STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056261	A. Building B. Wing	05/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Orchards at Tulare	604 E. Merritt Ave. Tulare, CA 93274

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. 32946 Based on interview, and record review, the facility failed to follow its policy and procedure regarding Advance Directive (AD-a legal document indicating resident preference on end-of-life treatment decisions) for one of one sampled resident (Resident 446) were informed about their right to complete and AD or had evidence of declining to complete an AD. This failure had the potential for responsible parties and/or medical professionals not to honor resident healthcare wishes and to not provide appropriate treatment in the event of an emergency medical situation. Findings: During a concurrent interview and record review on 5/7/25 at 8:35 a.m. of Resident 446 medical record with Business Office Manager (BOM). BOM reviewed the medical record for Resident 446 and was unable to provide evidence of Resident 446 and/or responsible party were offered an opportunity to formulate or decline an AD. During a review of the facility policy and procedure (P&P), titled Resident Rights Regarding Treatment and Advance Directive, dated 2025, indicated, Policy It is the policy of this facility to support and facilitate a resident's right to request, refuse and/or discontinue medical or surgical treatment and to formulate advance directive. Definitions: Advance directive is a written instruction, such as a living will or durable power of attorney for health care, recognized under state law (whether statutory or as recognized by the courts of the State), relating to the provision of health care when the individual is incapacitated. Policy Explanation and Compliance Guidelines: 1. On admission, the facility will determine if the resident has executed an advance directive, and if not, determine whether the resident would like to formulate an advance directive.

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

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

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 50939 Based on observation, interview, and record review, the facility failed to ensure two of 16 sampled residents (Resident 32 and Resident 73), personal belongings were replaced within a timely manner once the items were reported loss. These failures resulted in Resident 32 and Resident 73 lost items not being replaced During an interview on 5/6/25 at 10:33 a.m. with Resident 73, Resident 73 stated his watch had been missing since December 2024. Resident 73 stated he had reported his missing watch to the social worker. Resident 73 was told by the social worker that the facility will replace the missing watch. Resident 73 stated he was upset that his watch had been missing, and the facility had not replaced the watch. During a review of Resident 73's Admission Record, (AR) dated 5/7/25, the AR indicated Resident 73's admitted was 9/9/24. During a review of Resident 73's Minimum Data Set, (MDS - a federally mandated resident assessment tool) dated 3/14/25, the MDS indicated Resident 73 had a (Brief Interview for Mental Status - an assessment tool used by facilities to screen and identify memory, orientation, and judgement status of the resident) score of 15 (score of 13-15 means cognitively intact). During a review of Resident 73's Inventory List, (IL) dated 9/9/24, the IL indicated jewelry, one watch. During an interview on 5/7/25 at 10:30 a.m. with Acting Activities Director (AAD), AAD stated when she receives a theft or loss report, she will go speak to the resident. AAD stated the facility will replace missing items within seven days. During an interview on 5/7/25 at 10:36 a.m. with Administrator, Administrator stated her expectation from staff on loss or theft are to report to AAD, fill out the theft/loss form, and replace Resident 73's missing item within seven days. 45654 During an interview on 5/7/25 at 11:18 a.m. with Resident 32, Resident 32 stated a month ago her grey sweatshirt went missing. Resident 32 stated it was her favorite her daughter had given it to her. Resident 32 stated she reported the missing sweatshirt to housekeeping. During an interview on 5/8/25 at 10:55 a.m. with Laundry, Laundry stated social services tells us to look for missing clothing items. Laundry stated I inform my boss of missing clothing now since there is no current social services staff. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's policy and procedure (P&P) titled, Resident Personal Belongings, Undated, the P&P indicated, Policy: It is the policy of this facility to protect the resident's right to possess personal belongings .7. The facility will exercise reasonable care for the protection of the resident's property from loss or theft.

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27157 Based on interview and record review, the facility failed to ensure a Significant Change in Status MDS Assessment (MDS-a federally mandated resident assessment tool; SCSA- a comprehensive assessment completed within 14 days of the identification of a status change) was completed for one of one sampled resident (Resident 68) when Resident 68 had a major decline in two or more MDS areas as evidenced by unplanned significant weight loss and the development of a new wound. This failure had the potential for Resident 68 to have unmet care needs. Findings: During a concurrent interview and record review on 05/08/25 at 11:14 a.m. with MDS Coordinator (MDSC), MDSC reviewed Resident 68's electronic health record (EHR). MDSC stated she should have completed a significant change of status MDS at the same time she had completed a quarterly MDS on 2/26/25 as Resident 68 had major decline in two MDS care areas which were significant weight loss not on prescribed weight-loss regimen and a new wound that triggered on the quarterly MDS. During a review of Resident 68's quarterly MDS, dated [DATE], the quarterly MDS indicated, D 1. Number of Stage 4 pressure ulcers: 1, D 2. Number of these Stage 4 pressure ulcers that were present upon admission/reentry: 1. During a review of Resident 68's quarterly MDS, dated [DATE], the quarterly MDS indicated, D 1. Number of Stage 4 pressure ulcers: 3, D 2. Number of these Stage 4 pressure ulcers that were present upon admission/reentry: 2. During a review of Resident 68's RD [Registered Dietitian]/IDT [interdisciplinary team] Weight [wt] Variance Meeting [mtg] (Wt Mtg), dated 12/31/24, the Wt Mtg indicated, Wt: 85# (pounds). Wt Change: -23# (21. 3%[percent loss of body weight]) x [for] 3 months,.Prostat [supplement to increase protein and calories], MVM [multivitamin with minerals], Skin: Stage 4 [pressure injury with full-thickness skin and tissue loss] to sacrum [bone in the lower portion of the spine], unstageable [pressure injury with covered full-thickness skin and tissue loss] to R [right] leg, trauma wound to R leg, skin tear to R forearm, Resident sent to acute [hospital] (12/14/2024) for syncope [fainting] and readmitted (12/16/2024) s/p [status post] IV [intravenous] hydration. Resident with decreased appetite, new wound, and s/p antibiotic tx [therapy] for R leg trauma wound. During a review of Resident 68's Weights and Vitals Summary (WVS), the WVS indicated, on 08/23/2024, Resident 68 weighed 113 lbs. On 02/17/2025, Resident 68 weighed 87 pounds which is a -23.01 % Loss [of body weight] in last 6 months. (continued on next page)

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 05/06/25 at 2:44 p.m. with RD, Resident 68's Nutrition Evaluation (NE), dated 8/27/2024 was reviewed. The NE indicated relevant diagnoses.moderate protein-calorie malnutrition, adult failure to thrive [a process of physical and psychological decline], pressure ulcer. Diet order: Regular diet, Regular texture, Height: 59 [inches] Date: 8/23/24, Weight: 113 pounds (lbs) Date: 8/26/24, Appearance/Skin full thickness unstageable (pressure injury covered full-thickness skin and tissue loss to coccyx [tailbone], wound to R lateral leg, Nutrition Needs Estimate: 1,541 calories daily, Protein (Pro): 77 grams (g) daily, Fluids: 1,541 ml (milliliter- measurement of capacity), Discussed importance of meeting EEN [estimated energy needs] and hydration needs for wound healing. Resident verbalized understanding. Will continue to monitor weight x 4 weeks. Increased nutrient needs r/t [related to] wound healing, RD recommends: Prosat 30 ml BID [two times a day for increased calories of 200 and 30 g of pro]. Goals: 1) Will not have worsening in skin condition or new skin breakdown to the extent possible. 2) Will maintain adequate nutritional status as evidenced by stable. 3) Will not exhibit s/s (signs/symptoms) of dehydration. During a review of Resident 68's RD/IDT Weight Variance Meeting (Wt Mtg), dated 2/6/25, the Wt Mtg indicated Resident 68 was on a fortified diet [added 500 calories], Prostat 60 ml BID [added 400 calories and 60 g pro], on appetite stimulant indicative of not being on a prescribed weight-loss regimen. During a review of the facility's policy and procedure (P&P) titled, MDS 3.0 Completion, dated 2022, the P&P indicated, Policy: Residents are assessed, using a comprehensive assessment process, in order to identify care needs and to develop an interdisciplinary care plan. Policy Explanation and Compliance Guidelines: d. Significant change is a major decline or improvement in a resident's status that: (1) will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions (is not self-limiting, if a decline); 2) impacts more than one area of the resident's health status, and (3) requires interdisciplinary review and/or revision of the care plan. Quarterly Assessment - completed using an ARD [Assessment Reference Date] no > [greater than] 92 days from the most recent prior quarterly or comprehensive assessment (counting ARD to ARD). The R.N. [Registered Nurse] Coordinator signs, dates, and attests (in section Z0500A) to timely completion of the RAI [Resident Assessment Instrument], once all disciplines have completed their sections. 51540

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50939 Based on observation, interview, and record review, the facility failed to ensure the Minimum Data Set (MDS-a federally mandated resident assessment tool) Matrix was accurate and up to date for three of eight sampled residents (Resident 1, Resident 23 and Resident 68). This failure resulted in the documentation of an inaccurate assessment and an inaccurate quarterly MDS for Resident 68. Findings: During a review of the facility's Resident Matrix, (RM) dated 5/5/25, the RM indicated, Resident 1 listed anticoagulant (medication used to help prevent blood clots from forming or growing) and Resident 23 listed antibiotic. During an interview on 5/5/25 at 10:16 a.m. with Resident 1, Resident 1 stated he is not currently taking any anticoagulant medications. Resident 1 stated he stopped taking anticoagulant medications this past January. During a review of Resident 1's Admission Record (AR), dated 5/7/25, the AR indicated Resident 1's initial admitted was 11/22/24. During a review of Resident 1's MDS dated [DATE], the MDS indicated Resident 1 had a (Brief Interview for Mental Status [BIMS] -an assessment tool used by facilities to screen and identify memory, orientation, and judgement status of the resident) score of 13 (score of 13-15 means cognitively intact). During a concurrent interview and record review on 5/8/25 at 10:28 a.m. with Minimum Data Set Coordinator (MDSC), Resident 1's Discontinue Order, DO dated 12/6/24 was reviewed. The DO indicated, Order Summary: Eliquis Oral Tablet 5 MG [milligram] (Apixaban) Discontinue Dated: 12/6/2024 Reason for Discontinue: D/C [discontinue] per MD [Doctor of Medicine] orders. MDSC stated she had refreshed the matrix on 5/5/25. MDSC stated Resident 1 is currently not on an anticoagulant medication. During an interview on 5/5/25 at 10:31 a.m. with Resident 23, Resident 23 stated he is not currently taking antibiotics. During a review of Resident 23's AR, dated 5/7/25, the AR indicated Resident 23's initial admitted was 2/25/25. During a review of Resident 23's MDS dated [DATE], the MDS indicated Resident 23 had a BIMS score of 15. During a concurrent interview and record review on 5/8/25 at 10:36 a.m. with MDSC, Resident 23's DO dated 2/25/25 was reviewed. The DO indicated, Order Summary [OS]: ceftazidime [medication used to treat infections] Intravenous [IV-administered directly into a vein] Solution .Discontinue Date: 2/25/2025. MDSC stated Resident 23 was admitted in the facility with IV antibiotic therapy. MDSC stated Resident 23 was on ceftazadine and was discontinued on 3/18/25. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/8/25 at 10:39 a.m. with MDSC, MDSC stated she generally tried to keep the matrix up to date on Fridays. MDSC stated she can manually update the matrix. MDSC stated she didn't get a chance to update the Matrix and she should have updated the Matrix. During an interview on 5/8/25 at 10:43 a.m. with Administrator, Administrator stated her expectations for the MDSC is for the Matrix to be updated on Fridays. During a review of the facility's RAI Coordinator - Job Description, RAI Coordinator - Job Description dated 2020, the RAI Coordinator - Job Description indicated, Major Duties and Responsibilities: Accurate completion of all MDS assessments and any supporting assessments or clinical documentation. A policy was requested and none were provided. 27157 During a review of Resident 68's Resident Matrix (RM), dated 5/5/25, the RM was reviewed. The RM did not have a check mark in the box under Excessive Weight Loss Without Prescribed Weight Loss Program. During a concurrent interview and record review on 05/08/25 at 11:38 a.m. with MDS Coordinator (MDSC), Resident 68's quarterly Minimum Data Set (MDS-a federally mandated resident assessment tool), dated 2/26/25, was reviewed. The quarterly MDS, with Assessment Reference Date (ARD) dated 2/26/25 indicated, K0200 B. Weight (in pounds) - 87, section K0300. Weight Loss; Loss of 5% [percent] or more in the last month or loss of 10% or more in last 6 months was coded as 1. Yes, on prescribed weight-loss regimen. MDSC stated the section titled K0300. Weight Loss; Loss of 5% or more in the last month or loss of 10% or more in last 6 months was not coded accurately, as it should have been coded as 2. Yes, not on prescribed weight-loss regimen, as the facility was not intentionally trying to get Resident 68 to lose weight. During a review of Resident 68's Weights and Vitals Summary (WVS), the WVS indicated on 08/23/2024, Resident 68 weighed 113 pounds (lbs) On 02/17/2025, Resident 68 weighed 87 lbs which is a -23.01 % loss of body weight in last 6 months. During a concurrent interview and record review on 05/06/25 at 2:44 p.m. with Registered Dietitian (RD), Resident 68's Nutrition Evaluation (NE), dated 8/27/2024 was reviewed. The NE indicated relevant diagnoses.moderate protein-calorie malnutrition, adult failure to thrive (a process of physical and psychological decline), pressure ulcer. Diet order: Regular diet, Regular texture, Height: 59 [inches], dated 8/23/24 and weight of 113 lbs dated: 8/26/24. Appearance/skin full thickness unstageable (pressure injury covered full-thickness skin and tissue loss to coccyx (tailbone), wound to R (right) lateral leg, nutrition needs estimate: 1,541 calories daily, protein (pro): 77 grams (g) daily and fluids: 1,541 ml (milliliter-measurement of capacity). The NE indicated RD, Discussed importance of meeting EEN (estimated energy needs) and hydration needs for wound healing. Resident verbalized understanding. Will continue to monitor weight x 4 weeks. Increased nutrient needs related to wound healing, RD recommends: Prosat [nutrition supplement; increase of 200 calories; 30 g of pro] 30 ml BID (two times a day). Goals: 1) Will not have worsening in skin condition or new skin breakdown to the extent possible. 2) Will maintain adequate nutritional status as evidenced by stable. 3) Will not exhibit s/s [signs/symptoms] of dehydration. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 68's RD/IDT Weight Variance Meeting (Wt Mtg), dated 2/6/25, the Wt Mtg indicated Resident 68 was on a fortified diet [added 500 calories], Prostat 60 ml BID [added 400 calories and 60 g pro], on appetite stimulant indicative of not being on a prescribed weight-loss regimen. During a concurrent interview and record review on 05/08/25 at 11:45 a.m. with MDSC, Resident 68's RM, dated 5/5/25, was reviewed. MDSC stated Resident 68's RM was not accurate as it did not have a checkmark for Excessive Weight Loss Without Prescribed Weight Loss Program and should have. MDSC stated the error was made on Resident 68's RM because the quarterly MDS, dated [DATE], was not accurate. During a review of the facility's policy and procedure (P&P) titled, MDS 3.0 Completion, dated 2022, the P&P indicated, Policy: Residents are assessed, using a comprehensive assessment process, in order to identify care needs and to develop an interdisciplinary care plan. Policy Explanation and Compliance Guidelines: Quarterly Assessment - completed using an ARD [Assessment Reference Date] no > [greater than] 92 days from the most recent prior quarterly or comprehensive assessment (counting ARD to ARD). The R.N. [Registered Nurse] Coordinator signs, dates, and attests (in section Z0500A) to timely completion of the RAI [Resident Assessment Instrument], once all disciplines have completed their sections.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51540 Based on observation, interview, and record review the facility failed to provide quality care to one of one sampled resident (Resident 25) when: 1. Resident 25 had a chocking episode that was not immediately identified and addressed by nursing staff who were present in the dining room at the time of occurance. 2. A comprehensive (complete) assessment was not completed for Resident 25 after a chocking episode and delegation (assigning a task) of monitoring Resident 25 for safety was given to nonnursing staff position titled Hospitality Aid (HA). 3. Education was not provided to a family member who routinely fed Resident 25 who was on aspiration precautions (preventive measures taken to reduce the risk of accidental inhalation of food, liquid, or other substances into the lungs) to ensure swallow strategies, as assessed by a Speech Therapist (ST), was implemented. 4. Resident 25's thickened liquids (to help individuals with swallowing difficulties based on individualized assessment) order was not followed. These failures resulted in Resident 25 having unidentified needs and improper assessment during an episode of chocking with potential for aspiration or death. Findings: 1. During a review of Resident 25's facesheet, the facesheet indicated Resident 25 was admitted to the facility on [DATE] with diagnosis of aphasia (a language disorder that impairs a person's ability to understand and verbalize) and Alzheimer's (a brain disorder that impairs thinking and memory skills) disease. During a review of Resident 25's Minimum Data Set (MDS), dated [DATE], the MDS indicated Section C: BIMS [Brief Interview for Mental Status-an assessment tool used by facilities to screen and identify memory, orientation, and judgement status of the resident] score 0 [indicates severe cognitive impairment]. During an observation on 05/05/25 at 1:04 p.m. in the dining room, Resident 25 took a bite of food and began coughing continuously and then vomited into plastic red plate cover. Family Member (FM) 1, who was sitting next to Resident 25, flagged a nurse to check on Resident 25 after she vomited. Director of Staff Development (DSD), who was present in the dining room while Resident 25 was coughing, responded to FM 1 by going over to Resident 25. FM 1 requested Resident 25 be taken back to Resident 25's room. As Resident 25 was being wheeled out of the dining room by DSD, Resident 25 was still coughing. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 05/05/25 at 1:19 p.m. with the Assistant Director of Nursing (ADON), ADON stated she was in the dining room sitting in front of Resident 25 but was assisting another resident with eating. ADON stated she saw Resident 25 being wheeled out of the dining room, but other than that she did not hear anything. ADON stated DSD told her Resident 25 had vomited and DSD assessed her. During an interview on 05/07/25 at 10:18 a.m. with ADON, ADON stated the facility assigned DSD and Licensed Vocational Nurse (LVN) 3 to provide general supervision of residents eating in the dining room for emergent (emergency) reasons. ADON stated DSD and LVN 3 were present in the dining room and should have immediately attended to Resident 25 when she was coughing and vomiting, and that did not happen. During an interview on 05/07/25 at 11:15 a.m. with DSD, DSD stated he was aware of his responsibility to supervise during mealtimes. During a review of American Heart Association Basic Life Support (BLS) training, the BLS training indicated, The AHA's BLS course trains participants to promptly recognize several life-threatening emergencies. During a review of DSD's employee training, DSD was issued Basic Life Support (BLS) on 3/20/24 with an expiration date of 03/2026. During a review of the facility's policy and procedure (P&P) titled, Meal Supervision and Assistance, the P&P indicated .adequate supervision and assistance to prevent accidents. 2. a) During a concurrent observation and interview on 05/05/25 at 1:13 p.m. with DSD, Resident 25 was taken back to her room by DSD after coughing/choking and vomited while eating lunch in the dining room. DSD stated, FM 1 stated Resident 25 was vomiting which was why FM 1 called me over. DSD stated he took Resident 25 back to her room and performed an assessment, which consisted of palpating (examination by touch) Resident 25's stomach in which Resident 25 did not grimace (expression) in pain. DSD stated Resident 25 was left in her room sitting in her wheelchair. During an observation on 05/05/25 at 1:18 p.m. Resident 25 was sitting in her wheelchair in her room next to her bed. During an interview on 05/07/25 at 10:48 a.m. with ADON, ADON stated an appropriate resident assessment for someone who was choking should be assessing how the resident looks, are there signs and symptoms of aspiration, assessment of the way a resident was breathing, any respiratory (lung) distress, and any abdominal (stomach) pain. ADON stated palpating the abdomen only was not an accurate assessment to have completed on Resident 25 after the coughing and vomiting episode. During an interview on 05/07/25 at 11:01 a.m. with Licensed Vocational Nuse (LVN) 2, LVN 2 stated DSD said Resident 25 was observed to have one episode of coughing and one episode of vomiting in the dining room. LVN 2 stated DSD, and I laid Resident 25 in her bed (bed was at a 30-degree angle), and completed an assessment. LVN 2 stated the assessment included an assessment of G-Tube (gastrostomy tube-a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems) placement and residual (remaining or left over contents) and Resident 25's blood pressure was taken. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 05/07/25 at 11:26 a.m. with ADON, ADON stated LVN 2's assessment was not appropriate for Resident 25. ADON stated LVN 2 should have assessed respiratory distress (danger), signs and symptoms of continual coughing, obstruction (blockage) of airway, and completed an oral cavity (mouth) assessment. ADON stated the lack of proper assessment was not a safe practice, and the staff needed more education on focused assessments. ADON stated when a proper assessment was not completed there could be signs and symptoms that were missed, therefore potentially not addressed, which could cause the patient to have further distress. During a review of Resident 25's Change in Condition Evaluation (COC), dated 5/5/25, the COC indicated Resident 25, observed having x1 episode of vomiting and x1 episode of cough. Resident removed from dining and taken back to room, for further assessment. During a review of the facility's policy and procedure (P&P) titled, Change in a Resident's Condition or Status, dated 2/2021, the P&P indicated if a significant change in the resident's physical or mental condition occurs, a comprehensive assessment of the resident's condition will be conducted. b) During an interview on 05/05/25 at 1:13 p.m. with DSD, DSD stated he communicated to the HA to watch Resident 25 due to coughing and vomiting. DSD stated he did not mention the incident to anyone other than HA. During an interview on 05/06/25 at 10:56 a.m. with DSD, DSD stated the Hospitality Aid duties are to stay inside the room for redirection (to direct to a different place or purpose) of residents. During an interview on 5/6/25 at 12:47 p.m. with HA, HA stated his job was to watch all three residents in the room because those residents were at a higher risk of falling. HA stated no credentials (qualifications) are required for this position. During an interview on 05/07/25 at 10:48 a.m. with ADON, ADON stated the Hospitality Aid was not a licensed CNA (certified nursing assistant); therefore, they could only monitor for safety. ADON stated HAs cannot assist in feeding or providing care to residents. ADON stated DSD should have reported to Resident 25's primary nurse. ADON stated appropriate delegation to the HA was for risk of falls or in case Resident 25 was in severe distress, the HA could call for help; however, in this situation the seriousness was not falling, the seriousness of the event was the choking, therefore this was not an appropriate delegation. During a review of Job description for Hospitality Aide (JDHA), the JDHA indicated The primary purpose of your job position is the provision of services to the residents. At no time are you to provide direct care to the residents. 3. During an observation on 5/6/25 at 1:02 p.m. in the dining room, Resident 25 was sitting in a wheelchair at a dining table with Family Member (FM) 1 to the right. Resident 25 was served a lunch meal with pureed diet; red drink (appeared to be thin liquid). FM 1 started feeding Resident 25 large bites of pureed food on a spoon. Resident 25 took several sips of red colored drink after each bite. Resident 25 was still chewing when FM 1 gave Resident 25 another bite. During an interview on 5/6/25 at 1:13 p.m. with DSD, DSD stated the expectation was to educate and teach Resident 25's family member who routinely fed Resident 25 about her diet and feeding skills to maintain consistency (performing in a similar way) when family helps feed Resident 25. (continued on next page)

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	056261	A. Building B. Wing	05/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Orchards at Tulare	604 E. Merritt Ave. Tulare, CA 93274

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 05/07/25 at 10:18 a.m. with ADON, Resident 25's care plan titled Resident has declined in: swallowing function resulting to risk in aspiration, dated 1/2025 was reviewed. The care plan indicated interventions Aspiration precautions: slow rate, small bite size, chin tuck, double swallow, position upright as close to 90 degrees as possible. ADON stated she was aware Resident 25 needed to follow aspiration precautions listed on the care plan. ADON stated the only intervention she would not be able to visualize was double swallowing. ADON stated she could visualize position, chin tuck (ADON demonstrated chin tuck by moving her chin down to her chest), and small bites. ADON stated FM 1 does not have training regarding feeding precautions for Resident 25 and should have been trained. During an interview on 05/07/25 at 10:48 a.m. with ADON, ADON stated the way FM 1 was feeding Resident 25 was not appropriate based on observation of FM 1 feeding Resident 25 on 05/06/25. ADON stated this meant [name of FM 1] was not educated or did not understand the education provided to properly feed Resident 25 per Resident 25's Care Plan and aspiration precautions. During an interview on 05/07/25 at 10:46 a.m. with Minimum data Set Coordinator (MDSC), the MDSC stated a BIMS (Brief Interview for Mental Status) of zero, as listed for Resident 25, meant resident could not respond to the questions asked. MDSC stated when I spoke with Resident 25, she could verbalize (express) some needs but, at the time of the interview Resident 25 did not give a response to the questions. MDSC stated Resident 25 was more verbal on some days and other days Resident 25 was non-verbal. During an interview on 5/7/25 at 11:01 a.m. with LVN 2, LVN 2 stated FM 1 feeds Resident 25 100% of the time. During a review of Resident 25's Order Details (OD), dated 1/14/25, the OD: indicated ST [speech therapy] eval [evaluation] and tx [treatment] as indicated. During a concurrent interview and record review on 05/07/25 at 04:11 p.m. with ST, Resident 25's Care plan titled Resident has declined in: swallowing function resulting to risk in aspiration, dated 1/2025 was reviewed. The care plan indicated interventions Aspirations precautions: slow rate, small bite size, chin tuck, double swallow, position upright close to 90 degrees as possible. ST 1 stated this care plan was created by me and the interventions are compensatory (making up for a loss), the chin tuck protects the airway. ST stated diet recommendation was puree at this time food trials were being completed for Resident 25. ST stated the care plan indicated what was provided during treatments which included honey-thick liquids. ST stated Resident 25 was discharged on [DATE] from speech therapy because Resident 25 was sent to the hospital for vomiting and G-Tube dislodgement. ST stated Resident 25 never came back to speech therapy after returning from the hospital. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 05/07/25 at 04:11 p.m. with ST, Resident 25's Speech Therapy Note (STN) dated 1/21/25 was reviewed. The STN indicated PT (patient)/caregiver ed (educated) to ensure safety of intake and oral hygiene to reduce risks for bateria [sic] in the lungs and prevention of bacterial pneumonia. ST stated a caregiver was anyone who was caring for the resident, this included family and staff. ST stated I am not sure if her family member or Certified Nursing Assistant (CNA) was trained. ST stated for Resident 25 I educated Resident 25 to the best of her ability and understanding. ST stated because of Resident 25's diagnosis of aphasia ST had to model a lot of the education provided to Resident 25. ST stated if Resident 25 was still in speech therapy she would be responsible for training family on feeding Resident 25 appropriately. ST stated her expectations were the interventions should have continued for Resident 25's safety. 4. During an observation on 5/6/25 at 1:02 p.m. in the dining room, Resident 25 was served her lunch meal tray. Resident 25 was observed drinking a red colored liquid that appeared to be a thin liquid. During an interview on 5/6/25 at 1:15 p.m. with FM 1, FM 1 stated the red liquid was thin, not thick like the white drink she also was served. During an interview on 5/6/25 at 1:18 p.m. with Dietary Aide (DA), DA stated she prepared thickened punch and placed punch on meal trays. During a review of Resident 25's Order Summary (OS), dated 4/10/25, the OS indicated CCHO [diabetic diet]/NAS [no added salt] diet Puree texture, Nectar consistency, Dietary oral gratification PO [by mouth] diet small portion. During a review of Resident 25's Meal Ticket (MT), the MT indicated Resident 25 had nectar thickened liquids. During a review of the facility's policy and procedure (P&P) titled, Serving a Meal, the P&P indicated diets should be served in accordance with the physician orders. During a review of the facility's P&P titled, Therapeutic Diet Orders, the P&P indicated The facility provides all residents with foods in the appropriate form and/or the appropriate nutritive content as prescribed by a physician, and/or assessed by the interdisciplinary team to support the resident's treatment/plan of care, in accordance with his/her goals and preferences.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27157 Based on observation, interview, and record review, the facility failed to: 1. Ensure the Registered Dietitian (RD) accurately and comprehensively assessed nutritional status for one of one sampled resident (Resident 68) in accordance with standard of practice and facility policy and procedure (P&P) related to lack of re-assessing Resident 68's daily calorie, protein and fluid needs after a significant change in condition related to pressure injury and significant unplanned weight loss. 2. Effectively monitor nutrition interventions when facility did not document quantity consumed of oral nutrition supplement (ONS) provided on meal trays for one of one sampled resident (Resident 68) and did not convene a follow-up IDT (interdisciplinary team) weight variance meeting to evaluate effectiveness of a ONS that was provided to address Resident 68's significant unplanned weight loss until a month after the ONS was initiated, during which time Resident 68 continued to have further significant weight loss. In addition, in general, the facility was implementing HN (house nourishment) shake as an equivalent choice to Mightyshakes in which the calories provided were not nutritionally equivalent. Further, the facility lacked a variety of nutrition supplements to offer to residents, in general, who were assessed as needing additional calories and/or protein, or who may want to opt for a different ONS after prolonged use of the same one, including for Resident 68. (Cross Refer F842) 3. Effectively monitor, evaluate and identify, inadequate fluid intake during which time Resident 68 had increased fluid needs due to multiple pressure injuries, including Stage 4 (Full-thickness skin and tissue loss) and apply relevant approaches such as obtaining Resident 68's beverage preferences to help Resident 68 improve fluid intake. (Cross Refer F807) Facility failure to identify gaps in the systematic interdisciplinary process to include identifying, assessing and monitoring resident's food and fluid intake (hydration) in accordance with standard of practice and facility P&P had the potential to negatively contribute to a symptom, illness, or decline in nutrition and medical status for Resident 68. Findings: 1. During a concurrent observation and interview on 5/05/25 at 1:00 p.m. with Certified Nursing Assistant (CNA) 2 in Resident 68's room, Resident 68 was sitting up in bed. CNA 2 was encouraging Resident 68 to eat. Resident 68 stated she received a supplemental shake (to increase calories and protein) but did not like it so she did not drink it. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 05/06/25 at 2:44 p.m. with RD, Resident 68's Nutrition Evaluation (NE), dated 8/27/2024 was reviewed. The NE indicated, Relevant Diagnoses.moderate protein-calorie malnutrition, iron deficiency anemia, adult failure to thrive.esophageal reflux disease.urinary tract infection, pressure ulcer of sacral [bottom of the spine] region, unspecified stage. Labs from acute: (8/12) Hgb [hemoglobin; a red protein responsible for transporting oxygen] 8.4L [liter; a metric unit of capacity], Hct [hematocrit; the percentage of red blood cells in your blood] 26.8 L, Na [sodium] 4.1, Cr [Creatinine] 0.50 [a waste product produced from muscle metabolism], BUN [Blood Urea Nitrogen; a waste product produced in the liver when proteins are broken down] 7 [indicating healthy kidney function], diet order: Regular diet, Regular texture, Supplement Order: Ferrous Sulfate [a form of the mineral iron].Height: 59 [inches] Date: 8/23/24, Weight: 113 pounds (lbs) Date: 8/26/24, Appearance/Skin full thickness unstageable [covered full-thickness skin and tissue loss] to coccyx [tailbone], wound to R [right] lateral leg, appears hydrated, Nutrition Needs Estimate: Kcal: 1,541 kcal [calories] (30kcal/[per] kg [kilogram; A unit of mass in the metric system, equal to one thousand grams]), Protein [pro]: 77 gm [grams] (1.5 gm/kg), Fluids: 1,541 ml [milliliter; unit of capacity] (30 ml/kg), Intake: 50-100%, Adequacy of Intake: adequate,.UBW [usual body weight]: 113# [lbs].Discussed importance of meeting EEN [estimated energy needs] and hydration needs for wound healing. Resident verbalized understanding. Will continue to monitor weight x 4 weeks. Increased nutrient needs r/t [related to] wound healing AEB [as exhibited by] full thickness unstageable to coccyx, wound to R lateral leg. RD recommends: 1) Vit C 500mg BID [two times a day] 2) Prostat [nutrition supplement to increase calories and protein] 30 ml BID 3) MVI [multivitamin] QD [every day] RD.Goals: 1) Will not have worsening in skin condition or new skin breakdown to the extent possible. 2) Will maintain adequate nutritional status as evidenced by stable. 3) Will not exhibit s/s [signs/symptoms] of dehydration. RD stated her nutrition recommendations were ordered by the physician the following day. During a review of Prevention and Treatment of Pressure Ulcers/Injuries: Clinical Practice Guideline (CPG), dated 2019, the CPG indicated, In healthy people, water/fluid intake should be approximately 30 mL/kg body weight/day or 1 mL/kcalorie/day. During a review of Resident 68's Progress Notes (PN), dated 9/8/24, 9/16/24, and 9/24/24, the PN indicated Resident 68 refused weekly weight measurements despite risks vs benefits of weight explained. During a review of Resident 68's History and Physical (H&P), dated 10/14/24, the H&P indicated, Resident 68 had the mental capacity to make medical decisions. During a concurrent interview and record review on 05/06/25 at 2:50 p.m. with RD, Resident 68's RD/IDT [interdisciplinary] Weight [wt] Variance Meeting [mtg] (Wt Mtg), dated 10/3/24 was reviewed. The Wt Mtg indicated Resident 68 had a 7.7% (percent) loss of body weight in one month. RD stated Resident 68 was eating 76-100% of meals and there was a stage 4 to sacrum, unstageable to R leg. RD stated Resident 68 was placed on a fortified diet that provided an additional 500 calories a day and double protein diet, in addition to Prostat 30 ml BID she had been receiving. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 05/06/25 at 2:55 p.m. with RD, RD stated it was standard of practice to reassess daily calorie, protein and fluid needs after a significant change in condition, whether it was during this IDT weight meeting or any other nutrition assessment. RD stated she did not do that for Resident 68 after she had significant weight loss. Although there was documentation of food intake [76-100% of meals] there lacked an evaluation as to whether the food intake met Resident 68's caloric needs as there was no accurate, relevant nutrition assessment of her needs after a significant change of condition. Lack of a current nutrition assessment posed a barrier in determining whether Resident 68's nutrition plan of care needed to be updated and revised. The RD and/or RD/IDT Wt Mtg note lacked indication that Resident 68's Monitor Fluid Intake logs (CNA documentation of Resident 68's fluid intake from meal trays) were reviewed which may lead to early identification of insufficient fluid intake to help prevent and/or minimize complications. There lacked documentation to indicate a review and evaluation of potential sources of fluid loss to include review of IDT Weight/Nutrition/Skin Progress Note, dated 9/3/24, and 9/5/24 that noted moderate serous drainage (watery, clear, or slightly yellow/tan/pink fluid that has separated from the blood and presents as drainage) from the Stage 4 pressure wound to sacrum and light serous drainage from the R leg, if chronic and prolonged, may require re-assessing for an additional amount of fluid per kilogram of body weight for Resident 68. Without an accurate and comprehensive re-assessment of fluid needs after a significant change of condition, there was not a mechanism to evaluate fluid intake as compared to assessed needs in order to identify and communicate quantity of ml of fluids not being consumed by Resident 68 to bring to the attention of IDT and/or physician in a timely manner, so MD could determine whether additional tests or interventions may have been warranted. During a review of Advances in Skin & Wound Care (WC), dated 2020, the WC indicated those with draining wounds require additional fluids/water to replace lost fluid, and should be monitored as dehydration could be a factor in weight loss. During a review of the facility's P&P titled, Nutritional Management, dated 1/2025, the P&P indicated, Compliance Guidelines: A comprehensive nutritional assessment will be completed by a dietitian.upon significant change in condition.Components of the assessment may include, but are not limited to:.Food and fluid intake, Evidence of fluid loss.Evaluation/analysis: The dietitian shall use data gathered from the nutritional assessment to estimate the resident's calorie, nutrient, and fluid needs and whether intake is adequate to meet those needs. Current standards of practice/formulas are used in calculating these estimates. During a review of Resident 68's PN, dated 10/7/24 and 10/14/24, the PN indicated Resident 68 refused weekly weight measurements despite risks vs benefits of weight explained. During a concurrent interview and record review on 05/06/25 at 3:00 p.m. with RD, Resident 68's Wt Mtg, dated 11/6/24, was reviewed. RD stated due to Resident 68's refusals to have her weight taken the facility did not become aware of her significant unplanned weight loss of 10.2% of body weight until she allowed her weight to be taken on 11/4/24 and she was 97 lbs. The Wt Mtg note, dated 11/6/24, indicated, Po intake: 51-75%, Diet: Fortified diet, Double Protein diet.Skin: stage 4 to sacrum, unstageable to R leg, Prior Interventions: fortified diet, double protein, wound supplements [Prostat 30 ml BID].RD has explained importance of meeting EEN for wound healing and preventing weight loss. Family brings resident outside favorite food. CDM [Certified Dietary Manager; Dietary Supervisor (DS)] updated food preferences. Resident in agreement to add HN [house nourishment] w [with]/meals and ice cream. IDT Recommendations: add HN [4 oz] w/meals and weekly weights. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 05/06/25 at 3:05 p.m. with RD, Resident 68's Wt Mtg, dated 12/5/24, was reviewed. The Wt Mtg note indicated Resident 68 weighed 90 lbs which was 7.2% further unplanned significant weight loss in a month and was an 18 lb wt loss (16.7% loss of body weight) over 3 months, po intake was 51-75% overall of breakfast, lunch and dinner meals, and skin continued with stage 4 to sacrum, unstageable to R leg. The Wt Mtg indicated during the time since the previous Wt Mtg, Prostat had been increased from 30 ml BID to 60 ml BID and an antidepressant medication was started on 11/21/24. There was no documentation of reviewing Resident 68's fluid intake utilizing Resident 68's Monitor Fluid Intake logs to evaluate and compare to assessed fluid needs. The Wt Mtg indicated, Dietitian met with resident to educate resident on the importance of wt measurements, meeting EEN and hydration needs for wound healing and wt maintenance. Resident verbalized understanding and indicated she is eating more and drinking the protein shakes. No new food preferences at this time. IDT Recommendations: RNA [restorative nursing assistance] dining and continue with weekly weights. RD stated she did not re-assess Resident 68's daily calorie, protein and fluid needs after significant change of condition (further, continued significant wt. loss) even though that was an established standards of performance. The facility's P&P Nutritional Management, dated 1/2025, was not followed and implemented, as the P&P indicated a comprehensive nutrition assessment will be completed by a dietitian upon significant change of condition, and data gathered to assess fluid as required per the facility's P&P. During an interview on 5/6/25 at 3:10: p.m. with RD, RD stated she did not recommend any additional interventions to increase calories and protein after Resident 68 had lost 16.7% of her body weight over 3 months because we were already giving her fortified diet which adds 500 calories, double protein, HN 4 oz with meals, Prostat and ice cream and she was eating 51-75% of her meals. RD was asked how she determined the interventions were adequate when Resident 68 had 7 lbs further weight loss since her significant wt loss the month prior. RD repeated she was eating 51-75% of her meals. RD was asked if she evaluated whether Resident 68 was in a hypermetabolic (a condition where the body's metabolism is increased above normal levels) and/or hypercatabolic (an abnormally high rate of metabolic breakdown of substances within the body leading to tissue breakdown and weight loss) state using evidence based guidelines for stage 4 pressure injury with co-existing other wounds that could contribute to further increased protein/energy [calories]/fluids per kg of UBW (113 lbs) nutritional needs related to increased demand of nutrients to support wound healing, as evidenced by delayed wound healing of stage 4 pressure injury to coccyx (tailbone), and continued significant weight loss. RD stated she did not need to re-assess daily calorie, protein and fluid needs to find out if Resident 68 was not eating or drinking enough. Lack of sufficient monitoring and evaluation of effectiveness of interventions and lack of comprehensive re-assessment of nutritional needs after a significant change of condition taking into consideration potential changes to metabolic state, and/or discussing with the doctor, may impede identifying a need for alternate nutrition approaches and revision of the nutrition care plan versus continuation of the same nutrition plan of care with negative outcomes. During review of Resident 68's nutrition assessment, dated 8/27/2024, RD calculated daily calorie needs at 30kcal/kg of admission weight and had not re-evaluated and reassessed Resident 68's daily calorie, protein and fluid needs since admission, despite being admitted with diagnosis of moderate protein calorie malnutrition, multiple occasions of significant unintended weight loss and no improvement in wound healing. Further, RD had not monitored and documented fluid intake from meal trays and compared to assessed needs to bring the quantity of deficit of insufficient fluid intake to the attention of the doctor as required per the facility's P & P titled Nutritional Management, dated 1/2025. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Prevention and Treatment of Pressure Ulcers/Injuries: Clinical Practice Guideline (CPG), dated 2019, the CPG indicated, Provide 30 to 35 kcalories/kg body weight/day for adults with a pressure injury who are malnourished or at risk of malnutrition. In adults who are underweight or who have had significant unintended weight loss, additional energy intake may be required. 2. During a general dining observation on 5/5/25 from 12:30 p.m. to 12:55 p.m. in the dining room, HN shake was the only ONS observed to be in use for those residents with an order. During a concurrent observation and interview on 5/05/25 at 1:00 p.m. with CNA 2 in Resident 68's room, Resident 68 was sitting up in bed. CNA 2 was encouraging Resident 68 to eat. Resident 68 stated she received a supplemental shake [HN shake to increase calories and protein) but did not like it so she did not drink it. During an interview on 05/06/25 at 10:53 a.m. with CNA 1, CNA 1 stated CNAs document quantity consumed of HN (house nourishment shake) with the overall fluid intake from any of the fluids consumed located on the meal tray in which the total number of ml (milliliter) was typed into a box on the Activities for Daily Living (ADL) Flow Sheet (Monitor Fluid Intake/Document Fluid Intake Ml's logs). CNA 1 stated CNAs did not document the type of fluid by name, such as the name HN supplement or shake would not appear on the Document Fluid Intake Ml's flowsheet, therefore there would not be a mechanism for the RD or nursing leadership to provide oversight to ensure the HN supplement (shake or ONS) was being consistently provided as ordered, and would not be able to tell whether the HN ONS was being routinely consumed. During a concurrent observation and interview on 5/06/25 at 11:50 a.m. with Dietary Supervisor (DS) in the kitchen, 4 ounce (oz) sized cartons of strawberry flavored Mighty Shake were placed on meal trays for those residents who had an order for HN (house nourishment). DS stated we did not have Mightyshakes available yesterday so we made vanilla flavored HN shakes because they are equivalent. During review of the facility's recipe titled High Protein House Supplement Recipe (HN shake recipe), the HN shake recipe indicated a 4 oz portion provided 117 calories and 6 gm protein per serving. During a review of Nutrition Facts located on a 4 oz carton of Mightyshakes (MS), the MS provided 220 calories and 6 g of protein per serving, almost doubled the amount of calories provided versus the HN recipe. During a concurrent interview and record review on 05/06/25 at 3:00 p.m. with RD, Resident 68's Wt Mtg, dated 11/6/24, was reviewed. RD stated Resident 68 weighed 97 lbs on 11/4/24 which was a loss of 10.2% of body weight. RD stated IDT recommendations were to add HN 4 oz w/meals. During a concurrent interview and record review on 05/06/25 at 3:05 p.m. with RD, Resident 68's Wt Mtg, dated 12/5/24, was reviewed. The Wt Mtg note indicated Resident 68 weighed 90 lbs which was 7.2% further unplanned significant weight loss in a month and was an 18 lb wt loss (16.7% loss of body weight) over 3 months. The Wt Mtg indicated, Dietitian met with resident to educate resident on the importance of wt measurements, meeting EEN [estimated energy needs] and hydration needs for wound healing and wt maintenance. Resident verbalized understanding and indicated she is eating more and drinking the protein shakes. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/6/25 at 3:20 p.m. with RD, RD was asked how much of the 4 oz HN shake with meals Resident 68 consumed in the past month, after it was initiated a month prior as an intervention to prevent further weight loss. RD stated she would not be able to estimate how many calories and protein she consumed during the past month from the HN shake to determine whether the intervention was adequate to meet Resident 68's nutritional needs because the CNAs document the intake of the HN shake with the overall fluid intake of any beverages on the meal tray that was consumed. RD was asked if it was adequate to follow up on the effectiveness of the HN shake provided to address significant unintended weight loss a month later, during which time Resident 68 had lost 7 more lbs and may have benefited from an alternative ONS option to help minimize further weight loss earlier than waiting a month. RD stated following up a month later was not timely nutrition care. During a review of Resident 68's Wt Mtg, dated 12/31/24, Wt Mtg indicated, Wt: 85#. Wt Change: -23# (21. 3%) x 3 months, po intake: 0-50%, Diet: fortified, double protein diet, Supplements: HN 4 oz with meals, ferrous sulfate, Vit C, Prostat, MVM, Skin: Stage 4 to sacrum, unstageable to R leg, trauma wound to R leg, skin tear to R forearm, Resident sent to acute (12/14) for syncope [fainting] and readmitted (12/16) s/p [status post] IV [intravenous] hydration. Resident with decreased appetite, new wound, and s/p antibiotic tx [therapy] for R [right] leg trauma wound. CDM [Certified Dietary Manager; Dietary Supervisor (DS)] met with resident to update food preferences. Residents likes and dislikes updated, resident desires to take a break from HN and instead add ice cream and chocolate pudding w [with]/L [lunch]&D[dinner]. Resident own RP [responsible party] and aware of increased risks for continued weight loss and skin deterioration with poor meal consumption and in agreement with below recommendations. IDT Recommendations: d/c [discontinue] HN, appetite stimulant, ST [speech therapist] eval. There was no documentation specifying alternative ONS were offered to Resident 68, if any. During an interview on 05/07/25 at 08:57 a.m. with LVN 3, it was shared with LVN 3 that there was no documentation that Resident 68 was offered an alternative ONS when she did not want HN shake and instead requested ice cream. LVN 3 stated she usually sees the facility using HN shake the majority of the time, and stated, why not Magic Cup instead of ice cream. During a review of Sysco 4 oz container of ice-cream the facility provided was 130 calories and 2 g protein, versus a 4 oz serving of Magic Cup (Frozen supplement that resembles ice-cream) would provide 290 calories and 9 g protein. During an interview on 05/07/25 at 09:07 a.m. with Resident 68's specialized MD in wounds, in the presence of LVN 3, MD stated he agreed, without adequate fluid intake and offering alternative nutrition interventions the facility did not do all they could to improve wound healing. (Cross Refer F807) (continued on next page)

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Orchards at Tulare	604 E. Merritt Ave. Tulare, CA 93274

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 05/08/25 at 09:16 a.m. with DS, DS stated the facility primarily used HN shake recipe for ONS. DS reviewed the food purchase/ONS purchases from January 2024 to present and stated it was very likely there were no further ONS purchases made by her or the RD, other than one food invoice for one case of 32 oz sized carton of Sysco Imperial Supplement MedPlus Vanilla (which would provide 240 kcal and 10 g pro per 4 oz serving), and Sysco supplemental shake, strawberry and vanilla flavor, which provided 200 kcal and 8 g pro per 4 oz with a delivery date of 5/4/24. DS stated Prostat that was ordered for Resident 68 was purchased and delivered from the facility's central supply and she did not know of any other routine ONS that would be available at the facility. DS stated there was a recall of Sysco health shakes, however, the recall of Sysco Imperial Supplement Shake did not occur until Februrary 2025. During a review of the U.S. Food and Drug Administration (FDA) website, FDA indicated, On February 22, 2025, [NAME] LLC recalled 4 oz. [NAME] ReadyCare and Sysco Imperial Frozen Supplemental Shakes. Frozen supplemental shakes under brands [NAME] ReadyCare and Sysco were the only shakes that were recalled starting in February 2025. https://www.fda.gov/food/outbreaks-foodborne-illness/outbreak-investigation-listeria-monocytogenes-frozen-supplemental-shakes-february-2025. Statement Regarding Recall of Nutritional Shakes - Prairie Farms Dairy, Inc. The Vital Cuisine Mightyshakes observed in use by the facility on 5/6/25 during lunch trayline were not recalled. During a review of Resident 68's Progress Notes, (PN) dated 1/16/25, the PN indicated, Met with resident to update food preferences. Resident would like to discontinue with house nourishments and receive ice cream with lunch and dinner instead. Nurse informed. Dietary supervisor available prn., signed by DS. During a review of Resident 68's PN, dated 1/30/25, the PN indicated, IDT-Skin Integrity Review Mtg: . Asked for ONS [HN shake] to be d/c despite risks vs benefits and high risk of continued weight loss explained. During review of Resident 68's Discontinue Order, (DO) dated 2/3/25, the DO indicated, House Supplement three times a day 4 oz HN with meals, preferences reviewed with resident and updated by kitchen director [DS]. During a review of Resident 68's Admission history and physical examination (H&P), dated 2/5/25 as Late Entry, the H&P indicated, Resident 68 weighed 86 lbs with poor nutrition and continue Ensure [an ONS], however, Resident 68 did not have an order for Ensure, and was not provided with Ensure. During review of multiple PN's, as indicated above, Resident 68 had been telling the facility since 12/31/24 that she did not like nor want the HN shake (it was recommended by IDT on 11/6/24). There were no documented ONS alternatives specifically listed as to what ONS, if any, were offered to Resident 68 who had documented increased nutritional needs. During a review of Resident 68's Order Summary Report (OSR), dated 5/8/25, the OSR indicated regular diet, mechanical soft texture, fortified ordered on 1/17/25 and Prostat BID 60ml [increased from 30 ml BID Resident 68 had since admission]. During a review of Resident 68's progress note, dated 2/6/25, she was eating 26-50% of her fortified diet (double protein was no longer documented). (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 68's interdisciplinary nutrition Care Plan Report, with a target date of 5/26/25, Resident 68's nutrition interventions were fortified diet, ice cream with lunch and dinner, Prostat 60 ml BID, antidepressant medication and appetite stimulant medication, vitamins and/or minerals as ordered, ST eval was her nutritional care plan. During a review of Resident 68's Medication Administration Record (MAR), dated May 2025, the MAR indicated from 5/1/25 through 5/5/25 Resident consumed 50% of the ordered Prostat 8 out of 10 times the Prostat was provided to Resident 68. There was no documentation an alternative nutrition intervention, to promote variety and continued palatability, designed for wound healing was offered to Resident 68 who had been receiving the same Prostat for a prolonged period of time since admission, nine months earlier. During a review of the facility's P&P titled, Nutritional Management, dated 1/2025, the P&P indicated, Policy: The facility provides care and services to each resident to ensure the resident maintains acceptable parameters of nutritional status in the context of his or her overall condition. Compliance Guidelines: A comprehensive nutritional assessment will be completed by a dietitian within 72 hours of admission, annually, and upon significant change of condition.Components of the assessment may include, but are not limited to:.Food and fluid intake, Evidence of fluid loss.Evaluation/analysis: The dietitian shall use data gathered from the nutritional assessment to estimate the resident's calorie, nutrient, and fluid needs and whether intake is adequate to meet those needs. Current standards of practice/formulas are used in calculating these estimates. Care plan implementation: The resident's goals and preferences regarding nutrition will be reflected in the resident's plan of care. Interventions will be individualized to address the specific needs of the resident.Monitoring/revision:.Evaluating the care plan to determine if current interventions are being implemented and are effective.The care plan will be updated as needed, such as when a resident's condition changes, goals are met or the resident changes his or her goals, interventions are determined to be ineffective, or as new causes of nutrition-related problems are identified. The comprehensive care plan should describe any interventions offered, but declined by the resident or resident's representative. 3. During a review of Resident 68's Wt Mtg, dated 12/31/24, Wt Mtg indicated, Wt: 85#. Wt Change: -23# (21.3%) x 3 months, po intake: 0-50%, Diet: fortified, double protein diet, Supplements: HN 4 oz with meals, ferrous sulfate [form of iron], Vit C, Prostat, MVM [multivitamin with minerals], Skin: Stage 4 to sacrum, unstageable to R leg, trauma wound to R leg, skin tear to R forearm, resident sent to acute [hospital] (12/14/2024) for syncope [fainting] and readmitted (12/16/2024) s/p [status post] IV [intravenous] hydration. Resident with decreased appetite, new wound, and s/p antibiotic tx [therapy] for R leg trauma wound. CDM met with resident to update food preferences. Residents likes and dislikes updated, resident desires to take a break from HN and instead add ice cream and chocolate pudding w[with]/L[lunch]&D[dinner]. Resident own RP [responsible party] and aware of increased risks for continued weight loss and skin deterioration with poor meal consumption and in agreement with below recommendations. IDT Recommendations: d/c [discontinue] HN, appetite stimulant, ST [speech therapy] eval [evaluation]. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and record review on 05/06/25 at 3:30 p.m. with RD, RD was asked if monitoring fluid intake to assess hydration was part of an RDs responsibility when conducting a nutrition assessment and/or follow up, and RD stated yes. RD was asked if she reviewed Resident 68's fluid intake from meals as documented by CNAs, and RD stated Resident 68 was not on I & O's [No order to require nursing to document all fluid intake and urine output]. RD was asked if a resident's fluid intake from meals was standards of practice to consider when evaluating whether a resident was consuming enough fluids to promote adequate hydration, and RD stated, yes. RD stated she had not been gathering data from resident's individualized Monitor Fluid Intake logs to evaluate fluid intake from meals and had not been documenting fluid intake to compare to a resident's assessed daily fluid needs to assess hydration status which was a component of nutrition assessment. During a concurrent interview and record review on 05/06/25 at 3:40 p.m. with RD, RD began reviewing Resident 68's Monitor Fluid Intake logs recorded from meals for the week prior to Resident 68's admit to the hospital on 12/14/24 when IV hydration was administered. RD stated, I don't know how accurate that is [the documentation by CNAs related to ml fluid intake from meal trays] which was why I have not been reviewing the fluid intake logs. RD was asked if she had brought her concern to Quality Assurance committee and participated in providing recommendations for performance improvement related to accurate monitoring, tracking and analyzing hydration status for residents to promote early identification of insufficient fluid intake prior to complications such as dehydration, and RD stated no. RD stated Resident 68 had inadequate fluid intake for the majority of the week based on the fluid monitoring logs from meal trays prior to being discharged to the hospital. RD stated she had not identified the insufficient fluid intake to communicate the concern to IDT and/or the physician as she had not been reviewing the fluid intake logs. RD stated she had not been documenting fluid intake to determine whether Resident 68's daily fluid needs were being met, or improving toward a goal as she had also not re-assessed Resident 68's daily fluid needs after Resident 68 had a significant change of condition. RD did not follow and implement the facility's P & P's titled Nutritional Management, dated 1/2025, Hydration, dated 2022, nor Weight Assessment and Intervention, dated 2011 in which all three P&P's required RD to assess Resident 68's individual fluid needs to establish a goal for fluid intake, including after a significant change of condition, evaluate fluid intake as to whether intake meets Resident 68's individualized hydration needs, and monitor intake and notify the physician responsible for care of Resident 68 if there was lack of improvement toward fluid goals. (Cross Refer F807) During an interview on 05/06/25 at 03:57 p.m. with Director of Nursing (DON), DON stated the CNAs see how much fluid residents are drinking and they chart that into PCC (software used for resident's electronic health record) so in IDT meetings ADON (Assistant Director of Nursing) should access those monitoring fluid intake logs and discuss with IDT. During an interview on 05/06/25 at 04:06 p.m. with ADON, ADON stated, yes, daily monitoring of the fluid intake from meals log to identify potential concerns before outcome becomes worse would be ideal, I do not routinely monitor the fluid intake documented by the CNAs. During a concurrent observation and interview on 5/7/25 at 11:58 a.m. with Resident 68 in Resident 68's room, Resident 68 was lying in bed, lips were observed to be cracked and dry, and eyes appeared to have dark circles around them. Resident 68 stated facility staff had not asked her what her beverage preferences were or beverages she would drink if she were home. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 68's Nutrition Status Care Plan Report (IDT nutrition care plan/IDTNCP), dated 5/6/2025, the IDTNCP indicated, Interventions, lacked notation to indicate Resident 68 had been ordered an HN shake 4 oz with meals [TRUNCATED]

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. 45654 Based on observation, interview, and record review, the facility failed to follow its policy and procedure (P&P) titled, Pain Management, for one of one sampled resident (Resident 77) when Resident 77's pain was not controlled consistently. This failure had the potential for Resident 77's pain not to be correctly managed. Findings: During an interview on 5/7/25 at 1:50 p.m. with Resident 77, Resident 77 stated two weeks ago the nurse told her she needed to take a different medication and not her regular pain medication. Resident 77 stated she felt horrible for hours going without her pain medication. During a review of Resident 77's Physician Order (PO) dated 4/21/25, the PO indicated, Oxycodone HCL [narcotic medication for acute pain 0- no pain, 1-3 mild pain, 4-6 moderate pain interfering with daily activities, 7-9 severe pain, difficult to tolerate or manage, 10 worst pain possible]oral tablet 5 mg [milligram], give 1 tablet by mouth every 4 hours as needed for moderate pain 4-6. During a review of Resident 77's PO, dated 4/21/25, the PO indicated, Acetaminophen Tablet 325 mg give 2 tablets by mouth every 4 hours as needed for Mild pain 1-3 Not to exceed 3 grams Acetaminophen in 24 hours. During a concurrent interview and record review on 5/8/25 at 10:25 a.m. with Assistant Director of Nursing (ADON), Resident 77's Medication Administration Record (MAR) dated April 2025 was reviewed. The MAR indicated the following: On 4/21/25 at 5:00 p.m. Oxycodone HCL 5 mg. On 4/21/25 at 10:54 p.m. Oxycodone HCL 5 mg. On 4/22/25 at 10:34 a.m. Oxycodone HCL 5 mg. On 4/22/25 at 4:16 p.m. Oxycodone HCL 5 mg. On 4/22/25 at 10:50 p.m. Oxycodone HCL 5 mg. On 4/23/25 at 6:17 a.m. Oxycodone HCL 5 mg. On 4/23/25 at 11:38 a.m. Oxycodone HCL 5 mg. On 4/23/25 at 4:48 p.m. Oxycodone HCL 5 mg. On 4/23/25 at 11:37 p.m. Oxycodone HCL 5 mg. On 4/24/25 at 10:00 a.m. Oxycodone HCL 5 mg. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/24/25 at 3: 00 p.m. Oxycodone HCL 5 mg. On 4/25/25 at 4:54 a.m. Oxycodone HCL 5 mg. On 4/25/25 at 11:00 a.m. Oxycodone HCL 5 mg. On 4/26/25 at 6:30 a.m. Oxycodone HCL 5 mg. On 4/27/25 at 5:13 p.m. Acetaminophen 325 mg. On 4/28/25 at 3:19 a.m. Acetaminophen 325 mg. On 4/26/25 at 11:16 a.m. Oxycodone HCL 5 mg. On 4/29/25 at 11:00 a.m. Oxycodone HCL 5 mg. On 4/29/25 at 9:30 a.m. Oxycodone HCL 5 mg. ADON stated Resident 77 was a chronic pain management resident. ADON did not provide an answer for Resident 77 receiving Acetaminophen medication on 4/27/25 and 4/28/25. During a review of the facility's P&P titled, Pain Management, dated 10/2022, the P&P indicated, Pain Management and Treatment, 1. Based upon the evaluation, the facility in collaboration with the attending physician/prescriber, other health care professional and the resident and/or the resident's representative will develop, implement, monitor and revise as necessary interventions to prevent or manage each individual resident's pain at admission.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 52221 Based on observation, interview, and record review, the facility failed to ensure accurate documentation and accountability for the destruction of controlled substances, the facility did not ensure controlled substances were destroyed in the presence of a licensed pharmacist, and destruction was appropriately documented with a nurse and a pharmacist signatures. This failure had the potential to result in diversion or mismanagement of controlled medications. Findings: During an observation on 5/7/25 at 8:38 a.m. in the Director of Nursing (DON) office, there was a locked cabinet used to store medications to be destroyed. During a concurrent interview and record review on 5/7/25 at 8:38 a.m. with the Assistant Director of Nursing (ADON), The facility Controlled Medication Destruction Log (MDL), dated 03/25 and 04/25 were reviewed. The MDL indicated, entries had not been dated and signed without a pharmacist involvement. ADON stated she was unable to clarify the following entries: had been dated and signed without pharmacist involvement. The MDL indicated the following: On 3/6/25 RX # R817831 Oxycodone [Oxycodone is a prescription opioid pain medication used to relieve moderate to severe pain (generally falls within a range of 5-10 on a 0-10 pain scale)]. 10 mg. On 3/7/25 RX # 752758 Lorazepam [providing short-term relief from anxiety symptoms and is often prescribed for various anxiety disorders, including generalized anxiety disorder and panic disorder]. 0.5 mg. On 3/7/25 RX # 752006 Morphine 15 mg. [pain medication used to relieve severe pain (generally falls within a range of 7-10 on a 0-10 pain scale)]. On 3/7/25 RX # 831375 Hydrocodone [a semi-synthetic opioid that is used to treat moderate to severe pain and as a cough suppressant (generally falls within a range of 5-6 on a 0-10 pain scale)]. 5-325 mg. On 3/7/25 RX # C8809092 Lorazepam 0.5 mg. On 3/7/25 RX # C0874708 Lorazepam 30 ml. On 3/7/25 RX # 824460 Morphine 15 mg. On 5/5/25 RX # 831375 Hydrocodone 10-325 mg. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/7/25 at 9:08 a.m. with Pharmacy Consultant (PC), PC stated she had not participated in the destruction of the medications in question. PC stated the nurse had incorrectly documented the destruction of narcotics without proper verification. PC stated no concurrent destruction had occurred for those entries and the documentation errors did not reflect actual disposal events. During a review of the facility's policy and procedure (P&P) titled, Discarding and Destroying Medications, dated 4/2019, the P&P indicated, Policy Statement: Medications will be disposed of in accordance with federal, state and local regulations governing management of non-hazardous pharmaceuticals, hazardous waste and controlled substances .3b. the receiving pharmacist and a registered nurse employed by the facility sign a separate log that lists the resident's name; the name, strength, prescription number (if applicable) and amount of the medication returned; and the date the medication was returned .6c. Disposal of controlled subtances must take place immediately (no longer than three days) after discontinue of use by the resident .7d. Document the disposal on the medication disposition record. 7e. Include the signature(s) of at least two witnesses .11. The medication disposition record will contain the following information: a. The resident's name; b. Date medication disposed; c. the name and strength of the medication; d. The name of the dispensing pharmacy; e. the quantity disposed; f. Method of disposition; g. Reason for disposition; and h. Signature of witnesses.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. 52221 Based on observation, interview, and record review, the facility failed to ensure three of twenty eight opportunities for medication administration were performed without error, resulting in an 11% medication error rate. These failures had the potential for: 1. Resident 46, ineffective medication delivery. 2. Resident 46, omissions are inconsistent with manufacturer instructions for use. 3. Resident 34, to rotate injection sites as required. Findings: 1. During a review of the manufacturer's instructions for Combivent Respimat(inhaler for breathing difficulties) indicated, The patient should exhale fully, place lips around the mouthpiece, then inhale slowly and deeply while pressing the inhaler button. After inhalation, the patient should hold their breath for 10 seconds or as long as comfortable. During an observation on 5/6/25 at 9 a.m. in Resident 46's room during a medication pass, a Respiratory Therapist (RT) was observed administering Combivent Respimat to Resident 46. Resident 46 was not instructed to exhale fully prior to inhalation and hold their breath following the dose. During an interview on 5/6/25 at 9:15 a.m. with RT, RT stated, I just forgot to tell him to exhale and hold his breath. I know I'm supposed to, but I was moving quickly. 2. During a review of the manufacturer's instructions for Ellipta (inhaler for breathing difficulties) indicated: Instruct the patient to exhale fully before inhaling the dose. After inhaling, the patient should hold their breath for about 3-4 seconds, or as long as comfortably possible. During a cocurrent observation and interview on 5/6/25 at 9 a.m. in Resident 46's room, the RT was administering Ellipta to Resident 46. Resident 46 was not instructed to exhale prior to inhalation and was not told to hold their breath after receiving the dose. At 9:15 a.m., the RT stated, I just forgot to do it-I'll make sure to go slower next time. 3. During a review of the manufacturer's instructions for Humalog (used to treat low blood sugars) indicated, Injection sites should be rotated within the same region to reduce the risk of lipodystrophy [how the body breaks down fat]. During a concurrent observation and interview on 5/6/25 at 9:10 a.m. in Resident 34's room, Licensed Vocation Nurse (LVN) 2 was administering Humalog insulin to Resident 34 in the left lower abdomen. At 9:20 a.m., with LVN 2 stated, I gave it in the same spot as before because I forgot to rotate. I'll try to do better next time. During a review of Resident 34's Medication Administration Record, (MAR) dated 5/1/25, the MAR indicated, the left lower abdomen was also the last documented injection site.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 27157 51540 Based on observation, interview, and record review the facility failed to: 1. Follow the planned menu for finger foods diet for one of one sample resident (Resident 18) during lunch trayline (a system of food preparation). 2. Ensure the allotted fluid from dietary was followed as ordered pertaining to a fluid restriction for one of one sample resident (Resident 32). These failures had the potential for Resident 18 to have loss of independence and dignity, and Resident 32 to not have adequate hydration. Findings: 1. During an observation on 5/6/25 at 12:03 p.m. in the kitchen during lunch trayline observation, Resident 18's meal tray card indicated finger foods. A whole piece of chocolate cake was served onto Resident 18's lunch meal tray and placed on the meal delivery cart for distribution. Per the therapeutic diet spreadsheet Chocolate cake cut into smaller pieces was the planned menu for finger foods. During an interview on 05/06/25 at 12:03 p.m. with Registered Dietitian (RD), RD was asked to check if the planned menu for finger foods was followed. RD stated the cake was not cut into pieces as written on the therapeutic menu extension, it was just a smaller piece. During an observation on 5/6/25 at 12:09 p.m. in the kitchen, observed RD giving the chocolate cake to staff and asked them to cut into smaller pieces as indicated on Resident 18's meal tray ticket and on the menu. RD stated she did not like that because it might fall into pieces when picked up. During a review of Resident 18's Diet Order (DO), dated 5/1/23, the DO indicated, Regular diet: regular texture, thin liquids consistency, finger foods. During a review of Resident 18's Meal Tray Ticket (MTT), the MTT indicated, Resident 18 was on a finger food diet. During a review of Resident 18's Care plan-nutrition status (CP), dated 7/27/23, the CP indicated, Resident 18 is at risk for weight loss, dehydration, skin breakdown, and altered nutritional status.interventions: Diet as orders: finger food, fortified, regular diet. (continued on next page)

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Orchards at Tulare	604 E. Merritt Ave. Tulare, CA 93274

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/6/25 at 12:13 p.m. with RD in the kitchen, RD stated she approved the menus, including the planned menu for finger foods. RD stated she was aware it was the facility's RD responsibility to review and approve the menus and she had not identified concerns with the finger foods menu in advance in order to provide instruction to dietary staff on modification to the menu to address concerns that it may impede a resident's dignity while eating amongst others, or potential with difficulty getting the food into the mouth, if the food might be falling between the fingers. During an interview on 05/08/25 at 10:18 a.m. with the Dietary Supervisor (DS), DS stated the RD did sign the current menu cycle that included cutting up the cake into smaller pieces for the finger foods planned menu. DS stated she expects the dietary aid (DA) who prepared and placed the whole cake onto Resident 18's lunch meal tray to have had the skill set to follow the planned menu as indicated on the therapeutic spreadsheet for finger foods. During a review of the facility's job description (JD) titled Dietitian, dated 2023, the JD indicated, Major Duties and Responsibilities: Reviews menu changes to ensure compliance with the facility's policy and procedures and state and federal guidelines. Updates diet orders and menu changes as required. Conducts audits of relevant nutritional care on a routine basis. During a review of the facility's policy and procedure (P&P) titled Menus and Adequate Nutrition, dated 2/2025, the P&P indicated, The facility's dietician or other clinically qualified nutrition professionals will review all menus for nutritional adequacy and approve the menus. During a review of the facility's diet manual (DM), dated 2023, the DM indicated, Regular Diet-Finger Foods (RDFF), dated 2023, the RDFF indicated the finger foods diet is a regular diet that provides food in appropriate size and shape to be eaten without utensils, but rather with fingers. This allows residents to maintain independence, dignity and quality of life.cut food to size per the diet order. If no size is indicated, cut food in bite-size pieces (approximately 1). During a review of the facility's P&P titled Tray Identification, dated 4/2007, the P&P indicated, Appropriate identification/coding shall be used to identify various diets. 1. To assist in setting up and serving the correct food trays/diets to residents, the food services department will use appropriate identification to identify the various diets. 2. The food service manager or supervisor will check trays for correct diets before the food carts are transported to their designated areas. During review of the Academy of Nutrition and Dietetics (AND) Nutrition Care Manual (NCM), dated 2025, the NCM defined finger foods as finger foods can be easily picked up with the hands without falling apart. Indication: Using fingers to pick up foods enables self-feeding, independence, and diet adequacy. 2. During a review of Resident 32's facesheet, the facesheet indicated Resident 32 was admitted on [DATE] with diagnosis of end stage renal disease. During a review of Resident 32's Minimum Data Set (MDS-a federally mandated resident assessment tool) dated 5/5/25, the MDS section C indicated Resident 32's Brief Interview for Mental Status (BIMS-an assessment tool used by facilities to screen an identify memory, orientation, and judgement status of the resident) was a score of 15 (able to understand and verbalize thoughts and needs). (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 32's DO, dated 11/14/24, the DO indicated Resident 32 was on a fluid restriction. During a review of Resident 32's CP dated 8/29/23, the CP indicated Resident 32 is at risk for weight loss, dehydration, skin breakdown, and altered nutritional status r/t [related to] medical condition/dx [diagnosis] ESRD [end stage renal [kidney] disease] w/[with] dialysis tx [treatment]. Interventions: diet as ordered.Fluid restriction: 1500 ml [milliliters-a measurement of volume]/ [per] day; Dietary: 1080 ml; Nursing: 420 ml. During a review of Academy of Nutrition and Dietetics Nutrition Care Manual (NCM), dated 2025, the NCM indicated to determine how to distribute total fluids throughout the day. During a concurrent interview and record review on 05/08/25 at 10:13 a.m. with DS, Resident 32's meal tray card (MTC) indicated 1080 ml fluid restriction. DS reviewed Resident 32's MTC that listed the following: 4 fl oz [fluid ounces- a measurement of liquid] fruit juice and 8 fl oz Soy Milk. For lunch 8 fl oz Soy Milk and 4 fl oz Water. For dinner 4 fl oz of Soy Milk and 4 fl oz Water. DS stated, 4 oz is missing and she [Resident 32] has been stating she is thirsty too. DS stated the facility's expectation was for the total allotted amount of 1080 fl oz per 24 hours to be served by dietary, not more and not less. During a review of the facility's policy and procedure (P&P) titled, Therapeutic Diet Orders, the P&P indicated The facility provides all residents with foods in the appropriate form and/or the appropriate nutritive content as prescribed by a physician, and/or assessed by the interdisciplinary team to support the resident's treatment/plan of care, in accordance with his/her goals and preferences.

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F 0807 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides drinks consistent with resident needs and preferences and sufficient to maintain resident hydration. 27157 Based on observation, interview, and record review, the facility failed to ensure one of one sampled resident(Resident 68) beverage and/or liquid preferences were obtained to provide sufficient drinks and liquids the resident prefers to help maintain hydration. Facility's failure to obtain Resident 68's beverage preferences placed Resident 68 at an increased risk for dehydration and delayed wound healing. Findings: During a concurrent observation and interview on 5/7/25 at 11:58 a.m. with Resident 68 in Resident 68's room, Resident 68 stated when she was at home she liked to drink Pepsi, Kool-Aid, and pineapple juice. Resident 68 stated in here they only give her the liquids they have in the kitchen that day. Resident 68 stated no one has come to ask her preferences for liquids. During a review of Resident 68's RD [Registered Dietitian]/IDT [interdisciplinary team] Weight [wt] Variance Meeting [mtg] (Wt Mtg), dated 12/31/24, the Wt Mtg indicated, Wt: 85# (pounds). Wt Change: -23# (21. 3%[percent]) x [for] 3 months, po [by mouth] intake: 0-50% [of total meals], Diet: fortified [increased calories], double protein diet, Supplements: HN [house nourishment/HN shake] 4 oz [ounce] with meals, ferrous sulfate [a compound containing iron], Vit [vitamin] C, Prostat [supplement to increase protein and calories], MVM [multivitamin with minerals], Skin: Stage 4 [pressure injury with full-thickness skin and tissue loss] to sacrum [bone in the lower portion of the spine], unstageable [pressure injury with obscured full-thickness skin and tissue loss] to R [right] leg, trauma wound to R leg, skin tear to R forearm, Resident sent to acute [hospital] (12/14/2024) for syncope [fainting] and readmitted [to skilled nursing facility on 12/16/2024] s/p [status post] IV [intravenous] hydration. Resident with decreased appetite, new wound, and s/p antibiotic tx [therapy] for R leg trauma wound. CDM [Certified Dietary Manager/DS-Dietary Supervisor] met with resident to update food preferences. Residents likes and dislikes updated, resident desires to take a break from HN [house nourishment shake to increase calories and protein] and instead add ice cream and chocolate pudding [Note: both items turn to liquid at room temperature and therefore are considered alternative sources of liquids] w[with]/L [lunch] & D [dinner], (continued on next page)

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F 0807 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 05/08/25 at 10:11 a.m. with DS, DS stated she obtained Resident 68's food preferences frequently. DS was asked if she obtained Resident 68's beverage and/or liquid preferences. DS stated, yes, she offers the beverages they have such as milk (soy or almond and regular), punch, iced tea, water, fruit juice (100%-pineapple, orange, grape, apple, and cranberry juice) as these juices are always in stock. DS stated these preferences are documented on Resident 68's meal tray card. DS reviewed Resident 68's meal tray card that indicated for breakfast 4 fl [fluid] oz Fruit Juice [flavor unspecified], 8 fl oz Milk Whole, for lunch 4 oz ice cream, 4 fl oz Milk Whole, 8 fl oz SF [sugar free] Beverage [flavor unspecified] and for dinner 4 oz ice cream, 8 fl oz Iced Tea, and 4 fl oz Milk Whole. DS stated the liquids listed on Resident 68's meal tray card were standing orders, meaning they consisted of the routine beverages facility maintained in stock. It was shared with DS that Resident 68 stated she had to drink what was given to her on the meal trays but if she were home one of her beverages she liked to drink was pineapple juice. DS showed a carton of pineapple juice that was readily available in the kitchen. DS stated if she knew she liked pineapple juice she would have offered it. DS was asked if there were any other facility policies and procedures (P&P) that guided staff to obtain beverage preferences as the P&P titled Food Preferences, dated 2023, indicated, Food preferences will be obtained as soon as possible.Updating of food preferences will be done as the resident's needs change and/or during the quarterly review, and lacked specific guidance directing staff to obtain liquids preferences. DS stated that was the only P&P the facility had related to preferences whether food or beverage. During a review of Resident 68's Nutrition Status Care Plan Report (IDT nutrition care plan/IDTNCP), dated 5/6/2025, the IDTNCP indicated, Goal: Will not exhibit s/s [signs/symptoms] of dehydration, there were no beverage preferences listed and/or resident's goals related to person centered care to direct acceptable interventions in accordance with Resident 68's preferences on how to achieve the goal of preventing dehydration. During a review of the facility's P&P titled, Hydration, dated 2022, the P&P indicated, Policy: The facility offers each resident sufficient fluid, including water and other liquids, consistent with resident needs and preferences to maintain proper hydration and health. Compliance Guidelines: The facility will utilize a systematic approach to optimize the resident's hydration status: Developing and consistently implementing pertinent approaches. Identification/assessment: The dietary manager or designee shall obtain the resident's beverage preferences upon admission, significant change in condition, and periodically throughout his or her stay.Care plan implementation: The resident's goals and preferences regarding hydration will be reflected in the resident's plan of care. Interventions will be individualized to address the specific needs of the resident.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 51540 Based on observation, interview, and record review the facility failed to ensure sanitary conditions in the kitchen when: 1. A brown colored substance and a dead bug were observed between a reach-in freezer and reach-in refrigerator. 2. The ice machine was not sanitized in accordance with manufacturers' guidelines. 3. Baseboards were observed to be peeling away from the wall under a sink leaving a potential entry for pests. These failures placed the residents at an increased risk for foodborne illness. Findings: 1. During a concurrent observation and interview on 05/05/25 at 10:04 a.m. with Dietary Supervisor (DS) in the kitchen, a brown colored substance on the floor behind a white pest control trap located between a reach-in refrigerator and a reach-in freezer was observed. DS was asked what the brown colored debris/substance was, and DS stated, I don't know. DS stated the floor between the freezer and refrigerator was dirty with debris and the external side stainless steel walls of both units that faced each other had a buildup of dust. During an interview on 05/05/25 at 10:04 a.m. with DS, DS stated she had not seen any pests in the kitchen. During a concurrent observation and interview on 05/05/25 at 10:29 a.m. with Maintenance Supervisor (MS) in the kitchen, MS observed the round brown colored item on the floor behind a white pest control trap located between a reach-in refrigerator and a reach-in freezer. MS stated that was a bug, and it looked like a water bug which he stated was a type of cockroach. MS stated the floor between the two units was dirty with debris and a dead waterbug/cockroach, as well as a buildup of dust alongside the external surfaces of the two units that faced each other. MS observed behind the two units in which there was another white pest control trap and dirty flooring. MS stated the white pest control traps were placed there by outside pest control company. During a review of the FDA Food Code (FDAFC), dated 2022, FDAFC indicated, Non-food contact surfaces of equipment shall be cleaned at a frequency necessary to preclude accumulation of soil residues. During a review of FDAFCA, dated 2022, FDAFCA indicated, The objective of cleaning focuses on the need to remove organic matter from food-contact surfaces so that sanitization can occur and to remove soil from nonfood contact surfaces so that pathogenic [capable of causing disease] microorganisms will not be allowed to accumulate, and insects and rodents will not be attracted. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	2. During an interview on 05/05/25 at 10:13 a.m. with MS, MS stated he was responsible for cleaning the ice machine. MS stated the facility did not have an outside vendor to clean the ice machine. MS stated once a month he deep cleaned the ice machine located in the kitchen, which was the facility's only ice machine. MS stated the only product that was circulated through the ice machine was Nickel Safe Ice Machine Cleaner (NSIMC) and he showed the bottle of NSIMC. MS was asked how he sanitized the ice-machine and MS stated with Nickel Safe Ice Machine Cleaner, it does both. During a review of the manufacturer's guidelines (MGs) for the Koolaire Ice Machine located in the kitchen, the MGs indicated, Cleaning/Sanitizing Procedure: This procedure must be performed at a minimum of once every six months.Ice machine cleaner is used to remove lime scale and mineral deposits. Ice machine sanitizer disinfects and removes algae and slime.Wait until the trough refills, then add the proper amount of Manitowoc Ice Machine Sanitizer to the water trough. During a review of the facility's policy & procedure (P&P) titled Ice Machine Cleaning Procedures (IMCP), dated 2023, the IMCP indicated, The ice machine needs to be cleaned and sanitized monthly. Information about the operation, cleaning and care of the ice machine can be obtained from owner's manual, the manufacturer and/or in the directional panel on the inside of the machine. 3. Clean inside of ice machine with a sanitizing agent per the manufacturer's instructions. 3. During a concurrent observation and interview on 05/05/25 at 10:08 a.m. with DS in the kitchen, the baseboards underneath the sink were separating from the floor showing an open crevice. DS stated the open crevice between the floor and baseboard was identified via audit of the kitchen by the Registered Dietitian and MS was aware. DS did not know when the repair was to be made. During a concurrent observation and interview on 05/05/25 at 10:32 a.m. with MS in the kitchen, MS observed the baseboard separating from the floor alongside the wall in which the dirty side of the dish machine was located. MS stated that it could be an entry for pests and stated he was aware. MS stated the facility started talking about the need to fix that and had been talking about replacing the flooring. MS was asked if there were any action plans put into place that he could provide for review, and MS stated no. During a review of Food & Nutrition-Monthly Inspection Checklist (FNMIC), dated 03/25/25, the FNMIC indicated old tile needs repair and also baseboards. During a review of FNMIC, dated 04/15/25, the FNMIC indicated old tile, baseboards repair. During a review of the facility's P&P titled Sanitation Inspection, the P&P indicated it is the policy of this facility as part of the department's sanitation program, to conduct inspections to ensure food service areas are clean, sanitary and in compliance with applicable state and federal regulations. According to the FDA (Food and Drug Administration) Food Code 2013, Floors that are of smooth, durable construction and that are nonabsorbent are more easily cleaned. Requirements and restrictions regarding floor coverings, utility lines, and floor/wall junctures are intended to ensure that regular and effective cleaning is possible and that insect and rodent harborage is minimized. (Cleanability 6-201.11 Floors, Walls, and Ceilings. 6-201.12 Floors, Walls, and Ceilings, Utility Lines)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 27157 Based on observation, interview, and record review, the facility failed to ensure a system to maintain an accurate and complete medical record (electronic health record/EHR) for one of one sampled residents (Resident 57) when the EHR had not contained documentation that an order for 4 ounces (oz) house nourishment (HN shake) with breakfast was provided to Patient 57. In addition, quantity consumed of HN shake was included in the overall fluid intake from all fluids served for breakfast impeding interdisciplinary team (IDT) ability to identify and assess intake of the planned nutrition intervention. Further, due to a Certified Nursing Assistant (CNA) 1 late entry documentation of fluid intake from the breakfast meal, the EHR contained inaccurate information reflecting Resident 57 consumed fluids from her breakfast meal at 11:03 a. m. This deficient practice had the potential for residents to not receive the ordered nutrition intervention and/or services to support their highest practicable well-being. Findings: During a review of Resident 57's Order Summary (OS), dated 6/11/2024, the OS indicated add 4 oz house nourishment with breakfast. During a review of Posted Meal Times (PMT), located in front of the dining room, the PMT indicated breakfast was served at 7 a.m., lunch at 12 p.m., and dinner at 5 p.m. During a concurrent observation and interview on 05/06/25 at 11:03 a.m. with CNA 1 in rooms 25-29 hallway, CNA 1 stated she assisted Resident 57 with eating her breakfast earlier in the morning. CNA 1 was observed entering 40 ml (milliliter: a unit used in the metric system for measuring capacity) onto an electronic device attached to the wall in the hallway. CNA 1 stated 40 ml was the total consumption of fluids from all fluids located on Resident 57's breakfast meal tray that consisted of milk, apple juice, and a little tiny bit of HN shake. During a review of Resident 57's Document Fluid Intake Ml's (DFI) log, dated 5/6/2025, the DFI indicated 11:03 (11:03 a.m.) with 40 documented to the right of 11:03 under a column titled Amount. The other two meal time's listed for 5/6/25 on the DFI indicated 14:44 (2:44 p.m.) and 18:00 (6:00 p.m.). No where on the DFI log nor on the Medication Administration Record was documentation to show the order of 4 oz House Nourishment with breakfast was implemented. During an interview on 5/6/25 at 3:20 p.m. with RD, RD was asked how much of the 4 oz HN shake with meals Resident 68 consumed in the past month, after it was initiated a month prior as an intervention to prevent further weight loss. RD stated she would not be able to estimate how many calories and protein she consumed during the past month from the HN shake to determine whether the intervention was adequate to meet Resident 68's nutritional needs because CNAs included the HN shake with the overall fluid intake of any beverages consumed with the meal. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 05/07/25 at 09:51 a.m. with Director of Staff Development (DSD), DSD stated he was responsible for training CNAs on how to document resident consumption of solid food intake and of fluids from meals provided. DSD showed his power point training on how he instructed CNAs to document quantity of total ml of fluids consumed from a meal tray to include oral nutrition supplements (ONS) such as HN shake on the ADL (Activities of Daily Living) flow sheet (ie.DFI log). DSD stated the facility's policy and procedure (P&P) did not provide specific details on how and where to document ONS but that was how he trained CNAs to do it. DSD stated the closest P&P to this subject matter was titled Serving a Meal. During a review of the facility's P&P titled, Serving a Meal, dated 1/2025, the P&P indicated, Remove the tray when the resident has finished and record the percentage of food consumed as 25%, 50%, 75% or 100%. During a review of the facility's P&P titled, Nutritional Management, dated 1/2025, the P&P indicated, Policy: The facility provides care and services to each resident to ensure the resident maintains acceptable parameters of nutritional status.Compliance Guidelines: A comprehensive nutritional assessment will be completed by a dietitian.Components of the assessment may include, but are not limited to:.Food and fluid intake, Monitoring/revision:.Examples of monitoring include: Evaluating the care plan to determine if current interventions are being implemented and are effective. During a review of the facility's P&P titled, Documentation in Medical Record, dated 2022, the P&P indicated, Policy: Each resident's medical record shall contain an accurate representation of the actual experiences of the resident and include enough information to provide a picture of the resident's progress through complete, accurate, and timely documentation. Licensed staff and interdisciplinary team members shall document all assessments, observations, and services provided in the resident's medical record in accordance with state law and facility policy. Documentation shall be accurate, relevant, and complete, containing sufficient details about the resident's care and/or response to care.

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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. 52221 Based on observation, interview, and record review, the facility failed to ensure staff followed infection control practices for one of one sampled residents (Resident 34) during the administration of an injectable medication. This failure had the potential to increase the risk of exposure to blood-borne pathogens. Findings: During a concurrent observation and interview in Resident 34's room on 5/6/25 at 11:09 a.m. with Licensed Vocational Nurse (LVN) 2, LVN 2 was administering Humalog insulin quick pen (used to treat low blood sugar) to Resident 34 in the left lower abdomen. LVN 2 used her ungloved hand, to uncap and dispose of the contaminated needle tip. LVN 2 stated, I'm not going to lie, I just grabbed it without thinking and threw it out. During a review of the facility's policy and procedure (P&P) titled, Medication Administration -Subcutaneous Insulin, dated 1/2023, the P&P indicated, Put on gloves, engage safety device, and discard syringe and needle in appropriate syringe disposal container.