STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056274	A. Building B. Wing	01/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Red Bluff Health Care Center	555 Luther Road Red Bluff, CA 96080

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 policy review, the facility failed to maintain the facility in a clean, safe and comfortable home-like environment when:1. The sliding glass door in room [ROOM NUMBER] did not lock properly.2. room [ROOM NUMBER] had buckled, worn brown flooring that was on the right side of the sliding glass door, which made this door hard to slide.3. There was a hole in the bathroom door in room [ROOM NUMBER].4. The bathrooms on the south hall, rooms 14 through 25 needed repair and paint.5. The sliding glass doors were hard to open and slide and unclean in 10 resident rooms on the south hall.6. The nurses' station had chipped and worn areas around the sink and the molding and flooring.7. The Brio water fountain in the front lobby had a stained, unclean drain for the resident and community use. This failure had the potential to negatively affect client's health, safety, and comfort and the potential to spread other bacteria in the facility to other residents, staff, visitors, and the community. Findings:1. During a review of the facility's policy and procedure (P&P) titled. Maintenance Service, revised 12/2009, the P&P indicated the maintenance department shall be provided to all areas of the building, grounds, and equipment. The Maintenance department is responsible for maintaining the buildings, grounds, and equipment in a safe and operable manner at all times.During an observation on 1/20/26 at 9:19 am, the sliding glass door is room [ROOM NUMBER] was not locked properly and the lock needed to be repaired or replaced.During an interview on 1/20/26 at 9:45 am, the Administrator (Admin) confirmed the sliding glass door in room [ROOM NUMBER] did not lock properly. Admin stated, We will get this fixed immediately. I confirm the lock on room [ROOM NUMBER]'s door does not lock properly. During an interview on 1/20/26 at 9:50 am, the Maintenance Director (Main) confirmed the lock on room [ROOM NUMBER] did not work properly and stated, I did not know about this, or I would have already fixed this, I will get this done as soon as possible.2. During an observation on 1/20/26 at 9:20 am, there was a buckling, raised, weak area of the brown flooring in room [ROOM NUMBER] beside the sliding glass door, making the sliding glass door hard to open.During an interview on 1/21/26 at 2:30 pm, with the Admin, the Admin confirmed there was an area in the flooring that needed repair, and blue tape had already been placed over it for the maintenance department to repair. 3. During an observation on 1/20/26 at 9:24 am, there was a hole in the inside portion of the bathroom door of room [ROOM NUMBER].During an interview on 1/21/26 at 2:35 pm, with the Admin, the Admin confirmed the hole in the bathroom door would be repaired or replaced. 4. During an observation on 1/20/26 from 9:21 am to 9:37 am, the shared residents' bathrooms in rooms 14, 15, 17, 19 and room [ROOM NUMBER] had holes, chipped paint, chipped molding, and white paint marks on the brown flooring. 5. During an observation on 1/20/26 from 8:20 am to 9:15 am, the sliding glass doors (rooms 14, 15, 16, 17, 18, 19, 20, 21, 22, and room [ROOM NUMBER]) tracks had cumulative dust and debris and were difficult to slide properly.During an interview on 1/20/26 at 2:30 pm, with the Admin, the Admin confirmed all the sliding glass doors on the south hall (rooms 14 through 23) tracks were not clean with cumulative dust and dirt and were hard to slide. The Admin confirmed the bathrooms in rooms 14 through 25 needed paint and minor repairs, one bathroom door had a hole in it.During an interview on 1/21/26 with the Director of Nursing (continued on next page)

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

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	(DON), the DON confirmed the bathrooms on the south hall including rooms 14 through 25 needed paint and minor repairs to the molding, and the flooring around the pipes. The DON also confirmed room [ROOM NUMBER] had a hole in the bathroom door, and room [ROOM NUMBER] had flooring that needed repair. DON stated, I do confirm all the sliding glass doors on this hall need to be cleaned at the sliders, and all the locks should work properly for safety.During an interview on 1/22/26 at 9:15 am, with the Admin, the Admin stated, We need a new check list to include the sliding glass doors and tracks for the staff to follow to make sure this is done consistently.During an interview on 1/22/26 at 9:37 am, with the Environmental Supervisor (EVS), the EVS stated, I will change the check list and logs to add all the items that need to be cleaned regularly and for the deep cleaning to make sure these doors are included in the routine cleaning. I confirm the staff was not cleaning the door tracks because it is not on their list of duties. 6. During a concurrent observation and interview on 1/20/26 at 11:16 am, with Registered Nurse (RN) M, RN M confirmed the nurse's station sink area was unclean, with cumulative dust and debris. The wood molding on the left side of the station door was chipped and needed repair and paint. RN stated, I confirm this station needs some work, the flooring is also worn from the chairs we use in here.7. During a review of the facility's policy and procedure (P&P) revised 8/2010, titled, Cleaning and Disinfection of Environment, revised 8/2010, the P&P indicated environmental surfaces will be cleaned and disinfected according to current Center of Disease Control (CDC) recommendations for disinfection of healthcare facilities. Non-critical items (items that come in contact with intact skin but not mucous membranes). Non-critical environmental surfaces include bedrails, some food utensils, bedside tables, furniture and floors. Housekeeping surfaces (floors and tabletops) will be cleaned on a regular basis, when spills occur, and when these surfaces are visibly soiled. Environmental surfaces will be disinfected (or cleaned) on a regular basis, example three times per week) and when surfaces are visibly soiled.During an observation on 1/22/26 at 11:36 am, the Brio water fountain in the front lobby had a stained, unclean drain to this water fountain used by residents and the community.During an interview on 1/22/26 at 2:45 pm, with the Main, Main confirmed the water fountain had a stained water drain and was used by residents and the community. Main stated, We have hard water, but the filters are changed as required, I have the logs and the machine's light will come on when it needs to be changed. I will remove the drain and scrub it. There is no rust, there is a red button on the right side of the drain.

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to ensure that seven of eight sampled residents knew the correct procedure to file a grievance with the facility (Resident 1, Resident 19, Resident 22, Resident 23, Resident 25, Resident 39, Resident 45), three of the eight sampled residents were not informed of the findings of the investigations or any corrective actions that were taken for their grievances, (Resident 1, Resident 19, Resident 22), and three of the eight sampled residents stated that they were fearful of retaliation if they filed a grievance (Resident 22, Resident 39, and resident 45).This deficient practice had the potential for residents to be unaware or confused about the process for filing grievances, for grievances to be left uninvestigated or corrected, or residents not being informed of the actions taken for their grievances and for residents to have a concern of retaliation if they filed a grievance or complaint. During a record review of facility policy titled Investigating Grievances/Complaints dated 2001 MED-PASS indicated, Upon the receipt of a grievance and complaint report, [grievance officer] will begin an investigation into the allegations. The department director of an involved employee will be notified of the nature of the complaint and that an investigation is underway. The investigation and report will include, as each may apply: The date and time of the alleged incident; the circumstances surrounding the alleged incident; the location of the alleged incident; the names of any witnesses and their account of the alleged incident; the resident's account of the alleged incident; the employee's account of the alleged incident; accounts of any other individuals involved; and recommendations for corrective action. Facility policy further indicated The resident, or person acting in behalf of the resident, will be informed of the findings of the investigation, as well as any corrective actions recommended, within _____ working days of the filing of the grievance or complaint. Facility policy also indicated A copy of the ?Resident Grievance/Complaint Investigation Report Form' must be attached to the ?Resident Grievance/Complaint Form' and filed in the business office. Facility policy indicated Copies of all reports must be signed and will be made available to the resident or person acting in behalf of the resident. Resident 1 had a Brief Interview for Mental Status score of 15 (BIMS- a screening tool used to assist with identifying a residents current ability to think and reason. The total possible BIMS score ranges from 00-15; 13-15 is cognitively intact, 08-12 is moderately impaired, 00-07 is severely impaired).During a record review of Resident 1's admission record, she was admitted to the facility on [DATE] with diagnoses that included acute respiratory failure (life-threatening event where lungs rapidly fail to oxygenate blood or remove carbon dioxide, requiring emergency care), chronic obstructive pulmonary disease (COPD - a condition involving constriction of the airways and difficulty or discomfort in breathing), pneumonia (a lung infection causing the air sacs to fill with fluid or pus, leading to inflammation and making breathing difficult), and dependence on supplemental oxygen (use of oxygen provided by an oxygen tank supplied by a tube in the nostrils). During a record review of Resident 19's admission record, she was admitted to the facility on [DATE] with diagnoses that included unspecified dementia (progressive or persistent loss of intellectual functioning, especially with impairment of memory and abstract thinking, and often with personality change), nutritional deficiency (not getting enough calories), and glaucoma (eye disease that damages the optic nerve leading to vision loss and potential blindness). Resident 19 had a BIMS score of 05.During a record review of Resident 22's admission record, he was admitted to the facility on [DATE] with diagnoses that included congestive heart failure (a chronic condition where the heart muscle weakens and cannot pump enough oxygen-rich blood to meet the body's needs, causing blood and fluid to back up in the lungs, legs, and other parts of the body), myocardial infarction (heart attack), and abnormalities of gait and mobility (changes in normal walking patterns). Resident 22 had a BIMS score of 14.During a record review of Resident 23's admission record, she was admitted to the facility on [DATE] with (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	diagnoses that included osteoarthritis of the right and left knee (degenerative joint disease where the protective cartilage cushioning the ends of bones wears down over time), low back pain, and localized edema (swelling of a specific area of the body). Resident 23 had a BIMS score of 13.During a record review of Resident 25's admission record, she was admitted to the facility on [DATE] with diagnoses that included muscle weakness, seizures (a temporary disruption of normal brain activity caused by sudden, excessive electrical signals, leading to changes in awareness, behavior, sensation, or muscle control), and hyperlipidemia (high concentration of fats or lipids in the blood). Resident 25 had a BIMS score of 11.During a record review of Resident 39's admission record, she was admitted to the facility on [DATE] with diagnoses that included COPD, primary focal hyperhidrosis, and atrial fibrillation (a rapid, irregular heartbeat caused by chaotic electrical signals in the heart's upper chambers). Resident 39 had a BIMS score of 13.During a record review of Resident 45's admission record, she was admitted to the facility on [DATE] with diagnoses that included atrial fibrillation, dysphagia (difficulty swallowing), and difficulty in walking. Resident 45 had a BIMS score of 08.During an interview on 1/21/26 at 10:00 am, Resident 1 stated she went to the Administrator's office (Admin) and told him her concerns that pertained to Certified Nursing Assistant (CNA) H who was rough around the edges with her. Resident 1 stated she did not receive any feedback from Admin on how her concern was handled. Resident 1 stated she did not know how to file a grievance or where the forms were.During an interview on 1/21/26 at 10:00 am, Resident 19 stated CNA H bothered her and made her feel uncomfortable. Resident 19 stated she told Admin I his office, but did not hear back from him. Resident 19 stated she did not know how to file a grievance or where the forms were.During an interview on 1/21/26 at 10:00 am, Resident 22 stated the Director of Nursing (DON) was not kind, and he had a fear of retaliation from DON and CNA H if he mentioned his concerns to Admin. Resident 22 named CNA H by name to Admin but stated I never knew if he did anything about it. Resident 22 stated complaint process was to go to Admin's office or Social Service/Admission's (SS/Admit) office to verbally express any complaints or concerns. Resident 22 stated he did not know how to file a grievance or where the forms were.During an interview on 1/21/26 at 10:00 am, Resident 23 stated she asked CNA H for help with pulling her brief (adult diaper) past her knees when she sat on her toilet. Resident 23 stated her bathroom window was open. Resident 23 stated CNA H told her You need to do it yourself. Resident 23 stated it made her feel like she was alone and could not count on staff to help her when she needed help. Resident 23 stated she did not know how to file a grievance or where the forms were.During an interview on 1/21/26 at 10:00 am, Resident 25 stated she told Admin about her concerns about CNA H. Resident 25 stated she went to Admin's office to tell him CNA H was not nice to her and thought this was the complaint process. Resident 25 stated she did not know how to file a grievance or where the forms were.During an interview on 1/21/26 at 10:00 am, Resident 39 stated she was left on her toilet, cold, with her brief down below her knees because it was difficult to pull up past her knees. Resident 39 stated this made her feel humiliated. Resident 39 stated she told Admin, but she felt scared to push it any further because of fear of retaliation by CNA H and staff. Resident 39 stated she did not know how to file a grievance or where the forms were.During an interview on 1/21/26 at 10:00 am, Resident 45 stated she had concerns and complaints she would like to file with the facility but had a fear of retaliation from staff. Resident 45 stated she did not know how to file her concerns or complaints about the facility. Resident 45 stated she did not know how to file a grievance or where the forms were.During an interview on 1/21/26 at 11:41 am, Admin confirmed the facility did not have grievance forms available for the residents to access when they wanted to. Admin stated he developed his own complaint process for residents where they would come to his office, verbalize their complaint/concern, and if he felt their complaint/concern was a grievance, he would help them fill out a grievance form, or he would handle it himself. Admin confirmed there was no tracking of residents' complaints/concerns, interventions, or effectiveness of interventions. Admin confirmed he should have the grievance forms available for residents in case some wanted to remain anonymous. Admin stated the grievance form was difficult (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	for residents to fill out, and this was the reason he put the grievance forms in SS/Admit's office, and instead, used one line on his personal Daily Morning Meeting form (a form Admin created for his own personal use to keep track of his work) called Customer Service. Admin stated if a resident was unhappy, he would draw a mad face. Admin stated he would write down room numbers of residents on the Customer Service line to recall what he needed to follow up with, but admitted sometimes, he would forget what they needed. During an interview on 1/21/26 at 1:21 pm, SS/Admit stated she had a grievance binder in her office. SS/Admit confirmed the last grievance filed by a resident at the facility was on 7/22/24. SS/Admit stated this was because everyone's happy. SS/Admit stated she was not sure who the facility grievance officer was. SS/Admit stated she was not sure why residents used to give her grievances, but not anymore. SS/Admit stated she was unaware that residents went to Admin to complain and that he listed those complaints on his own personal form. SS/Admit confirmed residents deserved the right to file grievances and that the fear of retaliation by staff could be a fear of some of them.During an interview on 1/21/26 at 1:33 pm, DON confirmed SS/Admit was the facility grievance officer. DON confirmed residents went to Admin and SS/Admit and verbalized their concerns and complaints, but the investigations of those concerns or complaints were not documented or tracked. DON stated she was unaware Admin had his own personal form where he listed resident concerns. DON confirmed residents have the right to file a grievance. DON stated Admin should not pre-determine if a resident concern or complaint warranted a grievance. DON confirmed it was not the facility's place to be involved in whether a resident filed a grievance, or not. During an interview on 1/21/26 at 3:00 pm, Admin stated SS/Admit defined a grievance as something of a resident's was stolen or missing. Admin confirmed a grievance reason can be anything a resident wanted it to be. Admin confirmed facility needed to implement and allow access to the grievance process for residents. Admin confirmed it was a resident's right to file a grievance and have that grievance investigated and followed up on by facility. Admin confirmed facility had not followed its grievance policy and should have.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, and record reviews, the facility failed to report allegations of mistreatment, made by five of eight sampled residents (Resident 1, Resident 19, Resident 22, Resident 25, and Resident 39) to the appropriate local, state, and federal agencies nor were the residents informed of the progress of an investigation.This failure caused resident complaints/concerns of mistreatment by staff to go unreported with the potential of continued mistreatment, physical and/or psychosocial harm to residents. During a record review of facility policy titled Abuse Investigation and Reporting revision date 07/2017 indicated, All reports of resident abuse, neglect, exploitation, misappropriation of resident property, mistreatment and/or injuries of unknown source shall be promptly reported to local, state and federal (as defined by current regulations) and thoroughly investigated by facility management. Findings of abuse investigations will also be reported. Facility policy also indicated, The Administrator (Admin) will keep the resident and his/her representative informed of the progress of the investigation, and the Admin will suspend immediately any employee who has been accused of resident abuse, pending the outcome of the investigation. Facility policy further indicated, The Admin will ensure that any further potential abuse, neglect, exploitation or mistreatment is prevented.During a record review of Resident 1's admission record, she was admitted to the facility on [DATE] with diagnoses that included acute respiratory failure (life-threatening event where lungs rapidly fail to oxygenate blood or remove carbon dioxide, requiring emergency care), chronic obstructive pulmonary disease (COPD - a condition involving constriction of the airways and difficulty or discomfort in breathing), pneumonia (a lung infection causing the air sacs to fill with fluid or pus, leading to inflammation and making breathing difficult), and dependence on supplemental oxygen (use of oxygen provided by an oxygen tank supplied by a tube in the nostrils). Resident 1 had a Brief Interview for Mental Status score of 15 (BIMS- a screening tool used to assist with identifying a residents current ability to think and reason. The total possible BIMS score ranges from 00-15; 13-15 is cognitively intact, 08-12 is moderately impaired, 00-07 is severely impaired).During a record review of Resident 19's admission record, she was admitted to the facility on [DATE] with diagnoses that included unspecified dementia (progressive or persistent loss of intellectual functioning, especially with impairment of memory and abstract thinking, and often with personality change), nutritional deficiency (not getting enough calories), and glaucoma (eye disease that damages the optic nerve leading to vision loss and potential blindness). Resident 19 had BIMS score 05.During a record review of Resident 22's admission record, he was admitted to the facility on [DATE] with diagnoses that included congestive heart failure (a chronic condition where the heart muscle weakens and cannot pump enough oxygen-rich blood to meet the body's needs, causing blood and fluid to back up in the lungs, legs, and other parts of the body), myocardial infarction (heart attack), and abnormalities of gait and mobility (changes in normal walking patterns). Resident 22 had a BIMS score of 14.During a record review of Resident 23's admission record, she was admitted to the facility on [DATE] with diagnoses that included osteoarthritis of the right and left knee (degenerative joint disease where the protective cartilage cushioning the ends of bones wears down over time), low back pain, and localized edema (swelling of a specific area of the body). Resident 23 had a BIMS score of 13.During a record review of Resident 25's admission record, she was admitted to the facility on [DATE] with diagnoses that included muscle weakness, seizures (a temporary disruption of normal brain activity caused by sudden, excessive electrical signals, leading to changes in awareness, behavior, sensation, or muscle control), and hyperlipidemia (high concentration of fats or lipids in the blood). Resident 25 had a BIMS score of 11.During a record review of Resident 39's admission record, she was admitted to the facility on [DATE] with diagnoses that included COPD, primary focal hyperhidrosis, and atrial fibrillation (a rapid, irregular heartbeat caused by chaotic electrical signals in the heart's upper chambers). (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident 39 had a BIMS score of 13.During a record review of Resident 45's admission record, she was admitted to the facility on [DATE] with diagnoses that included atrial fibrillation, dysphagia (difficulty swallowing), and difficulty in walking. Resident 45 had a BIMS score of 08.During an interview on 1/21/26 at 10:00 am, Resident 1 stated she went to Admin's and told him her concerns that pertained to Certified Nursing Assistant (CNA) H who was rough around the edges with her and made her feel uneasy. Resident 1 stated CNA H did not speak nice to her or help her when Resident 1 requested help. Resident 1 stated she did not receive any feedback from Admin on how her concern was handled. During an interview on 1/21/26 at 10:00 am, Resident 19 stated CNA H bothered her and made her feel uncomfortable. Resident 19 stated she told Admin in his office but did not hear back from him.During an interview on 1/21/26 at 10:00 am, Resident 22 stated the Director of Nursing (DON) was not kind, and he had a fear of retaliation from DON and CNA H if he mentioned his concerns to Admin. Resident 22 named CNA H by name to Admin but stated I never knew if he did anything about it. Resident 22 stated complaint process was to go to Admin's office or Social Service/Admission's (SS/Admit) office to verbally express any complaints or concerns. During an interview on 1/21/26 at 10:00 am, Resident 23 stated she asked CNA H for help with pulling her brief (adult diaper) past her knees when she sat on her toilet. Resident 23 stated her bathroom window was open. Resident 23 stated CNA H told her You need to do it yourself. Resident 23 stated it made her feel like she was alone and could not count on staff to help her when she needed help. During an interview on 1/21/26 at 10:00 am, Resident 25 stated she told Admin about her concerns about CNA H. Resident 25 stated she went to Admin's office to tell him CNA H was not nice to her and thought this was the complaint process. During an interview on 1/21/26 at 10:00 am, Resident 39 stated she was left on her toilet, cold, with her brief down below her knees because it was difficult to pull up past her knees. Resident 39 stated this made her feel humiliated. Resident 39 stated she told Admin, but she felt scared to push it any further because of fear of retaliation by CNA H and staff. During an interview on 1/21/26 at 10:00 am, Resident 45 stated she had concerns and complaints she would like to file with the facility but had a fear of retaliation from staff, especially CNA H. During an interview on 1/21/26 at 11:10 am, Minimum Data Set/Director of Staff Development (MDS/DSD) stated CNA H sometimes yells down the hallway instead of using the walkie-talkie (a small portable radio set for receiving and sending messages) we have for staff. MDS/DSD confirmed she could understand how residents felt uneasy around CNA H. MDS/DSD stated she had never given CNA H any disciplinary actions because Admin and DON oversaw disciplinary actions for CNAs.During an interview on 1/21/26 at 11:41 am, Admin stated there were around four complaints a year in regard to CNA H's treatment of residents. Admin stated residents complained about how she spoke to them and how it made them feel disrespected. Admin stated residents also complained that she did not help them when they requested. Admin stated he did not enforce written disciplinary action with CNA H because he felt she was coachable. Admin confirmed a staff member was not coachable if she required four verbal disciplinary counseling sessions a year. Admin confirmed there was no tracking of residents' complaints/concerns, interventions, or effectiveness of interventions. Admin stated the grievance form was difficult for residents to fill out, and this was the reason he put the grievance forms in Social Service's (SS) office, and instead, used one line on his personal Daily Morning Meeting form (a form Admin created for his own personal use to keep track of his work) called Customer Service. Admin stated if a resident was unhappy, he would draw a mad face. Admin stated he would write down room numbers of residents on the Customer Service line to recall what he needed to follow up with, but admitted sometimes, he would forget what they needed. Admin confirmed residents came to his office all the time to verbalize their complaints/concerns about staff.During an interview on 1/22/26 at 11:35 am, Licensed Nurse (LN) K stated he spoke to CNA H about her communication with residents. LN K stated residents have complained that she was verbally aggressive towards them. LN K stated he spoke to DON in regard to CNA H's behavior a couple of times.During an interview on 1/22/26 at 12:01 pm, CNA A stated she had received resident complaints (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	in regard to how CNA H treated residents. CNA A stated CNA H was verbally aggressive and sometimes, physically rough with residents. CNA A stated residents told her they did not want CNA H to take care of them anymore. CNA A stated she told LN J about resident complaints in regard to CNA H. CNA A stated she felt facility could do a better job to protect the residents from being mistreated by staff. CNA A stated CNA H told residents You can do it. Do it yourself.During an interview on 1/22/26 at 11:57 am, LN J confirmed she had received complaints from residents in regard to how CNA H treated them. LN J stated the complaints regarded how CNA H was verbally aggressive and residents feeling mistreated. LN J stated CNA H told residents what to do. LN J confirmed residents have the right to refuse care and the right to refuse to do something. LN J stated she understood how a resident would likely refuse care if they felt like they were being mistreated by staff. LN J stated she told DON and Admin about resident complaints in regard to CNA H, and was told by both they would talk to them.During an interview on 1/22/26 at 12:06 pm, Assistant Director of Nursing (ADON) stated CNA H was verbally aggressive with residents and that it made the residents feel uncomfortable and not want to complete activities or get out of bed. ADON stated CNA H was blunt in how she communicates with residents.During an interview on 1/22/26 at 2:05 pm, Admin stated he felt CNA H's behaviors towards the residents were not abuse. Admin confirmed he did not report resident concerns and implement facility abuse investigation process because determined the resident complaints did not constitute abuse. Admin stated his definition of abuse meant cuts, bruises, scars, or injuries. Admin stated abuse is determined if SS/Admit, DON, or himself says it is. Admin stated if there was a suspicion of abuse, he initiated an investigation, but was not going to fill out an SOC 341 for every little thing (a mandatory California Department of Social Services form used by those legally required to report suspected child/elder abuse or neglect to authorities, to report suspected physical abuse, neglect, financial abuse, isolation, or abandonment of elders (age 65+) or dependent adults (ages 18-64). It must be submitted within two working days of a verbal report). Admin stated he did not feel CNA H was uncoachable because the DON told him that CNA H was a good aide. Admin stated his definition of a good aide was someone who completed their tasks, was not late, and smiled in interviews. Admin stated, I can identify with the residents and how they feel about [CNA H] because I once felt that way, but if I go and talk to them, and explain ?Hey, this is just how she is,' then they usually go ?Okay,' and it ends up being fine. During an interview on 1/23/26 at 8:32 am, SS/Admit stated abuse to her meant fiduciary (financial), physical, mental, sexual, and emotional distress. SS/Admit stated suspected abuse was investigated immediately. SS/Admit stated Admin decided if a resident's complaint/concern in regard to staff to resident treatment constituted abuse. SS/Admit stated Admin decided if an SOC 341 was filled out. SS/Admit confirmed facility did not follow its reporting policy and should have.During an interview on 1/23/26 at 9:32 am, DON stated abuse to her meant sexual, verbal, fiduciary, physical, and neglect. DON confirmed abuse should be determined by how staff treatment towards a resident made that resident feel. DON stated abuse allegations were handled by herself, SS/Admit, and Admin. DON confirmed SOC 341 was only filled out if she or Admin felt it needed to be. DON stated CNA H had been verbally counseled in regard to her treatment of residents and how her treatment made them feel. DON confirmed residents had complained about CNA H not being nice to them. DON stated she was unaware that Admin had verbally counseled CNA H multiple times. DON confirmed facility did not follow its reporting policy and should have.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure oxygen equipment was stored and dated per policy for two out of three sampled residents (Resident 1 and Resident 31) when the oxygen tubing for Resident 1 and Resident 31 was lying on their wheelchairs, uncovered and not dated.This failure had the potential to contaminate the oxygen tubing and cause an infection to the residents which could spread to other residents, staff, and visitors. Findings:During a review of the facility's policy and procedure (P&P) titled, Oxygen Storage and Use, dated 10/22/2010, the P&P indicated, to provide safe storage and use of oxygen. The oxygen cannula, mask etc. shall be changed when soiled. The cannula, mask, etc. shall be stored in a plastic bag when not in use. Logging and changing of oxygen shall be completed per facility policy.During a review of Resident 1's admission Record, dated 11/3/25, indicated Resident 1 was admitted to the facility on [DATE] with diagnoses that included acute and chronic respiratory failure (severe shortness of breath, rapid breathing that can be an emergency lasting short term or ongoing persistence of difficulty breathing), chronic pulmonary obstructive disease (COPD, a progressive lung disease that causes shortness of breath), pneumonia (common, often serious infection of one or both lungs from bacteria or a virus that inflames the air sacs), dependence of supplemental oxygen (no longer able to get enough air into the lungs for normal breathing), heart disease, diabetes (too much sugar in the blood), and neuralgia (painful nerve pain. During a review of Resident 1's most recent Minimum Data Set, (MDS, a resident assessment tool) for Resident 1 dated 11/13/25, the MDS indicated that Resident 1 had a brief interview for mental status (BIMS) score of 15 out of 15, which indicated Resident 1 had the mental capacity to make medical decisions.During a review of Resident 1"s Active Orders (AO), dated 12/22/25, the AO indicated Resident 1 was ordered Oxygen 3 liters (l) via nasal cannula (n/c, through the nose) day and night for shortness of breath and/or to maintain oxygen levels greater or equal to 90%.A review of Resident 1's Active Orders (AO), dated 12/22/25, the AO indicated indicated Resident 1 was ordered change oxygen and or nebulizer tubing every seven days and (date and label all components) every week, every Tuesday.During an observation on 1/20/26 at 8:55 am, Resident 1's oxygen tubing was lying on the back of her wheelchair, not covered or dated.During a review of Resident 31's admission Record, dated 6/4/18, indicated Resident 31 was admitted to the facility on [DATE] with diagnoses that included acute and chronic respiratory failure, COPD, diabetes, malaise (general fatigue, feeling unwell, lacking energy), neuralgia, depressive episodes (recurrent periods of sadness and loss of interest) and chronic pain (persistent pain lasting over 3 months).During a review of Resident 31's most recent Minimum Data Set, (MDS, a resident assessment tool) for Resident 31 dated 11/29/25, the MDS indicated that Resident 31 had a brief interview for mental status (BIMS) score of 10 out of 15, which indicated Resident 31 had a moderate cognitive (ability to think, reason, and problem solve) impairment. During a review of Resident 31's Active Orders (AO), dated 12/22/25, the AO indicated Resident 31 was ordered Oxygen 2 l via (n/c) for shortness of breath and/or to maintain oxygen levels greater or equal to 90% at bedtime while sleeping.A review of Resident 31's Active Orders (AO), dated 12/22/25, the AO indicated indicated Resident 31 was ordered Change oxygen and or nebulizer tubing every seven days and (date and label all components) every week, every Tuesday.During an observation on 1/20/26 at 8:57 am, Resident 31's oxygen tubing was lying on her wheelchair inside her red shoes, not covered or dated.During an interview on 1/21/26 at 8:22 am, with Registered Nurse (RN) M and Licensed Nurse (LN) J, RN M and LN J confirmed oxygen tubing not covered can cause an infection. RN M stated, We added oxygen tubing storage to the orders for [Resident 1] and [Resident 31] and moving forward it will be part of the admission process for all nurses to document in the record. We will add this order for oxygen storage when any resident is admitted or ordered oxygen. We are going to use the clear plastic bags for storage on the wheelchairs. The nurses will date and change as needed. During an interview on 1/21/26 at 9:00 am, with the (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Director of Nursing (DON), DON confirmed the oxygen tubing needed to be changed for Resident 1 and Resident 31 weekly and as needed and stored in a plastic bag with the date. The DON confirmed not following theses orders could cause an infection for Resident 1 and Resident 31 for not keeping the oxygen tubing stored in a clean plastic bag.

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observe each nurse aide's job performance and give regular training. Based on interview and record review, the facility failed to complete annual performance evaluations for four of five sampled Certified Nursing Assistants (CNAs - CNA C, F, G and H).This failure had the potential for direct care staff not to provide quality of care and meet the needs of the residents.During a record review of facility policy titled Performance Evaluations dated 2001 MED-PASS indicated, A performance evaluation will be completed on each employee at the conclusion of his/her 90-day probationary period, and at least annually, thereafter. The performance evaluation meeting will occur at the same time as the employee's compensation review. Facility policy further indicated Performance evaluations may be used in determining employee promotions, shift/position transfers, demotions, terminations, wage increased, etc., and to improve the quality of the employee's work performance.During a record review of CNA C's employment file, CNA C was hired on 9/14/22. CNA C did not have performance evaluations completed for 2024.During a record review of CNA F's employment file, CNA F was hired on 6/9/22. CNA F did not have performance evaluations completed for 2024.During a record review of CNA G's employment file, CNA G was hired on 5/5/05. CNA G did not have performance evaluations for 2024.During a record review of CNA H's employment file, CNA H was hired on 6/9/22. CNA H did not have performance evaluations for 2024.During a concurrent interview and record review with Administrator (Admin) on 1/21/26 at 11:41 am, CNAs' personal files were reviewed, the Admin confirmed CNA H did not have performance evaluations completed for 2024 and should have. Admin stated Minimum Data Set Nurse (MDS)/Director of Staff Development (DSD) was supposed to complete performance evaluations every year per facility policy.During a concurrent interview and record revie with MDS/DSD on 1/22/26 at 8:44 am, CNAs' personal files were reviewed. the MDS/DSD confirmed CNA C, F, G, and H did not have performance evaluations for 2024. MDS/DSD confirmed facility policy stated staff were supposed to have annual evaluations, and facility did not follow their policy.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 maintain the food preparation and service areas in a clean and sanitary condition, when the following was identified:A visibly dirty dishwasher.Visibly soiled fans, including an air-conditioning fan located in the pantry.Dirty hanging light fixtures with visible debris.Visibly soiled ceiling above cooking area.An open container of cheese without proper covering.Resident Refrigerator visibly soiled and holding expired items.This had the potential to contaminate food and place residents at risk for foodborne illness. 1.During a concurrent interview and record review on 1/23/26 at 10:20 a.m. with the Nutritional Services Director (NSD), the facility's policy and procedure titled Dishwashing Machine Operation, dated 2020, was reviewed. The NSD confirmed that the policy indicated the dishwashing machine was to be checked for cleanliness prior to the start of each meal service, wiped down per equipment cleaning procedures, and maintained free of built-up debris and lime scale as necessary. During a concurrent observation and interview, on 1/20/26, at 8:05 a.m., with the NSD, the dishwasher was observed to be soiled on the exterior, with lime scale stains noted on the front and sides of the machine. The NSD confirmed the dishwasher should have been wiped down prior to food service, in accordance with facility policy.2. During a review of the facility's policy and procedure titled Cleaning Instructions: Ceilings and Walls, dated 2020, the policy indicated ceilings were to be cleaned using a mild detergent with germicidal solution at least annually or as needed. Walls were to be cleaned daily to remove dirt, splatters, and food stains, and cleaned and sanitized at least monthly or as needed. In food preparation areas, walls were to be washed, rinsed, sanitized, and allowed to air dry.During a concurrent observation and interview, on 1/20/26, at 8:10 a.m., with the NSD, the air-conditioning unit cover located in the pantry was observed to be visibly dirty, with dust and debris present. A standing fan located next to the dishwasher was also observed to be visibly soiled, with food-like debris and dirt present. The NSD confirmed these items should not have been visibly soiled, in accordance with facility policy.3. During a review of the facility's policy and procedure titled Cleaning Instructions: Ceilings and Walls, dated 2020, the policy indicated ceilings were to be cleaned using a mild detergent with germicidal solution at least annually or as needed. Walls were to be cleaned daily to remove dirt, splatters, and food stains, and cleaned and sanitized at least monthly or as needed. In food preparation areas, walls were to be washed, rinsed, sanitized, and allowed to air dry.During a concurrent observation and interview, on 1/20/26, at 8:05 a.m., with the NSD, the light fixtures located over the cooking areas in the kitchen were observed to be visibly covered with dust. The NSD confirmed cleaning of the light fixtures was the responsibility of the Maintenance Department, and stated the fixtures had not been cleaned due to the type of light fixture.During an interview on 1/21/26, at 11:15 a.m., with Maintenance (MAIN), MAIN stated the light fixtures were fluorescent bulbs and were unable to be cleaned. MAIN stated there was a plan to replace the fluorescent bulbs with LED lighting and confirmed the parts were available but the replacement had not yet been completed. MAIN confirmed this is required to be in compliance with facility policy.4. During a concurrent observation and interview on 1/20/26 at 8:10 a.m. with NSD, in the kitchen above the stove, a bedpan was observed positioned to collect water leaking from the ceiling. Additionally, a lock and chain were observed over a pipe located directly above the cooking range; the pipe was visibly soiled with dust. NSD confirmed that cleaning of these areas is the responsibility of the maintenance department and stated that maintenance was aware of the issue and has been working on the leaking ceiling for several months. NSD further confirmed that these conditions had the potential to contaminate food and food-contact surfaces. During the observation, NSD immediately removed the bedpan, stating that it should not have been present in the food preparation area.During an interview on 1/21/2026 at 11:15 a.m. with MAIN, MAIN acknowledged that the lock and chain observed over the pipe located above the cooking range should be removed and that the pipe should be painted to allow for proper cleaning, in accordance with the facility's policy (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	related to maintenance and sanitation of the physical environment. MAIN further acknowledged awareness of the leaking ceiling and stated that attempts had been made to correct the issue, including repairs with sheetrock, and confirmed that maintenance had been addressing the leaking ceiling over an extended period of time.5. During an observation on 1/20/2026 at 8:05 a.m. during the initial kitchen tour, an open container of sliced cheese was observed in the kitchen refrigerator.During a concurrent interview and record review on 1/23/2025 at 10:00 a.m. with NSD, the facility's policy and procedure related to the storage of dairy products was reviewed. The policy indicated that refrigerated cheese is to be kept tightly packaged. NSD confirmed that the sliced cheese observed in the kitchen refrigerator on 1/20/2026 was not covered or stored in accordance with the facility policy.6. During a review of the facility's policy and procedure titled Refrigerators in Resident Rooms (Nurses Fridge), dated 2020, the policy indicated the facility was to monitor resident room refrigerators daily for temperature compliance, discard food items maintained outside acceptable temperature ranges or past their use-by date, discard leftover food after three days, and ensure refrigerators were cleaned and sanitized by housekeeping at least monthly or as required. During a concurrent observation and interview on 1/22/2026 at 3:00 p.m. with Assistant Director of Nursing (RN M), at the nurses' station while reviewing the resident food refrigerator used to store food brought in from outside the facility, the refrigerator was observed to be visibly dirty. RN M confirmed that the condition was not acceptable and that multiple food items observed were expired and should have been discarded after three days in accordance with facility policy.

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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 interview and record review, the facility failed to ensure accurate documentation of psychiatric (mental health) diagnosis in the medical records for one out of 30 sampled residents (Resident 6) based on standards of practice. This failure could lead to inaccurate treatment and monitoring of Resident 6's psychotropic (medications that affect mood or behavior) medication use.Review of Resident 6's medical record, titled Order Summary Report (a list of all doctor orders and medical conditions), dated 1/2026, the record indicated Resident 6 was on a medication called Seroquel (or quetiapine, a medication used to treat the mood and mental health issues) for bipolar disorder (a chronic mental illness that fluctuated between depression and anxiety) as follow: SEROquel Tablet 25 MG (quetiapine; MG means milligram, a unit of measure); Give 2 tablets by mouth at bedtime for Bipolar m/b (manifested by) manic episodes (mania means abnormally elevated, euphoric, or irritable mood, accompanied by intensely high energy and activity levels) . start date : 2/13/2025. Further review of the records indicated Seroquel originally was started on 9/13/23 about one month after admission to the facility and the dosage was increased on 2/13/25.Review of Resident 6's medical record, titled History and Physical (a summary of medical condition upon admission), dated 8/24/23, the record written by Medical Doctor 1 (MD 1), indicated okay to use hospital H&P from 8/24/23.Review of Resident 6's medical record, titled History and Physical (a summary of medical conditions written by a medical doctor) from hospital upon admission to the facility, dated 8/24/23, the record did not include any reference to diagnosis of bipolar disorder.Review of a Resident 6's medical record for a neuropsychiatric consultation (a medical specialist for mental and brain health), dated 9/5/23, the record indicated the diagnosis of Lewy Body dementia (a type of memory loss leading to fluctuations in cognitive function, visual hallucinations, movement issues similar to Parkinson's, and sleep disruptions), epilepsy (or seizure, a surge in brain activity), and parkinsonism (nerve damage affecting body movement and tremors). The record did not include bipolar disorder. The neuropsychiatric doctor started Seroquel on September of 2023.Review of Resident 6's electronic medical record under Medical Diagnosis section, on 1/22/26, indicated Bipolar Disorder, Current Episode manic without Psychotic Feature, Mild, Created date: 9/13/23; Classification: During Stay.Review of the Resident 6's medical record, titled Medication Administration Record (or MAR), dated 1/2026, the record on nurses' behavior monitoring for manic episodes indicated no manic behaviors were documented during day and evening shifts. The MAR did not define what specific behavior the nursing staff should have monitored.Review of Resident 6's Care Plan Report (a nursing plan of care), dated 1/2026, the document written by facility's social worker, indicated The resident has a behavior problem OF MANIC BEHAVIOR, CONFABULATING STORIES r/t (related to) BIPOLAR DX (DX means diagnosis). The plan of care interventions indicated to Administer medications as ordered. Monitor/document for side effects and effectiveness. The care plan did not address what type confabulation stories nursing staff were dealing with.In an interview with Certified Nurse Assistant N (CNA N), on 1/22/26, at 8:40 AM, CNA N stated Resident 6 was easy to work with, pleasant, cooperative and had not seen her being aggressive. CNA N stated Resident 6 mostly stayed in her room and when she went to dine, she preferred to sit with two specific residents.In an interview with Licensed Nurse J (LN J), on 1/22/26, at 9:05 AM, LN J stated Resident 6 wanted things her way and often resisted change. LN J stated Resident 6 often felt being abandoned by her family and they were ignoring her. LN J stated Resident 6 was not aggressive.In an interview with Patient 6, in her room, on 1/22/26, at 8:45 AM, Patient 6 stated it was hard for her to live after her husband passed away and she missed him. Resident 6 didn't know much about the medication she was taking.In an interview with Director of Nursing (DON), in her office, on 1/22/26, at 10:50 AM, the DON stated Resident 6 had repeatedly expressed wishes to die and currently is on comfort care based on her wish and her sister who regularly visited her in the facility. The DON could not comment on documentation of diagnosis and monitoring of mania behavior in the medical record. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The DON stated the mental health evaluation and regular psychotherapy visit was facilitated by the facility.In an interview with Medical Doctor 1 (MD 1), on 1/22/26, at 1:48 PM, MD 1 stated the mental health issues were pre-existing and upon admission a neuropsychiatric evaluation was performed. MD 1 stated the family, and her sister may know better the history of mental illness prior to admission to the facility. MD 1 stated Resident 6 may have had two episodes of low-level mania that may have contributed to the bipolar diagnosis. MD 1 acknowledged the initial neuropsychiatric consult did not address the bipolar diagnosis.Review of the facility's policy, titled Antipsychotic Medication Use, dated 4/2007, the policy indicated Residents will only receive antipsychotic medications when necessary to treat specific conditions for which they are indicated and effective. The attending physician and other staff will gather and document information to clarify a resident's behavior, mood, function, medical condition, symptoms and risks. Attending physician and facility staff will identify acute psychiatric episodes and will differentiate them from enduring psychiatric conditions. Nursing staff will document in detail an individual's target symptoms. The attending physician will identify evaluate and document with input from other disciplines and consultant as needed, symptoms that may warrant the use of antipsychotic medications .The review of the American Psychiatric Association (APA, a nationally recognize mental health organization which establishes the authoritative standards for mental health diagnoses) practice guidelines, titled The American Psychiatric Association Practice Guidelines for the Psychiatric Evaluation of Adults, dated 8/2015, last accessed via https://psychiatryonline.org/doi/epdf/10.1176/appi.ajp.2015.172050, the guideline indicated proper diagnosis involves assessing psychiatric symptoms, medical health, and the patient's social and cultural context, as well as their functional impairment.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to ensure accurate documentation and ongoing pain assessment for one of five residents reviewed for unnecessary medication use (Resident 31).This failure had the potential for unsafe mediation use and risk of adverse effects from opioid use including difficulty breathing and mental confusion. Findings: During a review of Resident 31's medical record indicated that Resident 31 was admitted to the facility on [DATE] with diagnoses that included respiratory failure (a serious condition where the lungs can't pump enough oxygen into the blood), chronic obstructive pulmonary disease (COPD - a progressive lung disease that restricts airflow, making it difficult to breath), diabetes (blood sugar disease), in addition to chronic pain. During a record review of the Resident 31's Order Summary Report, dated 1/2026, the record indicated the following pain medication orders: Morphine Sulfate . Oral Solution 20 MG/ML (opioid pain medication; MG/ML is milligram per milliliter, a measure of strength); Give 0.25 ml (ml is milliliter, a measure of volume) by mouth every 4 hours as needed for Mild Pain Hold for RR<12 (RR means respiratory rate- or breathing rate) AND Give 0.5 ml by mouth every 4 hours as needed for Moderate Pain Hold for RR<12 AND Give 0.75 ml by mouth every 4 hours as needed for Severe Pain Hold for RR<12; Start date 09/19/25 Norco Oral Tablet 5-325 MG (Hydrocodone-Acetaminophen, combination pain medication with opioid); Give 1 tablet by mouth every 12 hours for Chronic Pain . Hold for RR<12; Start date: 5/23/24The Norco order did not prompt the nursing staff to document pain level with each dose administered.During a review of Resident 31's electronic medical record under Pain Level Summary, with a date range of 10/24/25 to 1/21/26, indicated that Resident 31's pain was a 0 (no pain) on a scale of 0 to 10 (excruciating pain) every day. During a review of Resident 31's electronic medical record under Post Fall Review, dated 12/17/25, indicated that Resident 31 had a history of falls. The review did not identify narcotics as a medication that may have contributed to the fall. During an interview on 1/22/26 at 8:52 am with Resident 31, Resident 31 was laying in bed in their room and confirmed that they do have pain every day. Resident 31 stated the pain can range from an 8 to a 10 on a scale of 0 to 10. Resident 31 stated that their pain can be in her feet, lower back, and finger. During an interview with Licensed Nurse (LN) J, on 1/22/26 at 9:04 am, LN J stated Resident 31 will let nursing staff know if pain medication is needed. LN J confirmed that they did not check Resident 31's pain level when opioid pain medication was administered. LN J could not explain why Resident 31 was documented with a pain level of 0 every day for the past two months. During an interview on 1/22/26 at 9:28 am with the Director of Nursing (DON), the DON stated that for any scheduled pain medication staff only needed to assess pain once a shift. The DON stated the interdisciplinary team (IDT - healthcare team) was responsible for addressing pain management issues and recurrent falls episodes. The DON confirmed that at the last IDT meeting on 11/23/25 for Resident 31, they did not discuss pain management, and they should have assessed recurrent falls along with opioid medication use. During a review of the facility policy titled Pain Assessment and Management, dated 10/2010 indicated that a comprehensive pain assessment should be conducted upon admission., at the quarterly review, whenever there is a significant change in condition, and whenever there is a new onset of pain or worsening of existing pain. Monitor the residents' pain by performing a basic assessment with enough detail. If pain symptoms have resolved or there is no longer an indication for pain medication, the multidisciplinary team and physician shall try to discontinue or taper pain medications to the extent possible.

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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure safe use and accountability of narcotic controlled medication (opioid drugs of abuse) use when: Resident 46's Norco (a combination opioid pain medication) was removed from the Controlled Drug Record (CDR - an accountability sheet that tracked narcotic removal with nurse initial, date, and time) without the corresponding documentation in the Medication Administration Record (MAR - a legal document where nursing staff documented medications given to residents). This failure had the potential to contribute to unsafe drug handling, poor pain control, and risk of drug diversion (drug loss). Findings:During a review of Resident 46's medical record indicated that Resident 46 was admitted to the facility on [DATE] with diagnoses that included arthritis, chronic pain, and diabetes (blood sugar disease). A review of Resident 46's MAR, dated 1/2026, indicated the following order for pain management: Norco. take one tablet by mouth every four hours as needed.; Start date 12/11/25. During a record review of Resident 46's CDR for Norco pain medication, with the date range of 12/20/25 to 1/20/26, the CDR record listed Norco removal for PRN (as needed) use. A comparative review of Resident 46's CDR and MAR for the same time period, indicated the following:1/7/26 at 1600 (4:00 pm); no MAR documentation 1/9/26 at 2140 (9:40 pm); no MAR documentation 1/15/26 at 1500 (3:00 pm); no MAR documentationThe record indicated Norco removal from the CDR with no corresponding documentation in the MAR. During a concurrent interview and record review with the Director of Nursing (DON) on 1/22/26 at 12:31 pm, the DON confirmed that Norco removal documentations were missing from the MAR on 1/7/26, 1/9/26, and 1/15/26 and it should have been documented in the MAR to match the CDR. During review of the facility policy titled Administering Medications, dated 12/2012 indicated when an individual administers a medication, they must initial the residents MAR on the corresponding line after it is given before giving the next medication.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056274	A. Building B. Wing	01/23/2026

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview and record review, the facility failed to ensure safe storage of medication and supplies with a census of 52 residents when:Medication room refrigerator stored expired and discontinued medications, and the refrigerator temperature was not monitored twice daily for vaccine storage.Medication cart stored undated and expired medications. These failures had the potential to contribute to unsafe medication use and risk of ineffective medications reaching vulnerable residents in the facility. Findings: 1a. During a concurrent inspection of facility main medication room accompanied by the Assistant Director of Nursing (ADON), on 1/20/26 at 9:23am, the following issues were noted: a. a bag of Vancomycin (antibiotic in injection form) had expired on 1/1/26. b. an open vial of Tuberculin Purified Protein Derivative Solution (PPD - testing agent for tuberculosis a dangerous lung disease) dated 9/11/25. The manufacturer label on the vial indicated that the vial should be discarded 30 days after being opened. The ADON acknowledged the findings and stated that outdated medications should have been removed from active medication storage areas. 1b. Review of the monitoring log of the medication refrigerator temperature, posted on the refrigerator door, dated 1/2026, the log indicated the refrigerator temperature was monitored and recorded once a day. The medication refrigerator was storing vaccines. The ADON stated they were not aware of twice daily temperature monitoring and documentation for storing vaccines in the medication refrigerator. 2.During a concurrent inspection of medication cart on the facility's south hall, on 1/20/26 at 2:27 pm, accompanied by Licensed Nurse (LN) J. The following were noted: a. Three bottles of unopened eye drop medication called Latanoprost (drug for eye disease) when the drug label on the bottle indicated to keep refrigerated until opened. b. One bottle of eye drop medication Latanoprost had an open date of 11/6/25 when the medication label indicated to discard the eye drops six weeks after it had been opened. c. Four bags of DuoNeb (drug used to help with breathing difficulties) were opened, out of foiled wrap and did not have an open date. Manufacturer label indicated the medication was to be discarded two weeks after opening. d. One Insulin Glargine (long-acting drug for blood sugar disease) pen had an open date of 12/8/25 when the manufacturer label indicated to discard 28 days after being opened. e. One bottle of Acidophilus with Pectin (probiotic used to help with gut health) was opened and stored in the medication cart when the label on the bottle indicated to keep refrigerated after opening. LN J acknowledged the findings and stated the staff should have been more vigilant with reading the medication storage labeling. During a concurrent interview and record review on 1/22/26 at 9:28 am with the Director of Nursing (DON), the DON confirmed that Latanoprost needed to be stored in the refrigerator until opened and follow the manufacture beyond use date of six weeks after being opened. The DON stated Insulin needed to be discarded 28 days after being opened per the manufacturer label. The DON stated the nursing staff should have followed manufacturing labeling to keep Acidophilus with Pectin refrigerated once opened. The DON stated DuoNeb should have been dated once opened and out of the foil wrap per drug manufacturer instruction. During a review of the facility policy titled Storage of Medication, dated 4/2007, the policy indicated the facility shall not use discontinued, outdated, or deteriorated drugs. all such drugs shall be returned to the dispensing pharmacy or destroyed. Medications requiring refrigeration must be stored in a refrigerator. Review of the Center for Disease Control (or CDC, a federal agency with mission to protect public health) guideline, titled Vaccine Storage and Handling Toolkit; Vaccines Storage and Handling Information dated 3/29/24, last accessed on 1/27/26 via https://www.cdc.gov/vaccines/hcp/downloads/storage-handling-toolkit.pdf , the document indicated Checking and recording minimum/maximum temperatures at start of each workday . Reviewing and analyzing temperature data at least weekly for any shifts in temperature trends. The document further indicated Check and record storage unit minimum and maximum temperatures at the (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	start of each workday. If your TMD (Temperature Monitoring Device) does not read minimum/maximum temperatures, then check and record the current temperature a minimum of two times per workday (at the start and end of the workday).During a review of the facility policy titled Administering Medications, dated 12/2012 indicated that when opening a multi-dose container, the date opened shall be recorded on the container.

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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. Based on observation, interview and record review the facility failed to ensure compliance with infection prevention practices with census of 52 residents when:1. Blood Pressure (or BP, the force of blood pushing against the walls of arteries as the heart pumps it around the body) device cuff was not cleaned after Resident 46 use.2. The pill cutter stored in the medication cart had white powder like residues inside the device.These failed practices could contribute to unsafe care and spread of infection in the facility.Findings:1. During a medication administration observation, in South hall, accompanied by Licensed Nurse J (LN J), on 1/20/26, at 8:33 AM, LN J took up a blood pressure device into the Resident 46 room. LN J wrapped the BP cuff around Resident 46's arm and measured the blood pressure. LN J upon exit from the room, placed the BP device/cuff on where two other BP cuffs hanging on the side of the mobile medication cart. LN J did not clean the BP cuff and continued with medication administration.In an interview with LN J, in the South hall, on 1/20/26, at 8:55 AM, LN J stated the BP cuff should have been cleaned after each use in between residents. 2. During a medication cart inspection, in the South hall, accompanied by LN J, on 1/20/26, at 2:27 PM, the shared pill cutter device had significant amount of white powder and dust inside the device. LN J stated the pill cutter was shared and used to splitting the pills when needed. LN J stated the pill cutter should have been cleaned after each use. In an interview on 1/22/26 at 9:45 AM, the Director of Nursing (DON) stated that staff should have followed infection prevention practices when cleaning shared patient care devices like BP cuffs and pill cutters. BP cuffs should have been cleaned with Sani-wipes (purple) after each use, staying wet for about 2 minutes. A second cuff should be used alternately. BP cuffs must be cleaned immediately and kept separate from clean ones. The DON also noted that pill cutter dust must be wiped to prevent cross-contamination.Review of the facility's policy, titled Infection Control Guidelines for All Nursing Procedures, dated 4/2013, the policy indicated Standard Precautions will be used in the care of all residents in all situations, regardless of suspected or confirmed presence of infectious diseases. Standard precautions apply to blood, body fluids, secretions and excretions regardless of whether or not they contain visible blood, non-intact skin and/or mucous membranes.Review of the facility's policy, titled Administering Medications, dated 12/2012, the policy under Infection Control Practices indicated Staff shall follow establish facility infection control procedures (handwashing, antiseptic techniques, gloves, isolation precaution, etc.) for the administration of medication, as applicable.