STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056266	A. Building B. Wing	05/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Keystone Post-Acute	3672 North First Street Fresno, CA 93726

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to promote quality of life for two of 11 sampled residents (Resident 59 and Resident 30) when Resident 59 did not receive a shower on 5/8, 5/12, 5/15, 5/19, and 5/26 and Resident 30 did not receive a shower on 5/9, 5/13, 5/16, and 5/20. This failure resulted in nine missed opportunities for personal hygiene care and resulted in Resident 59 to feel dirty, neglected and isolated and Resident 30 to feel dirty and gross. Findings: During interview on 5/27/25 at 10:23 a.m. with Resident 59 in her room, Resident 59 stated she had not received a shower in three weeks and expressed a desire to have one. Resident 59 stated staff were not providing her scheduled showers and had not provided a reason for why she was not receiving them. Resident 59 stated she is supposed to be showered on Monday and Thursday. Resident 59 stated she had not refused any showers. Resident 59 stated this made her feel dirty and neglected, and as a result she mostly stayed in her room. During a review of Resident 59 ' s admission Record (AR - a summary of information regarding a patient which includes patient identification, past medical history, insurance status, care providers, family contact information and other pertinent information), dated 5/29/255, the AR indicated Resident 59 was admitted to the facility from an acute care hospital on 4/10/25 with diagnoses of muscles weakness, type two diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), fracture of left femur (a break in the bone of the thigh), and hypertension (HTN-high blood pressure). During a review of Resident 59 ' s Minimum Data Set (MDS - a resident assessment tool used to identify cognitive [mental processes] and physical functional level assessment), dated 4/15/25, the MDS section C indicated Resident 59 had a Brief Interview for Mental Status (BIMS - a test given by medical professionals to determine cognitive (involving the process of thinking, learning and understanding) understanding on a scale of 1-15) score of 15 (a score of 0-7 suggests severe cognitive impairment, 8-12 suggests moderately impaired, 13-15 suggests cognitively intact), which suggested Resident 59 was cognitively intact. (continued on next page)

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

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/27/25 at 11:27 a.m. with Resident 30 in her room, Resident 30 stated she last received a shower two weeks ago and expressed that she would like to receive showers on her scheduled days. Resident 30 stated I feel dirty and smelly because she had not been receiving regular showers. Resident 30 stated she felt gross and wished she could have a shower. During a review of Resident 30 ' s AR, dated 5/30/25, the AR indicated Resident 59 was admitted to the facility from an acute care hospital on [DATE] with diagnosis of muscle weakness, type two diabetes mellitus, and major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest). During a review of Resident 30 ' s MDS, dated 4/7/25, the MDS section C indicated Resident 30 had a BIMS score of 11, which suggested Resident 30 was moderately impaired. During an interview on 5/29/25 at 1:56 p.m. with Certified Nursing Assistant (CNA) 7, CNA 7 stated resident showers were scheduled and that residents should have received showers twice a week. CNA 7 explained the facility maintained a binder with the shower schedule and that staff were expected to complete a shower sheet was given. CN 7 stated the nurse would then sign the sheet. CNA 7 stated that residents had the right to be showered. During a concurrent interview and review of facility Shower Binder on 5/30/25 at 4:35 p.m. with CNA 7, dated for the month of May 2025, CNA 7 stated there were no completed shower sheet filed for Resident 59 on Thursday 5/8/25, Monday 5/12/25, Thursday 5/15/25, and Thursday 5/22. The record showed Resident received a shower on Monday 5/5/25 and refused a shower on Monday 5/19/25. During an interview on 5/30/25 at 10:42 a.m. with CNA 8, CNA 8 stated resident showers were documented in two areas. One area was the shower binder, where staff filled out the form and filed it according to the date. CNA 8 stated the second method was through the electronic medical record. CNA 8 stated if a shower was not provided, staff entered NA. CNA 8 stated the risk to the resident from not receiving regular showers included potential for infections, skin issues, self-esteem problems, matted hair and buildup of grime. During a concurrent interview and review of Shower Binder dated May 2025 and Documentation Survey Report, dated May 2025 on 5/30/25 at 4:35 p.m. with Licensed Vocational Nurse (LVN) 3, LVN 3 stated Resident 30 was scheduled to receive showers on Tuesdays and Fridays. However, there were no shower sheets filed for Tuesday 5/6/25, Friday 5/9/25, Tuesday 5/13/25, Friday 5/16/25 or Tuesday 5/20/25. The shower sheet for Friday 5/23/25 indicated Resident 30 had refused the shower on that date. The Documentation Survey Report, dated May 2025 indicated for Resident 30 she had missed five scheduled showers during the month of May-on 5/9/25, 5/16/25, 5/20/25, 5/27/25 and 5/30/25. During a concurrent interview and record review on 5/30 at 4:35 p.m. with LVN 3, Resident 59 ' s Documentation Survey Report, dated May 2025 was reviewed. LVN 3 stated the Documentation Survey Report, and the information documented in the shower binder were accurate, Resident 59 had only received one shower for the month of May, on 5/5/25. LVN 3 verified there was no progress notes associated with missed or refused showers and no care plans addressing bathing/showering or potential refusal in Resident 59 and 30 ' s medical record. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 6/3/25 at 9:32 a.m. with Director of Staff Development (DSD) 2, the DSD 2 stated it was her expectation for CNAs to complete resident showers as scheduled. DSD 2 stated her expectation was CNAs to shower the residents on their scheduled days, complete the shower sheet and have the nurse sign it. The DSD 2 stated there should have been a shower sheet filed for each scheduled shower day, indicating whether the shower was given or not-there should not have been any blank spaces. DSD 2 stated blank spaces, and N/A indicated a missed shower. The DSD 2 stated a progress note should have been written by the nurse if a resident missed or refused a shower. During an interview on 6/3/25 at 11:38a.m. with the Infection Preventionist (IP) 1, the IP 1 stated that her expectation of the nursing staff was to address the reasons why residents were missing their scheduled showers. IP 1 stated staff should have escalated a reason why a shower was not given to a resident. IP 1 emphasized showers were important because they provided an opportunity to assess the resident and because it was the resident ' s right to receive them. The IP 1 stated that there had not been any recent issues with water or equipment that would have impacted the ability to provide showers during the month of May. During an interview on 6/3/25 at 11:45 a.m. with the Director of Nursing (DON), the DON stated, it was her expectation of staff to escalate the issue of missed showers. The DON emphasized that showering and bathing preferences are part of resident rights and should have been addressed accordingly.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0551 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give the resident's representative the ability to exercise the resident's rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure one of eleven sampled residents (Resident 38) was provided the opportunity to participate in his care process when the facility did not attempt to contact Resident 38's family or friends to act as a representative or decision maker on or throughout admission and did not involve Resident 38's, family, friends or a patient care representative prior to obtaining informed consents. This failure had the potential to result in Resident 38's wishes and preferences not being upheld by the acting facility representative which had the potential to lead to decreased autonomy (ability to make own decisions and control own actions) or participation in his care planning process. Findings: During a review of Resident 38's admission Record (AR- document containing resident personal information), dated [DATE], the AR indicated, Resident 38 was admitted to the facility on [DATE], with diagnoses which included dementia (decline in cognitive functioning that interfere with daily life), major depressive disorder (mood disorder that causes persistent feeling of sadness and loss of interest), dysphagia (difficulty swallowing) and muscle weakness. The AR indicated Resident 38's decision maker and representative was the Administrator (ADM). The AR indicated Resident 38 had a Family Friend (FF) 1 allowed to obtain medical information. During a review of Resident 38's Minimum Data Set (MDS- a resident assessment tool) assessment, dated [DATE], the MDS assessment indicated Resident 38's Brief Interview for Mental Status (BIMS- an assessment tool used by facilities to screen and identify memory, orientation, and judgement status of the resident) assessment score was 10 out of 15 which indicated Resident 38 had moderate cognitive deficit (a decline in thinking abilities, like memory, reasoning, and problem-solving). During a review of Resident 38's Informed Consent to Treat (ICT), dated [DATE], the ICT indicated, the administrator (ADM) signed the consent on [DATE]. The form indicated the ADM gave permission for the facility to treat Resident 38. The form was not signed or acknowledged by Resident 38, FF 1 or a resident representative. During a review of Resident 38's Physician Orders for Life-Sustaining Treatment (POLST- set of medical orders reflect a resident's wished for end-of-life intervention), dated [DATE], the POLST indicated, the ADM signed the consent on [DATE]. The form was not signed or acknowledged by Resident 38, FF 1 or a resident representative. During a review of Resident 38's Side/Bed Rail Informed Consent, dated [DATE], the Side/Bed Rail Informed Consent indicated, the ADM signed the consent on [DATE]. The form was not signed or acknowledged by Resident 38, FF 1 or a resident representative. (continued on next page)

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F 0551 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 38's Facility Verification of Resident Informed Consent for Physical Restraints, Psychotherapeutic Drugs, or Prolonged Use of a Device, dated [DATE], the Facility Verification of Resident Informed Consent for Physical Restraints, Psychotherapeutic Drugs, or Prolonged Use of a Device indicated, the medical provider obtained informed consent from the ADM on [DATE] for .Sertraline [psychotherapeutic drug-used to treat major depressive disorder] 12.5 mg [milligrams- unit of measurement for dosing medication] . The form was not signed or acknowledged by Resident 38, FF 1 or a resident representative. During a review of Resident 38's Medical Record (MR), dated [DATE], the MR did not indicate the facility completed interdisciplinary team (IDT) meetings prior to the ADM signing consents for the ICT, POLST, Side/Bed Rail Informed Consent, or Facility Verification of Resident Informed Consent for Physical Restraints, Psychotherapeutic Drugs, or Prolonged Use of a Device. The MR did not indicate Resident 38, FF 1 or a resident representative was involved, contacted or consulted for the ICT, POLST, Side/Bed Rail Informed Consent, or Facility Verification of Resident Informed Consent for Physical Restraints, Psychotherapeutic Drugs, or Prolonged Use of a Device. During an interview on [DATE] at 2:54 p.m. with the Family Friend (FF) 1, FF 1 stated Resident 38 had no family involved in his care. FF 1 stated he had known Resident 38 for a couple of years. FF 1 stated he was a patient advocate for Resident 38 at the previous facility Resident 38 was admitted to. FF 1 stated nobody from the facility contacted him to inquire if he would be Resident 38's decision maker or representative. FF 1 stated he had not received any updates on Resident 38's care or treatment. FF 1 stated Resident 38 and himself met with the Social Services Director (SSD) in February 2025 and Resident 38 agreed for FF 1 to receive medical updates and be involved in his care. FF 1 stated he had not been consulted or involved in obtaining any informed consents for Resident 38. FF 1 stated he did not know the ADM was Resident 38's decision maker or representative. FF 1 stated he did not understand how the ADM could make informed decisions for Resident 38 because he did not know him. FF 1 stated it was in Resident 38's best interest to include people who knew Resident 38 when making medical decisions to ensure Resident 38's wishes and preferences were upheld. (continued on next page)

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F 0551 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on [DATE] at 3:21 p.m. with the Social Services Director (SSD), Resident 38's MR, dated [DATE] was reviewed. The SSD stated, Resident 38 did not have the mental capacity to make his own medical decisions but was able to make his needs known. The SSD stated the ADM was Resident 38's acting decision maker and representative. The SSD stated Resident 38 was previously admitted to another facility within the same network and the ADM was assigned as the decision maker there. The SSD stated the facility assumed responsibility for each resident when they were admitted , regardless if the previous facility was in the same network. The SSD stated it was the responsibility of the facility to ensure each resident's decision maker was appropriately assigned on admission. The SSD stated there was no documentation in Resident 38's MR to reflect attempts were made to contact Resident 38's family, friends, or listed contacts to act as a decision maker or patient representative on admission. The SSD stated on [DATE] she met with Resident 38 and FF 1. The SSD stated Resident 38 gave permission for FF 1 to be involved in his care and receive medical updates. The SSD stated approximately a month ago the California Department of Aging provided an in-service on Interdisciplinary Team Process for Unrepresented Residents. The SSD stated the facility was expected to adhere to the in-service provided. The SSD stated if the facility received a medical treatment order requiring informed consent and no legal decision maker, family or friend was available to provide consent, an application was expected to be submitted to the California Department of Aging to assign a state-appointed patient representative. The SSD stated an IDT meeting was expected to be held for each medical decision requiring informed consent, and the family member, friend, or appointed patient representative was expected to participate. All IDT members were expected to agree on the treatment, document the meeting and decision, after which consent for the treatment could be obtained. The SSD stated this process was not followed for Resident 38. The SSD stated she was involved in IDT meetings. The SSD stated she could not recall attending IDT meetings for Resident 38's informed consents since admission. The SSD could not locate IDT meeting notes to determine the IDT met to discuss informed consents or consulted Resident 38's family, FF 1, or patient representative for the ICT, POLST, Side/Bed Rail Informed Consent, or Facility Verification of Resident Informed Consent for Physical Restraints, Psychotherapeutic Drugs, or Prolonged Use of a Device. The SSD stated it was important to ensure IDT meetings were performed for each medical treatment that required informed consent. The SSD stated it was important Resident 38, Resident 38's family, friends or a patient representative was involved in IDT informed consent meetings to ensure Resident 38's wishes and preferences were upheld. (continued on next page)

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F 0551 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on [DATE] at 9:03 a.m. with the Administrator (ADM), Resident 38's MR, dated [DATE], was reviewed. The ADM stated he was not related to Resident 38 and did not know Resident 38 prior to his admission to the facility. The ADM stated Resident 38 was previously admitted to another facility within the same network and he became the decision maker for Resident 38 before he was transferred to the current facility. The ADM was unable to locate IDT meeting notes to reflect attempts were made to contact Resident 38's family, friends or listed contacts to act as his decision maker on admission to the facility. The ADM could not locate any IDT meeting notes to indicate IDT met prior to obtaining informed consents for Resident 38's ICT, POLST, Side/Bed Rail Informed Consent, or Facility Verification of Resident Informed Consent for Physical Restraints, Psychotherapeutic Drugs, or Prolonged Use of a Device. The ADM could not locate any documentation to reflect Resident 38's, family, friends or patient representative were involved in obtaining informed consent for Resident 38's ICT, POLST, Side/Bed Rail Informed Consent, or Facility Verification of Resident Informed Consent for Physical Restraints, Psychotherapeutic Drugs, or Prolonged Use of a Device. The ADM stated himself, the Assistant Administrator (AADM), the Director of Nursing (DON), the SSD, the Minimum Data Set Coordinator (MDS), Infection Preventionist (IP), and Director of Staff Development (DSD) participated in IDT meetings and were responsible for making medical decisions that required informed consent for Resident 38. The ADM stated Resident 38 was at risk for not having his wishes or preferences upheld if there was no documentation to reflect Resident 38's, FF 1's, or a patient representatives' participation in the care planning process. During a concurrent interview and record review on [DATE] at 9:56 a.m. with the Director of Nursing (DON), Resident 38's MR, dated [DATE], was reviewed. The DON stated the ADM was Resident 38's decision maker. The DON stated the ADM became Resident 38's decision maker at the previous facility he was admitted to. The DON stated the facilities were within the same network and the ADM remained Resident 38's decision maker when he was transferred. The DON stated it was the responsibility of the facility to ensure Resident 38's decision maker was appropriate on admission. The DON stated the facility was responsible, on admission, for making their own attempts to reach Resident 38's family, friends or patient representative to inquire if they would be his decision maker or be involved in the decision-making process. The DON could not locate documentation to reflect the facility had attempted to contact Resident 38's family, friends, or a patient representative to act as Resident 38's decision maker or be involved in the decision-making process. The DON stated with the ADM as the acting decision maker the IDT was responsible to meet and discuss medical treatments that required informed consent for Resident 38. The DON stated it was expected Resident 38, family, friends, or a patient representative was involved in each IDT meeting to ensure Resident 38's preferences were upheld. The DON stated it was expected the IDT documented meetings and determinations for Resident 38's plan of care with each medical decision that required informed consent. The DON could not locate any IDT meeting notes to indicate IDT met or discussed Resident 38's plan of care prior to obtaining informed consents for Resident 38's ICT, POLST, Side/Bed Rail Informed Consent, or Facility Verification of Resident Informed Consent for Physical Restraints, Psychotherapeutic Drugs, or Prolonged Use of a Device. The DON could not locate any documentation to reflect Resident 38's, family, friends or patient representative were involved in obtaining informed consent for Resident 38's ICT, POLST, Side/Bed Rail Informed Consent, or Facility Verification of Resident Informed Consent for Physical Restraints, Psychotherapeutic Drugs, or Prolonged Use of a Device. The DON stated the facility placed Resident 38 at risk for not being represented accurately or honoring his wishes and preferences. (continued on next page)

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F 0551 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's handout provided by the California Department of Aging titled, Interdisciplinary Team Process for Unrepresented Residents, undated, the handout indicated, . as of [DATE], skilled nursing and intermediate care facilities that conduct interdisciplinary team (IDT) reviews of medical interventions requiring informed consent (California Health and Safety Code section 1418.8) must: include a patient representative when they convene an IDT to make medical decisions requiring informed consent for residents who lack capacity and have no legal surrogate .provide notices containing specified information both before and after an IDT review to the resident who is the subject of the IDT and to the resident's patient representative .provide specified data to the California Department of Aging (CDA), Office of the Long-Term Care Patient Representative as required .under these requirements, facilities are responsible for identifying a friend or relative, whose interests are aligned with the resident, to serve as a patient representative when an interdisciplinary team is convened .if the facility is unable to identify a representative, the Office of the Long-Term Care Patient Representative (OLTCPR), a program within the CDA, can help .the OLTCPR will provide trained representatives for specified residents who may need medical treatment but lack the capacity to make health care decisions, have no legal surrogate authorized to make decisions on their behalf, and have no friend or relative who can represent them on an IDT . During a review of the facility's policy and procedure (P&P) titled, 784.29. Informed Consent to Medical Treatment, undated, the P&P indicated, .verify that the client's health record contains documentation that the client has given informed consent to the proposed treatment or procedure . During a review of the facility's P&P titled, Resident Representative, dated 2/2021, the P&P indicated, .the resident's wishes and preferences are considered in the exercise of rights by the representative . resident representative is defined as: an individual chosen by the resident to act on behalf of the resident in order to support the resident in decision-making; access medical, social or other personal information of the resident; manage financial matters; or receive notifications; b. a person authorized by state or federal law including but not limited to agents under power of attorney, representative payees, and other fiduciaries) to act on behalf of the resident in order to support the resident in decision-making; access medical, social or other personal information of the resident; manage financial matters; or receive notifications; legal representative, as used in section 712 of the Older Americans Act; or d. the court-appointed guardian or conservator of a resident . Whether or not the resident has been judged incompetent by a court of law, if it is determined that the resident understands the risks, benefits, and alternatives to a proposed health care decision and expresses a preference, the resident's wishes are considered to the degree practicable .the resident may exercise his or her rights not delegated to a resident representative, including the right to revoke a delegation of rights (except as limited by state law) .the director of nursing (or designee) is responsible for making reasonable efforts to obtain updates or changes that are made by the resident, including the resident's revocation of delegated rights, to ensure that the resident's preferences are being upheld . During a review of the facility's P&P titled, Resident Rights, dated 2/2021, the P&P indicated, .resident's rights to .appoint a legal representative of his or her choice .exercise rights not delegated to a legal representative . (continued on next page)

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F 0551 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's P&P titled, Advanced Directives, dated 2/2021, the P&P indicated, .prior to or upon admission of a resident, the social services director or designee inquires of the resident, his/her family members and/or his or her legal representative, about the existence of any written advance directives .upon admission the interdisciplinary team assesses the residents decision-making capacity and identifies the primary decision-maker if the resident is determined not to have decision-making capacity .the interdisciplinary team conducts ongoing review of the residents decision-making capacity and invokes the resident representative or health care agent if the resident is determined not to have decision-making capacity. Changes are documented in the care plan and medical record .

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, facility failed to ensure one of 11 sampled residents (Resident 16) was provided with safe, clean, comfortable furniture that is in good working condition when the over-the-bed table had an approximate 2-inch by 1.5-inch chip out of the corner of the table with exposed sharp edges and a visible area that would be considered a porous surface leaving the area a potential for injury and unable to be cleaned. This failure had a potential to result in Resident 16 sustaining serious injuries, including skin tears and infection. Findings: During a review of Resident 16's admission Record (AR, a document containing resident personal information), dated 5/29/25, the AR indicated, Resident 16 was admitted to the facility on [DATE] with diagnoses which in included Cerebral Infarction (when part of the brain and brain cells does not get enough blood and oxygen because a blood vessel is blocked and those brain cells can die), Type 2 Diabetes (a disorder characterized by difficulty in blood sugar control and poor wound healing) and Cognitive Communication Deficit (when someone has a hard time talking or understanding because their brain is having trouble with thinking skills). During a review of Resident 16's Minimum Data Set (MDS - a resident assessment tool) assessment dated 3/27/25, the MDS assessment indicated Resident 16's Brief Interview for Mental Status (BIMS- an assessment tool used by facilities to screen and identify memory, orientation, and judgement status of the resident) assessment score was 6 out of 15 which indicated Resident 16 had had moderate cognitive deficit (a decline in thinking abilities, like memory, reasoning, and problem-solving). During a concurrent observation and interview on 5/27/2025 at 4:04 p.m. with Resident 16 in Resident 16's room, Resident 16's over-the-bed table had a 2-inch by 1.5-inch chip out of the corner of the table with exposed sharp edges and a visible area that would be considered a porous surface. Resident 16 stated he had noticed a big chip on his over-the-bed table. Resident 16 stated the big chip had been there for approximately 6 months. Resident 16 stated he would like a new table. During a concurrent observation and interview on 5/29/25 at 1:52 p.m. with Certified Nursing Assistant (CNA) 2 in Resident 16's room, CNA 2 stated that all furniture should be in good shape and that it may not look the prettiest, but it should be free of things that could harm the resident. CNA 2 stated that Resident 16's over-the-bed table had a large chip in the corner that had exposed sharp edges and a porous surface and that if Resident 16 fell onto the table he could get cut badly. CNA 2 stated Resident 16 should not have an over-the-bed table like that in Resident 16's room. During an observation on 5/29/25 at 3:47 p.m. Resident 16's over-the-bed table with the chip out of it remained in the room and Resident 16 has personal items placed on it. (continued on next page)

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Keystone Post-Acute	3672 North First Street Fresno, CA 93726

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview at the Nurse's station on 5/29/25 at 3:54 p.m. with Licensed Vocational Nurse (LVN) 4, LVN 4 reviewed a picture dated 5/28/25 of the resident's over-the-bed table and LVN 4 stated that Resident 16 had an over-the-bed table that had exposed sharp edges and a porous surface. LVN 4 stated there was the strong possibility of a skin tear and a stronger possibility of a bacteria infection. LVN 4 stated that Resident 16 could fall on to it and sustain a serious injury. LVN 4 stated the exposed part could be a trap for food as well. LVN 4 stated that the table needs to be replaced. During an observation on 5/29/25 at 6:00 p.m. Resident 16's over-the-bed table with the chip out of it remained in the room and Resident 16 had personal items placed on it. During a concurrent observation and interview on 5/30/25 at 8:22 a.m. with the Director of Staff Development (DSD) 2, who also works as an Infection Preventionist part-time for the facility, in Resident 16's room, DSD 2 stated that Resident 16's over-the-bed table had exposed sharp edges and a porous surface and Resident 16 could sustain a bad skin tear from the sharp edge. DSD 2 stated from an infection control standpoint, the area where the table is chipped would be considered porous and would not be cleaned easily therefore blood or bacteria could stay in the porous areas. During a concurrent interview and record reviewed on 6/3/25 at 10:20 a.m. with the Director of Nurses (DON), the DON reviewed a picture of Resident 16's over-the-bed table dated 5/28/25 of Resident 16's over-the-bed table. The DON stated that the over-the-bed table has very rough edges and is porous. The DON stated that it is everyone's responsibility to maintain a safe environment by keeping equipment clean and intact, so no skin tears can occur, and no bacteria can harbor in the porous area. The DON stated the over-the-bed table should have been removed immediately. The DON stated the staff did not follow the policies by notifying the Maintenance department promptly and removing the over-the-bed table as soon as the chip occurred. During a review of the policy and procedure (P&P) titled, Patient Room Management, undated, P&P indicated, . patient rooms will be maintained in a manner . ensuring they are free from hazards . requires that patient rooms meet standards for cleanliness, safety and privacy .maintenance staff will address repairs in patient rooms promptly to ensure the room is safe and functional .rooms will be free of potential hazards . the Administrator or designee will conduct regular inspections to ensure rooms meet cleanliness, safety . During a review of the policy and procedure (P&P) titled Accidents dated 9/2/22 indicated .the resident environment will remain as free of accidents as is possible .hazards refers to elements of the resident's environment that have the potential to cause injury . During a review of the policy and procedure (P&P) titled Safe and Homelike Environment dated 12/19/22 indicated .report any furniture in disrepair to Maintenance promptly .

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure a comprehensive individualized care plan was developed and implemented for one of 15 residents (Resident 57) when Resident 57 ' s care plan was not developed and implemented for monitoring and care of his central venous catheter port (a thin tube that goes into a vein in your arm or chest and ends at the right side of your heart and is attached to a device [port] under the skin) and surgical incision wound. This failure had the potential to put Resident 50 at increased risk for wound infection, pain, discomfort and medical complications of his indwelling central line due to improper care and monitoring of his device and surgical incision wound. Findings: During a concurrent observation and interview on 5/27/25 at 10:51 a.m. with Resident 57 in Resident 57 ' s room, Resident 57 was observed dressed sitting in a wheelchair with a dressing on his right upper chest. Resident 57 stated he had been at the facility for a couple of weeks. Resident 57 stated he had a port put in for chemotherapy (a drug treatment used to stop the growth of cancer cells). Resident 57 stated nurses have not changed his dressing and staff do not wear a gown or gloves when providing care. No enhanced barrier precautions (EBP- an infection control intervention designed to reduce transmission of resistant organisms [bacteria that have become resistant to certain antibiotics] that requires gown and glove use during high contact resident care activities) sign was observed on Resident 57 ' s door. During a review of Resident 57 ' s admission Record (AR - a summary of information regarding a patient which includes patient identification, past medical history, insurance status, care providers, family contact information and other pertinent information), dated 5/30/25, the AR indicated Resident 57 was admitted to the facility from an acute care hospital on [DATE] with diagnoses of fracture of left femur (a break in the bone of the thigh), liver cell carcinoma (a cancer of the liver), cerebral ischemia (damage to tissues in the brain due to a loss of oxygen to the area), and major depressive disorder (a mental health disorder characterized by persistently depressed mood or loss of interest in activities). During a review of Resident 57 ' s Minimum Data Set (MDS - a resident assessment tool used to identify cognitive [mental processes] and physical functional level assessment), dated 4/4/25, the MDS section C indicated Resident 57 had a Brief Interview for Mental Status (BIMS - a test given by medical professionals to determine cognitive (involving the process of thinking, learning and understanding) understanding on a scale of 1-15) score of seven (a score of 0-7 suggests severe cognitive impairment, 8-12 suggests moderately impaired, 13-15 suggests cognitively intact), which suggested Resident 57 was severely impaired. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/29/25 at 2:39 p.m. with Certified Nursing Assistant (CNA) 4, CNA 4 stated the CNAs did not look at resident ' s care plans (CP)s but received report on the residents from other CNAs or the nurse. CNA 4 stated residents on EBP because of a wound or catheter line would have had an EBP sticker by their name, and she would have gone to the nurse to find out what type of precautions the resident was on. CNA 4 stated she usually received report from the nurse or other CNAs on residents with wounds and on EBP. During a concurrent interview and record review on 5/29/25 at 4:15 p.m. with the Infection Preventionist (IP), Resident 57 ' s Care Plan (CP), undated was reviewed. The CP indicated there was no care plan for monitoring Resident 57 ' s catheter line or surgical incision. The IP stated Resident 57 did not have a care plan for his catheter line and Resident 57 ' s catheter line was new. The IP stated Resident 57 ' s catheter line was put in last week on 5/20/25. The IP stated Resident 57 should have had a CP for monitoring his catheter line site. The IP stated the CP was important to let staff know how to monitor for signs and symptoms of infection, behaviors, interventions to take, and if something happened to the resident, when to reach out to the doctor. The IP stated the CP was to ensure each resident received proper care. The IP stated Resident 57 ' s CP should have been put in when he returned to the facility after having his catheter line put in. The IP stated the CP needed to be individualized for each resident because everyone was different. The IP stated the CP needed to be personalized according to the needs and preferences of the resident. During an interview on 6/3/25 at 8:53 a.m. with the Director of Nursing (DON), the DON stated residents should have had a CP completed by the admission nurse, then followed up by the IP. If the IP was in the facility, she would have initiated the CP. The DON stated the nurses could have also updated a resident ' s care plan. The DON stated residents should have had a CP for EBP if they had wounds or central catheter lines, and the CP should have been resident specific. The DON stated the CP was important for staff to know how to take care of the resident. The DON stated if there was no CP for Resident 57, there was the risk of not giving Resident 57 the proper care needed. The DON stated if there was no care plan for catheter line site monitoring for Resident 57, he did not have a specific plan to meet his needs, and his CP would not have been individualized. During a review of the facility ' s job description document titled, MDS Coordinator, dated 11/24/16, indicated, . conduct resident assessments as required, develop plans of care, evaluate residents ' responses to intervention . complete . observations and care plans as needed . ensure all medications, treatments and at risk conditions . are included on resident ' s plan of care after the admission nurses have completed their admission care plans and significant change of condition care plans . During a review of the facility ' s job description document titled, Registered Nurse (RN), dated 1/22/25, indicated, . review care plans daily to verify that appropriate care is being rendered . verify that nurses ' notes reflect that the care plan is being followed when administering nursing care or treatment . ensure that assigned certified nursing assistants (CNAs) are aware of the resident care plans. Ensure that the CNAs refer to the resident ' s care plan prior to administering daily care to the resident . (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility ' s job duties document titled, Director of Nursing, dated 11/1/16, indicated, . assist the Resident Assessment/Care Plan Coordinator in the scheduling of care plans and assessments to be presented and discussed at each committee meeting . ensure that all personnel involved in providing care to the resident are aware of the resident ' s care plan. Ensure that nursing personnel refer to the resident ' s care plan prior to administering daily care to the resident . review nurses ' notes to determine if the care plan is being followed . During a review of the facility ' s policy and procedure (P&P) titled, Care Planning, dated 12/19/22, indicated, . the facility will inform the resident and/or resident representative of the risks and benefits of proposed care, of treatment . the care planning process will include an assessment of the resident ' s strengths and needs . the facility will discuss the plan of care with the resident and/or representative at regularly scheduled care plan conferences . initially, at routine intervals, and after significant changes .

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. Based on observation, interview and record review the facility failed to follow professional standards for one of 11 sampled residents (Resident 216) when Resident 216 did not have his urinary catheter(a hollow tube inserted into the bladder to drain and collect urine) changed per physician order, the physician was not notified that the catheter was not changed and Resident 216 had signs that included mucus and sediment in the catheter tubing, amber-colored foul-smelling urine. This failure resulted in a missed urinary catheter change, and the lack of notification regarding Resident 216 ' s catheter tubing had the potential of delayed diagnosis and treatment of a urinary tract infection, increasing risk of worsening infection. Findings: During an observation on 5/27/25 at 10:38 a.m. in Resident 216 ' s room, Resident 216 ' s urinary catheter bag contained dark-colored urine and there was visible sediment and mucus in the catheter tubing. The room had a strong odor of urine. During a review of Resident 216 ' s admission Record (AR - a summary of information regarding a patient which includes patient identification, past medical history, insurance status, care providers, family contact information and other pertinent information), dated 5/8/25, the AR indicated Resident 216 was admitted to the facility from an acute care hospital on 5/8/25 with diagnoses of urinary retention (unable to empty bladder completely), hemiplegia (total paralysis of the arm, leg and trunk on the same side of the body), and cerebrovascular accident (CVA-a stroke, loss of blood flow to a part of the brain). During a review of Resident 216 ' s Minimum Data Set (MDS - a resident assessment tool used to identify cognitive [mental processes] and physical functional level assessment), dated 5/13/25, the MDS section C indicated Resident 216 had a Brief Interview for Mental Status (BIMS - a test given by medical professionals to determine cognitive (involving the process of thinking, learning and understanding) understanding on a scale of 1-15) score of three (a score of 0-7 suggests severe cognitive impairment, 8-12 suggests moderately impaired, 13-15 suggests cognitively intact), which suggested Resident 216 was severely impaired. During a concurrent observation and interview on 5/29/25 at 10:32 a.m. at Resident 216 ' s bedside, Certified Nursing Assistant (CNA) 6 stated Resident 216 had dark-colored urine that was odorous and contained visible sediment. CNA 6 stated the symptoms of a urinary tract infection (UTI- an infection in the bladder/urinary tract) included confusion, pain foul-smelling urine and the presence of sediment. CNA 6 stated these findings should be alerted to the nurse. During an interview on 5/29/25 at 10:52 a.m. with CNA 7, CNA 7 stated symptoms of a urinary tract infection included bad smelling and abnormal colored urine. CNA 7 stated they were expected to notify the nurse if anything abnormal was found. During an interview on 5/29/25 at 11:05 with Licensed Vocational Nurse (LVN) 6, LVN 6 stated the symptoms of a urinary tract infection included foul-smelling urine. LVN 6 stated the entire catheter was to be changed monthly. LVN 6 stated if there was sediment in the catheter tubing, it should be changed, as this could be an indicator of an infection. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on 5/29/25 at 11:09 a.m. with LVN 6, Resident 216 ' s Order Summary Report, dated 5/29/25 was reviewed. The report indicated a physician order to change the catheter drainage bag on the 15TH of each month and as needed. During a concurrent interview and record review on 5/29/25 at 11:09 a.m. with LVN 6, Resident 216 ' s Treatment Administration Record (TAR), dated 5/1/25 - 5/31/25 was reviewed. LVN 6 stated the TAR indicated the physician ' s order for when to change Resident 216 ' s catheter was not generated as a task in the TAR and, therefore, was not scheduled or completed as ordered. LVN 6 stated the photo taken on 5/27/25 at 10:38a.m. of Resident 216 ' s catheter tubing indicated it should be changed. LVN 6 stated failing to timely identify or address these symptoms of a urinary track infection could lead to sepsis (a life-threatening blood infection). LVN 6 stated it was beneficial to the resident ' s health to catch these symptoms early. LVN 6 stated if they had been the nurse assigned, they would have assessed the urine, flushed the catheter, notified the physician, and documented the findings in a progress note. LVN 6 stated the physician would most likely have ordered a urinalysis (test that checks for infection in urine) to verify if Resident 216 had a UTI. During an interview on 6/3/25 at 11:38a.m. with the Infection Preventionist (IP)1, IP 1 stated catheter tubing should be clear and free from any discoloration or visible debris. IP 1 stated her expectation of staff was they should be competent in providing catheter care. IP 1 stated if there were any issues or concerns, they should have been escalated to the physician and nursing staff. IP 1 stated Resident 216 ' s catheter tubing should have been changed and the risk to the resident was the potential for developing an infection. During an interview on 6/3/25 at 11:45 a.m. with the Director of Nursing (DON), the DON stated it was her expectation of staff to be competent in inserting and maintaining a catheter. The DON stated if there were signs and symptoms of an infection-such as pain, foul odor, cloudy urine or sediment-staff were expected to escalate the finding by notifying the physician, changing the catheter tubing, completing a urinalysis and documenting a change in condition. The DON reviewed the picture of Resident 216 ' s catheter tubing taken on 5/27/25 at 10:38 a.m., the DON stated she would have expected staff to have taken those actions. During a review of Resident 216 ' s Indwelling Urinary Catheter Care Plan (CP), dated 5/9/25, the CP indicated, change catheter as ordered by physician .report to physician signs and symptoms of UTI: pain, burning, deepening of color, foul smelling urine. During a review of the facility ' s job description document titled Registered Nurse, dated 2025, the job description indicated, .initiate request for consultation or referral .discriminate between normal and abnormal findings, in order to recognize when to refer the resident to a physician for evaluation, supervision or directions .make written and oral reports/recommendations to the attending physician, medical director, or the DON, concerning the status and care of the residents . During a review of RegisteredNursing.org professional reference titled, Does a Nurse Always Have to Follow a Doctor ' s Orders?, dated 1/18/25, (found at https://www.registerednursing.org/articles/does-nurse-always-follow-doctors-orders/#:~:text=Unless%20there%20is%20a%20safety,not%20follow%20a%20doctor's%20order.) the reference indicated, .nurses cannot just randomly decide which order to follow and which not to follow. Unless there is a safety concern or an order that conflicts with personal or religious beliefs, failing to carry out orders can be grounds for discipline by the employer as well as the board of nursing, as it could be deemed neglect. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a professional reference review from the Centers for Disease Control and Prevention (CDC) titled, Guideline for Prevention of Catheter-Associated Urinary Tract Infections 2009, dated 6/6/2019, (retrieved from https://www.cdc.gov/infection-control/media/pdfs/Guideline-CAUTI-H.pdf) indicated, .What are the best practices for preventing UTI associated with obstructed urinary catheters? The available data examined the following practices: .Methods to prevent/reduce encrustations or blockage .Catheter materials preventing blockage For this question, available relevant outcomes included blockage/encrustation. We did not find data on the outcomes of CAUTI .

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on observation, interview, and record review, the facility failed to ensure pharmaceutical services met the needs of two out of three sampled resident's (Resident 54 and Resident 166) when three controlled medication (medication with a high potential for physical and mental dependence) entries for Resident 54 and four controlled medication entries for Resident 166 did not have received by dates in the controlled drug disposition log. This failure resulted in inadequate record keeping of controlled medication which had the potential to lead to inaccurate controlled medication inventory, delayed medication destruction, diversion (when healthcare providers obtain or use prescription medicines illegally) of controlled medications and delayed identification of controlled medication diversion. Findings: During a concurrent interview and record review on 5/28/25 at 2:27 p.m. with the Director of Nursing (DON) the facility's Controlled Drug Disposition Log, dated 5/2025, was reviewed. The disposition log indicated, Resident 54 had three controlled medication entries listed on the log for disposition: oxycodone with acetaminophen (controlled medication commonly used to treat pain), lorazepam (controlled medication commonly used to treat anxiety or seizures), and morphine sulfate (controlled medication commonly used to treat pain). Resident 166 had four controlled medication entries listed on the log for disposition: lorazepam twice and hydromorphone (controlled medication commonly used to treat pain) twice. The DON stated Resident 54's and Resident 166's-controlled medications had been brought to her by the floor nurse for waste. The disposition log entries did not include received by dates from the floor nurse to the DON. The DON could not identify or state the date she received the seven controlled medications based on the disposition log. The DON stated it was expected every time she received a controlled medication for waste from the floor nurse that she documented the received by date on the disposition log. The DON stated this process was not completed for Resident 54's three controlled medications or Resident 166's four controlled medications. The DON stated the facility policy was for the floor nurse to bring the DON controlled drug waste, complete the controlled drug disposition log in entirety, and then the medication would be disposed of with the pharmacist monthly or as needed. The DON stated it was important to document the received by date for each controlled medication to ensure timely disposition of controlled medications. The DON stated all controlled medications needed to be disposed of with the pharmacist within three months. The DON stated it was important the controlled drug disposition log was correctly and accurately completed to prevent drug diversion and ensure all controlled medications were accounted for. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/29/25 at 2:25 p.m. with the Pharmacist (PC), the PC stated she visited the facility monthly or as needed to review the Controlled Drug Disposition Log with the DON and dispose of controlled medications. The PC stated when a floor nurse needed to dispose of a controlled medication it is brought to the DON. The PC stated the DON then documented the residents name, prescription number, quantity, floor nurses name, and received by date from the floor nurse in the disposition log. The PC stated it was important the Controlled Drug Disposition Log was correctly and accurately completed to prevent drug diversion and ensure all controlled medications were accounted for. The PC stated it was important the received by date was documented to ensure timely disposition of controlled medications. The PC stated all controlled medications were required to be disposed of within 3 months. The PC stated without a received by date for each medication the facility could not ensure controlled medications were disposed of timely. The PC stated she expected the Controlled Drug Disposition Log to be completed accurately by the floor nurse and the DON. During an interview on 6/3/25 at 9:56 a.m. with the DON, the DON stated the Controlled Drug Disposition Log had not be filled out and completed accurately for Resident 54's three controlled medications and Resident 166's four controlled medications. The DON stated the received by date was expected, per policy and procedure, to be documented by her and the floor nurse on the disposition log for each controlled medication entry. The DON stated it was facility policy and procedure to ensure timely and accurate disposal of controlled medications. The DON stated facility policy and procedure had not been followed when the floor nurse and herself did not follow controlled medication disposition procedures for Resident 54's three controlled medications and Resident 166's four controlled medications. During a review of the facility's policy and procedure (P&P) titled 72371. Pharmaceutical Service-Disposition of Drugs, undated, the P&P indicated, .medications will be disposed of in accordance with federal, state and local regulations .the name of the patient, the name and strength of the drug, the prescription number, the amount destroyed, the date of destruction and the signatures of the witnesses required above shall be recorded in the patient's health record or in a separate log . During a review of the facility's P&P titled Controlled Substances, dated 11/2022, the P&P indicated, . controlled substances are counted upon delivery. The nurse receiving the medication, along with the person delivering the medication, must count the controlled substances together. Both individuals sign the designated controlled substance record .controlled substance inventory is monitored and reconciled to identify loss or potential diversion in a manner that minimizes the time between loss/diversion and detection/follow-up .

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure residents were free of significant medication errors for three of 15 residents (Residents 3, 16, and 31) when Residents 3, 16 and 31 failed to receive insulin (a short-acting insulin [a hormone that lowers the levels of sugar in the blood] used to treat diabetes [a disorder characterized by difficulty in blood sugar control and poor wound healing]) prior to eating their meal per physician's orders and manufacturer's recommendations. This failure had the potential to place the Residents 3, 16, and 31 at risk of not receiving the desired amount of insulin which could result in hypoglycemia (low blood glucose [b/s - a simple sugar] the body's primary source of energy from food) and potentially lead to negative medical outcomes. Findings: During a concurrent observation and interview on 5/28/25 at 7:48 a.m. with Registered Nurse (RN) 1 in Resident 3's room, observed meal carts in the hallway outside Resident 3's room while RN 1 was observed checking Resident 3's blood sugar (b/s) levels. Resident 3 was observed dressed, sitting on the side of her bed with her bedside table in front of her. RN 1 stated she was checking Resident 3's b/s close to her mealtime so she could give Resident 3's insulin right before Resident 3 ate her meal. RN 1 stated she was behind with the resident's b/s checks. Observed RN 1 poke Resident 3 three times with a needle due to continued error messages from the glucometer (an instrument for measuring the concentration of glucose in the blood), which delayed Resident 3's insulin administration. During an observation on 5/28/25 at 8:18 a.m. in Resident 3's room, observed Resident 3 sitting on the side of her bed eating her breakfast. RN 1 interrupted Resident 3's meal and administered insulin in the left upper quadrant of Resident 3's abdomen. During a review of Resident 3's admission Record (AR - a summary of information regarding a patient which includes patient identification, past medical history, insurance status, care providers, family contact information and other pertinent information), dated 3/15/24, the AR indicated Resident 3 was admitted to the facility from an acute care hospital on 7/13/22 with diagnoses of type 2 Diabetes Mellitus (when the blood sugar levels in the body are too high), schizophrenia (a disorder that affects a person's ability to think, feel, and behave clearly), acute respiratory failure (a serious condition that occurs when the lungs cannot get enough oxygen into the blood or remove enough carbon dioxide [a waste gas] from the blood), heart failure (a condition when the heart muscle doesn't pump enough blood to meet the body's needs which can cause fatigue and shortness of breath), and cognitive communication deficit (difficulty with thinking and how someone uses language). During a review of Resident 3's Minimum Data Set (MDS - a resident assessment tool used to identify cognitive [mental processes] and physical functional level assessment), dated 34/29/25, the MDS section C indicated Resident 3 had a Brief Interview for Mental Status (BIMS - a test given by medical professionals to determine cognitive (involving the process of thinking, learning and understanding) understanding on a scale of 1-15) score of 0 (a score of 0-7 suggests severe cognitive impairment, 8-12 suggests moderately impaired, 13-15 suggests cognitively intact), which suggested Resident 3 was severely impaired. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 3's Order Summary Report (OSP), dated 6/3/25, the OP indicated, . insulin Regular (human) inject 13 units subcutaneously (under the skin) before meals for Type II Diabetes Mellitus (DM) . insulin Regular (Human) inject as per sliding scale . subcutaneously before meals for Type II DM . During a concurrent observation and interview on 5/28/25 at 8:55 a.m. in Resident 16's room, Resident 16 was observed dressed in his wheelchair. Resident 16 stated he already ate his meal. RN 1 observed checking Resident 16's b/s. RN 1 stated she would notify Resident 16's physician due to Resident 16 already ate his meal prior to his b/s check. During a concurrent observation and interview on 5/28/25 at 9:01 a.m. with RN 1 in Resident 16's room, RN 1 was observed administering insulin to Resident 16 in the right upper quadrant of the abdomen. RN 1 stated Resident 16's physician stated to administer insulin as ordered and monitor the resident. During a review of Resident 16's AR, dated 6/3/25, the AR indicated Resident 16 was admitted on [DATE] from a skilled nursing facility with diagnoses of cerebral infarction (damage to tissues in the brain due to a loss of oxygen to the area), type II DM, acute respiratory failure, cognitive communication deficit, and acquired absence of right and left legs below the knees. During a review of Resident 16's MDS, dated 4/1/25, the MDS section c indicated Resident 16 had a BIMS score of zero, which indicated Resident 16 was severely impaired. During a review of Resident 16's OSR, dated 6/3/25, the OSR indicated, . (brand name insulin) . inject as per sliding scale . subcutaneously before meals . During a concurrent observation and interview on 5/28/25 at 8:23 a.m. with RN 1 in Resident 31's room, Resident 31 was observed dressed sitting in bed with his meal tray on his bedside table. RN 1 asked Resident 31 if he already ate his meal, which Resident 31 replied yes. RN 1 stated she needed to call Resident 31's physician as she had not checked Resident 31's fasting b/s prior to him eating his meal. During a concurrent observation and interview on 5/28/25 at 8:35 a.m. RN 1 observed administering insulin to Resident 31 in the right lower quadrant. RN 1 stated the physician ordered 2 units (unit of measurement) to be given and to monitor the resident. During a review of Resident 31's AR dated 6/3/25, the AR indicated Resident 31 was admitted from the acute care hospital on 3/25/25 and re-admitted on [DATE] with diagnoses of hemiplegia (paralysis [the loss of the ability to move and sometimes to feel anything] of one side of the body) and hemiparesis (muscle weakness or partial paralysis on one side of the body that can affect the arms, legs, and facial muscles), type II diabetes mellitus, cognitive communication deficit, and partial amputation (surgical removal) of two or more left lesser toes. During a review of Resident 31's MDS, dated 5/28/25, the MDS section C indicated Resident 31 had a BIMS score of 12, which suggested resident 31 was moderately impaired. During a review of Resident 31's OSP, dated 6/3/25, the OSP indicated, . (brand name insulin) . inject as per sliding scale . subcutaneously before meals and at bedtime for DM2 . (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/28/25 at 10:05 a.m. with RN 1 stated resident's b/s checks should be taken before the residents eat their meal to get an accurate reading of the resident's blood sugar. RN 1 stated residents could have gotten adverse (harmful) side effects from the medication. RN 1 stated staff needed to monitor the residents. During an interview on 6/03/25 at 9:13 a.m. with the Director of Nursing (DON), the DON stated her expectation was resident' b/s should have been taken prior to the residents eating their meals so the nurse would get an accurate reading of the resident's blood sugar. The DON stated the residents could have had a higher reading of their blood sugar after eating their meal than if they were fasting. The DON stated the resident's insulin should not have been given. During a review of the facility job description document titled, Registered Nurse, dated 1/22/25, the document indicated, . the Registered Nurse is responsible for providing direct nursing care to the residents. Such care must be delivered in accordance with current federal, state, and local standards, guidelines, and regulations that govern our facility . prepare and administer medications as ordered by the physician . During a review of professional reference titled, Insulin, Regular, dated 7/3/23, retrieved from: https://www.ncbi.nlm.nih.gov/books/NBK553094/#:~:text=Insulin%2C%20regular%20when%20administrated%20subcutaneously, injection%20sites%20to%20avoid%20lipodystrophy, indicated . Insulin, regular when administrated subcutaneously, should be injected 30 to 40 minutes before each meal . if insulin is administered not with meals or inappropriate dosage, it can be life-threatening. Untreated hypoglycemia (low blood sugar) can cause seizures, coma, and even death, especially in elderly patients . During a review of the Food and Drug Administration (FDA) information packet titled, INFORMATION FOR THE PHYSICIAN (Insulin brand name) REGULAR INSULIN HUMAN INJECTION, USP, (rDNA ORIGIN) 100 UNITS PER ML (U-100) DESCRIPTION, dated 3/20/11, retrieved from: https://www.accessdata.fda.gov/drugsatfda_docs/label/2011/018780s120lbl.pdf indicated, . OVERDOSAGE Excess insulin may cause hypoglycemia and hypokalemia . hypoglycemia may occur as a result of an excess of insulin relative to food intake, energy expenditure, or both . adjustments in drug dosage, meal patterns, or exercise may be needed . DOSAGE AND ADMINISTRATION (Insulin brand name) U-100, when used subcutaneously, is usually given three or more times daily before meals .

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observations, interview, and record review, the facility failed to properly label medication in the medication room and in two of three medication carts when: 1. Resident 25's inhaler was stored in the medication room and not labeled. 2. Resident 11's, Resident 19's and Resident 28's eye drops, as well as Resident 167's liquid morphine sulfate (controlled medication used to treat pain) was stored in medication cart A and not labeled. 3. Resident 39's and Resident 216's eye drops was stored in medication cart B and not labeled. These failures had the potential to result in misidentification of a medication, for Residents 25, 11, 19, 28, 167, 39 and 216 and had the potential for needed medication to not be available for resident use. Findings: 1. During a concurrent observation and interview on 5/28/25 at 2:27 p.m. with the Director of Nursing (DON) in the medication room, Resident 25's albuterol sulfate (powder medication that is inhaled and used to treat shortness of breath) inhaler was observed with no resident or pharmacy label on the inhaler. The DON stated Resident 25's inhaler did not have a resident or pharmacy label on the inhaler. The DON stated all inhalers were expected to have a pharmacy label on the inhaler. The DON stated pharmacy was responsible to place pharmacy labels on all inhalers. The DON stated the nurse administering the inhaler should have identified that the inhaler did not have a resident or pharmacy label on the inhaler and notified pharmacy. The DON stated it was important to ensure all inhalers were labeled so the correct medication was administered to the correct resident as ordered. 2. During a concurrent observation and interview on 5/29/25 at 12:57 p.m. with Licensed Vocational Nurse (LVN) 6 at medication cart A, Resident 11's latanoprost (a liquid medication placed in the eye to treat conditions that cause increased pressure in the eye) eye drops, Resident 19's lubricant eye (a liquid medication placed in the eye to treat dry eyes) drops, and Resident 28's brinzolamide (a liquid medication placed in the eye to treat conditions that cause increased pressure in the eye) eye drops were observed with no resident or pharmacy label on the eye drop bottles. Resident 167's morphine sulfate (controlled drug medication used to treat pain) liquid bottle was observed with no resident or pharmacy label on the medication bottle. LVN 6 stated all eye drop bottles were expected to have resident or pharmacy labels on the bottle. LVN 6 stated it was important to have resident or pharmacy labels on eye drop bottles to ensure the correct medication was administered to the correct resident. LVN 6 stated eye drop bottles were at risk for falling out of their box and without a label the medication could not be linked to the correct resident accurately, especially if multiple residents were prescribed the same eye drop medication. LVN 6 stated all morphine sulfate liquid bottles were expected to have a resident or pharmacy label on the bottle. LVN 6 stated it was important to have a resident or pharmacy label on the bottle to ensure the controlled medication was administered to the correct resident. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. During a concurrent observation and interview on 5/29/25 at 1:56 p.m. with Registered Nurse (RN) 2 at medication cart B, Resident 39's olopatadine (a liquid medication placed in the eye to treat eye itchiness) eye drops and Resident 216's bimatoprost (a liquid medication placed in the eye to treat conditions that cause increased pressure in the eye) eye drops were observed with no resident or pharmacy label on the eye drop bottles. RN 2 stated all eye drop bottles were expected to have resident or pharmacy labels on the bottle. RN 2 stated it was important to have resident or pharmacy labels on eye drop bottles to ensure the correct medication was administered to the correct resident. RN 2 stated if the eye drop bottles were lost it would not be known which medication belonged to each resident and could potentially lead to the incorrect medication. RN 2 stated there was a risk for spreading infections if the wrong eye drop bottle was administered to the wrong resident. During an interview on 5/29/25 at 2:18 p.m. with the Pharmacist in Charge (PIC), the PIC stated all resident medication within the medication room and medication carts were expected to be labeled with a resident pharmacy label on the bottle of the medication. The PIC stated Resident 25's albuterol sulfate inhaler was expected to have a resident pharmacy label on the inhaler. The PIC stated Resident 11's latanoprost eye drops, Resident 19's lubricant eye drops, and Resident 28's brinzolamide eye drops were expected to have a resident pharmacy label on the eye drop bottle. The PIC stated Resident 167's morphine sulfate liquid bottle was expected to have a resident pharmacy label on the bottle. The PIC stated Resident 39's olopatadine eye drops and Resident 216's bimatoprost eye drops were expected to have a resident pharmacy label on the eye drop bottle. The PIC stated pharmacy was responsible to ensure resident medication had pharmacy labels on the bottle. The PIC stated it was the floor nurse's responsibility to notify pharmacy if they identified a resident medication did not have a resident pharmacy label on the medication bottle. The PIC stated it was important each resident medication, inhaler or eye drop had a resident pharmacy label to ensure the correct medication bottle was used to administer medication to the correct resident. During an interview on 6/3/25 at 9:56 a.m. with the DON, the DON stated she expected every medication assigned to a resident to have a resident or pharmacy label on the inhaler, eye drop or medication bottle to ensure the medication was administered to the correct resident. The DON stated residents were at risk of infection if the wrong bottle of medication was administered to the wrong resident. The DON stated eye drops and inhalers touched the eyes and mouth of resident's and if not labeled there was a risk the medication was administered to the wrong resident with a similar prescription. The DON stated it was important to label morphine sulfate to ensure accurate controlled drug monitoring. The DON stated it was the policy of the facility to ensure pharmacy placed a resident label on each resident inhaler, eye drop and medication bottle. The DON stated the facility had not followed medication labeling policies for Resident 25, Resident 11, Resident 19, Resident 28, Resident 167, Resident 39 or Resident 216. During a review of the facility's policy and procedure (P&P) titled, 72357. Pharmaceutical Service- Labeling and Storage of Drugs, undated, the P&P indicated, .all drugs obtained by prescription shall be labeled . During a review of the facility's P&P titled, Medication Administration, dated 9/2/22, the P&P indicated, . compare medication source (bubble pack, vital, etc.) with MAR to verify resident name, medication name, form, dose, route, and time .

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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. Based on observation, interview and record review the facility failed to prepare and distribute food in accordance with professional standards for food service safety when one three-compartment sink in the kitchen did not contain air gaps (unobstructed vertical space between the water outlet and the flood level of a fixture) to prevent backflow of sewage (waste) water on 5/27/25 for 58 of 59 residents who consumed food prepared in the kitchen. This failure placed residents at risk for foodborne illness (illness caused by consuming contaminated food or drink) and food contamination. Findings: During an observation and interview on 5/27/25 at 9:15 a.m., with Kitchen Staff (KS) 1, during a tour of the kitchen, three-compartment sink did not have a visible air gap (unobstructed vertical space between the water outlet and the flood level of a fixture) to prevent backflow of sewage (waste) water. KS 1 stated the three-compartment sink was utilized by the cooks to clean their dishes. At the time of the observation, compartment 1 of the sink was filled with hot water and sanitizer. During an observation on 5/28/25 at 7:55 a.m., in the kitchen two turkey breasts were observed thawing under running water in compartment two of the three-compartment sink while compartment one contained sanitizer solution and dirty dishes. During an interview on 5/28/25 at 8:07 a.m., with Maintenance Director (MD), MD stated there were no air gaps for any of the sinks in the kitchen. During a concurrent observation and interview on 5/28/25 at 11:40 a.m., with [NAME] 1, lunch meat was observed thawing under running water in compartment two of the three-compartment sink, while dirty dishes were soaking in compartment one. [NAME] 1 stated there was no dedicated prep sink in the kitchen and the three-compartment sink was utilized for both food preparation and cleaning the dirty dishes. During a concurrent observation and interview on 5/28/25 at 12:17 p.m., in the kitchen, [NAME] 1 opened two large cans of diced pears and poured them into a colander (bowel used to strain off liquid) in compartment two of the two-compartment sink. At the time, compartment one was being used to soak dirty dishes. [NAME] 1 stated an air gap is used to prevent backflow. [NAME] 1 stated food could become contaminated if the sink backed up while being used for food preparation. During an interview on 5/30/25 at 9:19 a.m., with Certified Dietary Manger (CDM), the CDM stated there was potential for cross-contamination (transfer from one substance or object to another) to occur. The CDM stated if the sink were to become backed up, it could contaminate the food in the sink, which could lead to foodborne (a disease aquired from eating contaminated food or drinks) illness among the residents. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a review of the facilities policy and procedure (P&P) titled, Sanitation, dated 2023, the P&P indicated, . if a connection exists between the system and a source of contaminated water during times of negative pressure, contaminated water may be drawn into and foul the entire system .an air gap is the most reliable backflow prevention device. It is the physical separation of the potable and on and non-potable water supply systems by an air space. All steam tables, ice machines and bins, food preparation sinks, display cases, soda fountains, espresso machines and other equipment that discharge liquid waste or condensate shall be drained through an air gap into an open floor sink . During a review of the facilities policy and procedure (P&P) titled Thawing of Meats, dated 2023, the P&P indicated, .thaw in a clean and sanitized food sink separate from wash sinks . During a review of professional reference titled, FDA Food Code 2022, section 5-402.11 Backflow Prevention, (A) A direct connection may not exist between the sewage system and a drain originating from equipment in which food, portable equipment, or utensils are placed. (B) Equipment and fixtures used for food preparation or utensil washing must be installed with an air gap or air brake as required to prevent backflow of sewage into the equipment.

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Administer the facility in a manner that enables it to use its resources effectively and efficiently. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure one of eleven sampled residents (Resident 38) was effectively and efficiently cared for by the administrator to maintain Resident 38's highest practicable physical, mental, and psychosocial well-being when the Administrator (ADM) was the acting decision maker for Resident 38. This failure had the potential to result in Resident 38 to not maintain his highest well-being, wishes and preferences not being upheld which had the potential to lead to decreased autonomy (ability to make own decisions and control own actions) or participation in his care planning process. Findings: During a review of Resident 38's admission Record (AR- document containing resident personal information), dated [DATE], the AR indicated, Resident 38 was admitted to the facility on [DATE], with diagnoses which included dementia (decline in cognitive functioning that interfere with daily life), major depressive disorder (mood disorder that causes persistent feeling of sadness and loss of interest), dysphagia (difficulty swallowing) and muscle weakness. The AR indicated Resident 38's decision maker was the Administrator (ADM). The AR indicated Resident 38 had a Family Friend (FF) 1 who was allowed to obtain medical information. During a review of Resident 38's Minimum Data Set (MDS- a resident assessment tool) assessment, dated [DATE], the MDS assessment indicated Resident 38's Brief Interview for Mental Status (BIMS- an assessment tool used by facilities to screen and identify memory, orientation, and judgement status of the resident) assessment score was 10 out of 15 which indicated Resident 38 had moderate cognitive deficit (a decline in thinking abilities, like memory, reasoning, and problem-solving). During a review of Resident 38's Informed Consent to Treat (ICT), dated [DATE], the ICT indicated, the ADM signed the consent on [DATE]. The form indicated the ADM gave permission for the facility to treat Resident 38. During a review of Resident 38's Physician Orders for Life-Sustaining Treatment (POLST- set of medical orders reflect a resident's wished for end-of-life intervention), dated [DATE], the POLST indicated, the ADM signed the consent on [DATE]. During a review of Resident 38's Side/Bed Rail Informed Consent (SBR), dated [DATE], the Side/Bed Rail Informed Consent indicated, the ADM signed the consent on [DATE]. During a review of Resident 38's Facility Verification of Resident Informed Consent for Physical Restraints, Psychotherapeutic Drugs, or Prolonged Use of a Device (RIPD), dated [DATE], the Facility Verification of Resident Informed Consent for Physical Restraints, Psychotherapeutic Drugs, or Prolonged Use of a Device indicated, the medical provider obtained informed consent from the ADM on [DATE] for .Sertraline [psychotherapeutic drug-used to treat major depressive disorder] 12.5 mg [milligrams- unit of measurement for dosing medication] . (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on [DATE] at 2:54 p.m. with Family Friend (FF) 1, FF 1 stated Resident 38 had no family involved in his care. FF 1 stated he had known Resident 38 for a couple of years. FF 1 stated he was a patient advocate for Resident 38 at the previous facility Resident 38 was admitted to. FF 1 stated nobody from the facility contacted him to inquire if he would be Resident 38's decision maker or be involved in Resident 38's care. FF 1 stated he had not received any updates on Resident 38's care or treatment. FF 1 stated Resident 38 and himself met with the Social Services Director (SSD) in February 2025 and Resident 38 agreed for FF 1 to receive medical updates and be involved in his care. FF 1 stated he had not been consulted or involved in obtaining any informed consents for Resident 38. FF 1 stated he did not know the ADM was Resident 38's decision maker. FF 1 stated he did not understand how the ADM could make informed decisions for Resident 38 because he did not know him. FF 1 stated it was in Resident 38's best interest to include people who knew Resident 38 when making medical decisions to ensure Resident 38's wishes and preferences were upheld. During a concurrent interview and record review on [DATE] at 3:21 p.m. with the Social Services Director (SSD) , Resident 38's Medical Record (MR), dated [DATE] was reviewed. The SSD stated it was the responsibility of the facility to ensure each resident's decision maker was appropriately assigned on admission. The SSD stated the ADM was Resident 38's acting decision maker and has been since his admission on [DATE] . The SSD stated on [DATE] she met with Resident 38 and FF 1. The SSD stated Resident 38 gave permission for FF 1 to be involved in his care and receive medical updates. The SSD stated approximately a month ago the California Department of Aging provided an in-service on Interdisciplinary Team Process for Unrepresented Residents. The SSD stated the facility was expected to adhere to the in-service provided. The SSD stated if the facility received a medical treatment order requiring informed consent and no legal decision maker, family or friend was available to provide consent, an application was expected to be submitted to the California Department of Aging to assign a state-appointed patient representative. The SSD stated an interdisciplinary team (IDT) meeting was expected to be held for each medical decision requiring informed consent, and the family member, friend, or appointed patient representative was expected to participate. All IDT members were expected to agree on the treatment, document the meeting and decision, after which consent for the treatment could be obtained. The SSD stated there was no documentation within Resident 38's MR to reflect the ADM met with the interdisciplinary team prior to signing Resident 38's informed consents for, ICT, POLST, SBR or RIPD. The SSD stated there was no documentation within Resident 38's MR to reflect the ADM met or consulted with Resident 38, FF 1 or a patient representative prior to signing Resident 38's informed consents for, ICT, POLST, SBR or RIPD. The SSD stated Resident 38 was at risk for not having his medical decision wishes and preferences upheld if the ADM did not meet with the IDT Resident 38, FF 1 or a patient representative to discuss plan of care prior to signing informed consents. The SSD stated it was best practice to include decision makers who knew Resident 38 personally. The SSD stated it would be difficult for the ADM to know Resident 38's wishes and preferences with no input from his interdisciplinary team, FF 1, patient representative, or Resident 38. (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on [DATE] at 9:03 a.m. with the ADM, Resident 38's MR, dated [DATE], was reviewed. The ADM stated he was not related to Resident 38 and did not know Resident 38 prior to his admission to the facility. The ADM stated he was not aware of any family involved in Resident 38's life. The ADM stated he was aware Resident 38 had known FF 1 for several years and FF 1 was previously involved in his care at a previous facility. The ADM stated he was aware the California Department of Aging visited the facility approximately a month ago and had provided an in-service on Interdisciplinary Team Process for Unrepresented Residents. The ADM stated he expected the facility to follow the California Department of Aging on Interdisciplinary Team Process for Unrepresented Residents to ensure the facility did what was best for Resident 38 and ensured Resident 38's highest level of physical, mental, and psychosocial well-being. The ADM could not state or locate documentation to reflect he met with the interdisciplinary team prior to signing Resident 38's informed consents for, ICT, POLST, SBR or RIPD. The ADM could not state or locate documentation to reflect he met or consulted with Resident 38, FF 1 or a patient representative prior to signing Resident 38's informed consents for, ICT, POLST, SBR or RIPD. The ADM stated Resident 38 was at risk for not having his wishes or preferences upheld if there was no indication of a meeting to reflect Resident 38's, FF 1's, or a patient representatives' participation in the care planning process when acquiring informed consent. The ADM stated it was best to include individuals who knew residents personally to ensure resident preferences were upheld. During a concurrent interview and record review on [DATE] at 9:56 a.m. with the Director of Nursing (DON) , Resident 38's MR, dated [DATE], was reviewed. The DON stated the ADM had been Resident 38's decision maker since admission. The DON could not locate documentation to reflect the ADM met with the interdisciplinary team prior to signing Resident 38's informed consents for, ICT, POLST, SBR or RIPD. The DON could not locate documentation of a meeting to reflect the ADM met or consulted with Resident 38, FF 1 or a patient representative prior to signing Resident 38's informed consents for, ICT, POLST, SBR or RIPD. The DON stated with the ADM as the acting decision maker the interdisciplinary team was responsible to meet and discuss medical treatments that required informed consent for Resident 38 to ensure Resident 38's highest level of physical, mental, and psychosocial well-being. During a review of the facility's job description titled, Administration, dated [DATE], the job description indicated, . plan and implement all policies and procedures, in accordance with laws, regulations and legal requirements governing the operation of the property. Ensures compliance with all federal, state and legal regulations and company policies and procedures . During a review of the State requirements professional reference titled, Title 22 California Code of Regulations (CCR) Section §72501 Licensee- General Duties,, indicated, .except where provided for in approved continuing care agreements, or except when approved by the Department, no facility owner, administrator, employee or representative thereof shall act as guardian or conservator of a patient therein or of that patient's estate, unless that patient is a relative within the second degree of consanguinity . (continued on next page)

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's handout provided by the California Department of Aging titled, Interdisciplinary Team Process for Unrepresented Residents, undated, the handout indicated, . as of [DATE], skilled nursing and intermediate care facilities that conduct interdisciplinary team (IDT) reviews of medical interventions requiring informed consent (California Health and Safety Code section 1418.8) must: include a patient representative when they convene an IDT to make medical decisions requiring informed consent for residents who lack capacity and have no legal surrogate .provide notices containing specified information both before and after an IDT review to the resident who is the subject of the IDT and to the resident's patient representative .provide specified data to the California Department of Aging (CDA), Office of the Long-Term Care Patient Representative as required .under these requirements, facilities are responsible for identifying a friend or relative, whose interests are aligned with the resident, to serve as a patient representative when an interdisciplinary team is convened .if the facility is unable to identify a representative, the Office of the Long-Term Care Patient Representative (OLTCPR), a program within the CDA, can help .the OLTCPR will provide trained representatives for specified residents who may need medical treatment but lack the capacity to make health care decisions, have no legal surrogate authorized to make decisions on their behalf, and have no friend or relative who can represent them on an IDT . During a review of the facility's policy and procedure (P&P) titled, 784.29. Informed Consent to Medical Treatment, undated, the P&P indicated, .verify that the client's health record contains documentation that the client has given informed consent to the proposed treatment or procedure . During a review of the facility's P&P titled, Resident Representative, dated 2/2021, the P&P indicated, .the resident's wishes and preferences are considered in the exercise of rights by the representative . resident representative is defined as: an individual chosen by the resident to act on behalf of the resident in order to support the resident in decision-making; access medical, social or other personal information of the resident; manage financial matters; or receive notifications; b. a person authorized by state or federal law including but not limited to agents under power of attorney, representative payees, and other fiduciaries) to act on behalf of the resident in order to support the resident in decision-making; access medical, social or other personal information of the resident; manage financial matters; or receive notifications; legal representative, as used in section 712 of the Older Americans Act; or d. the court-appointed guardian or conservator of a resident . Whether or not the resident has been judged incompetent by a court of law, if it is determined that the resident understands the risks, benefits, and alternatives to a proposed health care decision and expresses a preference, the resident's wishes are considered to the degree practicable .the resident may exercise his or her rights not delegated to a resident representative, including the right to revoke a delegation of rights (except as limited by state law) .the director of nursing (or designee) is responsible for making reasonable efforts to obtain updates or changes that are made by the resident, including the resident's revocation of delegated rights, to ensure that the resident's preferences are being upheld .During a review of the facility's P&P titled, Resident Rights, dated 2/2021, the P&P indicated, .resident's rights to .appoint a legal representative of his or her choice .exercise rights not delegated to a legal representative .

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to establish and maintain an effective infection prevention and control program for two of 26 sampled residents (Resident 57 and Resident 216) when: 1. When Resident 57 was not placed on Enhanced Barrier Precautions (EBP - an infection control intervention designed to reduce transmission of resistant organisms [bacteria that have become resistant to certain antibiotics] that requires gown and glove use during high contact resident care activities) for his central venous catheter port (a thin tube that goes into a vein in your arm or chest and ends at the right side of your heart and is attached to a device [port] under the skin) incision wound. This failure placed Resident 57 at risk for cross-contamination (the process when germs are unintentionally transferred from one substance or object to another, which causes a harmful effect) and infection (an invasion of the body by germs that cause disease). 2. When Resident 216 ' s urinary catheter (a hollow tube inserted into the bladder to drain and collect urine) was observed to have visible mucus (a sticky fluid that can show up in a catheter tube if there is irritation or infection), sediment (tiny little flakes or particles) in the tubing, the urine had a foul odor and was dark in color. This failure had the potential to result in the spread of infection, delayed treatment and increased risk of complications such as sepsis (infection in the blood) and hospitalization. 1. During a concurrent observation and interview on 5/27/25 at 10:51 a.m. with Resident 57 in Resident 57 ' s room, Resident 57 was observed dressed sitting in a wheelchair with a dressing on his right upper chest. Resident 57 stated he had been at the facility for a couple of weeks. Resident 57 stated he had a port put in for chemotherapy (a drug treatment used to stop the growth of cancer cells). Resident 57 stated nurses have not changed his dressing and staff do not wear a gown or gloves when providing care. No EBP sign on Resident 57 ' s door. During a review of Resident 57 ' s admission Record (AR - a summary of information regarding a patient which includes patient identification, past medical history, insurance status, care providers, family contact information and other pertinent information), dated 5/30/25, the AR indicated Resident 57 was admitted to the facility from an acute care hospital on [DATE] with diagnoses of fracture of left femur (a break in the bone of the thigh), liver cell carcinoma (a cancer of the liver), cerebral ischemia (damage to tissues in the brain due to a loss of oxygen to the area), and major depressive disorder (a mental health disorder characterized by persistently depressed mood or loss of interest in activities). During a review of Resident 57 ' s Minimum Data Set (MDS - a resident assessment tool used to identify cognitive [mental processes] and physical functional level assessment), dated 4/4/25, the MDS section C indicated Resident 57 had a Brief Interview for Mental Status (BIMS - a test given by medical professionals to determine cognitive (involving the process of thinking, learning and understanding) understanding on a scale of 1-15) score of seven (a score of 0-7 suggests severe cognitive impairment, 8-12 suggests moderately impaired, 13-15 suggests cognitively intact), which suggested Resident 57 was severely impaired. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview on 5/27/25 at 4:10 p.m. with Registered Nurse (RN) 1, outside Resident 57 ' s room. No Enhanced Barrier Precautions (EBP - an infection control intervention designed to reduce transmission of resistant organisms [bacteria that have become resistant to certain antibiotics] that requires gown and glove use during high contact resident care activities) sign or personal protective equipment (PPE - clothing and equipment that is worn or used to provide protection against hazardous substances and/or environments) cart was observed outside Resident 57 ' s room. RN 1 stated EBP was required for everyone who had an opening in their body to the outside or wound. RN 1 stated EBP was for infection control to protect the residents and staff from getting or transferring infections. RN 1 stated all staff who provided direct care for Resident 57 should have worn the appropriate PPE which was a gown and gloves. RN 1 stated Resident 57 was not on EBP for his Central venous catheter port (a thin tube that goes into a vein in your arm or chest and ends at the right side of your heart and is attached to a device [port] under the skin, and he should have been put on EBP after he had his port placed. During an interview on 5/27/25 at 4:15 p.m. with Certified Nursing Assistant (CNA) 5, CNA 5 stated EBP was put in place to protect residents and to prevent staff from carrying germs into resident rooms. CNA 5 stated the resident should have had a cart outside their door and a sign on their door if they were on EBP so staff would know they needed to gown up to provide care for the resident. CNA 5 stated residents who had catheters, open areas, wounds, ports, colostomy (a surgical procedure that brings one end of the large intestine out through the abdominal wall to allow waste to leave the body) bags, or any opening should have been put on EBP. CNA 5 stated if a resident was not on EBP and should have been on EBP, there was a risk of the resident getting an infection. During an interview on 6/03/25 at 8:53 a.m. with the Director of Nursing (DON), the DON stated if a resident needed to be put on EBP, he should have been put on EBP on admission. The DON stated the desk nurse would have informed the Charge Nurse if a resident needed to be on EBP if the Infection Preventionist (IP) was not at the facility and the IP would have followed up with staff when she came in. The DON stated if a resident was not on EBP and should have been, there was a risk of spreading infection. The DON stated if staff was not protected with a gown, they could have transmitted germs to another resident. During a review of the facility ' s job description document titled Infection Preventionist, dated 2022, the job description indicated, . develops and implements an ongoing infection prevention and control program to prevent, recognize and control the onset and spread of infections . establishes facility-wide systems for the prevention . and control of infections . oversees resident care activities that increase risk of infection (i.e., use and care of urinary catheters, wound care . During a review of the facility policy and procedure (P&P) titled, Enhanced Barrier Precautions, dated 9/2/22, indicated, . it is the policy of this facility to implement enhanced barrier precautions for the prevention of transmission of multidrug resistant organisms (MDRO) . enhanced barrier precautions refer to the use of gown and gloves for use during high-contact resident care activities for residents known to be colonized or infected with a MDRO as well as those at increased risk of MDRO acquisition (e.g., residents with wounds or indwelling medical devices) . clear signage will be posted on the door or wall outside of the resident room indicating the type of precautions, required personal protective equipment (PPE), and the high-contact resident care activities that require the use of gown and gloves . an order for enhanced barrier precautions will be obtained for residents with any of the following . wounds (e.g., unhealed surgical wounds .) and/or indwelling medical devices (e.g., central lines .) . (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. During an observation on 5/27/25 at 10:38 a.m. in Resident 216 ' s room, Resident 216 ' s urinary catheter bag contained dark-colored urine and there was visible sediment and mucus in the catheter tubing. The room had a strong odor of urine. During a review of Resident 216 ' s AR, dated 5/8/25, the AR indicated Resident 216 was admitted to the facility from an acute care hospital on 5/8/25 with diagnoses of urinary retention (unable to empty bladder completely), hemiplegia (total paralysis of the arm, leg and trunk on the same side of the body), and cerebrovascular accident (CVA-a stroke, loss of blood flow to a part of the brain). During a review of Resident 216 ' s MDS, dated 5/13/25, the MDS section C indicated Resident 216 had a BIMS score of three which suggested Resident 216 was severely impaired. During a concurrent observation and interview on 5/29/25 at 10:32 a.m. at Resident 216 ' s bedside, Certified Nursing Assistant (CNA) 6 stated Resident 216 had dark-colored urine that was odorous and contained visible sediment. CNA 6 stated the symptoms of a urinary tract infection (UTI- an infection in the bladder/urinary tract) included confusion, pain foul-smelling urine and the presence of sediment. CNA 6 stated these findings should be alerted to the nurse. During an interview on 5/29/25 at 10:52 a.m. with CNA 7, CNA 7 stated symptoms of a urinary tract infection included bad smelling and abnormal colored urine. CNA 7 stated they were expected to notify the nurse if anything abnormal was found. During an interview on 5/29/25 at 11:05 with Licensed Vocational Nurse (LVN) 6, LVN 6 stated the symptoms of a urinary tract infection included foul-smelling urine. LVN 6 stated the entire catheter was to be changed monthly. LVN 6 stated if there was sediment in the catheter tubing, it should be changed, as this could be an indicator of an infection. During a concurrent interview and record review on 5/29/25 at 11:09 a.m. with LVN 6, Resident 216 ' s Order Summary Report, dated 5/29/25 was reviewed. The report indicated a physician order to change the catheter drainage bag on the 15TH of each month and as needed. During a concurrent interview and record review on 5/29/25 at 11:09 a.m. with LVN 6, Resident 216 ' s Treatment Administration Record (TAR), dated 5/1/25 - 5/31/25 was reviewed. The TAR indicated the physician ' s order for when to change Resident 216 ' s catheter was not generated as a task in the TAR and, therefore, was not scheduled or completed as ordered. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and photo review on 5/29/25 at 11:09 a.m. with LVN 6. Photo was taken on 5/27/25 at 10:38 a.m. during the initial pool process. LVN 6 described the photo as showing mucus and sediment stuck along the inside wall of the catheter tubing. The tubing appeared discolored and the urine in the collection bag was amber in color. LVN 6 stated the catheter tubing should be changed. LVN 6 stated failing to timely identify or address these symptoms of a urinary track infection could lead to sepsis (a life-threatening blood infection). LVN 6 stated it was beneficial to the resident ' s health to catch these symptoms early. LVN 6 stated if they had been the nurse assigned, they would have assessed the urine, flushed the catheter, notified the physician, and documented the findings in a progress note. LVN 6 stated standard practice was to notify the physician and document the condition in a progress note. LVN 6 verified the physician had not been contacted regarding the missed catheter change that was ordered for 5/15/25. LVN 6 stated the physician would most likely have ordered a urinalysis (test that checks for infection in urine) to verify if Resident 216 had a UTI. During an interview on 6/3/25 at 11:38a.m. with the Infection Preventionist (IP)1, IP 1 stated catheter tubing should be clear and free from any discoloration or visible debris. IP 1 stated her expectation of staff was they should be competent in providing catheter care. IP 1 stated if there were any issues or concerns, they should have been escalated to the physician and nursing staff. IP 1 stated Resident 216 ' s catheter tubing should have been changed and the risk to the resident was the potential for developing an infection. During an interview on 6/3/25 at 11:45 a.m. with the Director of Nursing (DON), the DON stated it was her expectation of staff to be competent in inserting and maintaining a catheter. The DON stated if there were signs and symptoms of an infection-such as pain, foul odor, cloudy urine or sediment-staff were expected to escalate the finding by notifying the physician, changing the catheter tubing, completing a urinalysis and documenting a change in condition. After reviewing the picture of Resident 216 ' s catheter tubing taken on 5/27/25 at 10:38 a.m., the DON verified the photo showed mucus and sediment stuck along the inside wall of the catheter tubing. The tubing appeared discolored and the urine in the collection bag was amber in color. The DON stated she would have expected staff to have taken those actions. During a review of Resident 216 ' s Indwelling Urinary Catheter Care Plan (CP), dated 5/9/25, the CP indicated, change catheter as ordered by physician .report to physician signs and symptoms of UTI: pain, burning, deepening of color, foul smelling urine. During a review of the facility ' s job description document titled Registered Nurse, dated 2025, the job description indicated, .administer services within the applicable scope of nursing practice, which may include: catheterization .obtain sputum, urine and other specimens for lab tests .review care plans daily to verify that appropriate care is being rendered . During a review of the facility ' s job description document titled Licensed Vocational Nurse, dated 2023, the job description indicated, .provide assessment and diagnostic services to residents. Perform an assessment evaluation using techniques including observation, inspection and palpation .

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure one of 11 sampled residents (Resident 46) had access to a call light when Call light cord was found strung over the head of the bed and the call light was tucked between the mattress and the bed frame. This failure resulted in Resident 46 not being able to directly call for assistance and had the potential to place Resident 46 at risk for accidents and injuries. Findings: During a review of Resident 46's admission Record (AR, a document containing resident personal information), dated 5/29/25, the AR indicated, Resident 46 was admitted to the facility on [DATE] with diagnoses which in included wedge compression lumbar fracture of the first vertebra (the first bone in the lower back has been squished or crushed in a way that makes it look like a wedge - narrower in the front than the back) dysphagia (difficulty swallowing), Alzheimer's (a disease characterized by a progressive decline in mental abilities) and Cognitive Communication Deficit (when someone has a hard time talking or understanding because their brain is having trouble with thinking skills). During a review of Resident 46's Minimum Data Set (MDS - a resident assessment tool) assessment dated 3/28/2025, the MDS assessment indicated Resident 46's Brief Interview for Mental Status (BIMS- an assessment tool used by facilities to screen and identify memory, orientation, and judgement status of the resident) assessment score was unable to be determined due to Resident 46's severe cognitive deficit (a decline in thinking abilities, like memory, reasoning, and problem-solving) and could not complete the interview. During an observation on 5/27/25 at 8:50 a.m. in Resident 46's room, Resident 46 was observed disheveled with uncombed hair and crumbed-filed clothes. Resident 46 was unable to coherently answer questions or make eye contact when asked questions. Resident 46 stated [NAME] [NAME] to questions asked. Resident 46's call light was observed strung over the head of the bed and was tucked between the mattress and the bed frame. Resident 46's call light was not in reach. During a concurrent observation and interview on 5/27/25 at 9:13 a.m. with Certified Nursing Assistant (CNA) 3, CNA 3 stated that the resident's call light should not be strung over the head of the bed with the call light was tucked between the mattress and the bed frame. CNA 3 stated that the call light needs to be where Resident 46 could reach it. CNA 3 stated it would be a potential accident if the resident could not call for staff. CNA 3 stated even though Resident 46 was confused, Resident 46 still need to have the call light available. CNA 3 stated it would be a potential accident if the resident could not call for staff. (continued on next page)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/27/25 at 9:23 a.m. with Certified Nursing Assistant (CNA) 2, CNA 2 stated it is important for all residents to have their call light accessible to them and that having a a call light strung over the head of the bed and tucked between the mattress and the bed frame would not be considered accessible. CNA 2 stated Resident 46 would not be able to call for help. CNA 2 stated that it doesn't matter if Resident 46 is confused. Resident 46 should have their call light within their reach. CNA 2 stated that if she would have seen a call light out of reach of a resident that she would have moved it so resident could have access to it. CNA 2 stated that Resident 46 might not be able to get help in an emergency. CNA 2 stated if Resident 46's call light was not within reach, Resident 46 was at risk for an accident or injury such as, . choking . and would not be able to call out for assistance During an interview on 5/27/25 at 9:47 a.m. with Licensed Vocational Nurse (LVN) 4, LVN 4 stated that the call light should not be out of reach for any resident. LVN 4 stated a call light tucked under the mattress out of the resident's reach should not be like that. LVN 4 stated that if the resident can't reach the call light how can they call if they need help which could lead to serious problems. LVN 4 stated that no matter how confused a resident is, they need to have a call light in reach. They may need to be redirected a lot, but they still need it so maybe they will be able to use it. LVN 4 stated that without access to the call light, they could become an even higher risk for falls. LVN 4 stated if there was a medical emergency Resident 46 may not be able to call for help. LVN 4 stated that every resident, no matter of the confusion level, needs to have an accessible call light. During an interview on 5/27/25 at 4:30 p.m. with Responsible Party (RP) 2, RP 2 stated Resident 46 had Alzheimer's and was often very confused. RP 2 stated that Resident 46 should have the call light within reach for help when needed. During an interview on 6/3/25 at 10:17 a.m. with the Director of Nurses (DON), the DON stated that all residents should have call lights within reach; even for confused residents the call light should be within reach. The DON stated not having a call light within reach has the potential for residents to be frustrated or upset. The DON stated that Resident 46's call light behind head of bed tucked into mattress was not in reach and had the call light been in reach, in the event of an emergency, Resident 46 could possibly have used it. The DON stated the staff did not follow policies or in-service training regarding call lights. During a review of the minutes from an in-service held on 5/14/25 at 2:30 p.m. titled Call lights: Response Time/Within Reach the minutes indicated, .a call light within reach is crucial for patient safety and well-being . key reasons why a call light should be within reach: Timely Assistance, Fall Prevention, Reduced Anxiety . During a review of the facility's policy and procedure (P&P) titled, Call Lights: Accessibility and Timely Response dated 9/2/22, the P&P indicated, .Staff will ensure the call light is within reach of residents and secured, as needed .the call system will be accessible residents while in their bed .