nutritional supplements should be followed and implemented. The DON stated RNAs were responsible in doing weekly weights for the residents. The DON stated Resident 12's weekly weights should be implemented and completed to monitor Resident 12's weights to identify and evaluate the root cause of weight losses and prevent a delay in the implementation of new interventions. The DON acknowledged nutritional supplements and snacks consumption should be documented to validate effectiveness of nutritional interventions. During a review of facility's policy and procedures (P&P) titled, Nutrition Status Management, dated 8/2025, the P&P indicated, It is the policy of this facility to assess each resident's nutritional status and needs, including medications and medical conditions to ensure that all residents maintain acceptable parameters of nutritional status, such as body weight ad other available data, unless the resident's clinical condition demonstrates that this is not possible. 3. Clinical Evaluation: a. Nutritional assessment may include: Weighing and weight changes: Oral intake of foods and fluid. b. Any resident weight that varies from the previous reporting period by more than 5% in 30 days, 7.5% in 90 days and 10% in 180 days will be evaluated by the Interdisciplinary Team (IDT) to determine the cause of weight loss/gain and intervention required. d. Any resident meeting the criteria for weight loss and any resident at risk will be weighed weekly with the weight entered into POC/PCC. Weekly weights will be reviewed by the Registered Dietician (RD)/designee.During a review of facility's policy and procedures (P&P) titled, Weight Management, dated 8/2025, the P&P indicated, Residents identified to be at risk for weight variance, will have routine assessment and (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	care plan interventions implemented in accordance with Advance Directives. The objective of this process is to assess, and manage weight variances, to determine appropriate referrals and/or interventions to achieve the best possible clinical outcomes. 6. Weekly weight monitoring may be appropriate for: Significant unplanned weight loss/gain: Clinical conditions which may require more frequent monitoring.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure one of seven sampled Residents (Resident 12) was assessed for the risk of entrapment (resident caught, trapped, or entangled in the space in or about the bed and side rail) from bed (side) rails (adjustable metal or rigid plastic bars in various sizes that attach to the bed, and can be placed in a guard (raised) or lowered) prior to installation and had a consent form (form signed by resident or family explaining the risks of side rail use), physician order, indication for use, and care plans prior to the use of side rails when, Resident 12 had bed rails on the right and left side of her bed in the guard position (a position that is intended to prevent an individual from inadvertently rolling out of bed).These failures had the potential to cause entrapment, serious harm, injury, or death to Resident 12.Findings:During an observation on 4/21/2026 at 7:02 a.m. in Resident 12's room, Resident 12 was observed asleep in bed, wearing a gown with side rails up on the left and right side of the bed and a fall mat on the right side of Resident 12's bed.During a review of Resident 12's admission Record (AR - a summary of information regarding a patient which includes patient identification, past medical history, insurance status, care providers, family contact information and other pertinent information), dated 4/23/26, the AR indicated Resident 12 was admitted to the facility from an acute care hospital on [DATE] with diagnoses of cerebral infarction (damage to tissues in the brain due to a loss of oxygen to the area), Alzheimer's disease (a brain disorder that slowly destroys memory and thinking skills, and eventually, the ability to carry out the simplest tasks), dementia (loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life), schizophrenia (a mental illness that affects a person's ability to think, feel, and behave clearly), depression (persistent feelings of sadness, despair, loss of energy, and difficulty dealing with normal daily life), and history of falling.During a review of Resident 12's Minimum Data Set (MDS - a resident assessment tool used to identify cognitive [mental processes] and physical functional level assessment), dated 3/18/26, the MDS section C indicated Resident 12 had a Brief Interview for Mental Status (BIMS - a test given by medical professionals to determine cognitive (involving the process of thinking, learning and understanding) understanding on a scale of 1-15) score of three (a score of 0-7 suggests severe cognitive impairment, 8-12 suggests moderately impaired, 13-15 suggests cognitively intact), which indicated Resident 12 was severely cognitively impaired.During a review of Resident 12's MDS, dated 3/16/26, the MDS section GG (Functional Abilities) indicated Resident 12 had, .impairment on one side.upper extremity [shoulder, elbow, wrist, hand].used in the last 7 days.wheelchair.Dependent [helper does ALL of the effort. Resident does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the resident to complete the activity].chair/bed-to-chair transfer: The ability to transfer to and from a bed to a chair [or wheelchair].During an interview on 4/22/26 at 4:10 p.m. with Certified Nursing Assistant (CNA) 1, CNA 1 stated Resident 12 had her side rails up because she tried to get out of bed and had fallen in the past. During a concurrent interview and record review on 4/22/26 at 4:15 p.m. with Licensed Vocational Nurse (LVN) 1, Resident 12's electronic medical record (EMR), undated was reviewed. LVN 1 stated she was unable to find a consent or physician order for Resident 12's use of side rails.During a concurrent observation and interview on 4/22/26 at 4:28 p.m. with the Assistant Director of Nursing (ADON), in Resident 12's room, Resident 12 was observed sleeping in her bed with the right and left side rails of her bed in the guard position. The ADON stated it was important to have a consent for the use of side rails, as the rails were a form of restraint. The ADON was unable to provide a consent for Resident 12's use of side rails.During an interview on 4/23/2026 at 10:27 a.m. with LVN 1, LVN 1 stated Resident 12 should have a consent form and physician orders for the use of (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	side rails. LVN 1 stated side rails were considered a restraint. LVN 1 stated prior to installing the side rails, staff should have checked on Resident 12 more often, and the physician should have been notified to receive an order for the side rails. LVN 1 stated side rails could have caused an injury to Resident 12, if she tried to climb over the rails to get out of bed or she could have become stuck between the rails.During a concurrent observation and interview on 4/23/2026 at 1:04 p.m. with the Maintenance Supervisor (MNT) in Resident 12's room, the MNT stated before installing any bed rails, he needed a physician's order and then completed a bed assessment. The MNT stated a bed assessment consisted of measuring from the bed headboard to the end of the mattress, and from the headboard to the end of the rail. The MNT observed Resident 12's side rails in guard position. The MNT stated Resident 12 should have had grab bars that were secured to the bed. The MNT stated he was not sure why Resident 12's grab bars were not secured to the bed and were on the floor, and why she had side rails up. The MNT stated he needed to check if Resident 12 had a bed assessment for the use of side rails. During an interview on 4/23/2026 at 1:34 p.m. with the MNT, the MNT stated Resident 12 did not have a physician's order or bed assessment for the use of side rails. The MNT stated he did not know why Resident 12 had her side rails up. During an interview on 4/24/2026 at 10:32 a.m. with the Director of Nursing (DON), the DON stated Resident 12 should not have her side rails up on her bed. The DON stated Resident 12 needed a consent and bed assessment before the side rails were applied on her bed. The DON stated the facility was a non-restraint facility and side rails were considered a restrictive device. The DON stated residents could become entrapped or hang themselves on the side rails. The DON stated there needed to be a physician's order for the use of side rails and the resident needed to be assessed prior to the use of side rails to be sure the rails were needed. The DON stated interventions that needed to be completed prior to the use of side rails were to put Resident 12's bed in the lowest position, place a fall mat on the floor next to Resident 12's bed, place Resident 12 close to the nurses' station, and have Resident 12 attend activities in the morning and afternoon so staff could watch her. The DON stated if Resident 12 continued trying to get out of bed unassisted, staff needed to meet as a team to see what other interventions could have been put in place. The DON stated if a resident had bed rails, the resident needed a care plan to monitor the resident and make sure the device was safe and not loose.During a review of the facility's policy and procedure (P&P) titled, Bed Rails, dated 8/2025, the P&P indicated, .it is the policy of this facility to attempt to use appropriate alternatives prior to installing a side or bed rail .after the facility has attempted alternatives to bed rails and determined that these alternatives failed to meet the resident's assessed needs, the facility interdisciplinary team [IDT] will assess the resident for risks of entrapment.if the use of bed rails is recommended by the IDT, the facility must obtain informed consent from the resident, or if applicable, the resident representative for the use of bed rails prior to installation or use.During a review of the facility's P&P titled, Restraint Devices, Physical, dated 2006, the P&P indicated, .purpose.to prevent the resident from injuring himself or others.restraints of any type will not be used as punishment or as a substitute for more effective medical and nursing care or for the convenience of the facility staff.physical restraints are defined as any manual method or physical or mechanical device, material, or equipment attached or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body.assess resident's need for restraint device use.obtain informed consent for restraint device use.obtain physician's order for restraint device.list necessary monitoring and observation of the condition that necessitates restraint use.list alternate methods used.list plan to reduce and eliminate restraint use.list observation for risks and complications.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure residents were free of significant medication errors, when one resident (Resident 34) was administered expired latanoprost ophthalmic solution (a medication for glaucoma-eye diseases that damage the optic nerve, often due to high fluid pressure inside the eye, leading to irreversible vision loss or blindness) for over one month.This failure put Resident 34 at risk for infection due to bacteria or fungi growth from the expired medication and at risk of uncontrolled glaucoma, leading to permanent vision loss over time.Findings:During a concurrent observation, interview and record review on [DATE] at 1:14 p.m. in nursing station 4b with Charge Nurse (CRN) 1, latanoprost 2.5 ml (milliliters- metric unit used to measure the volume of a liquid) ophthalmic solution partially used and almost empty bottle with open date [DATE] and beyond use date [DATE] was in the medication cart available for use for Resident 34. CRN 1 stated discontinued medications should be removed from cart, so they are not accidentally administered. CRN 1 stated Resident 34 was using the medication at bedtime. CRN 1 stated there was no other latanoprost ophthalmic solution available in the medication cart to administer to Resident 34. The Medication Administration Record (MAR) for Resident 34 was reviewed. CRN 1 stated the medication was administered to Resident 34 from [DATE]- [DATE] and from [DATE]- [DATE]. CRN 1 stated expired medication was administered to Resident 34. CRN 1 stated it could cause adverse reactions, and the medication would not work like it should.During a review of Resident 34's admission Record (AR - a summary of information regarding a patient which includes patient identification, past medical history, insurance status, care providers, family contact information and other pertinent information), dated [DATE], the AR indicated Resident 34 was admitted to the facility on [DATE] which included type 2 Diabetes Mellitus (when the blood sugar levels in the body are too high), low tension glaucoma.During a review of Resident 34's Order Summary Report (OSR), dated [DATE], the OSR indicated, Resident 34 had an active order for .Latanoprost ophthalmic solution .Instill 1 drop in both eyes at bedtime for Glaucoma During an interview on [DATE] at 3:40 p.m. with the Director of Nursing (DON), the DON stated latanoprost is for glaucoma, a disease that could cause blindness. The DON stated if the medication was given beyond use date (shorten expiration date specified by manufacturer after opening of the product), then the medication was not potent. The DON stated that administering expired eye drops was also an infection control issue.During an interview on [DATE] at 10:32 a.m. with the Consultant Pharmacist (CRPH), the CRPH stated the expectation was nursing staff should dispose of the latanoprost ophthalmic solution 6 week after opening. The CPRH stated it could be stability or infection control issue.During a professional reference review retrieved from National Library of Medicine/National Institute of Health- Daily Med found at https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=2c87e99e-33d4-4060-8876-ff05557c05eb, titled, LATANOPROST OPHTHALMIC SOLUTION solution/ drops, no dated, the professional reference review indicated .Storage: . Once a bottle is opened for use, it may be stored at room temperature up to 25 C (77 F) for 6 weeks.During a review of the facility's policy and procedure (P&P) titled, Medication Storage, dated [DATE], the P&P indicated, . 8 Unused medications: The pharmacy on all medication rooms are routinely inspected by the consultant pharmacy for discontinued, outdated, defective, or deteriorated medications with worn, eligible, or missing labels. These medications are destroyed in accordance with our destruction of unused drugs policy.During a review of the facility's P&P titled, Medication Administration, no date, the P&P indicated, . Policy: medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice, in a manner to prevent contamination or infection.13. Identify expiration date. If expired, notify nurse manager. 14. Remove medication from source, taking care not to touch medication with bare hand.

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, and record review, the facility failed to ensure residents' food was prepared and processed appropriately to meet residents' needs for two of three sampled residents (Resident 86 and Resident 73) when large pieces of broccoli were not in proper form of minced and moist on their lunch meal tray on 4/23/26.This failure to properly process the minced and moist food can result in choking (when the airway is obstructed by food, drink, or foreign objects) for Residents 86 and 73 on a minced and moist diet at the facility. During a review of the lunch menu for 4/23/26 indicated, for the MM5 (minced and moist level 5 diet) the following: Japanese Vegetable Blend. soft mashed broccoli, sweet and sour pork SBMM (soft and bite and minced and moist), rice, puree bread.During an observation of the lunch meal service on 4/23/26 at 12:39 p.m. in the kitchen, Resident 86's lunch plate contained minced sweet and sour pork, rice, puree bread and large pieces of broccoli. The Registered Dietitian Consultant (RDC) was watching the lunch meal preparation. During a review of Resident 86's lunch meal ticket during the lunch meal service on 4/23/26, Resident 86's lunch meal ticket showed a handwritten diet order of minced and moist.During a concurrent observation and interview on 4/23/26 at 12:39 p.m. with Dietary [NAME] (DC) 2, DC 2 was looking at Resident 86's lunch meal plate containing minced sweet and sour pork, rice, puree bread and large pieces of broccoli. DC 2 stated the broccoli needed to be soft and the size was okay. The lunch meal tray continued down the tray line and placed into the meal cart.During a concurrent observation and interview on 4/23/26 at 12:40 p.m. with the RDC and the Dietary Manager (DM), in the kitchen, the RDC informed the DM, and the DM took out Resident 86's lunch meal tray from the meal cart. The DM started mashing the broccoli with the use of fork. The DM stated the broccoli needed to be soft and able to be mashed with a fork. The RDC stated the pieces of broccoli needed to be smaller. During an interview on 4/23/26 at 12:42 p.m. with the RDC, the RDC stated the dietary cooks were looking at incorrect recipe and they should have it to be at 4mm (Millimeters -used to measure food ingredient thickness, precise cuts, or small items) by 15 mm for minced and moist diet.During an interview on 4/23/26 at 12:43 p.m. with the DM, the DM stated Resident 73's lunch meal tray for small dining room was prepared at the beginning of meal service. The DM stated Resident 73 was on moist and minced diet and received the improper form of vegetable (broccoli). During a review of Resident 73's lunch meal ticket on 4/23/26, Resident 73's lunch meal ticket indicated, Diet Order: Minced and Moist Level 5.During a review of Resident 73's Face Sheet (FS - a summary of information regarding a patient which includes patient identification, past medical history, insurance status, care providers, family contact information and other pertinent information), dated 4/23/26, the FS indicated Resident 73 was admitted to the facility on [DATE] with diagnosis of dysphagia (difficulty swallowing).During a review of Resident 86's FS, dated 4/23/26, the FS indicated Resident 86 was admitted to the facility on [DATE] with diagnosis of hemiplegia (paralysis [the loss of the ability to move and sometimes to feel anything] of one side of the body) and hemiparesis (muscle weakness or partial paralysis on one side of the body that can affect the arms, legs, and facial muscles) following cerebral infarction (damage to tissues in the brain due to a loss of oxygen to the area), and acute respiratory failure (a serious condition that occurs when the lungs cannot get enough oxygen into the blood or remove enough carbon dioxide [a waste gas] from the blood).During an interview on 4/22/26 at 3:55 p.m. with the Registered Dietitian (RD), the RD stated it was her expectation for the dietary cooks to follow menus and recipes for right consistency and products. The RD stated dietary staff received training for International Dysphagia Diet Standardization Initiative (IDDSI) which was implemented in 1/2026. The RD stated she would expect dietary staff to test for consistency for the IDDSI diets. During an interview on 4/23/26 at 1:26 p.m. with the RDC and RD, the RDC and RD stated they were reaching out to their food distributor and vendor to seek clarification about recipes and menus for (continued on next page)

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	their dietary staff to easily understand and follow. The RDC and RD stated that the facility's recipes and menus were confusing for the dietary staff to follow in ensuring the proper food consistency was being provided for the residents. During a review of the facility's recipe titled, Soft Mashable Broccoli FL OR FZN, dated 4/23/26, the recipe indicated, .For the IDDSI Minced and Moist/Level 5 diet, all food pieces must be less than 4mm x 15mm in size.During a review of facility's dietary manual titled, IDDSI Food Level 5 Minced and Moist (Orange), undated, indicated, IDDSI Food Level 5/ Minced and Moist/Orange (MM5) diet is based on the Nutrition Care Manual's (NCM) Minced and Moist Food, Level 5 (Orange) diet and International Dysphagia Diet Standardization Initiative. Requires minimal chewing ability and consists of foods that are easy to swallow because they are minced, very soft, and moist and can be scooped and shaped. Foods pieces should be no larger than 4mm width by 15mm length for adults with no separate thin liquids present. Minced pieces of food should fit in between the tines of a fork.testing must be conducted at the community level to ensure all foods meet texture and size requirements as per the IDDSI testing methods.Vegetables - must be under 4 mm in size, non-stringy and non-fibrous, cooked until soft and easily mashable with a fork, spoon, or fingers, and drained of excess liquid.During a review of the facility's policy and procedures (P&P) titled, Food Preparation, dated 2023, the P&P indicated, .The facility will use approved recipes.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure resident's food preference was provided for one of 20 sampled residents (Resident 26) when Resident 26's lunch tray did not include double protein (one of the many substances found in food such as meat, cheese, fish, or eggs, that is necessary for the body to grow and be strong) on 4/21/26.This failure had the potential for Resident 26 not to receive her food preference which can result in undernutrition that could compromise her medical and nutritional status.During a review of the lunch menu for 4/21/26 indicated, for the house (regular diet) the following: .Baked Honey Glazed Ham 4.4 oz (ounces- a standard unit of weight), Baked Sweet Potato1 each, French Style [NAME] Beans 1/2 (half) cup.During a review of Resident 26's lunch meal ticket during the lunch meal service, Resident 26's lunch meal ticket showed two servings of protein under the standing order. During a concurrent observation of the lunch meal service and interview on 4/21/26 at 12:13 p.m. with Dietary Aide (DA) 1, DA 1 checked Resident 26's meal ticket according to the food provided in Resident 26's lunch tray. DA 1 put Resident 26's lunch tray into a food cart and validated that there was only one slice of ham in Resident 26's lunch tray. DA 1 confirmed that Resident 26's needed two slices of ham. DA 1 asked Dietary [NAME] (DC) 1 to provide another slice of ham. During a concurrent interview and record review on 4/21/26 at 12:14 p.m. with DA 1, Resident 26's lunch meal ticket was reviewed. The lunch meal ticket indicated, .Standing orders: Entree/Protein (2X) . DA 1 stated Resident 26 should be provided with double protein, and her lunch plate should include two slices of ham.During a concurrent interview and record review on 4/22/26 at 3:55 p.m. with the Registered Dietitian (RD), Resident 26's lunch meal ticket dated 4/21/26 was reviewed. The lunch meal ticket indicated, Diet Order: Regular.Standing orders: Entree/Protein (2X) . The RD stated the standing order was Resident 26's food preferences and not a physician's order. The RD stated Resident 26's food preference of double protein should be provided, and she should have two slices of ham in her lunch tray yesterday (4/21/26). During a review of Resident 26's Face Sheet (FS - a summary of information regarding a patient which includes patient identification, past medical history, insurance status, care providers, family contact information and other pertinent information), dated 4/22/26, the FS indicated Resident 26 was admitted to the facility on [DATE] with primary diagnosis of pneumonia (an infection that affects one or both lungs, causing the air sacs of the lungs to fill with fluid), type 2 Diabetes Mellitus (when the blood sugar levels in the body are too high), and protein calorie malnutrition (PCM- when a person doesn't eat enough proteins and calories to meet nutritional needs).

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to ensure food was stored, prepared and served in accordance with professional standards for food safety when:1. Gloves were not changed by Dietary [NAME] (DC) 2 after handling non-food items (a box made of cardboard) while making sandwiches for the residents' lunch meal on 4/22/26.This failure had placed residents at an increased risk of acquiring food-borne illnesses (an illness that comes from eating contaminated food [refers to food or beverages containing harmful microorganisms (bacteria, viruses, parasites), toxins, or foreign physical/chemical substances that make them unsafe for human consumption]).2. Incorrect thermometer usage in residents' freezer. Residents' freezer contained an oven thermometer (used to measure high heat to ensure accurate baking and identify hot spots).This failure had the potential for not obtaining and maintaining accurate temperatures for cold foods which could lead to the growth of microorganisms (bacteria) and placed residents at an increased risk of acquiring food-borne illnesses.3. Unlabeled frozen food was stored in residents' freezer.This failure had the potential to be served and consumed by other residents which could have a negative effect such as allergic reactions, aspiration (when food or liquid enters the lungs) and choking (when the airway is obstructed by food, drink, or foreign objects).1.During an observation on 4/22/26 at 10:25 a.m. with Dietary [NAME] (DC) 2, in the kitchen, DC 2 was preparing a turkey sandwich on top of the preparation table using gloves. DC 2 was placing five slices of turkey breast meat in each bread. DC 2 opened a cardboard box containing bags of bread, opened two plastic bags of bread and placed each bread on the preparation table. DC 2 touched all the bread on the preparation table with the same gloves. DC 2 did not change her gloves after opening the cardboard box of bread and continued to make a turkey sandwich using the same gloves.During an interview on 4/22/26 at 3:02 p.m. with the Registered Dietitian (RD), the RD stated it was her expectation to change gloves when touching anything else or visibly dirty. The RD stated gloves should be changed after opening a cardboard box and perform handwashing before continuing making a sandwich to prevent cross-contamination (when germs or allergens transfer from one substance to another).During an interview on 4/24/26 at 9:45 a.m. with the Infection Preventionist (IP), the IP stated he provided infection control training for all dietary staff for infection control. The IP stated dietary staff received training for handwashing and proper use of gloves. The IP it was his expectation to follow facility's policy and procedures (P&P) for handwashing and glove use to prevent cross-contamination and infection (the invasion and growth of germs in the body). The IP stated gloves should be changed after handling or touching non-food items and perform handwashing to prevent cross-contamination and potential risk of foodborne illnesses.During a review of facility's P&P titled, Glove Use Policy, dated 2023, the P&P indicated, The appropriate use of gloves is essential in preventing food borne illness. Gloved hands are considered a food contact surface that can get contaminated or soiled. Disposable gloves are a single use item and should be discarded after each use, and especially before handling clean food items. WHEN GLOVES NEED TO BE CHANGED. 2. Before beginning a different task. 2. During a concurrent observation and interview on 4/22/26 at 2:14 p.m. with the Activity Director (AD), in the activity room, the AD opened the residents' refrigerator with top mounted freezer. The top freezer of resident's refrigerator contained an oven thermometer. The AD stated she was responsible for monitoring the temperature of the residents' refrigerator. The AD stated she was unaware that an oven thermometer was used to check the temperature of the freezer. During a concurrent observation and interview on 4/22/26 at 2:15 p.m. with the Registered Dietitian Consultant (RDC), in the activity room, the RDC was checking the thermometer found at residents' freezer and validated it was an oven thermometer. The RDC stated the Registered Dietitian (RD) will provide a correct thermometer for the residents' freezer. The RDC stated it was important that correct thermometer for the freezer should be used to ensure frozen food remained frozen and maintained an accurate cold temperature. During an interview on 4/22/26 at (continued on next page)

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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 establish and maintain an effective infection prevention and control program to help prevent the development and transmission of infections for two of seven sampled residents (Resident 18, and Resident 43) when:1. Resident 18 was placed on Enhanced Barrier Precautions (EBP - an infection control intervention designed to reduce transmission of resistant organisms [bacteria that have become resistant to certain antibiotics] that requires gown and glove use during high contact resident care activities) and Certified Nursing Assistant (CNA) 2 and CNA 3 did not put on the appropriate personal protective equipment (PPE - clothing and equipment that is worn or used to provide protection against hazardous substances and/or environments) prior to providing high contact care to Resident 18.2. Resident 43's nasal cannula (NC-a flexible tube with two prongs that fit inside the nostrils), and oxygen tubing (flexible tube connected to an oxygen source) were found wrapped around Resident 18's oxygen concentrator (a device that produces 90 percent to 95 percent oxygen from room air).3. Resident 43's foley catheter drainage tubing (a tube that is inserted into the urinary bladder to collect urine into a bag) was touching the floor and contained a white sediment (solid particles found in urine) inside the tubing and urine.These failures placed Resident 18 and Resident 43 at risk for cross-contamination (the process when germs are unintentionally transferred from one substance or object to another, which causes a harmful effect), infection (an invasion of the body by germs that cause disease) and illness.Findings:During a concurrent observation and interview on 4/21/2026 at 7:28 a.m. with CNA 2 and CNA 3 in Resident 18's room, a sign was observed outside Resident 18's door, which indicated EBP were in place for residents in the room, and a brown sticker was next to Resident 18's name, which indicated Resident 18 was on EBP. Resident 18 was observed in bed, with her curtain drawn and CNA 2 and CNA 3 observed dressing Resident 18 and transferring her to a wheelchair. CNA 2 and CNA 3 were not wearing gowns and CNA 2 did not wear gloves. CNA 3 donned gloves and removed Resident 18's bed linens. CNA 3 stated today was his second day orienting with CNA 2 and he needed to wear a gown and gloves when providing care for residents on EBP. CNA 2 stated the brown sticker by a resident's name meant the resident was on EBP. CNA 2 stated she and CNA 3 should have worn appropriate PPE, a gown and gloves, before dressing Resident 18, transferring her to a wheelchair, and changing her bed linens. CNA 2 stated if staff did not wear the appropriate PPE, there was a risk of getting germs on the resident, on herself and transferring germs to other residents. CNA 2 and CNA 3 continued providing care to Resident 18, including putting Resident 18's shoes on without donning appropriate PPE.During a review of Resident 18's admission Record (AR - a summary of information regarding a patient which includes patient identification, past medical history, insurance status, care providers, family contact information and other pertinent information), dated 4/23/26, the AR indicated Resident 18 was admitted to the facility from an acute care hospital on 1/12/26 with diagnoses of subdural hemorrhage (bleeding in the area between the brain and the skull), multiple fractures of the pelvis (a break of the ring of bones that connect your spine to the hips), type 2 Diabetes Mellitus (when the blood sugar levels in the body are too high), Alzheimer's disease (a brain disorder that slowly destroys memory and thinking skills, and eventually, the ability to carry out the simplest tasks), and dementia (loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life).During a review of Resident 18's Minimum Data Set (MDS - a resident assessment tool used to identify cognitive [mental processes] and physical functional level assessment), dated 4/13/26, the MDS section C indicated Resident 18 had a Brief Interview for Mental Status (BIMS - a test given by medical professionals to determine cognitive (involving the process of thinking, learning and understanding) understanding on a scale of 1-15) score of three (a score of 0-7 suggests severe cognitive impairment, 8-12 suggests moderately impaired, 13-15 suggests cognitively intact), which indicated Resident 18 was severely cognitively (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	impaired.During a concurrent interview and record review on 4/23/2026 at 10:07 a.m. with Licensed Vocational Nurse (LVN) 1, Resident 18's Electronic Medical Record (EMR), undated was reviewed. LVN 1 stated a brown sticker indicated which resident in the room was on EBP. LVN 1 was unable to state why Resident 18 was on EBP. LVN 1 stated the Infection Preventionist (IP) placed residents on EBP precautions and informed and educated the staff why residents were on EBP and what PPE were needed to care for the residents. LVN 1 stated it was important for staff to know why a resident was on EBP and to wear appropriate PPE for patient safety and to prevent spreading of infections.During a concurrent interview and record review on 4/23/2026 at 10:47 a.m. with the IP, Resident 18's Care Plan (CP), undated was reviewed. The CP indicated, .the resident is on enhanced barrier precautions [EBP] related to [r/t] surgical incisions to left hip.date initiated: 1/30/26.the resident will remain free from infection related to open wounds through the review date.direct care staff to utilize gowns and gloves for all personal care.date initiated: 1/30/26. The IP stated Resident 18 was on EBP for surgery incisions to the left hip initiated on admission and discontinued today, 4/23/26. The IP stated he made the determination if a resident was to be put on EBP, and when a resident came off EBP. The IP stated he put an EBP sign on the resident's door and a brown sticker next to the resident's name if they were on EBP, and staff were educated and informed of what type of precautions and PPE were needed when caring for the resident. The IP stated staff should have used PPE during high contact care activities such as dressing and transferring Resident 18. The IP stated staff should have adhered to EBP practices and worn appropriate PPE if a resident had a dot by their name to prevent the transfer of germs and prevent Resident 18 from getting infections.During a review on 4/24/2026 at 10:27 a.m. with the Director of Nursing (DON), the DON stated EBP practices were put in place to protect the residents from getting infections. The DON stated every staff member needed to wear a gown and gloves during high contact with a resident on EBP.During a review of the facility's policy and procedure (P&P) titled, IPCP Standard and Transmission-Based Precautions, dated 1/2024, the P&P indicated, .it is the policy of this facility to implement infection control measures to prevent the spread of communicable diseases and conditions.Enhanced Barrier Protection [EBP]: expand the use of PPE and refer to the use of gown and gloves during high-contact resident care activities that provide opportunities for indirect transfer of Multidrug Resistant Organisms [MDRO - bacteria that have become resistant to multiple types of antibiotics making them more difficult to treat, can spread rapidly, and threaten patient safety] to staff hands and clothing then indirectly transferred to residents or from resident-to-resident.examples of high-contact resident care activities requiring gown and glove use for Enhanced Barrier Precautions include.dressing.transferring.providing hygiene.changing linens.the facility will implement a system to alert staff, residents and visitors that a resident is on transmission Based Precautions [TBP-used when standard precautions alone are not sufficient to prevent the spread of an infectious agent].post clear signage on the door or wall outside of the resident room indicating the type of Precautions and required PPE.for Enhanced Barrier Precautions, signage should also clearly indicate the high-contact resident care activities that require the use of gown and gloves. 2. During an observation on 4/21/2026 at 7:22 a.m. in Resident 43's room, Resident 43 was observed wearing a gown and an oxygen nasal cannula, asleep in her bed. Oxygen flow rate was set at 3 liters per minute (L/min-a unit of measurement).During a review of Resident 43's AR, dated 4/24/26, the AR indicated Resident 43 was admitted to the facility from an acute care hospital on [DATE] with diagnoses of Encephalopathy (damage or disease that affects the brain), spinal stenosis (a narrowing of the spine that causes pressure on the spinal cord and nerves and can cause pain) of the neck and lower back regions, atrial fibrillation (an irregular heartbeat), stiffness of the right hand, and major depressive disorder (a mental health disorder characterized by persistently depressed mood or loss of interest in activities).During a review of Resident 43's MDS, dated 3/12/26, the MDS section C indicated Resident 43 had a BIMS score of 14, which indicated Resident 43 was cognitively intact.During a review of Resident 43's Order Review List (ORL), undated, the ORL indicated, .oxygen at 3 Liters per minute [LPM] via NC as needed [PRN].change oxygen tubing and (continued on next page)

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