

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056281	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/09/2025
NAME OF PROVIDER OR SUPPLIER Foundation Skilled Nursing		STREET ADDRESS, CITY, STATE, ZIP CODE 925 North Cornelia Fresno, CA 93706	
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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide adequate supervision to prevent accidents for one of seven residents (Resident 17) when Resident 17 was assessed with poor safety awareness, did not use safe techniques in self-transfers, had unsteady gait, and suffered multiple falls on 11/18/25, 11/22/25, 11/23/25 and 11/24/25. Resident 17 had been determined as high risk for falls on quarterly assessment dated [DATE]. The facility failed to follow its facility's policy and procedure (P&P) titled, Falls and Fall Risk, Managing, when the facility did not implement effective interventions to prevent falls, including adequate supervision, addressing the cause of frequent self-transferring attempts and reviewing medication for a possible cause consistent with Resident 17's needs, goals and care. The facility failed to follow their policy and procedure titled, Red Sneaker Program (Fall Monitoring/Prevention) when the facility developed a plan to monitor residents every 15 minutes and was not accurately implemented by nursing staff in accordance with Resident 17's comprehensive care plan and the level of monitoring should have been changed to level 3 monitoring with direct supervision. These failures resulted in Resident 17 sustaining four unwitnessed falls on 11/18/25, 11/22/25, 11/23/25, and 11/24/25. During the fall on 11/24/25, Resident 17 was sent out to the acute care hospital due to severe pain in her right hip and inability to bear weight to right leg and was diagnosed with Periprosthetic fracture around internal prosthetic right hip (a broken bone around a hip replacement). During hospitalization, Resident 17 had a surgical procedure ORIF (open reduction internal fixation (is surgery used to stabilize and heal a broken bone) right femur (right thigh bone). Resident 17 experienced a significant change of condition after the fall on 11/24/25, suffered avoidable pain, injury to the right thigh, decreased mobility and decreased quality of life. Findings: During a concurrent observation and interview on 12/2/25 at 9:20 a.m. with Resident 17, in Resident 17's room, Resident 17 was awake, lying in bed with a white sheet covering her body. Resident 17's bed was at standard height position and wheelchair was parked beside Resident 17's left side of the bed. Resident 17 was alert and oriented and able to state her name. Resident 17 was able to recall her recent fall on 11/24/25. Resident 17 stated she fell in her room and went to acute care hospital. Resident 17 stated she fell while walking around the room and stated the fall happened in the morning. After the fall, Resident 17 stated she had no broken bones and showed her right arm with a dried skin tear. Resident 17 stated she is aware of her need to use the bathroom, and she was unable to walk by herself to go to the bathroom. Resident 17 stated, not easy to move my leg. Resident 17 stated she had a bandage on her right leg. Resident 17 stated she had shoulder discomfort and receiving pain medication, and stated, just feel sore here (pointing to right shoulder). During a review of Resident 17'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 12/8/25, the AR indicated, Resident 17 was initially admitted to the facility on [DATE] with diagnoses which included Alzheimer's Disease (a brain disorder that slowly destroys memory and thinking skills, and eventually, the ability to carry out the simplest tasks), Chronic Obstructive Pulmonary Disease (COPD- a chronic (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 0689 Level of Harm - Actual harm Residents Affected - Few	initiated date 8/7/23, Interventions/Tasks: Tasks Assistive device wheelchair, bed mobility; requires supervision assistance with bed mobility; Eating: requires set-up assistance; resident is ambulatory walk 10 feet -supervision; Toileting: resident requires supervision assistance w/toileting; Transfer: resident requires supervision assistance w/transfers initiated date 8/7/23 revision on 8/8/25. The RNS indicated had a decline in oral intake in the past week with multiple refusals and some 0-25 percent of oral intake. The RNS stated Resident 17's ADLs care plan indicated Resident 17 requires supervision with bed mobility, walking, transfers and toileting. The RNS stated Resident 17 had a decline in physical functioning and nutrition when she returned from the acute care hospital on [DATE]. The RNS stated Resident 17's care plan should be revised according to Resident 17's significant change of condition. The RNS stated Resident 17's ADLs care plan should reflect current level of function for staff to follow safely. During an observation on 12/5/25 at 7:45 a.m.-8:00 a.m. with Resident 17, in Resident 17's room, Resident 17 was lying asleep in bed. There were no staff who went to Resident 17's room to check Resident 17. During concurrent interview and record review on 12/5/25 at 10:45 a.m. with the RNS, Resident 17's Electronic Medical Records (EMR- a digital version of a patient's paper chart) titled Risk for Fall Assessment, dated 11/18/25, 11/22/25, and 11/24/25, and Quarterly Fall Assessments dated 11/1/23 and 2/1/24 were reviewed. The Risk for Fall Assessments indicated, .13i. Total score greater than 10 resident is considered at risk for falls: 11 13j. At risk for falls: Yes. The Quarterly Fall Assessments indicated, high fall risk score of 13. The RNS stated Resident 17's fall risk assessment scores were 11 which indicated risk for falls and 13 which indicated Resident 17 was high risk for falls. The RNS stated Resident 17 had an impaired safety awareness and unsteady gait that placed her at increased risk of falling. During concurrent interview and record review on 12/5/25 at 11:00 a.m. with the RNS, Resident 17's SBAR (Situation-Background-Assessment-Recommendation) post Fall, dated 11/18/25, 11/22/25, and 11/24/25 were reviewed. The SBAR post Fall, dated 11/18/25, indicated, .S. Situation 1. Prior to fall resident was a. Ambulating 2. Location in center: c. Hallway 5. Adaptive Equipment at time of fall: d. None 6. Footwear at time of fall b. Bare feet. B. Background 3. Fall Risk Factors: a. History of falls .10. Fall type b. Unwitnessed 10a. Fall Details a. Lost Balance. The SBAR post Fall, dated 11/22/25 indicated, .S. Situation 1. Prior to fall resident was i. Other: putting her slippers on 2. Location in center: a. Resident room [ROOM NUMBER]. Adaptive Equipment at time of fall: d. None 6. Footwear at time of fall b. Slipper s. B. Background 3. Fall Risk Factors: a. History of falls 10. Fall type b. Unwitnessed 10a. Fall Details d. Roll/slid out of bed. The SBAR post Fall, dated 11/24/25 indicated, .S. Situation 1. Prior to fall resident was b. Attempt to self-transfer 2. Location in center: a. Resident room. 5. Adaptive Equipment at time of fall: d. None 6. Footwear at time of fall b. Bare feet. Fall type b. Unwitnessed 10a. Fall Details a. Lost Balance. The RNS stated SBAR was also called a change in condition assessment. The RNS stated Resident 17's SBAR post fall dated 11/18/25, 11/22/25, and 11/24/25 were all unwitnessed falls and had identified risks factors of falling. During concurrent interview and record review on 12/5/25 at 11:20 a.m. with the RNS, Resident 17's Progress Note, dated 11/18/25, 11/22/25, 11/23/25, and 11/24/25 were reviewed. The Progress Note, dated 11/18/25, indicated, at 3:30 a.m. found resident sitting on the floor . The Progress Note, dated 11/22/25, indicated, Approximately 11:00 a.m. patient is sitting on the floor. The Progress Note, dated 11/23/25, indicated, at begin of shift, approximately 1405. was sitting on floor . The Progress Note, dated 11/24/25, indicated, Around 2:30 a.m. the CNA heard a loud thud. found resident on the floor . The RNS stated Resident 17 had been falling on the scheduled 15-minute check on 11/18/25, 11/22/25, and 11/24/25. The RNS stated the level 2 monitoring is an intervention for the facility's fall program. The RNS stated the facility's fall program (Red Sneaker Program) should be reviewed by Interdisciplinary Team (IDT) to prevent falls. The RNS stated Resident 17 level 2 monitoring was not effective, and she should be on level 3 monitoring (one on one) to prevent further falls and minimize fall related injuries. During an interview on 12/5/25 at 1:50 p.m. with CNA 6, CNA 6 stated Resident 17 had an episode of agitation (a feeling of irritability, mental distress or severe restlessness) on (continued on next page)		

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F 0689 Level of Harm - Actual harm Residents Affected - Few	were programs to mitigate the falls. During an interview on 12/9/25 at 2:48 p.m. with CNA 8, CNA 8 stated she was the assigned CNA for Resident 17, and she was responsible in doing 15-minute check when Resident fell on [DATE] at 2:30 a.m. CNA 8 stated on 11/24/25 around 2:30 a.m., she heard a loud sound coming from another room while she was performing care for one of her residents. CNA 8 stated she went to Resident 17's room and found her on the floor. CNA 8 stated Resident 17 was one of the residents in her group assignment. CNA 8 stated she could not do every 15-minute check for Resident 17 while providing care to other residents. CNA 8 stated Resident 17 fall could be prevented if 15-minute check was done timely and consistently. CNA 8 stated Resident 17, being a fall risk with behaviors, unsafe transfers and ambulation without calling for assistance, should be on level 3 monitoring. CNA 8 stated Resident 17 needs one-on-one supervision. During a review of Resident 17's Progress Note, dated 11/18/25 and 11/24/25 were reviewed. The Progress Note dated 11/18/25, indicated, S/P (status post) fall, Screen performed interviewed pt and staff members regarding pt's fall, findings of poor safety awareness and decline in functioning. Therapy to assess. The Progress Note dated 11/24/25, indicated, Attempt for screen made s/p fall however pt is currently at hospital, screen to be complete once pt returns. During a review of facility's policy and procedure (P&P) titled, Falls and Fall Risk, Managing, undated, the P&P indicated, Based on previous evaluations and concurrent data, the staff will identify the interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling. Fall Risk Factors 2. Resident conditions that may contribute to the risk of falls include. c. cognitive impairment, 6. Lower extremity weakness, g. medication side effects, i. functional impairments, .k. incontinence. 3. Medical Factors that contribute to the risk for falls include: a. arthritis; b. heart failure; c. anemia; d. neurological disorders; and e. balance and gait disorders; Resident-Centered Approaches to Managing Falls and Fall Risk 1. The IDT team in collaboration with the attending physician, will implement a resident-centered fall prevention plan to reduce the specific risk factor(s) of falls for each resident at risk or with a history of falls. 2. If a systematic evaluation of a resident's fall risk identifies several possible interventions, the staff may choose to prioritize interventions (i.e., to try one or a few at a time, rather than many at once.) 3. Examples of initial approaches might include exercise and balance training, a rearrangement of room furniture, improving footwear, changing the lightning, etc. 4. In conjunction with the consultant pharmacist and nursing staff, the attending physician will identify and adjust medications that may be associated with an increased risk of falling or indicate why those medications could not be tapered or stopped, even for a trial period. 5. If falling recurs despite initial interventions, staff will implement additional or different interventions or indicate why the current approach remains relevant. 6. If underlying causes cannot be readily identified or correct, staff will try various interventions, based on assessment of the nature or category of falling, until falling is reduced or stopped, or until the reason for the continuation of the falling is identified as unavoidable e. 7. In conjunction with the attending physician, staff will identify and implement relevant interventions (e.g., hip padding or treatment of osteoporosis, as applicable) to try to minimize serious consequences of falling. Monitoring Subsequent Falls and Fall Risk - 1. The staff will monitor and document each resident's response to interventions intended to reduce fall or the risk of falling. 2. If the resident continues to fall, the staff will re-evaluate the situation and decide whether it is appropriate to continue or change current interventions. As needed, the attending physician will help the staff reconsider possible causes that may not previously have been identified. During a review of facility's P&P titled, Red Sneaker Program (Fall Monitoring/Prevention) undated, the P&P indicated, Our facility strives to make the environment as free from accident hazards as possible. Resident safety and supervision and assistance t		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to follow policy and procedures to meet professional standards of quality for one of four sampled residents (Resident 64), when Resident 64's admission medications were not available on the next dose as ordered by the physician. Resident was admitted to the facility on [DATE]. These failures had the potential to place Resident 64 at an increased risk of health complications and change of condition resulting in hospitalization. Findings: During a concurrent observation and interview on 12/2/25 at 10:02 a.m. with Resident 64, in Resident 64's room, Resident 64 was awake lying in bed. Resident 64 was alert oriented x 4 (refers to someone who is alert and oriented to person, place, time and event). Resident 64 stated she was admitted from acute care hospital to the facility a couple of days. Resident 64 stated she fell at home and broke her pelvis. Resident 64 stated she had not received her medication since she came to the facility because she did not bring her medical card. During a review of Resident 64's Minimum Data Set (MDS - a resident assessment tool used to identify cognitive [mental processes] and physical functional level assessment), MDS section C -Cognition Assessment was not completed. During a concurrent interview and record review on 12/5/25 at 9:27 a.m. with Registered Nurse Supervisor (RNS), Resident 64's progress notes titled, Orders-Administration Note, dated 12/2/25, 12/3/25, and 12/4/25 were reviewed. The Orders-Administration Note, indicated, .12/2/25 Folic Acid (is used prevent anemia, and support cell growth) pending delivery . Bumetanide (is a type of diuretic or water pill. It helps ease fluid buildup (or edema) in adults with heart failure, liver problems like cirrhosis, and kidney problems) pending delivery. Diltiazem Extended Release (treat high blood pressure and chest pain) pending delivery. Sertraline (use to treat depression [persistent feelings of sadness, despair, loss of energy, and difficulty dealing with normal daily life]) pending delivery. Rifaximin pending delivery. Lactulose (is the first-line treatment used to prevent and treat hepatic encephalopathy (HE), a serious neurological complication of liver cirrhosis [a condition in which the liver is scarred and permanently damaged]) pending delivery faxed pharmacy. 12/3/25 Rifaximin (used to treat liver cirrhosis) pending delivery not available e-kit (emergency kit for medications). Gabapentin(used to treat nerve pain) pending delivery not available e-kit. 12/4/25 Rifaximin pending authorization. The RNS stated Resident 64's admission medications should be available on the next dose according to physician's orders. The RNS stated Resident 64's medications were ordered by the physician based on Resident 64's medical condition to prevent any complications to Resident 64. During a review Resident 64'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 12/8/25, the AR indicated, Resident 64 was admitted to the facility on [DATE] with diagnosis of End Stage Renal Disease, (a condition where the kidneys can no longer function on their own and dialysis [a process of removing excess water, and waste products from the blood] or kidney transplant is required to survive), chronic kidney disease (a condition when the kidneys suddenly are unable to filter waste products from the blood), multiple fractures (broken bones)of pelvis, Alcoholic Cirrhosis of the Liver (permanent scarring that damages the liver and interferes with its functioning), anemia (disease that occurs when the body doesn't have enough red blood cells to carry oxygen), essential (primary) hypertension (abnormally high blood pressure [the amount of force the heart uses to pump blood through the arteries] that is not the result of a medical condition), type 2 diabetes mellitus (when the blood sugar levels in the body are too high), and major depressive disorder(a mental health disorder characterized by persistently depressed mood or loss of interest in activities). During a review of Resident 64's Order Summary Report, dated 12/8/25, indicated, .Pharmacy: Bumetanide 2 mg (milligram- metric unit of measurement, used for medication dosage and/or amount) give 2 tablets one time a day related to chronic kidney disease.Folic Acid 1 mg give 1 tablet one time a day dietary supplement. Diltiazem (continued on next page)		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	HCL Extended Release 240 mg give 1 capsule one time a day related to Essential Hypertension. Lactulose 20mg/30ml (milliliter -a standard metric unit of volume used to measure liquid medications) give 30 ml three time a day related to Alcoholic Cirrhosis of the Liver.Rifaximin 550 mg give 550 mg two times a day related to Alcoholic Cirrhosis of the Liver; Sertraline HCL100 mg give 1.5 tablet one time a day related to Major Depressive DisorderDuring an interview on 12/9/25 at 2:10 p.m. with Licensed Vocational Nurse (LVN) 3, LVN 3 stated medications should be available as soon as possible, on next dose due for the residents to prevent a change of condition. LVN 3 stated the facility's current pharmacy delivery was taking longer to deliver the medications and stated there was delay in medication delivery. LVN 3 stated a delay in medication delivery can result in late administration of medications.During a telephone interview on12/9/25 at 2:15 p.m. with the Pharmacy General Manager of Operation (PGMO), the PGMO stated it was not acceptable for medication not available for the residents. The PGMO stated the pharmacy had multiple deliveries to provide the medications for the residents. The PGMO stated medications it was her expectation that medications should be available the next dose ordered. The PGMO stated she needed to investigate the cause of delay in delivery of Resident 64's medications.During a concurrent interview and record review on 12/9/25 at 2:39 p.m. with the RNS, Resident 64's Electronic Medication Administration Record (EMAR- an electronic daily documentation record used by a licensed nurse to document medications and treatments given to a resident) dated 12/2025 was reviewed. The EMAR indicated, . Rifaximin 550 mg give 550 mg two times a day related to Alcoholic Cirrhosis of the Liver on 12/1/25, 12/2/25, 12/3//25, 12/4/25, 12/6/25, and 12/7/25 at 0800 and 1700, indicated 11. The RNS stated the #11 in Resident 64 EMAR indicated medication not available. The RNS stated Resident 64's Rifaximin medication should be available to manage and treat Resident 64's medical condition of cirrhosis of the liver and can potentially result in complications when not received by Resident 64.During a review of Resident 64's care plan report dated 12/2/25, the care plan report indicated, .Hemodialysis Care Plan at risk for complications fluid volume/deficit.Diuretic Med Care Plan Requires the use of diuretic therapy related to cirrhosis of liver, hypertension.Interventions: Administer medication as ordered.Liver Disease Care Plan at risk for abdominal pain and swelling, blood stool related to Cirrhosis. Interventions: Administer medication as ordered.At risk for hypotension(abnormally low blood pressure)/Hypertension related to Hypertension.Interventions: Administer antihypertensive or other medications as ordered.Antidepressant Care plan use for Drug: Sertraline. Interventions: Give antidepressant medications ordered by physician.During an interview on 12/9/25 at 3:40 p.m. with the Director of Nursing (DON), the DON stated Resident 64 was a new admitted resident. The DON stated new admission residents should have their medications available the next day or the next dose for the residents to receive their medications on time especially. The DON stated licensed nurses can access the e-kit for antibiotics and pain medications. The DON stated it was her expectation that all medications must be available to the residents based on physician's orders. The DON stated it was her expectation for the pharmacy to deliver the medications on time for the licensed nurses to administer medications as ordered. The DON stated it was important for residents to receive their medication as ordered by the physician to prevent complications to the residents.During a review of the facility's policy and procedure (P&P) titled, Administering Medications, dated 4/2019, the P&P indicated, Medications are administered in a safe and timely manner, and as prescribed. 4. Medications must be administered in accordance with the orders, including any required time frame.During a review of facility's P&P titled, Medication Services, dated 6/1/24, the P&P indicated, The Community provides medication ordering and medication assistance/administration services. i. Pharmacy identification will be selected as part of the intake process. b. All pharmacies are requested to meet the following minimum quality standards: .ii. Have the ability to provide twenty-four (24) hour emergency service including delivery of medications seven (7) days a week.		

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to employ sufficient staff with appropriate competencies and skills sets to carry out the functions of food and nutrition services for two of two kitchen staff, Dietary [NAME] (DC)1 and Dietary Manager (DM) when DC1 and DM did not follow the menu at lunch on 12/3/25. This failure had the potential to result in residents nutritional needs not being met. During a concurrent observation and interview on 12/3/25 at 12:30 p.m. with DC1 and DM in the Kitchen, DC1 was preparing a lunch with a croissant sandwich with turkey breast, fresh tomatoes, cheddar cheese, regular bacon, and lettuce. DC1 prepared two garlic bread sticks instead of one. DC1 stated the menu for the lunch sandwich was not followed. DC1 stated, she used what food she had available in the facility and she had informed the DM. DM stated she forgot to order the correct ingredients for the croissant sandwich. DC1 stated, she served two garlic bread sticks instead of one. During a review of the facility's menu titled, TURKEY CROISSANT DELUXE SANDWICH 20Z, dated 12/3/25, the menu indicated, croissant sandwich ingredients included lettuce, oven roasted [NAME] tomatoes, pickled red onions, turkey breast, sliced cheddar cheese, mozzarella, bacon onion marmalade and avocado. During a review of the facility's diet spreadsheet titled, Fall25 Foundation, dated 12/3/25, the diet spreadsheet indicated, . LUNCH. HOMESTYLE BREAD.1. SLICE GARLIC BREAD. During an interview on 12/9/25 at 11:05 a.m. with the Registered Dietician (RD), the RD stated DM forgot to buy the correct ingredients for the croissant sandwich and used whatever available ingredients they had in the kitchen. The RD stated DC1 got nervous, and she gave two bread sticks instead of one. The RD stated the purpose of the menu is to provide nutritionally balanced diet for the residents'. The RD stated if the menu was not followed it would not meet the residents' nutritional needs. The RD stated the kitchen staff did not follow the correct menu. The RD stated kitchen staff should have used a substitute menu instead of omitting the ingredients. During a review of the facility's policy and procedure (P&P) titled, Meal Service, dated 2023, the P&P indicated, Meals that meet nutritional needs of the resident will be served in an accurate and efficient manner. The menus are planned to meet nutritional needs of residents in accordance with established national guidelines, Physician's order and, to the extent medically possible, in accordance with the most recent recommended dietary allowances of the Food and Nutrition Board of the National Research Council National Academy of Sciences. Menus are to be approved by the Facility Registered Dietician prior to the beginning of each quarterly menu cycle.		

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to employ sufficient staff with appropriate competencies and skills sets to carry out the functions of food and nutrition services for two of two kitchen staff, Dietary [NAME] (DC)1 and Dietary Manager (DM) when DC1 and DM did not follow the menu at lunch on 12/3/25. This failure had the potential to result in residents nutritional needs not being met. During a concurrent observation and interview on 12/3/25 at 12:30 p.m. with DC1 and DM in the Kitchen, DC1 was preparing lunch with croissant sandwich with turkey breast, fresh tomatoes, cheddar cheese, regular bacon, and lettuce. DC1 prepared two garlic bread sticks instead of one. DC1 stated the menu for the lunch sandwich was not followed. DC1 stated she used what food she had available in the facility and she had informed the DM. DM stated she forgot to order the correct ingredients for the croissant sandwich. DC1 stated she served two garlic bread sticks instead of one. During a review of the facility's menu titled, TURKEY CROISSANT DELUXE SANDWICH 20Z, dated 12/3/25, the menu indicated, croissant sandwich ingredients included lettuce, oven roasted [NAME] tomatoes, pickled red onions, turkey breast, sliced cheddar cheese, mozzarella, bacon onion marmalade and avocado. During a review of the facility's diet spreadsheet titled, Fall25 Foundation, dated 12/3/25, the diet spreadsheet indicated, . LUNCH. HOMESTYLE BREAD.1. SLICE GARLIC BREAD. During an interview on 12/9/25 at 11:05 a.m. with the Registered Dietician (RD), the RD stated DM forgot to buy the correct ingredients for the croissant sandwich and used whatever available ingredients they had in the kitchen. The RD stated DC1 got nervous and she gave two bread sticks instead of one. The RD stated the purpose of the menu is to provide nutritionally balanced diet for the residents. The RD stated if the menu was not followed it would not meet the residents' nutritional needs. The RD stated the kitchen staff did not follow the correct menu. The RD stated the kitchen staff should have used a substitute menu instead of omitting the ingredients. During a review of the facility's policy and procedure (P&P) titled, Meal Service, dated 2023, the P&P indicated, Meals that meet nutritional needs of the resident will be served in an accurate and efficient manner. The menus are planned to meet nutritional needs of residents in accordance with established national guidelines, Physician's order and, to the extent medically possible, in accordance with the most recent recommended dietary allowances of the Food and Nutrition Board of the National Research Council National Academy of Sciences. Menus are to be approved by the Facility Registered Dietician prior to the beginning of each quarterly menu cycle.		

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to follow-up with a positive Preadmission screening and Resident Review (PASARR-a federal requirement to ensure residents with mental disorder or intellectual disorder or intellectual disabilities are not inappropriately placed in a nursing home) level I screening for one of five sampled residents (Resident 7) when Resident 7's PASARR level I screening dated 4/8/25 required PASARR Level II mental health evaluation and was not completed. This failure had the potential for Resident 7 to not receive the appropriate services related to her mental disorders. During a concurrent observation and interview on 12/2/25 at 11:06 a.m during initial tour in the doorway of Resident 7's room, Resident 7 was standing outside of room, dressed appropriately and stated she liked to keep her door closed. Resident 7 stated she did not have any issues and staff are good to her. Resident 7 was observed ambulating in the hallway with steady gait. During a review of Resident 7's admission Record [AR-a document containing resident profile information], dated 12/5/25, the AR indicated Resident 7 was admitted to the facility on [DATE] with diagnoses which included bipolar disorder (sometimes called manic-depressive disorder, mood swings that range from the lows of depression to elevated periods of emotional high), schizoaffective disorder (mental disorder that can affect thoughts, mood, and behavior), anxiety (excessive and persistent worry, fear, or panic that is difficult to control and interferes with daily life) and dementia (a progressive decline in mental abilities). During a review of Resident 7's Minimum Data Set (MDS- a resident assessment tool used to identify resident cognitive and physical function), dated 10/2/25, the MDS section C indicated Resident 7 had a Brief Interview for Mental Status (BIMS-assessment of cognitive status for memory and judgment) assessment score of 3 out of 15 (a score of 13-15 indicates cognitively intact, 08-12 indicates moderately impaired, and 00-07 indicates severe impairment, 99 indicates unable to complete the interview), which indicated Resident 7's cognition was severely impaired . During a review of Resident 7's Notice of PASARR Level I Screening Report dated 4/8/25. The Notice of PASARR Screening Result indicated, .A Serious Mental Health Illness (SMI) Level II Mental Health Evaluation is Required . During a review of Resident 7's Notice of Attempted Evaluation dated 4/12/25, the Notice of Attempted Evaluation indicated, . UNABLE TO COMPLETE LEVEL II EVALUATION FOR SERIOUS MENTAL ILLNESS (SMI) . Facility staff were unresponsive to two or more separate attempts of communication within 48 hours of the level I screening . During a concurrent interview and record review on 12/4/25 at 2:05 p.m. with the Infection Preventionist (IP), Resident 7's clinical record was reviewed. The IP stated Resident 7 was admitted with psychotropic medication and are monitored for episodes of mania. The IP stated Resident 7's PASARR level I dated 4/8/25 was positive and needed a PASARR level II assessment. The IP stated PASARR level II was incomplete and should have been followed up and it was not. During a concurrent interview and record review on 12/5/25 with Minimum Data Set Coordinator (MDSC) 1, Resident 7's clinical document titled PASARR was reviewed and stated Level II should have been followed up and completed another Level I assessment. MDSN 1 stated she did not know who received PASARR Level II and filed in Resident 7's record without reviewing. MDSN 1 stated it was important to follow-up on the PASARR in order for facility to know what type of services and needs Resident 7 needed to address her behavior. During an interview on 12/9/25 at 12:30 p.m. with the Director of Nursing (DON), the DON stated her expectation was to make sure PASARR are reviewed for accuracy and complete another assessment if needed. The DON stated the MDSN, business office manager, medical records and admission director are all responsible in making sure there was a PASARR completed and reviewed for accuracy prior to admission of resident to the facility. During a review of facility document titled, Job Description: MDS Coordinator, dated 1/29/25, the Job Description indicated, .Coordinates the development and completion of resident assessment (MDS) in accordance with (continued on next page)		

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	current federal and state rules, regulations, and guidelines that govern the resident assessment . Facilitates the involvement of appropriate health professionals needed to improve or maintain the resident's functional abilities at the highest practicable level . During a review of facility's policy and procedure (P&P) titled, Resident Assessment - Coordination with PASARR Program, dated 2022, the P&P indicated, .All applicants to this facility will be screened for serious mental disorders or intellectual disabilities and related condition in accordance with the State's Medicaid rules for screening . The Social Service Director or designee shall be responsible for keeping track of each resident's PASARR screening status, and referring to the appropriate authority . Any level II resident who experiences a significant change in status will be referred promptly to the state mental health or intellectual disability authority for additional resident review . During a review of professional reference from the California Department of Health Care Services (DHCS) (a government agency that provides healthcare services to low-income and disabled Californians) titled, Preadmission Screening and Resident Review, undated, (found at https://www.dhcs.ca.gov/services/MH/Pages/PASRR.aspx), the reference indicated .The (DHCS), PASRR Section is responsible for determining if individuals with serious mental illness (SMI) and/or intellectual/developmental disability (ID/DD) or related conditions (RC) require: Nursing facility services, considering the least restrictive setting, Specialized services. This is achieved by completing the PASRR process. The PASRR process consists of a Level I Screening, Level II Evaluation, and a final Determination. Level I Screening-The Screening is submitted online by the facility and is a tool that helps identify possible SMI and/or ID/DD/RC. Level II Evaluation- If the Screening is positive for possible SMI and/or ID/DD/RC, then a Level II Evaluation will be performed. The Level II Evaluation helps determine placement and specialized services. The Department of Health Care Services (DHCS) is responsible for SMI Level II Evaluations, which by law must be performed by a third-party contractor		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide pharmaceutical services which ensured appropriate administration of medications to meet residents needs when:1.The facility Refrigerator Emergency-kit (E-kit-contains medications provided to residents during emergency situations) containing three vials of insulin (used for high blood sugar level) was opened and no form was found indicating the date and name of person who opened the E-kit and no communication to pharmacy requesting for a replacement. This failure placed residents receiving insulin at potential risk for taking expired or compromised medications which could lead to serious consequences including reduced effectiveness in treating resident's condition in an event of an emergency and potential adverse reaction.2.Marianne1. During a concurrent observation and interview on [DATE] at 8:05 p.m. in the medication room with Infection Preventionist (IP), Refrigerator E=kit was found with red tags. The IP stated Red tag means it was already opened. The IP stated she can not find a form completed when the E-kit was opened. The IP stated whoever opened the E-kit did not complete the form. The IP stated she was not sure when the E-kit was opened and what medication was taken. The IP stated she was not sure how soon should the pharmacy send a replacement once an E-kit was opened. During an interview on [DATE] at 9:35 a.m. with Licensed Vocational Nurse (LVN) 2, LVN 2 stated the practice when opening an E-kit was to complete the form that was usually with the E-kit with your name, date and medication taken and fax to pharmacy. LVN 2 stated she was not sure when pharmacy should send a replacement but it should be as soon as possible in case a medication from the E-kit was needed for emergency situations. LVN 2 stated E-kit have green tags when it was not opened and red tag once it was already opened. LVN 2 stated she checked the refrigerator in the morning prior to her morning medication pass but did not check the E-kit if it was opened. LVN 2 stated she did not open the E-kit and did not know who opened it because there was no form found. During an interview on [DATE] at 3:50 p.m. with Registered Nurse Supervisor (RNS), the RNS stated she did not know who opened the refrigerator E-kit because there was no form found. The RNS stated the practice was to complete the form when opening the E-kit then fax the form to pharmacy to let them know it was opened and a replacement was needed. The RNS stated the expectation was to get a replacement the same day in case of emergency situation when a medication was needed and was not available because the pharmacy did not replaced the E-kit. During an interview on [DATE] at 12:30 p.m. with the Director of Nursing (DON), the DON stated her expectation was to have the E-kit replaced the same day it was opened. The DON stated there was a form needed to be completed when opening an E-kit then fax pharmacy. The DON stated she was not sure when the E-kit was opened and how long it has been opened since there was no form completed. The DON stated there was no medicine missing from the E-kit and not sure why it was opened. The DON stated not sure if medication was tampered with or was replaced with another medication which could lead to potential serious health condition. During a review of facility (pharmacy[Omnicare]) policy and procedure (P&P) titled, Emergency Medication Supplies (Emergency Kits), revised date [DATE], the P&P indicated, Facility staff breaking the lock or tamper evident seal on the emergency kit should replace the lock with a tamper-evident lock or seal provided by the pharmacy and located in the emergency kit . record the name of the nurse who accessed the emergency kit, the date and time the e-kit was accessed . To indicate the emergency kit was opened by the facility staff and replacement of the box or replenishment of removed doses is needed, the tamper-evident lock or seals provided by the pharmacy may be a different color than the original one placed by the pharmacy . Fax the eKIT Withdrawal Communication form to the pharmacy. Retain the white copy in the facility files and place the duplicate yellow copy inside the tray from which the medication was removed .		

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the medication error rate was less than five percent when the facility's medication error rate was eight percent. There were 25 opportunities for errors and two medication errors occurred for one of five sampled residents (Resident 2) when: 1. Licensed Vocational Nurse (LVN) 1 prepared an expired medication of five tablets of Folic Acid (is used prevent anemia, and support cell growth) 1 mg (milligram- metric unit of measurement, used for medication dosage and/or amount) with an expiration date of 11/5/25 on 12/4/25. LVN 1 did not check the expiration date of the medication prior to medication administration. 2. Resident 2 did not receive the full dosage of inhaler (a small, handheld medical device that delivers medicine as a mist or spray directly to the lungs for treating respiratory conditions like asthma and chronic obstructive pulmonary disease [COPD- a chronic lung disease causing difficulty in breathing]) medication Tiotropium Bromide Monohydrate (is used for the treatment of breathing problems in patients with COPD). It is a specific type of dry powder inhaler (DPI- device designed to deliver tiotropium medication to the lungs in a powder form; a maintenance bronchodilator helps to keep narrowed airways open) when Resident 2 received one inhalation of the inhaler medication on 12/4/25. These failures resulted in a medication error for Resident 2 and the potential for Resident 2 to consume an expired medication and to experience shortness of breath. Findings: 1. During an observation and interview on 12/4/25 at 8:52 a.m. with LVN 1, outside Resident 2's room, LVN 1 was preparing Resident 2's 8:00 a.m. medications on the top of the medication cart. LVN punched five tablets of Folic Acid 1 mg from Resident 2's medication card into the medicine cup. LVN 2 prepared the rest of Resident 2's morning medications and ready to crush each medication. LVN 2 was preparing to crush Resident 2's five tablets of Folic Acid 1 mg, nurse surveyor asked LVN 1 the expiration date of the medication Folic Acid 1 mg. LVN 1 opened the medication cart, took the medication card containing Resident 2's Folic Acid mg, was looking for where she could find the expiration date on the medication label. LVN 1 checked Resident's 2's Folic Acid 1 mg and indicated an expiration date of 11/5/25, stated, it was expired. LVN 1 stated Resident 2's medication card containing Folic Acid 1 mg had been used and had been expired since 11/5/25. LVN 1 showed and given Resident 2's medication card containing the expired Folic Acid 1 mg to the Director of Nursing (DON). During a concurrent interview and record review on 12/4/25 at 2:20 p.m. with LVN 1, Resident 2's Electronic Medication Administration Record (EMAR- an electronic daily documentation record used by a licensed nurse to document medications and treatments given to a resident), dated 12/2025 was reviewed. The EMAR indicated, .Folic Acid 1 mg give 5 tablets by mouth one time a day related to Anemia order date 10/14/25. LVN 1 stated she was not checking the expiration dates of medications she was preparing during the medication pass on 12/4/25. LVN 1 stated Resident 2's medication card containing Folic Acid 1 mg was not checked on 12/4/25. LVN 1 stated Resident 2's medication card containing Folic Acid 1 mg had been used and had been expired. LVN 1 stated Resident 2's expired Folic Acid 1 mg five tablets had been administered to Resident 2 if not asked by nurse surveyor to check the expiration date. LVN 1 stated Resident 2 had the potential to experience side effects when expired medications were consumed. LVN 1 stated that expired medication will not be effective. During a review of Resident 2's Order Summary Report, dated 12/9/25, indicated, .Folic Acid 1 mg give 5 tablets by mouth one time a day related to Anemia (a condition where the body does not have enough healthy red blood cells) order date 10/14/24 During a record review of Resident 2's admission Record (AR), dated 12/9/25, the AR indicated Resident 2 was admitted to the facility on [DATE] with diagnosis of Anemia. During a review of Resident 2's Minimum Data Set (MDS - a resident assessment tool used to identify cognitive [mental processes] and physical functional level assessment), dated 10/9/25, the MDS section C indicated Resident 2 had a Brief Interview for Mental Status (BIMS - a test given by medical professionals to determine cognitive understanding on a scale of 1-15) score of (continued on next page)		

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4 (a score of 0-7 suggests severe cognitive impairment, 8-12 suggests moderately impaired, 13-15 suggests cognitively intact), which suggested Resident 2 was severely cognitively impaired. During an interview on 12/9/25 at 10:54 a.m. with the DON, Resident 2's medication card containing the expired Folic Acid 1 mg was checked and validated on 12/4/25. The DON stated Resident 2's medication card containing the expired Folic Acid 1 mg had been used with an expiration date of 11/5/25. The DON stated Resident 2's expired medications had the potential to cause side effects to Resident 2. The DON stated expired medication was not as effective and does not work well with the residents. The DON stated it was her expectation for all licensed nurses to check the expiration date of medications prior to administering the medication to prevent medication error. During a review of the facility's policy and procedure (P&P) titled, Administering Medications, dated 4/2019, the P&P indicated, Medications are administered in a safe and timely manner, and as prescribed. 4. Medications must be administered in accordance with the orders, including any required time frame. 10. The individual administering the medication must check the label THREE (3) times to verify the right resident, right medication, right dosage, right time and right method (route) of administration before giving the medication. 12. The expiration/beyond use date on the medication label is checked prior to administering. During a review of the professional reference (PR), found on https://www.ncbi.nlm.nih.gov/books/NBK519065/ an article titled, Medication Dispensing Errors and Prevention, dated 2/12/24, the PR indicated, .Types of Medication Errors: Prescribing, Omission, Wrong time, Unauthorized medication, Improper dose, Wrong dose prescription or wrong dose preparation, Administration errors such as incorrect route of administration, administering the drug to the wrong patient, extra dose, or wrong rate, Monitoring errors such as failing to take into account the patient's liver and renal function, failing to document allergy or potential for drug interaction, Compliance errors such as not following protocol or rules established for dispensing and prescribing medications. 2. During an observation and interview on 12/4/25 at 9:08 a.m. with LVN 1, outside Resident 2's room, LVN 1 was preparing Resident 2's inhaler medications on the top of the medication cart. LVN 2 was trying to figure out how to put the capsule of the inhaler medication Tiotropium Bromide Monohydrate into the inhaler device. LVN 1 asked the DON how to prepare the inhaler medication and stated she did not receive training about the inhaler medication Tiotropium Bromide Monohydrate. During an observation on 12/4/25 9:10 a.m. with LVN 1, in Resident 2's room, LVN 1 administered 1 inhalation of medication Tiotropium Bromide Monohydrate to Resident 2. During an observation and interview on 12/4/25 at 9:15 a.m., LVN 1 signed Resident 2's EMAR. LVN 1 stated she signed Resident 2's EMAR indicating she administered all morning medications including the inhaler medication Tiotropium Bromide Monohydrate. LVN 1 checked the label of Resident 2's inhaler medication Tiotropium Bromide Monohydrate and stated she mistakenly administered 1 inhalation of Resident 2's inhaler medication Tiotropium Bromide Monohydrate. During a concurrent interview and record review on 12/4/25 at 2:20 p.m. with LVN 1, Resident 2's EMAR, dated 12/2025 was reviewed. The EMAR indicated, .Tiotropium Bromide Monohydrate Inhalation capsule. 1 capsule inhale orally one time a day related to COPD one capsule inhaled via two inhalation and rinse mouth after inhalation. start date 5/30/25. LVN 1 stated she administered 1 inhalation of Resident 2's inhaler medication Tiotropium Bromide Monohydrate. LVN 1 stated she did not follow the physician's order of two inhalations and stated it was a medication error. LVN 1 stated Resident 2 should receive two inhalations for the medication to be effective. LVN 1 stated Resident 2 did not receive the full dosage of the inhaler medication and placed Resident 2's at risk for difficulty in his breathing. LVN 1 stated Resident 2 had a diagnosis of COPD. During an interview on 12/9/25 at 10:54 a.m. with the DON, the DON stated it was her expectation for all licensed nurses to follow the physician's order when administering medications to prevent medication error and residents will receive the full effectiveness of the prescribed medications. The DON stated Resident 2 did not receive a full dose of the inhaler medication Tiotropium Bromide Monohydrate and stated it was a medication error. The DON stated Resident 2 had the potential to experience shortness of breath when not receiving the full (continued on next page)		

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	dosage of the inhaler medication Tiotropium Bromide Monohydrate. During a record review of Resident 2's admission Record (AR), dated 12/9/25, the AR indicated Resident 2 was admitted to the facility on [DATE] with primary diagnosis of Chronic Obstructive Pulmonary Disease (COPD-a chronic lung disease causing difficulty in breathing).During a review of Resident 2's Minimum Data Set (MDS - a resident assessment tool used to identify cognitive [mental processes] and physical functional level assessment), dated 10/9/25, the MDS section C indicated Resident 2 had a Brief Interview for Mental Status (BIMS - a test given by medical professionals to determine cognitive understanding on a scale of 1-15) score of 4 (a score of 0-7 suggests severe cognitive impairment, 8-12 suggests moderately impaired, 13-15 suggests cognitively intact), which suggested Resident 2 was severely cognitively impaired.During a review of Resident 2's Order Summary Report, dated 12/9/25, indicated, .Tiotropium Bromide Monohydrate Inhalation capsule.1 capsule inhale orally one time a day related to COPD one capsule inhaled via two inhalation and rinse mouth after inhalation. start date 5/30/25.During a review of the facility's policy and procedure (P&P) titled, Administering Medications, dated 4/2019, the P&P indicated, Medications are administered in a safe and timely manner, and as prescribed. 4. Medications must be administered in accordance with the orders, including any required time frame.10. The individual administering the medication must check the label THREE (3) times to verify the right resident, right medication, right dosage, right time and right method (route) of administration before giving the medication. 12. The expiration/beyond use date on the medication label is checked prior to administering.During a review of the professional reference (PR), found on https://www.ncbi.nlm.nih.gov/books/NBK519065/ an article titled, Medication Dispensing Errors and Prevention, dated 2/12/24, the PR indicated, .Types of Medication Errors: Prescribing, Omission, Wrong time, Unauthorized medication, Improper dose, Wrong dose prescription or wrong dose preparation, Administration errors such as incorrect route of administration, administering the drug to the wrong patient, extra dose, or wrong rate, Monitoring errors such as failing to take into account the patient's liver and renal function, failing to document allergy or potential for drug interaction, Compliance errors such as not following protocol or rules established for dispensing and prescribing medications.		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview and record review the facility failed to ensure proper storage and disposal of medications and biologicals in accordance with facility policy and procedures when in side 1's medication cart, Resident 17 and Resident 45's discontinued bottles of Chlorhexidine Gluconate (antimicrobial mouthwash used to treat gingivitis (gum disease) was observed not separated from medications that were in use for facility residents. This failures had the potential for medications to be administered causing underdosing or overdosing of medications, or to be administered to the wrong residents causing harm to the resident. During a concurrent observation, interview and record review on 12/4/25 at 9:27 a.m. with Licensed Vocational Nurse (LVN) 1 in side 1's medication cart. Two bottles of Chlorhexidine Gluconate was observed with active medications. LVN 1 stated the medication were for Resident 17 and Resident 45. LVN 2 stated she did not know whether Resident 17 and Resident 45 were still given the medication because she did not administer the medication. Resident 17 and Resident 45's electronic medical administration record were reviewed. LVN 2 stated Resident 17's medication was ordered for 14 days only and was administered from 11/14/25 to 11/27/25 and a one time order administered on 11/28/25. LVN 2 stated Resident 45's chlorhexidine medication was ordered for 14 days only and medication was administered from 11/14/25 to 11/27/25. LVN 2 stated Resident 17 and Resident 45's medications should have been pulled out of the medication cart because they were no longer active medications. LVN 2 stated all discontinued and expired medications should be pulled out of the medication cart right away to prevent administering to residents and to prevent medication error. During a review of Resident 17's Physician Order (PO) Resident 17's PO indicated chlorhexidine gluconate start date 11/14/25 and an end date 11/28/25, Give 15 ml (milliliter-unit of measurement) orally every evening shift for gum irritation for 14 days. During a review of Resident 45's electronic medication administration (eMAR-digital system that replaces paper charts to streamline and secure the process of giving medications to patients) dated 11/1/25-11/30/25. The eMAR indicated, .Chlorhexidine Gluconate Mouth/Throat Solution . Give 15 ml orally for 14 days . chlorhexidine was administered daily from 11/14/25-11/27/25. During an interview on 12/5/25 at 2:50p.m. with the Registered Nurse Supervisor (RNS), the RNS stated all discontinued medications should be removed from the medication cart immediately because they are no longer active orders. The RNS stated separating discontinued and expired medications from active medications to prevent using medication which could lead to medication error. During an interview on 12/9/25 at 1:45 p.m. with the Director of Nursing (DON), the DON stated all discontinued medications should be removed from the medication because they are no longer active medication. The DON stated regarding Resident 17 and Resident 45's chlorhexidine medication, licensed nurse could have contacted the medical doctor to continue to give the medication once the order was completed. During a review of facility policy and procedure (P&P) titled Disposal/Destruction of Expired or Discontinued Medications, revision date 7/18/17, the P&P indicated, . Once an order to discontinue a medication is received, Facility staff should remove the medication from the resident's medication supply . Facility should place all discontinued or out-dated medications in a designated, secure location which is solely for discontinued medications or marked to identify the medications are discontinued and subject to destruction .		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observation, interview, and record review, the facility failed to maintain an effective infection prevention and control program to provide a safe and sanitary environment for two of four sampled residents (Residents 33 and 64) when: 1. Certified Nursing Assistant (CNA) 5 did not wear appropriate personal protective equipment (PPE- specialized clothing, equipment, and supplies worn by healthcare workers protect residents and themselves from potential infectious hazards) when CNA 5 provided direct care to Resident 33 who was on enhanced barrier precaution (EBP- measures used in healthcare settings to prevent the spread of infections) for a known history of Extended Spectrum Beta-Lactamase (ESBL- are a group of bacteria that commonly cause infections both in healthcare settings and communities) producing bacterial infection/colonization on 12/3/25. 2. Housekeeping Staff (HS) 1 used one pair of the same gloves when Resident 64 and Resident 64's roommate's blankets were touched and covered to respective residents on 12/2/25. These failure had the potential for CNA 5 and HS 1 to cause cross contamination (the physical movement or transfer of harmful bacteria from one person, object or place to another) to other residents and staff that CNA 5 came into contact within the facility which could lead to an infection (the invasion and growth of germs in the body), potentially causing health complications, and facility outbreak of infection (a sudden increase or clustering of disease cases beyond what's normally expected in a specific time, place, or population, often involving common exposure). 3. Licensed Vocational Nurse (LVN) 1 did not disinfect the glucometer after use and place the glucometer inside the medication cart. This failure had the potential for other residents to be at increased risk in acquiring blood borne pathogen diseases (is any infectious microorganism, like viruses or bacteria, present in human blood or other potentially infectious materials (OPIM) that can cause disease when transmitted from person to person, primarily through blood-to-blood contact, often via accidental needle sticks, contaminated sharps, or contact with broken skin/mucous membranes; with common examples being HIV, Hepatitis B (HBV), and Hepatitis C (HCV) viruses). 4. The facility failed to follow policy and procedures (P&P) for water management and testing. These failures had the potential to place all residents at an increased risk of acquiring Legionella bacteria (is a type of bacteria common found in natural freshwater [lakes, streams] but thrive in man-made water systems like cooling towers, hot tubs, showers, plumbing systems, and decorative fountains, growing best in warm, stagnant water), and infectious diseases including a pneumonia (an infection that affects one or both lungs, causing the air sacs of the lungs to fill with fluid)-type illness called Legionnaires' disease and a mild flu-like illness called Pontiac fever. Findings: 1. During a concurrent observation on 12/3/25 at 9:11 a.m. with CNA 5, in Resident 33's room, CNA 5 came to the room holding one plastic bag containing a diaper and another plastic bag containing clean linen while the nurse surveyor conducting an interview with Resident 33. CNA 5 informed the nurse surveyor that she needed to do a diaper and linen change for Resident 33. CNA 5 went to Resident 33's bedside without wearing appropriate PPE -gown and closed the privacy curtain. CNA 5 was walking towards Resident 33's door with a glove on her hand holding two plastic bags, one for soiled brief and one for used linens. CNA 5 was looking for another CNA to provide her with a container to dispose of the two plastic bags containing the soiled brief and used linens. During an interview on 12/3/25 at 9:20 a.m. with CNA 5, outside Resident 33's room, CNA 5 stated she did not wear appropriate PPE including gown while providing a brief change and linen change to Resident 33. CNA 5 stated she was not aware that she was on EBP. CNA 5 stated she did not check the sign by the door. CNA 5 stated she should check the sign at Resident 33's door and wear appropriate PPE before entering the room and providing direct care. CNA 5 stated not wearing PPE for residents on EBP can result in cross contamination of other residents and risk of getting infection. During an interview on 12/3/25 at 9:34 a.m. with Licensed Vocational Nurse (LVN) 3, LVN 3 stated CNAs should be wearing appropriate PPE when providing direct care to the residents on EBP. LVN 3 stated Resident 33 was on EBP for ESBL in urine. LVN 3 stated CNA 5 should wear gowns and gloves when (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	doing brief change and linen change to Resident 33 to prevent cross contamination and infection for our staff and other residents. Staff should change gloves when helping a resident on EBP and another resident to prevent cross contamination. During a concurrent interview and record review on 12/3/25 at 10:34 a.m. with the Infection Preventionist (IP), Resident 33's clinical record was reviewed. The IP stated Resident 33 was on EBP for a known history of ESBL- producing bacterial infection/colonization in her urine. The IP stated it was her expectation for all staff to follow facility's policy and procedure (P&P) for EBP when providing direct care such as activities of daily living (ADLs-), to prevent cross contamination, infection and facility outbreak. The IP stated CNA 5 should wear appropriate PPE when she performed brief and linen change to Resident 33 to prevent cross contamination and transmission of possible infection to other residents and staff. During an interview on 12/9/25 at 9:29 am. with the Director of Nursing (DON), Resident 33 had an EBP sign by her door. The DON stated it was her expectation for nursing staff to follow the P&P for EBP in which the need of wearing appropriate PPE when providing direct patient care was important to prevent cross contamination and possible infection to residents. During a review of facility's P&P titled, Enhanced Barrier Precaution, dated 9/27/24, the P&P indicated, It is the policy of this facility to implement enhanced barrier precautions for the prevention of transmission of multidrug-resistant organisms. 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) .3. Implementation of Enhanced Barrier Precautions - a. Make gowns and gloves available PRIOR TO PERFORMING TASKS. Note: face protection may also be needed if performing activity with risk of splash or spray. 4. High-contact resident care activities include: e. Changing linens; f. Changing briefs or assisting with toileting. 6. Examples of targeted and epidemiologically important MDROs include but are not limited to: g. ESBL-producing Enterobacterales. 7. Enhanced barrier precautions should be used for the duration of the affected resident's stay in the facility. During a review of the professional reference (PR), found on https://www.cdc.gov/long-term-care-facilities/hcp/prevent-mdro/PPE.html an article titled, Implementation of Personal Protective Equipment (PPE) Use in Nursing Homes to Prevent Spread of Multidrug-resistant Organisms (MDROs), dated 7/12/22, the PR indicated, . [Multi Drug Resistant organisms] (MDROs - germs which have become resistant to medications) may be indirectly transferred from resident-to-resident during these high-contact care activities. Nursing home residents with wounds . are at especially high risk of both acquisition of and colonization with MDROs. The use of gown and gloves for high-contact resident care activities is indicated, when Contact Precautions do not otherwise apply. 2. During an observation on 12/2/25 at 9:42 a.m. outside Resident 64's room, Resident 64's name had an EBP sign and an EBP poster posted on her door. Resident 64's roommate had no EBP sign by her name. During observation on 12/2/25 at 9:48 a.m. with Housekeeper Staff (HS) 1, in Resident 64's room, HS 1 was holding Resident 64's blanket with a glove in her hand and covered Resident 64 with her blanket. HS 1 continued mopping Resident 64's floor area-around and underneath Resident 64's bed using the same pair of gloves. HS 1 went to Resident 64's roommate wearing the same pair of gloves and touched Resident 64's roommate's blanket and covered resident's body. HS 1 went outside Resident 64's room where the housekeeping cart was parked. HS 1 removed her gloves and used an alcohol-based hand rub (ABHR) gel. During an interview on 12/3/25 at 9:26 a.m. with HS 1, in front of Resident 64's room, HS 1 stated the signage indicated Resident 64 was on EBP and her roommate in first bed was not on EBP. HS 1 stated she did not receive training about EBP and was not aware who the IP was. HS 1 stated she did not notice the EBP signage outside Resident 64's room. sign for EBP. HS 1 validated she touched and placed the blankets for Resident 64 and her roommate using the same glove. HS 1 stated she should change her gloves after assisting Resident 4 to prevent cross contamination to Resident 64's roommate. During an interview on 12/3/25 at 9:34 a.m. with Licensed Vocational Nurse (LVN) 3, LVN 3 stated CNAs should be wearing appropriate PPE when providing direct care to the residents on EBP. LVN 3 stated (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident 64 was on EBP due to presence of dialysis catheter and her roommate in first bed was not on EBP. LVN 3 stated HS 1 should change her gloves in between resident care to prevent cross contamination and possible infection to residents. During a concurrent interview and record review on 12/3/25 at 10:34 a.m. with the Infection Preventionist (IP), Resident 64's clinical record was reviewed. The IP stated Resident 64 was a dialysis resident and had a dialysis catheter. The IP stated Resident 64 was on EBP due to dialysis catheter. The IP stated HS 1 must change her gloves when providing care from one resident to another resident to prevent cross contamination and transmission of possible infection to residents. During an interview on 12/9/25 at 9:29 am. with the DON it was her expectation for all staff to follow P&P for Standard Precautions. The DON stated gloves must be changed in between resident care to avoid cross contamination and possible infection to residents. During a review of facility's P&P titled, Standard Precautions, dated 10/2018, the P&P indicated, Standard Precautions - Standard precautions are used in the care of all residents regardless of their diagnoses, or suspected or confirmed infection status. Standard precautions are presume that all blood, body fluids, secretions, and excretions (except sweat), non-intact skin and mucous membranes may contain transmissible infectious agents. 1. Standard precautions apply to the care of all residents in all situations regardless of suspected or confirmed presence of infectious disease. 2. Gloves - g. Gloves are removed promptly after use, before touching non-contaminated items and environmental surfaces, and before going to another resident. h. After gloves are removed, wash hands immediately to avoid transfer of microorganisms to other residents or environments. 3. During an observation and interview on 12/3/25 at 11:40 a.m. with LVN 1 outside Resident 2's room, wiping the glucometer machine with a white wipe for 2 seconds, placed inside a cup to air dry and secured inside the medication cart. LVN 1 stated she will use the same glucometer machine to another residents. LVN 1 stated residents on blood sugar checked shared the same glucometer machine. During an interview on 12/9/25 at 9:44 a.m. with the DON, the DON stated she needed to check and review the P&P for cleaning and disinfecting of glucometer machine. The DON stated the facility was using a disinfectant wipe with purple top, wet time should be 3-4 minutes based on manufacturer's guidelines. The DON stated it was her expectation for all nurses to follow the P&P for cleaning and disinfecting of glucometer machine. The DON stated glucometer machines should be cleaned and disinfected properly to prevent the transmission of blood-borne pathogens. During an interview on 12/9/25 at 11:25 a.m. with LVN 1, LVN 1 validated she did not disinfect the glucometer machine after using Resident 2. LVN 1 stated she did not follow the wet time of 3 minutes instead she did air dry for more than 3 minutes. LVN 1 stated, glucometer machine should be properly cleaned and disinfected after each use to prevent transmission of infection. During a review of facility's P&P titled, Standard Precautions, dated 10/2018, the P&P indicated, Standard Precautions - Standard precautions are used in the care of all residents regardless of their diagnoses, or suspected or confirmed infection status. Standard precautions are presumed that all blood, body fluids, secretions, and excretions (except sweat), non-intact skin and mucous membranes may contain transmissible infectious agents. 1. Standard precautions apply to the care of all residents in all situations regardless of suspected or confirmed presence of infectious disease. 5. Resident-Care Equipment - a. Resident-care equipment soiled with blood, body fluids, secretions, and excretions are handled in a manner that prevents skin and mucous membrane exposure, contamination of clothing, and transfer of microorganisms to other residents and environments. During a review of facility's P&P titled, Cleaning and Disinfection of Resident-Care Items and Equipment, dated 10/2018. Resident-care equipment, including reusable items and durable medical equipment will be cleaned and disinfected according to current CDC recommendations for disinfection and the OSHA bloodborne pathogens standard. d. Reusable items are cleaned and disinfected or sterilized between residents. 4. Reusable resident care equipment will be decontaminated and/or sterilized between residents according to manufactures' instructions. 4. During an interview on 12/3/25 at 10:34 a.m. with the IP, the IP stated she was a member of water management committee. The IP stated the facility had a policy and (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	procedures for Legionella. The IP stated the facility's Environmental Services Maintenance (ESM) was responsible in testing and monitoring the water for the detection of Legionella. The IP stated it was important to follow the P&P for Legionella water management to prevent an outbreak of Legionella. During an interview on 12/9/25 At 9:13 a.m. with the ESM, the ESM stated an outside service company was facilitating the testing of water for Legionella detection, dated 7/21/25 and 11/17/25. The ESM stated no Legionella detected on 7/21/25 and result was pending for 11/17/25. The ESM stated the outside service company indicated the water testing for Legionella was checked quarterly. During a concurrent interview and record review on 12/9/25 at 1:55 p.m. with ESM, the water management and testing policy was reviewed. The ESM stated she had no chance to implement the water testing P&P for Legionella including the monthly water testing in water pipelines, to ensure there was no standing water, and water was not sitting for a longer period; weekly water flushing, and temperature monitoring to prevent Legionella. The only testing was done was from outside service company which was done quarterly and stated, only relied on their result. The ESM stated the facility's P&P for water management and testing should be followed, implemented and documented to prevent Legionella outbreak. During a review of facility's P&P titled. WATER MANAGEMENT AND TESTING POLICY - Skilled Nursing Facility Water Safety & Risk Management Program - Date: 8/1/2025. 1. PURPOSE - To establish a comprehensive water management and testing program for the Skilled Nursing Facility (SNF) that ensures safe potable water for residents, staff, and visitors. This policy addresses risk associated with waterborne pathogens - particularly Legionella - and defines monitoring, testing, control measures, documentation, and reporting processes. 4. LEGIONELLA TESTING REQUIREMENTS. 4.1 Frequency - Monthly Legionella testing must be performed on: Incoming well water sample - Hot water distribution point(s) - Cold water distribution point(s) - High-risk resident care areas (showers, therapy tubs, etc.) . 5. ROUTINE WATER SYSTEM MONITORING. 5.1 Temperature Monitoring - Hot water storage tanks: 140F minimum - Hot water at point of use: 105-120F (per resident safety requirements) - Cold water: < 77F when possible (reduces Legionella growth). 5.2 Disinfectant Residual Monitoring - Measure at least weekly. 5.3 Fixture Flushing - Flushing must occur: Weekly for rarely used fixtures - After any area is unoccupied for > 7 days - After plumbing disruptions. 9. DOCUMENTATION & RECORDKEEPING. Maintain for minimum of 3-5 years: Monthly Legionella lab reports - Temperature log sheets - Disinfectant residual logs - Fixture flushing logs.		

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep all essential equipment working safely. Based on observation, interview, and record review, the facility failed to maintain a resident care equipment in safe operating condition when the facility's mechanical lift (a mechanical device used by caregivers to safely lift and transfer individuals with limited mobility from one surface to another (bed, chair, toilet) using a sling, minimizing physical strain and preventing injury) was not functional to deliver residents' care and activities of daily living (ADLs- routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves). This failure resulted in a delay in implementing residents' care including residents' transfers and obtaining weights as ordered and placed residents and staff at an increased risk of accidents. Findings: During an observation on 12/2/25 at 8:39 a.m. with Resident 5, in Resident 5's room, Resident 5 was lying asleep in bed. During an observation on 12/2/25 at 12:39 p.m. with Resident 5, in Resident 5's room, Resident 5 was lying asleep in bed, with food tray at bedside table. During a concurrent observation and interview on 12/3/25 at 10:03 a.m. with Certified Nurse Assistant (CNA) 11, in Resident 5's room, CNA 11 was giving Resident 5 a carton of house supplement via straw. CNA 11 stated Resident 5 should be up in a chair during melas. CNA 11 stated Resident 5 requires a mechanical lift transfer. CNA 11 stated the facility's mechanical lift was not working and stated a new battery for the mechanical lift was ordered. During an interview on 12/4/25 at 9:58 a.m. with the Restorative Nurse Assistant (RNA), the RNA stated the two mechanical lifts were not working due to battery problems. The RNA stated there was no back-up battery for the mechanical lift. The RNA stated the battery for the mechanical lift was ordered and had not been delivered. The RNA stated the facility borrowed another mechanical lift to another facility because their mechanical lift was not functioning well when tested, and stated, it was stacked in the air. The RNA stated the mechanical lift could not move to its normal position which is not safe for residents' use. The RNA stated she was scheduled to weigh all residents for their monthly weights. The RNA stated residents' weight must be obtained by the fifth of every month and stated, due on 12/5/25. The RNA stated the facility should maintain a safe functional mechanical lift to prevent delay in care of the residents. During an interview on 12/9/25 at 9:34 a.m. with the Director of Nursing, the DON stated the two mechanical lifts were not functional because the battery was not charging. The DON stated resident care equipment should be maintained in good working conditions to safely implement the care that resident's needs. The DON stated residents that require a mechanical lift transfer could not get up by the CNAs which resulted in the residents staying in bed that can result in isolation, decrease participation and socialization during activities. The DON stated residents' weights were not done as scheduled every fifth of the month. The DON stated the delay in obtaining weights for residents can cause in a delay of implementation of significant weight changes interventions. The DON stated the facility should maintain operational resident care equipment to continue to provide the care for all residents. During an interview on 12/9/25 at 1:55 p.m. with the Environment Services Maintenance (ESM), the ESM stated he was responsible in monitoring all resident care equipment including mechanical lifts were functional. The ESM stated he checked the batteries of mechanical lift weekly and batteries did not arrive as expected. The ESM stated a non-functioning mechanical lift was not safe for residents and staff use. The ESM stated resident care equipment should be maintained in safe operating conditions to prevent accidents. During a review of professional reference retrieved from www.cdc.gov/niosh titled, Safe Lifting and Movement of Nursing Home Residents, dated 2/2006, indicated, .Keep equipment readily available and accessible. The number of lifts required will depend on the level of physical dependency among the residents. As a general rule, one full-body lift should be provided for every eight to ten non-weight bearing residents. Provide back-up battery packs on remote chargers as needed so that lifts can be used 24 hours per day while batteries are being recharged. Implement a routine maintenance program to ensure equipment is kept in good working order (the maintenance program should include tagout and repair procedures for broken equipment).		

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to maintain an effective pest control program when flies were flying around resident's room (room [ROOM NUMBER]) on 12/2/265 and 12/3/25 and transferring from one table to another in resident's dining room during lunch on 12/3/25. This failure had the potential for cross-contamination (the process by which bacteria or other microorganisms are unintentionally transferred from one substance or object to another, with harmful effects) and for residents to acquire food borne illnesses (are caused by eating or drinking something that is contaminated with germs). During an observation on 12/2/25 at 8:39 a.m. in room [ROOM NUMBER], multiple flies (three) were going around the round, landing on residents' clothing and privacy curtain. During concurrent observation and interview on 12/2/25 at 9:11 a.m. with Licensed Vocational Nurse (LVN) 3, in room [ROOM NUMBER], LVN 3 validated flies were flying around inside room [ROOM NUMBER]. LVN 3 stated she had seen flies in room [ROOM NUMBER]. LVN 3 stated room [ROOM NUMBER] was close to the exit door where other residents accessed exit door multiple times a day. LVN 3 stated there should be no flies inside the residents' room and inside the facility. LVN 3 stated flies carry bacteria that can cause food borne illnesses to residents. During an observation 12/2/25 at 12:39 p.m. with Resident 5, in Resident 5's room, Resident was asleep. Resident 5 was in room [ROOM NUMBER]. Resident 5's food tray was on top of bedside table with no cover and two flies were flying around Resident 5's food. During a concurrent observation and interview on 12/3/25 at 10:03 a.m. with Certified Nurse Assistant (CNA) 11, in Resident 5's room, CNA 11 was giving Resident 5 a carton of house supplement via straw with two flies flying around Resident 5. CNA 11 was swinging her hand to keep the flies away from the food and Resident 5, and stated, I don't know what to do. CNA 9 stated there should be no be flies inside Resident 5's room. CNA 11 stated flies were not clean and could contaminate the food. During a concurrent observation and interview on 12/3/25 at 10:34 a.m. with the Infection Preventionist Nurse (IP), at the nursing station, a fly swatter (is a household device used to kill the flies) was on the top of the counter. The IP stated the facility was using a fly swatter to eliminate the flies in the facility. The IP stated presence of flies inside the facility can potentially cause cross-contamination and residents could get sick with food-borne illnesses like diarrhea (loose stools). During an observation and interview on 12/3/25 at 11:45 a.m. with the Administrator (ADM), in the residents' dining room, the ADM swung his hand to keep the flies away from the resident's food. The ADM asked the Restorative Nurse Assistant (RNA) to remove the food from the table and replace it with a new one. During an interview on 12/3/25 at 11:55 a.m. with the RNA, in the resident's dining room, the RNA stated the flies in the dining room were transferring from one table to another. The RNA stated, . once in a while, I see flies here (dining room). During an observation on 12/3/25 at 12:22 a.m., in the hallway, the ADM was holding a fly swatter beside the food tray cart. During an interview on 12/4/25 at 8:00 a.m. with CNA 10, CNA 10 stated she was at the dining room yesterday (12/3/25) during lunch when a fly flew around resident's food and water pitcher. CNA 10 stated flies can contaminate the food, and residents can get sick. During an interview on 12/9/25 At 9:13 a.m. with the Environmental Services Maintenance (ESM), the ESM stated he needed to check the pest control services done at the facility. The ESM stated he needed to ensure the facility has an effective pest control service. The ESM stated there should be no flies inside the facility especially in resident's dining room and resident's room. The ESM stated flies can lay eggs and can transfer germs to the resident's food. During an interview on 12/9/25 at 9:34 a.m. with the Director of Nursing (DON), flies can transfer the bacteria into the resident's food and put residents at risk for infection and food borne illnesses. During a review of facility's policy and procedures (P&P) titled, Pest Control, dated 5/2008, the P&P indicated, Our facility shall maintain an effective pest control program. 1. This facility maintains an on-going pet control program to ensure that the building is kept free of insects and rodent. 6. Maintenance services assist, when appropriate and necessary, in providing pest control services.		

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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. Based on observation, interview, and record review, the facility failed to provide and maintain a safe, clean, and sanitary environment for one of four sampled residents (Resident 2), when Resident 2's mattress on the floor beside his bed was dirty with brownish dirt built up on the top of the mattress and observed nursing staff walking on the floor mattress. This failure had the potential for Resident 2 acquiring an infection (the invasion and growth of germs in the body). Findings: During an observation and interview on 12/3/25 at 11:40 a.m. with LVN 1, in Resident 2's room, LVN 1 stepped on Resident 2's mattress on the floor beside Resident 2's bed. Resident 2's mattress on the floor was dirty with brownish dirt built up on the top of the mattress. LVN 1 stated, Resident 2's mattress on the floor was dirty and should be cleaned by the housekeeper and covered with a bed sheet. LVN 1 stated Resident 2 had episodes of purposely rolling over from bed to the mattress on the floor. LVN 1 stated Resident 2's floor mattress should remain clean to prevent infection. During a review of Resident 2's Minimum Data Set (MDS - a resident assessment tool used to identify cognitive [mental processes] and physical functional level assessment), dated 10/9/25, the MDS section C indicated Resident 2 had a Brief Interview for Mental Status (BIMS - a test given by medical professionals to determine cognitive understanding on a scale of 1-15) score of 4 (a score of 0-7 suggests severe cognitive impairment, 8-12 suggests moderately impaired, 13-15 suggests cognitively intact), which suggested Resident 2 was severely cognitively impaired. During an interview on 12/4/25 at 9:58 a.m. with the Restorative Nurse Assistant (RNA), the RNA stated Resident 2's mattress on the floor was dirty. The RNA stated having a dirty floor mattress is an infection control issue. RNA stated housekeepers should keep Resident 2's mattress cleaned to prevent infection to Resident 2. The RNA stated Resident 2 keeps rolling out of bed to the floor mattress, the floor mattress prevented him from getting hurt. During an interview on 12/9/25 At 9:30 a.m. with HS 2, HS 2 stated Resident 2's mattress on the floor was very dirty. HS 2 we are responsible for cleaning the mattress on the floor. HS 2 stated Resident 2's mattress on the floor should be cleaned and disinfected twice a day and as needed and should have a bed sheet over the bed. HS 2 stated dirty bed can harbor bacteria and can cause infection to Resident 2. During an interview on 12/9/25 At 9:13 a.m. with the Environmental Services Maintenance (ESM), the ESM stated it was her expectation for housekeeping staff to clean and disinfect resident care areas including equipment. The EMS stated Resident 2's mattress on the floor was dirty and should be cleaned to prevent infection. The EMS stated staff walking on Resident 2's floor mattress can harbor germs or bacteria. During an interview on 12/9/24 at 9:44 a.m. with the DON, the DON stated dirty mattress on the floor for resident use was an infection control issue. The DON stated housekeeper should clean and disinfect Resident 2's mattress on the floor to prevent infection to Resident 2. During a review of facility's P&P titled, Standard Precautions, dated 10/2018, the P&P indicated, Standard Precautions - Standard precautions are used in the care of all residents regardless of their diagnoses, or suspected or confirmed infection status. Standard precautions are presume that all blood, body fluids, secretions, and excretions (except sweat), non-intact skin and mucous membranes may contain transmissible infectious agents. 1. Standard precautions apply to the care of all residents in all situations regardless of suspected or confirmed presence of infectious disease. 5. Resident-Care Equipment - a. Resident-care equipment soiled with blood, body fluids, secretions, and excretions are handled in a manner that prevents skin and mucous membrane exposure, contamination of clothing, and transfer of microorganisms to other residents and environments. During a review of facility's P&P titled, Cleaning and Disinfection of Resident-Care Items and Equipment, dated 10/2018. Resident-care equipment, including reusable items and durable medical equipment will be cleaned and disinfected according to current CDC recommendations for disinfection and the OSHA bloodborne pathogens standard. d. Reusable items are cleaned and disinfected or sterilized between residents . 4. Reusable resident care equipment will be decontaminated and/or sterilized between residents according to manufactures' instructions .		

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure one of five sampled residents (Resident 13) was free from unnecessary psychotropic (drugs that affect brain activities associated with mental processes and behavior) medications when the facility did not attempt or implement behavior monitoring for Resident 13's use of olanzapine (medication used to treat schizophrenia [a mental illness that is characterized by disturbances in thoughts]). This failure placed Resident 13 at risk for experiencing adverse effects from receiving medication without behavior monitoring. During a concurrent observation and interview on 12/2/25 at 2:40 p.m. in Resident 13's room, Resident 13 was ambulating inside the room with steady gait and appropriately dressed. Resident 13 stated he was in the acute care hospital for a week prior to admission in the facility. Resident 13 stated he was in the facility to work with therapy to get stronger and will eventually go home. Resident 13 stated he did not know anybody in the facility but felt safe. During a review of Resident 13's, admission Record [AR- a document containing resident profile information], dated 12/5/25, the AR indicated Resident 13 was admitted to the facility on [DATE] with diagnoses which included schizoaffective disorder (a mental illness that can affect thoughts, mood, and behavior), subdural hemorrhage (brain bleed) and muscle weakness. During a review of Resident 13's Physician Order, dated 11/26/25, the Physician Order indicated, OLANzapine Oral Tablet 5 (five) MG (milligram- unit of measurement) . Give 5 mg by mouth at bedtime RELATED TO SCHIZOAFFECTIVE DISORDER . During a concurrent interview and record review on 12/4/25 at 2:03 p.m. with Infection Preventionist (IP), Resident 13's medication orders were reviewed. The IP stated Resident 13 was receiving psychotropic medication and no behavior monitoring in place. The IP stated there should have been a behavior monitoring as soon as psychotropic medication was started. The IP stated it was important to monitor behavior to note if there was an increase or decline in behavior and if gradual dose reduction was required. During a concurrent interview and record review on 12/5/25 at 2:47 p.m. with Registered Nurse SUpervisor (RNS), The RNS reviewed Resident 13's Order Summary and stated she did not find an order to monitor behavior when Resident 13 was started on the psychotropic medication. The RNS stated it was important to monitor behavior of residents taking psychotropic medications in order to make adjustments of their medications if needed to titrate the dose or to discontinue. During an interview on 12/9/25 at 12:25 p.m. with the Director of Nursing (DON) the DON stated her expectation was to ensure a behavior monitoring was started as soon as soon as a psychotropic medication was started. The DON stated behavior monitoring was important to know when a medication was working or not and whether to discontinue or continue medication. The DON stated the licensed nurse receiving the order was responsible in ensuring there was a behavior monitoring started. During a review of facility policy and procedure (P&P) untitled and undated, the P&P indicated, Residents are not given psychotropic drugs unless the medication is necessary to treat specific condition, as diagnosed and documented in the clinical record, and the medication is beneficial to the resident, as demonstrated by monitoring and documentation of the resident's response to the medication(s) . A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior . The indications for use of any psychotropic drug will be documented in the medical record .		

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure their policy on discharge was followed for one of three sampled Residents (Resident 61) when Resident 61 was discharged against medical advice (AMA-patient chooses to leave before the doctor recommends discharge) when Resident 61 was discharged AMA on 9/14/25 and there was no documentation the medical doctor and administrator were notified. This failure had the potential to put Resident 61 at risk for complications like worsening of condition. Findings: During a review of Resident 61's admission Record (AR- a document containing resident profile information) dated 12/9/25, the AR indicated Resident 61 was admitted to the facility on [DATE] with diagnoses which included Spinal Stenosis (narrowing of spinal canal squeezing the nerves and causing pain, numbness, tingling, or weakness), muscle weakness and abnormalities of gait and mobility. During a concurrent interview and record review on 12/9/25 at 8:30a.m. with Minimum Data Set Nurse (MDSN) 2, MDSN Reviewed resident 61's clinical record and stated there was no documentation of Resident 61's discharged . MDSN 2 stated Resident 61 was AMA on 9/14/25. MDSN 2 stated the medical doctor (MD), Administrator (ADM) and Director of Nursing (DON) should have been notified but there was no documentation. MDSN 2 stated the medical record person was responsible in auditing to ensure accurate and complete resident records. During a concurrent interview and record review on 12/9/25 at 9:35 a.m. with Medical Records Person (MRP), the MRP stated she audits resident discharges to ensure all signatures are in place. The MRP stated she remember auditing Resident 61's records and provided a copy to the nurse who was on-duty when Resident 61 was discharged AMA. The MRP stated she did not remember following up with the nurse and just assumed it was completed. The MRP reviewed Resident 61's record and stated, MD was not notified the day of Resident 61's AMA, the MRP stated there should have been a nursing note indicating why Resident 61 wanted to leave AMA and notification to ADM and DON. During an interview on 12/9/25 at 12:11 p.m. with the DON, the DON stated licensed nurses should ensure AMA form was signed when residents wishes to be discharged AMA. The DON stated the MD, ADM and DON should be notified and documented in the progress note. During an interview on 12/9/25 at 3:30 p.m. with the ADM, the ADM stated he was made aware of Resident 61's AMA discharge but was not sure when he was notified. The ADM stated he was not aware there was no documentation of Resident discharged and MD was not notified the day Resident 61 was discharged . The ADM stated the practice was to make sure MD and ADM was notified when residents wanted to leave AMA. During a review of facility's policy and procedure (P&P) titled, AMA (Against Medical Advice) Policy, undated, the P&P indicated, . Any staff member aware that a resident wishes to leave AMA should immediately notify the nursing supervisor, administrator and the attending physician . Document the resident's intent to leave AMA, including their stated reasons and the information provided to them about potential risks . Provide the resident with a written discharge summary, including current treatment, medications, and follow-up care instructions . Arrange follow-up call within 24-48 hours post-discharge to assess the resident's situation and provide additional support if needed .		

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure Minimum Data Set Assessment (MDS-assessment of physical and psychological functions and needs) accurately reflected resident's health and functional status for one of four sampled residents (Resident 11) when Resident 11's use of Divalproex (medication used for mood stabilization) was inaccurately coded in the MDS assessment. This failure had the potential to result in Resident 11's care needs not met and the potential for adverse reaction to not be monitored. During a concurrent observation and interview on 12/2/25 at 12:15 p.m. during an initial tour in Resident 11's room, Resident 11 was lying in bed covered with blanket and lunch tray was on top of over the bed table. Resident 11 stated he already ate and refused to answer questions stated, Goodbye. During a review of Resident 11's admission Record [AR- a document with personal identification and medical information], dated 12/5/25, the AR indicated Resident 11 was admitted to the facility on [DATE] with diagnoses which included Alzheimer's disease (a diseases characterized by a progressive decline in mental abilities), muscle weakness and dementia (a progressive state of decline in mental abilities). During a concurrent interview and record review on 12/4/25 at 2:05 p.m. with Infection Preventionist (IP), the IP stated Resident 11 was confused and has Alzheimer's disease. The IP stated Resident 11 was ordered Divalproex medication for mood stabilization. During a concurrent interview and record review on 12/9/25 at 8:50 a.m. with Minimum Data Set Nurse (MDSN) 2, MDSN 2 reviewed Resident 11's Admit MDS assessment dated [DATE] Section N (Medications) and Section I (Active Diagnoses). MDSN 2 stated Resident 11 was taking medication for mood stabilization and did not marked in Section I. MDSN 2 stated she did not code Resident 11 as having mood disorder and she should have. MDSN 2 stated it was her responsibility to ensure MDS assessment were accurate. During an interview on 12/9/25 at 12:20 p.m. with the Director of Nursing (DON), the DON stated her expectation was for MDS assessments to be accurate. The DON stated missing or inaccurate MDS assessments are reviewed by the MDS and IDT. During a review of the facility document titled, Job Description: MDS Coordinator, dated 1/29/25, the Job Description indicated, . Coordinates the development and completion of the resident assessment (MDS) in accordance with current federal and state rules, regulations, and guidelines that govern the resident assessment . Ensures the timely electronic submission of of face validity of all Minimum Data Sets to the state database . During a review of facility's policy and procedure (P&P) titled, MDS Error Correction revised 9/2010, the P&P indicated, . Once completed, edited and accepted . MDS data may not be changed just because the resident's status has changed during the course of his or her stay in the facility . Modification requests are used when information in the record contains clinical or demographic errors . During a review of professional reference titled, Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual version 1.19.1 10/24, indicated, . Identify Diagnoses: The disease conditions in this section require a physician-documented diagnosis . in the last 60 days . Check the following information sources in the medical record for the last 7 [seven] days to identify active diagnoses: transfer documents, physician progress notes, recent history . medication sheets, doctor's orders .		

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to complete a level 1 Preadmission Screening and Resident Review (PASARR), (a Federal requirement to ensure residents with mental disorder or intellectual disorder or intellectual disabilities are not inappropriately placed in a nursing home) screening notifying the state mental health authority or state intellectual disability authority promptly after a significant change for three of five sampled residents (Residents' 1, 3 and 6). This failure had the potential for Residents' 1, 3, and 6 to not receive the appropriate services related to their mental disorders. During a review of Resident 1's admission Record (AR-a document containing resident profile information), dated 12/5/25, the AR indicated Resident 1 was admitted to the facility on [DATE] with diagnoses which included psychosis (a severe mental condition in which thought, and emotions are so affected that contact is lost with reality), psychoactive substance abuse (use of mind-altering drugs in ways that harm health, relationships, or responsibilities causing dependence, tolerance, and negative impacts on mood, cognition, and behavior) and muscle weakness. During a review of Resident 1's PASARR Level I Screening Report dated 11/04/25, the PASARR indicated, . A LEVEL II MENTAL HEALTH EVALUATION IS NOT REQUIRED . During a review of Resident 1's Order Summary Report [OSR], dated 12/5/25, The OSR indicated, . OLANzapine [used to treat psychosis] Oral Tablet 10 MG [milligram-unit of measurement] Give 1 [one] tablet by mouth every 8 [eight] hours for Psychosis . Order Date: 11/11/25, Start Date: 11/11/25 . During a review of Resident 3's AR dated 12/5/25, the AR indicated Resident 3 was admitted to the facility on [DATE] with diagnoses which included Schizophrenia (a mental illness characterized by disturbances in thought), Schizoaffective disorder (a mental illness that can affect thoughts, mood, and behavior) and anxiety (a feeling of worry, nervousness, or uneasiness about an upcoming event or something with uncertain outcome causing physical signs like racing heart, sweating or restlessness). Review of Resident 3's PASARR Level I Screening Report, dated 10/14/25 indicated, . Level I-Negative for SMI [Serious Mental Illness]/Negative for ID [Intellectual Disability]/ DD [Developmental Disability]/RC[Related Condition] Resident 3 did not have diagnosis of serious mental illness and not taking psychotropic medications . During a review of Resident 3's OSR, dated 12/9/25, the OSR indicated, . PARoxetine [medication used to treat depression] HCl Oral Table 10 MG [Paroxetine HCl] Give 1 tablet by mouth one time a day related to MAJOR DEPRESSIVE DISORDER . Order Date: 7/11/25 . QUetiapine Fumarate [medication used to treat schizophrenia] Oral Tablet 50 MG [Quetiapine Fumarate] Give 1 tablet by mouth two times a day . Order Date: 5/5/25 . During a review of Resident 6's AR, dated 12/5/25, the AR indicated Resident 6 was re-admitted to the facility on [DATE] with diagnoses which included schizophrenia, depression (a serious mood disorder causing persistent sadness and loss of interest in activities, affecting how you feel, think, and handle daily life) and psychosis. During a review of Resident 6's PASARR Level I dated 3/14/25 indicated, . Level I Negative for SMI/Negative for ID/DD/RC . No diagnosis of Serious Mental Illness . During a review of Resident 6's OSR, dated 12/5/25, the OSR indicated, . [brand name] Oral tablet 5 [five] MG (Aripiprazole) Give 2 [two] tablet . two times a day for give 2 tabs of 5mg=10mg related to SCHIZOPHRENIA . Order Date: 10/14/25 . trazodone HCl [hydrochloride] Oral Tablet 50 MG [Trazodone HCl] Give 1 tablet . Order Date: 9/3/25 . During a concurrent interview and record review on 12/5/25 at 4:11 p.m. with Minimum Data Set Coordinator (MDSC)1, MDSC 1 stated PASARR screening are completed for new admission, change in condition like a new psychotropic medication was started and re-admission to the facility. MDSC 1 reviewed Resident 1's PASARR Level 1 dated 11/4/25 and stated Resident 1 did not have psychotropic medication when admitted in the facility. Resident 1 was ordered Olanzapine on 11/11/25 and a new PASARR Level 1 screening should have been completed but there was none. During a concurrent interview and record review on 12/5/25 at 4:18 p.m. with MDSC 1, Resident 3's PASARR Level 1 dated 10/14/25 screening completed at the acute hospital was reviewed. MDSC 1 (continued on next page)		

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stated Resident 3's PASARR Level 1 was not accurate and it should have been reviewed for accurateness. MDSC 1 stated a new PASARR Level 1 should have been completed and submitted to accurately reflect resident condition. During a concurrent interview and record review on 12/5/25 at 4:30 p.m. with MDSC 1, Resident 6's PASARR Level 1 screening dated 3/14/25 was reviewed. MDSC 1 stated Resident 6's PASARR Level 1 was negative, there should have been another PASARR Level 1 screening completed when Resident 6 was started on psychotropic medications on 9/4/25 and 10/14/25 but there was none. During a concurrent interview and record review on 12/4/25 at 1:55 pm. with Infection Preventionist (IP), the IP reviewed Resident 1's clinical record and stated Resident 1 was admitted to the facility 11/4/25 and one of the diagnoses was unspecified psychosis. The IP stated Resident 1 was started on psychotropic medication after admission to the facility. The IP reviewed Resident 3's clinical record and stated Resident 3 is taking psychotropic medications and has diagnosis of schizophrenia and schizoaffective disorder. The IP stated Resident 6 was readmitted to the facility on [DATE] and was ordered psychotropic medications. The IP stated she was not responsible in the PASARR assessment. The IP stated all residents clinical records should be accurate and reflects current status of residents. During an interview on 2/9/25 at 12:25 p.m. with the Director of Nursing (DON), the DON stated the business office manager, MDS nurse, medical records and admission director are responsible in making sure there was a PASARR completed for each residents in the facility. The DON stated her expectation was to make sure PASARR are reviewed for accuracy and complete a new PASARR assessment if needed. During a review of facility's policy and procedure (P&P) titled, Resident Assessment - Coordination with PASARR Program, dated 2022, the P&P indicated, . All applicants to this facility will be screened for serious mental disorder or intellectual disabilities and related conditions in accordance with the State's Medicaid rules for screening . Any resident who exhibits a newly evident or possible serious mental disorder, intellectual disability, or a related condition will be referred promptly to the state mental health or intellectual disability authority for a level II resident review. Examples include: a. A resident who exhibits behavioral, psychiatric, or mood related symptoms suggesting the presence of a mental disorder (where dementia is not the primary diagnosis). b. A resident whose intellectual disability or related condition was not previously identified and evaluated through PASARR .		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure a comprehensive, person-centered care plan (a plan that provides direction for individualized care of the resident) was developed and implemented to meet the identified needs for one of three sampled residents (Resident 13) when: Resident 13 did not have a care plan for olanzapine (psychotropic medication used to treat schizophrenia and bipolar disorder). This failure placed Resident 13 at risk for harm by not identifying and monitoring harmful side effects of medication. During a review of Resident 13's admission Record [AR- document containing resident profile information], dated 12/5/25, the AR indicated Resident 1 was admitted to the facility on [DATE] with diagnoses which included schizoaffective disorder (a mental illness that can affect thoughts, mood, and behavior), psychoactive substance abuse (use of mind-altering drugs that cause harm, health problems, or social issues leading to dependence or addiction) and traumatic brain injury. During a review of Resident 13's Minimum Data Set (MDS-a resident assessment tool used to identify resident cognitive, physical abilities and needs) assessment dated [DATE], the MDS assessment indicated Resident 13's Brief Interview for Mental Status (BIMS-screening tool used to assess resident cognition status) 0-15 scale (0-6 severe cognitive deficit, 7-12 moderate cognitive deficit, 13-15 no cognitive deficit) assessment score was 15 out of 15 which indicated Resident 13 had no cognitive deficit. During a review of Resident 13's Physician's Pharmacy Order, (a report of all orders for resident while in facility), dated 11/26/25, the Physician's Pharmacy Order indicated Resident 13 had an order for Olanzapine 5 mg tablet at bedtime to treat Schizoaffective disorder. During a concurrent interview and record review on 12/4/25 at 1:55 p.m. with the Infection Preventionist (IP), the IP reviewed Resident 13's Electronic Medical Record (EMR) and stated Resident 13's Olanzapine was ordered on 11/26/25. The IP stated she did not find a care plan for Resident 13's Olanzapine. The IP stated there should have been a care plan initiated as soon as the order was received to direct staff on how to care for Resident 13. During a concurrent interview and record review on 12/5/25 at 4:25 p.m. with Minimum Data Set Coordinator (MDSC)1, MDSC1 reviewed Resident 13's clinical record and stated she was not able to find a care plan for Resident 13's use of olanzapine medication. MDSC 1 stated it was important to have a care plan initiated to monitor for side effects of medications and for all staff to be aware of the plan of care. During an interview on 12/9/25 at 12:40 p.m. with the Director of Nursing (DON), the DON stated care plan was to be initiated on admission. The DON stated her expectation was to ensure care plan for psychotropic medication orders are initiated right away by the licensed nurse receiving the order in order to monitor for possible side effects to the resident. The DON stated the Interdisciplinary Team (IDT- group of professionals from different fields working closely to achieve common, patient-centered goals) may also initiate a care plan or add to the interventions. During a review of facility's policy and procedure (P&P) titled, Person Centered Care Planning, dated 9/27/24, the P&P indicated, .The facility will inform the resident, in a language he or she can understand, of his or her rights regarding planning and implementing care, including the right to be informed of his or her total health status .The facility will notify the resident and/or resident representative, in advance, of the care to be furnished and the type of caregiver or professional that will furnish care, as well as the changes to the plan of care .During a review of facility's policy and procedure (P&P) untitled and undated, the P&P indicated, Residents are not given psychotropic drugs unless medication is necessary to treat a specific condition, as diagnosed and documented in the clinical record . The resident's response to the medication(s), including progress towards goals and presence/absence of adverse consequences, shall be documented in the resident's medical record .		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews and record review, the facility failed to ensure nail care was provided for two of seven sampled residents (Residents 51 and 4) when: Resident 51's fingernails were long and dirty with brownish to blackish dirt built up underneath the nails. Resident 4's fingernails were long. This failure had the potential for Resident 51 and 4 in sustaining an avoidable skin related injuries (including cuts (laceration), scrapes (abrasion), scratches, etc.) and infection (the invasion and growth of germs in the body). Findings: 1. During an observation on 12/2/25 at 11:59 a.m. with Resident 51, in the resident's dining room, Resident 51 was holding the bread with her left hand. Resident 51 had long and dirty fingernails on both hands with brownish to blackish dirt underneath the fingernails. During a concurrent observation and interview on 12/2/25 at 12:20 p.m. with Resident 51, in the resident's dining room, Resident 51 was cutting the bread into small pieces using her left hand and put the bread into her mouth. Resident 51 smiled when asked her name. During a concurrent observation and interview on 12/9/25 at 8:24 a.m. with the Restorative Nurse Assistant (RNA), in resident's dining room, the RNA was cueing and supervising Resident 51 during breakfast. The RNA stated Resident 51 had long and dirty fingernails on both hands with brownish to blackish dirt underneath the fingernails. The RNA stated Resident 51 touches the food with her hands. RNA stated Resident 4 was dependent on staff to carry out activities of daily living (ADLs- routine tasks/activities such as bathing, dressing, personal hygiene, and toileting a person performs daily to care for themselves). RNA stated Certified Nurse Assistants (CNAs) were responsible in doing nail care every week. RNA stated Resident 51's fingernails should be trimmed and cleaned to prevent infection. RNA stated bacteria can grow in long and dirty fingernails. During an interview on 12/9/25 at 11:40 a.m. with Minimum Data Set Coordinator (MDSC) 2, MDSC 2 stated nail care should be provided by nursing staff weekly to prevent self-inflicting skin tears and infection. MDSC 2 stated nursing staff to ensure good and proper hygiene should be provided to all residents. During an interview on 12/9/25 at 3:23 p.m. with the Director of Nursing (DON), the DON stated Resident 51's fingernails should be trimmed by CNAs. The DON stated long fingernails can harbor microorganisms (bacteria) that can cause infection and self-inflicting skin injuries like skin scratches. During a review of Resident 51'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 9/5/25, the AR indicated Resident 51 was admitted to the facility on [DATE] with primary diagnosis of Dementia (a progressive state of decline in mental abilities). During a review of facility's policy and procedure titled, Fingernails/Toenails, Care of, dated, 2/18, the P&P indicated, The purpose of this procedure are to clean the nail bed, to keep nails trimmed, and to prevent infections. General Guidelines 1. Nail care includes daily cleaning and regular trimming. 2. Proper nail care can aid in the prevention of skin problems around the nail bed. 4. Trimmed and smooth nails prevent the resident from accidentally scratching his or her skin. 2. During a concurrent observation and interview on 12/9/25 at 9:00 a.m. with the RNA, in Resident 4's room, the RNA was applying splint to Resident 4's right hand. Resident 4's right hand with long fingernails. The RNA checked 4's fingernails on both hands and stated Resident 4's fingernails were long. Resident 4's agreed to nail care when the RNA asked permission. The RNA stated CNAs were responsible in doing nail care every week. The RNA stated Resident 4 was dependent on staff to carry out ADLs. During an interview on 12/9/25 at 11:40 a.m. with MDSC 2 on 12/9/25 at, MDSC 2 stated nail care should be provided by nursing staff weekly to prevent self-inflicting skin tears and infection. MDSC 2 stated nursing staff to ensure good and proper hygiene should be provided to all residents. During an interview on 12/9/25 at 2:39 p.m. with LVN 3, LVN 3 stated, licensed nurses were responsible for Resident 4's nail care for her fingernails due to Resident 4's being diabetic (a person diagnosed with Diabetes Mellitus [DM- a disorder characterized by difficulty in blood sugar control (continued on next page)		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and poor wound healing]. LVN 3 stated desk nurses on weekends were responsible in providing nail care for residents with diagnosis of DM and to check residents' nails to ensure their nails are trimmed and cleaned to prevent infection and self-inflicting scratches. During an interview on 12/9/25 at 3:23 p.m. with the DON, the DON stated Resident 4's fingernails should be trimmed by licensed nurses. The DON stated long fingernails can harbor microorganisms (bacteria) that can cause infection and self-inflicting skin injuries like skin scratches. During a review of Resident 4'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 12/8/25, the AR indicated Resident 4 was admitted to the facility on [DATE] with primary diagnosis of hemiplegia (paralysis [the loss of the ability to move and sometimes to feel anything] of one side of the body) and hemiparesis (muscle weakness or partial paralysis on one side of the body that can affect the arms, legs, and facial muscles) following cerebral infarction (damage to tissues in the brain due to a loss of oxygen to the area) affecting left dominant side, and other diagnosis of type 2 DM, essential hypertension (HTN-high blood pressure), and polyneuropathy (a condition in which a person's peripheral nerves are damaged causing symptoms like pain, numbness, tingling, and weakness, usually starting in the feet and hands and spreading upwards). During a review of Resident 4's Minimum Data Set (MDS - a resident assessment tool used to identify cognitive [mental processes] and physical functional level assessment), dated 10/21/25, the MDS section C indicated Resident 4 had a Brief Interview for Mental Status (BIMS - a test given by medical professionals to determine cognitive understanding on a scale of 1-15) score of 14 (a score of 0-7 suggests severe cognitive impairment, 8-12 suggests moderately impaired, 13-15 suggests cognitively intact), which suggested Resident 14 was cognitively intact. During a review of Resident 4's electronic medical record (EMR- a digital version of a patient's paper chart) titled, Care Plan Report, undated was reviewed. The Care Plan Report indicated, I have a physical functioning deficit related to: Mobility impairment. ROM (Range of Motion) limitations left sided weakness, self-care impairment Date initiated: 4/24/25. Interventions: Nail Care PRN (as needed) . During a review of facility's policy and procedure titled, Fingernails/Toenails, Care of, dated, 2/18, the P&P indicated, The purpose of this procedure are to clean the nail bed, to keep nails trimmed, and to prevent infections. General Guidelines 1. Nail care includes daily cleaning and regular trimming. 2. Proper nail care can aid in the prevention of skin problems around the nail bed. 4. Trimmed and smooth nails prevent the resident from accidentally scratching his or her skin.		

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to assist the resident in gaining access to vision services for one of seven sampled residents (Resident 33) when Resident 33's eye specialist referral dated 5/30/25 was not implemented. This failure resulted in Resident 33 experiencing worsening eyesight on her left eye and placed Resident 33 at an increased risk of being blind (having severe visual impairment or permanent sight loss). Findings: During a concurrent observation and interview on 12/3/25 at 8:57 a.m. with Resident 33, in Resident 33's room, Resident 33 was awake lying in bed, in upright position. Resident 33's room was dark with privacy curtain covering her entire bed and window curtains completely close. Resident 33 was alert oriented x 4 (refers to someone who is alert and oriented to person, place, time and event). Resident 33 stated she's been at the facility for over a year and had concern about her vision in her left eye. Resident 33 stated she had a left eye cataract (a cloudy area in the lens of the eye that leads to a decrease in vision of the eye) and right eye retinal detachment (a serious eye condition where the retina peels away from the back of the eye, cutting off its blood supply and function, often signaled by sudden floaters, flashes, or a dark shadow in your vision, requiring immediate medical attention to prevent permanent vision loss). Resident 33 stated prior to her admission to the facility, her personal doctor scheduled cataract surgery for her left eye. Resident 33 stated she was instructed by her personal doctor to follow up with her doctor at the facility about the left eye cataract surgery, since she was residing at the facility as a long-term care resident. Resident 33 stated she's been reminding her doctor and nurses at the facility regarding the need for cataract surgery in her left eye and needing a referral for an eye specialist. Resident 33 stated the doctor came yesterday (12/2/25) and reminded about the cataract surgery. Resident 33 stated when she was admitted at the facility, she can still see shadow-like shapes and currently see black circles. Resident 33 stated she wanted her cataract to be removed to improve her vision. Resident 33 stated she liked staying in her room and wanting to enjoy watching her tablet again. Resident 33 stated she listened to her tablet and books. During a concurrent interview and record review on 12/4/25 at 4:52 p.m. with, Minimum Data Set Coordinator (MDSC) 2 Resident 33's Minimum Data Set (MDS - a resident assessment tool used to identify cognitive [mental processes] and physical functional level assessment) Section B: Hearing, Speech, and Vision and Section C: Cognitive patterns assessments, dated 10/6/24 (5-day assessment) and 9/30/25 (Annual assessment). The MDS Section B indicated, highly impaired. MDSC 2 stated highly impaired means Resident 33 can still see, and stated, can still see some. The MDS Section C indicated Resident 33 had a Brief Interview for Mental Status (BIMS - a test given by medical professionals to determine cognitive understanding on a scale of 1-15) score of 14 (a score of 0-7 suggests severe cognitive impairment, 8-12 suggests moderately impaired, 13-15 suggests cognitively intact), which suggested Resident 33 was cognitively intact. MDSC 2 indicated and stated Resident 33's MDS entry date was 10/1/24, indicating Resident 33 was admitted to the facility on [DATE]. MDSC 2 stated Resident 33 had a diagnosis of cataract and retinal detachment when admitted on [DATE]. MDSC 2 stated Resident should be referred to an eye specialist related to vision impairment. During a concurrent interview and record review on 12/5/25 at 9:45 a.m. with Registered Nurse Supervisor (RNS), Resident 33's clinical record was reviewed. The RNS stated Resident 33 was admitted to the facility on [DATE] and had an ophthalmologist referral on 12/2/25. The RNS stated Resident 33 should be referred to an eye specialist by the Social Services Director (SSD) to evaluate Resident 33's vision. The RNS stated it was important for Resident 33's vision to be evaluated by an eye specialist to identify eye concerns to help improve her vision. The RNS stated the SSD arranged all specialist referrals. The RNS stated the admission staff was covering for SSD. During an interview on 12/5/25 at 4:47 p.m. with the Activities Director (AD), the AD stated Resident 33 stayed in her room most of the time listening to her tablet. The AD stated Resident 33's vision was impaired. During a concurrent interview and record (continued on next page)		

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	review on 12/9/25 at 3:30 p.m. with the Director of Nursing (DON), Resident 33's eye evaluation dated 5/30/25, indicated, .Diagnosis: Cataracts R(right)/L(left).Recommendations: Ophthalmology Referral-Optic OS (left eye) pallor.Goals of Treatment - within 2 months.Signature Notes: Referral letter written. The DON stated Resident 33's ophthalmology referral on 5/30/35 should be implemented and followed through to prevent worsening of Resident 33's vision. The DON stated Resident 33's ophthalmology referral should be immediately carried out after being evaluated by an eye doctor to help Resident 33 to see better which she can use in performing her activities of daily living and stated, for her independence.During a facility's review of policy and procedures titled. Eye/Vision Care Policy. To ensure that residents of Countryside Care Center receive comprehensive and timely eye care services, promoting optimal vision, health and quality of life. This includes assessments and treatments provided by contracted external services when necessary. This policy applies to all residents and involves collaboration with external eye care providers in accordance with California's health care regulations. 1. Assessment and Identification of Needs - Identification of Concerns: Document and report any changes in vision or eye health observed by staff or reported by resident. 2. Coordination with External Services - Contracting External Providers: Identify and contract with licensed eye care providers (optometrists and ophthalmologists) to deliver services on-site r through coordinated off-site visits. 3. Provision of Care - Treatment Plans: Collaborate with eye care providers to develop individualized treatment plans for residents requiring glasses, medication, or surgical interventions. 4. Monitoring and Follow-Up - Documentation: Keep detailed records of all assessments, treatments, and communication with external providers in the resident's medical life. Follow-Up Care: Monitor residents' responses to treatments and adjust plans as necessary, in collaboration with external providers. - Ensure timely follow-up appointments and interventions as recommended by vision care specialists.		

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NAME OF PROVIDER OR SUPPLIER Foundation Skilled Nursing		STREET ADDRESS, CITY, STATE, ZIP CODE 925 North Cornelia Fresno, CA 93706	
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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 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide appropriate services, equipment, and assistance to maintain or improve mobility for one of seven sampled residents (Resident 4), when Resident 4's Restorative Nursing Programs (is a formal, planned and organized program of care which is intended to restore a lost ability or maintain the highest level of function of the residents) were not implemented after therapy services dated 10/23/25 and 11/12/25, and Resident 4's left hand splint (is a device designed to prevent contractures [a permanent tightening and shortening of muscles, tendons, ligaments, or skin, which restricts movement and causes stiffness or deformity in a joint, preventing normal motion] by gently stretching and maintaining the position of affected joints, such as the hand, wrist, or foot) and left leg boot (a device that provide support, stability, and protection to the lower leg, ankle, and foot) were not applied based on Resident 4's needs and assessment. This failure had the potential for Resident 4 to develop a decrease in range of motion (ROM -is the full extent or distance a body part can move around a joint) to her left upper and lower extremities, worsening of mobility and overall decreased in well-being. Findings: During a concurrent observation and interview on 12/2/25 at 11:14 a.m. with Resident 4, in Resident 4's room, Resident was lying in bed with a fixed pole on right side of bed. Resident 4 was awake, alert oriented x 4 (refers to someone who is alert and oriented to person, place, time and event). Resident 4 stated, they need to give me physical therapy. Resident 4 stated she had a massive stroke (when blood stops flowing to a part of your brain) with left side weakness, hospitalized and was admitted to the facility for therapy. Resident 4 stated she's been at the facility for eight months. Resident 4 stated she only received a little therapy, they need to give me more physical therapy, I am getting weaker. Resident 4 stated she was on RNA programs, the RNA was applying a splint to her left hand and booth to her left leg. Resident 4 stated she did not receive RNA programs for more than a month. Resident 4 stated her splint, and boot had been missing for more than a month. Resident 4 stated she wanted to get stronger, and stated, I want to go home. During a review of Resident 4's Minimum Data Set (MDS - a resident assessment tool used to identify cognitive [mental processes] and physical functional level assessment), dated 10/21/25, the MDS section C indicated Resident 4 had a Brief Interview for Mental Status (BIMS - a test given by medical professionals to determine cognitive understanding on a scale of 1-15) score of 14 (a score of 0-7 suggests severe cognitive impairment, 8-12 suggests moderately impaired, 13-15 suggests cognitively intact), which suggested Resident 14 was cognitively intact. During a concurrent interview and record review on 12/4/25 at 9:58 a.m. with RNA, Resident 4's RNA programs 5/28/25 were reviewed. The RNA programs dated 5/28/25 indicated, .assist/apply resident with of application of splint to left upper extremity resting hand splint remove after 6-8 hours. boot on left lower extremity up to 6 hours. RNA stated she was applying the splint and booth to Resident 4 from May until late August 2025, up to 12 weeks. RNA stated Resident 4's splint and boot had been missing since late August of this year. RNA stated Resident 4 was not currently on RNA programs and she was not on therapy services and stated, I don't know the reason why? RNA stated she was waiting for the therapy department to start Resident 4's RNA programs. RNA stated Resident 4 had the potential of getting weaker without therapy services and RNA programs. RNA stated RNA programs helped residents in maintaining and preventing their physical mobility and ROM. During a concurrent interview and record review on 12/4/25 at 4:52 p.m. with Minimum Data Set Coordinator (MDSC) 2, Resident 4's RNA programs were reviewed. MDSC 2 stated she was overseeing RNA programs and follows therapy's restorative nursing referral. MDSC 2 stated Resident 4 was previously on RNA programs for left hand splint, left leg boot, Active Range of Motion (AROM -the movement you can create at a joint using only your own muscles, without any outside help or resistance), and Passive Range of Motion (continued on next page)		

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	(PROM- means the movement of a joint through the range of motion with no effort from the patient and was discontinued on 10/2/25. MDSC 2 stated she did not receive RNA referral from therapy. MDSC 2 stated Resident should be on RNA programs to maintain current function. During a concurrent interview and record review on with Registered Nurse Supervisor (RNS), Resident 4'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 12/8/25, and Order Summary dated 12/2025. The AR indicated Resident 4 was admitted to the facility on [DATE] with primary diagnosis of hemiplegia (paralysis [the loss of the ability to move and sometimes to feel anything] of one side of the body) and hemiparesis (muscle weakness or partial paralysis on one side of the body that can affect the arms, legs, and facial muscles) following cerebral infarction (damage to tissues in the brain due to a loss of oxygen to the area) affecting left dominant side. The RNS stated there was no RNA order indicated in the Order Summary Report. The RNS stated Resident 4 was at risk for a decline in mobility and ROM related to diagnosis of Cerebral infarction with left side weakness/paralysis. The RNS stated Resident 4 should be getting RNA programs to maintain her physical mobility and prevent contractures. During a concurrent observation and interview on 12/9/25 at 9:00 a.m. with Resident 4, in Resident 4's room with RNA at the bedside, RNA was applying splint to Resident 4's right hand. RNA checked Resident 4's left lower extremity. Resident 4's left lower extremity was limp, and flaccid(weak). Resident 4 stated RNA found the left-hand splint at bedside drawer today (12/9/25). Resident 4 stated, my left leg was dropping. Resident 4 stated she needed the left leg boot to keep her leg in straight and stable position. Resident 4 stated left leg splint was still missing. During an interview on 12/9/25 at 9:10 a.m. with RNA, RNA stated she did not receive instructions from the therapist regarding Resident 4's new RNA program for bed mobility. RNA stated there was no RNA referral for Resident left hand splint and left leg boot application. RNA stated the process when a resident is transitioning to RNA, the therapy assigned will provide training to RNA to ensure proper and safe implementation of RNA programs. RNA stated Resident 4 should continue RNA programs for splint and boot for contracture management. During a concurrent interview and record review on 12/9/25 at 11:25 a.m. with MDSC 2, Resident 4's Restorative Nursing Referral, dated 11/26/25 and therapy notes were reviewed. The Restorative Nursing Referral indicated, . Referral for Bed Mobility: Yes. Restorative Nursing Referral Accepted: Yes, signed date: 12/4/25. MDSC 2 stated the Restorative Nursing Referral was communicated by the therapy department on 12/4/25 for bed mobility only. MDSC stated Resident 4's PT service was ended on 10/23/25 and OT service ended on 11/12/25. MDSC 2 stated Resident 4's Restorative Nursing Referral should start on the last treatment dates of 10/23/25 and 11/12/25. MDSC 2 stated there was no restorative nursing referral for left hand splint and left leg boot. MDSC 2 stated establishing an RNA program for Resident 4 is important in maintaining the level of functioning and managing potential contractures. During an interview on 12/9/25 at 2:35 p.m. with Licensed Vocational Nurse (LVN) 3, LVN 3 stated RNA programs are important to maintain residents' physical and functional mobilities. During a review of Resident 4's electronic medical record (EMR- a digital version of a patient's paper chart) titled, Care Plan Report, undated was reviewed. The Care Plan Report indicated, I have a physical functioning deficit related to: Mobility impairment. ROM (Range of Motion) limitations left sided weakness, self-care impairment Date initiated: 4/24/25. Interventions: bed mobility assistance, locomotion assistance, monitor and report changes in physical functional ability, ROM ability. During a concurrent telephone interview and record review on 12/9/25 at 3:27 p.m. with the Director of Rehabilitation (DOR), Resident 4's therapy notes were reviewed. The DOR stated OT services' last day of treatment was 11/12/25 and PT services' last day of treatment was 10/23/25. The DOR stated there was a delay in transitioning to RNA programs for more than a month. The DOR stated the expectation for transitioning to RNA programs should be on the day or a day after the discharge on skilled services (Physical Therapy (PT) and Occupational Therapy (OT). The DOR stated timely transition of RNA programs was important to make sure Resident 4 will maintain the (continued on next page)		

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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 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	level of functioning including ROM and manage potential contractures. The DOR stated Resident 4 should continue RNA programs for applying left hand splint and left leg boot for contracture management. The DOR stated the therapist should be providing training with RNA to make sure RNA can implement the RNA programs properly. During a review of Resident 4's OT Treatment Encounter Notes, dated 11/12/25, indicated, .RUE (right upper extremity) hemiplegia Goal: Establish RNA for contracture management.During a review of facility's policy and procedures (P&P) titled, Restorative Therapy Program Policy, undated, the P&P indicated, To provide a structured restorative therapy program that supports residents in maintaining or improving their functional abilities, with a focus on enhancing quality of life and promoting independence. Interdisciplinary Team Review: - The interdisciplinary team, including nurses, therapists, and physicians, reviews assessments to identify potential candidates for restorative therapy program. - Implement a range of activities, including strength and balance exercises, functional mobility training, activities of daily living (ADL) training, cognitive exercises, and group therapy sessions. - Conduct ongoing assessments to monitor resident progress and adjust care plans as necessary. - Regularly evaluate the program's effectiveness through resident outcomes, satisfaction surveys, and family feedback.During a review of facility's P&P titled, Contracture Management Policy, undated, the P&P indicated, To provide structured guidelines for the prevention, identification, and management of contractures in residents at . aimed at improving mobility, maintaining function, and enhancing quality of life. This policy applies to all nursing and therapy staff involved in the care of resident who are at risk of or are currently experiencing contractures. Contracture: A permanent shortening of a muscle, tendon, or joint capsule that results in limited range of motion. Indicators of Risk: - Immobility, neurological disorders, previous history of contractures, and conditions causing muscle weakness or paralysis. 4. Implementation of Contracture Management - Therapeutic Interventions: - Apply specific therapeutic interventions like stretching, splinting, or using orthotic devices as per care plan. Monitoring and Adjustment: - Monitor residents for changes in condition or response to interventions. - Adjust care plans based on effectiveness and resident feedback. 6. Quality Assurance and Compliance - Program Evaluation: - Regularly review and evaluate the effectiveness of contracture management strategies.		

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain dental services for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews, and record review, the facility failed to ensure dental services were provided for one of seven sampled residents (Resident 4) when Resident 4 was not seen and evaluated by a dentist (a doctor who specializes in teeth, gums, and mouth) as necessary to manage Resident 4's oral health. This failure had resulted in Resident 4 experiencing toothache (pain in or around the tooth) and had the potential to put Resident 4 at an increased risk of dental problems including tooth infection (happens when bacteria invade the tooth's inner pulp, causing pus buildup, severe pain (throbbing, sharp), swelling, fever, and sensitivity), tooth cavities, and gums disease. Findings: During a concurrent observation and interview on 12/2/25 at 11:14 a.m. with Resident 4, in Resident 4's room, Resident was lying in bed with a fixed pole on right side of bed. Resident 17 was awake, alert oriented x 4 (refers to someone who is alert and oriented to person, place, time and event). Resident 4 complained of toothache and stated she was receiving pain medication and had relieved the pain. Resident 4 stated she needed to see a dentist. Resident 4 stated had been at the facility for eight months and she had not seen a dentist. Resident 4 stated she had been asking nurses for a dental examination and stated social service director (SSD) was not always available when asked about a dentist. During a review of Resident 4's Minimum Data Set (MDS - a resident assessment tool used to identify cognitive [mental processes] and physical functional level assessment), dated 10/21/25, the MDS section C indicated Resident 4 had a Brief Interview for Mental Status (BIMS - a test given by medical professionals to determine cognitive understanding on a scale of 1-15) score of 14 (a score of 0-7 suggests severe cognitive impairment, 8-12 suggests moderately impaired, 13-15 suggests cognitively intact), which suggested Resident 14 was cognitively intact. During a concurrent interview and record review on 12/5/25 at 9:27 a.m. with Registered Nurse Supervisor (RNS), Resident 4'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 12/8/25, and clinical health record. The AR indicated Resident 4 was admitted to the facility on [DATE] with primary diagnosis of hemiplegia (paralysis [the loss of the ability to move and sometimes to feel anything] of one side of the body) and hemiparesis (muscle weakness or partial paralysis on one side of the body that can affect the arms, legs, and facial muscles) following cerebral infarction (damage to tissues in the brain due to a loss of oxygen to the area) affecting left dominant side. The RNS stated there was no dental assessment and evaluation completed by the dentist since Resident 4's admission on [DATE]. The RNS stated the facility had a dentist that visits the facility and Resident 4 should have been seen and evaluated by the dentist. The RNS stated SSD was responsible in arranging dental appointments and she will check who was covering for their SSD. The RNS stated she will contact the dental hygienist to assess Resident 4's teeth and oral health. The RNS stated that oral health is important to prevent oral and dental problems including toothache and infection. During a concurrent observation and interview on 12/9/25 at 9:00 a.m. with Resident 4, in Resident 4's room with RNA at the bedside, Resident 4 stated her toothache was getting better and stated, just a little pain. Resident 17 stated she has not seen a dentist. During an interview on 12/9/25 at 9:44 a.m. with the Director of Nursing (DON), the DON stated the dentist came recently and list of residents were given. The DON stated Resident 4 should have been evaluated by the dentist from admission and as needed. The DON stated Resident 4's complaint of toothache should be assessed by a dentist to prevent infection. During a review of Resident 4's electronic medical record (EMR- a digital version of a patient's paper chart) titled, Care Plan Report, undated was reviewed. The Care Plan Report indicated, I have a physical functioning deficit related to: Mobility impairment. ROM (Range of Motion) limitations left sided weakness, self-care impairment Date initiated: 4/24/25. Interventions: Oral care assistance. Dental exams as necessary .During a review of facility's policy and procedures (P&P) titled, Routine Medical and Dental Care, dated 6/1/24, (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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F 0791 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the P&P indicated, Routine medical care, dental care, and other health-related services for the residents.1. Upon admission the following information is collected from all of the residents' healthcare providers (physicians, dentist, mental health professional, etc.) and documented in the resident's record: 2. The Resident Services Director or designee will assist residents with scheduling medical, dental, and other health-related appointments as requested. 3. All requests for dental services must be referred to the Resident Services Director. During a review of facility's P&P titled, Dental Emergencies, dated 12/1/23, the P&P indicated, Residents will receive emergency dental care when needed. 3. Acute pain, broken dentures, broken teeth, or any other dental emergency will be reported to the Residents Services Director for immediate arrangement of dental care.		

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F 0911 Level of Harm - Potential for minimal harm Residents Affected - Many	Ensure resident rooms hold no more than 4 residents; for new construction after November 28, 2016, rooms hold no more than 2 residents. Based on observation during the survey period of 12/2/25 through 12/9/25, the facility failed to ensure each bedroom accommodated no more than four residents in three of 19 rooms (Rooms' 1, 2, and 14). This failure had the potential to adversely effect care provided to residents. Findings: During the initial tour on 12/2/25 at 9:30 a.m. the following rooms had more than four residents in each bedroom. Although the bedrooms accommodated more than four residents, each room met the particular needs of each residents. There was sufficient room for nursing care and for residents to ambulate. There was adequate closet and storage space. Bedside stands were available for each residents. Wheelchair and toilet facilities were accessible. The health and safety of residents would not be adversely affected by the continuance of this waiver. Room Number Number of Beds 1 6 2 6 14 6 Recommend waiver continue in effect. HFES Signature Date Request waiver continue in effect. _____ Facility Administrator Signature Date		