STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056296	A. Building B. Wing	03/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Crescent City Care Center	1280 Marshall Street Crescent City, CA 95531

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that residents requiring oxygen were provided humidifiers (bottled water that attaches to an oxygen concentrator and moistens the oxygen, preventing dry nose and throat), clean concentrators (a medical device that provides supplemental oxygen to people with breathing-related conditions by pulling in ambient air, filtering out nitrogen, and delivering purified oxygen) and orders for therapy for 13 of 15 residents (Residents: #18, #20, #23, #22, #25, #31, #40, #41, #98, #48, #55, #76, #81) observed receiving oxygen therapy when thirteen residents did not have humidifiers in use as required for their oxygen delivery systems, seven residents had visibly soiled or dirty oxygen concentrator filters, and eleven residents did not have physician orders for oxygen therapy, despite actively receiving oxygen during the survey.These deficient practices placed residents at risk for inadequate humidification, ineffective oxygen delivery, respiratory compromise, and potential infection due to unmaintained equipment.Findings:A review of Resident 18's admission record indicated admission to the facility on [DATE] for pneumonia (an infection / inflammation in the lungs). An observation on 3/24/26 indicated she had no humidifier on her concentrator and record review revealed no orders for oxygen therapy.A review of Resident 20's admission record indicated admission to the facility on 7/7/2025 for an encounter for orthopedic aftercare following surgical amputation and he has no memory impairment. An observation on 3/24/26 indicated he had no humidifier on his concentrator.A review of Resident 23's admission record indicated admission to the facility on 3/16/2022 for intervertebral disc degeneration (wear and tear of the spine). An observation on 3/24/26 indicated she had no humidifier, a dirty filter on her concentrator and record reviewed revealed no orders for oxygen therapy.A review of Resident 22's admission record indicated admission to the facility on 1/29/2026 for dysphasia (difficulty swallowing). An observation on 3/24/26 indicated he had a dusty concentrator and record review revealed no orders for oxygen therapy.A review of Resident 25's admission record indicated admission to the facility on 2/8/2020 for an unspecified open wound, left thigh. An observation on 3/24/26 indicated she had no humidifier on her concentrator.A review of Resident 31's admission record indicated admission to the facility on [DATE] for cellulitis of the left lower limb. An observation on 3/24/26 indicated he had no humidifier on her concentrator and record review revealed no orders for oxygen therapy. A review of Resident 40's admission record indicated admission to the facility on 1/11/2025 for encounter for surgical aftercare following surgery on the digestive system. An observation on 3/24/26 indicated she had no humidifier and a dusty filter on her concentrator and record review revealed no orders for oxygen therapy.A review of Resident 41's admission record indicated admission to the facility on 1/11/2025 for encounter for surgical aftercare following surgery on the digestive system. An observation on 3/24/26 indicated she had no humidifier on her concentrator.A review of Resident 98's admission record indicated admission to the facility on 3/17/2026 for a fracture of the neck of the right femur. An observation on 3/24/26 indicated she had no humidifier and a dusty filter on her concentrator and record review revealed no orders for oxygen therapy.A review of Resident 48's admission record indicated admission to the facility on 5/16/2025 for acute respiratory failure. An observation on 3/24/26 indicated she had no humidifier and a dusty (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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	filter on her concentrator.A review of Resident 51's admission record indicated admission to the facility on [DATE] for chronic obstructive pyelonephritis (a serious kidney infection). An observation on 3/24/26 indicated a concentrator and record review revealed he had no orders for oxygen therapy.A review of Resident 55's admission record indicated admission to the facility on 1/18/2025 for acute respiratory failure. An observation on 3/24/26 indicated he had a dusty filter on his concentrator and record review revealed no orders for oxygen therapy.A review of Resident 76's admission record indicated admission to the facility on 4/28/2024 for encounter for Huntington's Disease (a disorder that causes the progressive breakdown of nerve cells in the brain). An observation on 3/24/26 indicated she had no humidifier and a dusty filter on her concentrator.A review of Resident 81's admission record indicated admission to the facility on 1/24/2023 for myopathies (a breakdown of the muscles). An observation on 3/24/26 indicated she had no humidifier on her concentrator and no orders for oxygen therapy.A review of Resident 83's admission record indicated admission to the facility on [DATE] for cellulitis of the right lower limb. An observation on 3/24/26 indicated she had no humidifier on her concentrator and record review revealed no orders for oxygen therapy.A review of Resident 86's admission record indicated admission to the facility on 8/16/2026 for acute and chronic respiratory failure. An observation on 3/24/26 indicated she had no humidifier on her concentrator and record review revealed no orders for oxygen therapy.During a review of the rooms with concentrators on 03/25/2026 from approximately 9:30 AM to 9:45 AM with the Director of Nursing (DON) and the Facility Maintenance Manager (FMM) when visiting Resident #40, the DON stated, That is awfully dirty, my concern would be respiratory injury. The FFM stated, I buy them and maintain them if they break, but I do not clean them. I can provide a copy of the user's manual.During a concurrent observation and interview when visiting Resident #55, the DON stated, No water in humidifier, no filter in machine. More respiratory injury. I don't know if there is a cleaning regiment for these. The DON checked with housekeeping and returned and stated, Housekeeping cleans the outsides of these, but they don't open them, nor do they deal with the filters.The DON confirmed that having no water in the humidifier could dry out respiratory track and make breathing uncomfortable, that dirty filters could leave to respiratory injury and that all Resident's on oxygen therapy should have an order from the physician. A review of the policy and procedure entitled, Oxygen Administration. Revised 5/20/2024, states, oxygen is administered under orders of a physician. The policy stated the facility will follow manufacturer recommendations for the frequency of cleaning equipment filters, and to change humidifier bottles when empty.A review of the DeVilbus 5-Liter Oxygen Concentrator Instruction Guide provided by the facility stated, inspect the vents periodically and wife with a dry cloth as needed to remove dust. Recommends a cleaning interval of every 7 days.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, staffing was not sufficient to meet the needs of thirteen Sampled Residents (Resident #6, Resident #29, Resident #55, Resident #9, Resident # 35, Resident #86, Resident #53, Resident #3, Resident # 34, Resident 54, Resident 81, Resident #5, and Resident #67 when:There was no staff assistance with dining for Sampled Residents #9, #86 and #35 and resulted in no lunch eaten by all three residents; and Sampled Resident #86 was not turned every two hours. Staff did not provide activities of preference for Sampled Resident #34, did not provide nail care for Residents #6, #29. #55, #54 and Resident #81, and did not get Resident #81, Resident #5 and Resident #67 out of bed.Sampled Residents #3, #6 and #53 were observed to not have call lights lights within reach on multiple occasion.These failures had the potential to result in:Resident potential for or worsening of malnutrition for Resident 9, Resident 86, and Resident 35, and a potential for development of skin issues like rashes and skin ulcers for Resident 86. Resident frustration and boredom for Resident 34, decreased self-esteem, injury, infection, decreased mobility and range of motion for Residents 6, 29, 55, 54, 81, 5 and 67, and Residents not being able to call for help due to call lights being inaccessible with could result in frustration and anger, and had the potential to result in falls and injuries 1. Resident #9 was admitted [DATE] with diagnoses that included Malnutrition (inadequate protein intake), Adult failure to Thrive (functional decline, weight loss, malnutrition) and Diabetes (An inability to produce enough insulin to metabolize sugar in the blood) among others. His Brief Interview for Menal Status (BIMS) (A cognitive assessment to determine how mental intact a resident was. A score of 0-9 indicated severe impairment, 10-12 indicated moderate impairment and 13-15 indicated no cognitive impairment.), score indicated 14. Resident #35 admitted [DATE] with diagnoses that included Malnutrition, Adult Failure to Thrive and Diabetes. His BIMs indicated a score of 15. Resident #86 was admitted [DATE] with diagnoses that included Malnutrition, Diabetes, Adult Failure to Thrive, Cellulitis (A potentially serious infection affecting the skin's deeper layers) among others. Her BIMs indicated a score of 8. During an observation on 3/23/26 at 9:06 a.m., 11 a.m., 12:58 a.m., and 4:45 p.m. Resident #86 was observed sitting up in bed on her back , at a 90 degree angle. Her head was observed to lean onto her right shoulder. During an observation on 3/23/26 at 12:58 p.m., lunch trays were delivered to #86. Resident #86 was sitting up in bed and she was not eating her lunch. During an observation on 3/23/26 at 1:10 p.m. Resident #9 and was sleeping on his left side and Resident #86 was sitting up in bed with the head of the bed at 90 degrees and had not eaten any lunch. During an observation on 3/23/26 at 1:15 p.m. Resident #9 and Resident 35's lunch trays were delivered to their room. Resident #35's tray was observed on his bedside table and the warming lid removed. He was observed to be sleeping on his left side. Resident #35's lunch tray was placed on his bedside table with the warming lid off. Resident #35 was seated on the left side of the bed facing the (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	window with his back to his lunch tray. During an observation on 3/23/26 at 2:30 p.m. Resident #9 was sleeping on his left side and his lunch had not been eaten. Resident #35 was observed to be seated on the left side of bed with the lunch tray untouched on the left side of the bed. His lunch was observed not to have been eaten. Resident #86's lunch tray was observed to have been removed and placed in the tray cart, with 0% consumed. During an observation on 3/23/26 at 3:12 p.m. and 4:45 p.m Resident #9 was sleeping on his left side. During an observation and interview on 3/23/26 at 12:58 p.m. Resident #86 was observed lying in bed on her back, at a 90 degree angle. Her head was observed to lean onto her right shoulder. A lunch tray had been placed in front of her. She stated she needed help with cutting her food. An observation of the hallway and nursing station indicated no staff were available to assist Resident #86. During an interview with US C on 3/23/26 at 1 p.m., he stated the process for serving residents lunch was to make sure they are sitting up and ready to eat. He stated he usually started to help residents cut up their food right away. During an observation and interview with Resident #35 on 3/23/26, at I:30 PM, he was seated on the left side of the bed and his lunch tray had been placed on the bedside table on the right side of the bed. He stated he was unaware his lunch had been delivered. He stated he was not hungry and was not offered any substitutions. He stated he did not know you could ask for substitutions. During an observation and interview on 3/24/2026 at 8:20 a.m. US E was observed to go into Resident 86's room at 8:18 a.m. and ask how her breakfast was. She stated not good. Her breakfast tray was observed to not indicate any breakfast had been eaten. He was observed to not go back and not ask Resident # 86 if she wanted a substitution. At 8:20 a.m. he stated he was in a rush. He stated he normally got an assignment of 12-16 residents every day and he could not help them with meals, and he could not take the time to turn them every two hours. He stated staffing was a struggle. He stated with his assignment he could not turn residents every two hours, change their briefs, give them all showers, assist with meals and get resident out of bed and dressed. During an interview on 3/24/26 at 2:15 p.m. with LS A stated all residents should be turned every two hours. During an interview on 3/24/2026 at 11:36a.m., Visitor stated when she was in the facility to visit residents, she had observed that residents were neglected, left in their beds, not participating in activities. She stated Resident #14's fingernails were long and dirty, and it took multiple calls to the facility to get someone to address the issue. She stated his television was not working and he did not leave his room. She stated he told her without the television he would listen to his roommate's music and listen to the people in the hall talk. Visitor stated it was a Sad situation for all the residents. During an interview on 3/25/26 at 11:55 a.m., US B stated she was assigned 12 residents. She stated she works a lot of overtime and double shifts because the facility was short staffed. She stated on the night shift you would be assigned 20 residents or more. She stated the staffing was so low she Cannot provide care like showers, hydration, turning every two hours. During an interview on 3/25/26 at 11:35 a.m., DSD stated the facility was unable to meet the required staffing requirements. She stated staffing was assigned according to the census and not only by (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	resident acuity. She stated without the staff you could not provide more than one or two showers a week for residents. A review of a facility policy titled, Activities of Daily Living, revised 12/19/22, indicated, The facility will, based on the resident's comprehensive assessment and consistent with the resident's needs and choices, ensure a resident's abilities in ADLs do not deteriorate unless deterioration is unavoidable. Care and services may include transfer and ambulation. 2. A review of Resident 34's admission record indicated he was admitted on [DATE] with a diagnosis of Parkinson's Disease among others. A review of Resident 24's MDS indicated he had a BIMS score of 11, indicating mild cognitive impairment. A record review of resident 34's care plan indicated he had a decline in functional mobility and his preferences for activities were to be invited to group activities and outdoor activities. During a concurrent observation and interview on 3/23/26 at 9:20 a.m. with resident 34 in his room, Resident 34 had contractures of arms and legs. Resident 34 stated staff did not do what he asked and never got him out of bed, and he was so bored and wanted to go outside. During a review of Resident 34's Activities log indicated he was offered in-room activities and refused or was not available for activities. During an interview on 3/26/26 at 4:30 p.m. with the Activities Director (AD), AD stated she had two new assistants and the refusals marked were incorrect. AD stated Resident 34 did not refuse but got frustrated with not being able to do what he used to be able to do and likes company the most. AD stated that activities staff could not move Resident 34 on their own and other staff were unavailable to assist him out of bed for activities. During an interview on 3/27/26 at 8:53 a.m. with the Director of Nursing (DON), DON stated, activities on the care plan should be attempted, if it was their preference and they voiced it, staff should facilitate it, and if not, it could affect their mood and could contribute to depression. A review of a facility policy titled, Activities, revised 12/19/23, indicated, It is the policy of this facility to provide an ongoing program to support residents in their choice of activities based on their comprehensive assessment, care plan, and preferences. It further indicated, Activities will include individual, small and large group activities, as well as Indoor and Outdoor activities and social activities. A review of Resident #6's admission record indicated the resident was admitted on [DATE] with a diagnosis of paraplegia. A review of Resident #6's MDS indicated the resident had no memory impairment. During a concurrent observation and interview on 3/27/26 at 10:51 a.m., Resident #6's toenails appeared thick, long, and discolored, with visible dirt and debris under the nails. Resident #6 stated, I've asked to have my toenails done, but I'm a diabetic so they don't like to do them. A review of Resident #29's admission record indicated the resident was admitted on [DATE] with a (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	diagnosis of paralytic syndrome. A review of Resident #29's MDS indicated the resident had no memory impairment. During a concurrent observation and interview on 3/23/26 at 10:03 a.m., Resident #29's fingernails were observed to be long with pointed ends. Resident #29 stated, I have a hard time getting them to brush my teeth and do my nails. A review of Resident #55's admission record indicated the resident was admitted on [DATE] with a diagnosis of acute respiratory failure. A review of Resident #55's MDS indicated the resident had no memory impairment. During a concurrent observation and interview on 3/23/26 at 9:08 a.m., Resident #55's toenails appeared thick, long, and discolored. On 3/25/26 at 4:12 p.m., Resident #55 stated, I've asked, but they don't do them. A review of the facility policy titled Nail Care, revised 12/19/22, indicated: Routine cleaning and inspection of nails will be provided during ADL care on a routine basis, and routine nail care including trimming and filing will be provided on a regular schedule. A review of Resident 54's admission record indicated she was admitted on [DATE] with diagnosis of Encephalopathy, Dementia, and repeated falls with unsteadiness on feet. A review of Resident 54's MDS dated [DATE] indicated she could not complete the assessment. During a concurrent observation and interview on 3/23/26 at 10:19 a.m. in Resident 54's room with Licensed Nurse B (LN B) , Resident 54 was observed with yellow discolored very long fingernails and toenails and dry skin on her feet. LN B confirmed presentation of fingernails and toenails and stated Resident 54 was feisty and uncooperative at times and when we offer nail care she refuses. LN B offered Resident 54 nail care and she replied, yes, that would be very nice. A review of Resident 81's admission record indicated she was admitted [DATE] with diagnoses of unspecified myopathies, unsteadiness on feet, osteoporosis with falls, A-Fib, PTSD and anxiety. A review of Resident 81's MDS indicated she had a BIMS score of 12 indicating mild cognitive impairment. During a concurrent observation and interview on 3/23/26 at 10:27 a.m. in Resident 81's room, Resident 81 is seen with long discolored fingernails with dirt and debris under nails and long thick toenails with dry skin on feet. Resident 81 stated staff took her clippers away and when she asked staff to provide nail care they say they do not have the time and the nurses would not do it either. During an interview on 3/26/26 at 8:50 a.m. with LN B, LN B stated they had been short staffed for some time and with the increase in acuity of residents some days it was not possible to get to nail care. During an interview on 3/26/26 at 9:52 a.m. with Unlicensed Staff B (US B), US B stated many staff call out and quit and sometimes she has as many as 20 residents (assigned to her per shift). Today US B had 12 residents, and on average US B had around 15 residents. US B further stated some days US B only has time to focus on the minimum and that nail care and oral care would be low priorities, (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 3/26/26 at 10:04 a.m. with Unlicensed Staff A (US A), US A stated they did not feel they had enough time to get to everything and US A focused on incontinence care and that nail care and oral care fell off the list. During an interview on 3/27/26 at 8:53 a.m. with the DON, DON stated nail care should be done on weekly rounds and should be clipped, filed and clean. DON further stated she knew the CNA's found it difficult to find the time and it put residents at risk for infection, injury and could affect self-esteem. During a review of a facility policy titled, Nail Care, revised 12/19/22 indicated, Routine cleaning and inspection of nails will be provided during ADL care on a routine basis and routine nail care including trimming and filing will be provided on a regular schedule. A review of Resident 81's admission record indicated she was admitted [DATE] with diagnoses of unspecified myopathies (muscle diseases), unsteadiness on feet among others. A review of Resident 81's MDS indicated she had a BIMS score of 12 indicating mild cognitive impairment. A review of Resident 5's admission record indicated he was admitted on [DATE] with diagnoses of alcohol induced persisting dementia, Bi-polar disorder among others. A review of Resident 5's MDS dated [DATE] indicated he had a BIMS score of 00 indicating severe cognitive impairment. A review of Resident 67's admission record indicated she was admitted on [DATE] with diagnoses of cerebral infarction (stroke) among others. A review of Resident 67's MDS dated [DATE] indicated she had a BIMS score of 06 indicating severe cognitive impairment. During an observation on 3/24/26 at 8:15 a.m, Residents 81,5, and 67 are all seen in bed. During an observation on 3/24/26 at 11:00 a.m, Residents 81,5, and 67 are all seen in bed. During an observation on 3/25/26 at 7:50 a.m. Residents 81, 5, and 67 are all seen in bed. During an observation on 3/25/26 at 12:20 p.m. Residents 81, 5, and 67 are all seen in bed. During an observation on 3/25/26 at 2:55 p.m. Residents 81, 5, and 67 are all seen in bed. During an observation on 3/25/26 at 4:35 p.m. Residents 81, 5, and 67 are all seen in bed. During an observation on 3/25/26 at 5:40 p.m. Residents 81, 5, and 67 are all seen in bed. During an observation on 3/26/26 at 7:55 a.m. Resident 81, 5, and 67 are all seen in bed. During an observation on 3/26/26 at 10:00 a.m. Resident 81, 5, and 67 are all seen in bed. During an observation on 3/26/26 at 1:49 p.m. Resident 81, 5, and 67 are all seen in bed. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an observation on 3/26/26 at 4:15 p.m. Resident 81, 5, and 67 are all seen in bed. During an interview on 3/25/26 at 12;35 p.m. with Resident 81 in her room, Resident 81 stated, she is in bed all day, she was out of bed once a week for shower if the lift was available, if not staff did a bed bath. Resident 81 stated she watched TV to stay entertained and hadn't been out of the facility since 7/4/24. During an interview on 3/26/26 at 9:52 a.m. with US B, US B stated, they did not have time to get residents out of bed, and this often required two people and a lift, and this was not often available. US B stated they were aware of Resident 67 and that she should be up in her wheelchair daily, but this does not happen. During an interview on 3/26/26 at 10:34 a.m. with US A, US A stated they would like to get residents up, but it depends on which resident and how they need to be transferred. US A stated they could not do it independently. US A stated they were not sure about the policy but ideally residents should be out of bed once a day at least. During an interview on 3/27/26 at 8:53 a.m. with the DON, DON stated, bed bound residents could be really difficult, and she would like to see everyone up in a chair at least once a day, but time and staff were a factor. DON stated you needed time and two people, and this may fall to the bottom of the list of resident care needs. A review of a facility policy titled, Activities of Daily Living, revised 12/19/22, indicated, The facility will, based on the resident's comprehensive assessment and consistent with the resident's needs and choices, ensure a resident's abilities in ADLs do not deteriorate unless deterioration is unavoidable. Care and services may include transfer and ambulation. 3. During an observation on 3/23/26 at 9:31 a.m., Resident #3 was sitting in bed with the call light on the ground, wrapped around the bed handrail. The IP (Infection Preventionist) confirmed the resident could not use the call light in its observed position.During an observation on 3/25/26 at 4:31 p.m., Resident #3 was asleep in bed. The call light was observed on the floor.During an observation on 3/26/26 at 9:31 a.m., Resident #3 was awake in bed. The call light was observed on the floor. During an observation on 3/27/26, Resident #6 was sleeping in bed with the call light lying on the ground. During an observation on 3/23/26 at 8:32 a.m. Resident #53 was in bed, and the call light was observed on the neighboring resident's bedside table. At 8:37 a.m., the ADON was asked to enter the room to locate Resident #53's call light. The ADON found it on the neighboring resident's bedside table and stated, I don't know how it got to the other side of the room. It should always be available to the resident. During an observation on 3/25/26 at 4:32 p.m. Resident #53 was asleep in bed; the call light was on the floor. A review of the facility's policy titled Call Lights: Accessibility and Timely Response, revised 12/22, indicated that Staff will ensure the call light is within reach of resident and secured, as needed.

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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 0800 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs. Based on observations, interviews, and record review, the facility failed to provide a census of 87 residents with a wellˆbalanced diet that met their daily nutritional and special dietary needs, while honoring individual food preferences when:The facility did not maintain current and complete dietary preference documentation, as only 5 of 87 residents had documented preferences; and The facility did not provide staff with accurate and upˆtoˆdate diet order information, as dining room staff relied on a diet roster that was two weeks outdated.These failures had the potential to place residents at risk for decreased meal satisfaction, leading to reduced intake and missed therapeutic diets, potentially resulting in medical complications.1. During a record review of the facility's 85 lunch tray tickets dated 3/24/26, only five of the tray tickets had documented preferences.2. During an observation on 3/23/26 at 12:08 p.m., in the main dining room, one facility staff member was observed walking around the dining room offering residents hot drinks such as coffee or tea and another staff member was observed walking around offering residents a bowl of chicken soup.During an interview on 3/23/26 at 12:20 p.m. with the Infection Preventionist Nurse (IP), the IP stated if staff assigned to help in the dining room during meal times is unsure of a resident's diet, dining room staff are trained to refer to a report called Diet Type Report which was printed daily by the Certified Dietary Manager (CDM). The report indicates the current diet type and texture orders for all residents currently residing in the facility.During a concurrent interview and record review on 3/23/26 at 12:23 p.m. with the IP, the IP confirmed the Diet Type Report available for the dining room staff to refer to was dated 3/9/26. The IP stated she would let the CDM know a current report was needed immediately.During an interview on 3/27/26 at 10:45 a.m. with the Director of Nursing (DON), the DON stated she expected all residents to receive meals according to their current diet order. The DON further stated using an outdated Diet Type Report places residents at risk of receiving incorrect diet types and textures which can lead to choking and aspiration, medical complications, and decreased meal intake.A review of the facility's policy and procedure (P&P) titled Therapeutic Diet Orders, revised 5/23, the P&P indicated, The facility provides all residents with foods in the appropriate form and/or the appropriate nutritive content as prescribed by a physician, and/or assessed by the interdisciplinary team to support the resident's treatment/plan of care, in accordance with his/her goals and preferences.

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F 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. Based on observation, interview, and record review, the facility failed to provide support personnel to safely and effectively carry out the functions of the food and nutrition services department for a census of 87 residents when the Dishwasher (DW) operated the dishwashing machine at 108 degrees Fahrenheit and could not identify the required operating temperature or describe how to test for chlorine sanitation.This failure had the potential to affect the facility's ability to maintain effective sanitation practices for all residents and to cause foodborne illnesses in a vulnerable resident population.During an interview on 3/25/26 at 10:33 a.m., with the DW, the DW stated he was a new employee and remained in training. The DW could not specify the temperature at which the dishwashing machine should operate. The DW also could not describe how to test for chlorine sanitation. During an observation on 3/25/26 at 10:37 a.m., the DW operated the dishwashing machine, and the temperature gauge showed 108 degrees Fahrenheit.During an interview on 3/26/26 at 5:30 p.m., with the Certified Dietary Manager (CDM), the CDM stated DW had been employed at the facility for three weeks and had not completed the required competency checks yet. The CDM also mentioned that using the dishwashing machine incorrectly could create safety concerns for facility residents because of inadequate sanitation.During an interview on 3/27/27 at 10:45 a.m., with the Director of Nursing (DON), the DON stated she expected all dietary staff to prove competent in their assigned positions. The DON agreed any staff who operated the dishwashing machine should know the correct operating temperature and how to check for proper sanitation. The DON also stated operating the dishwashing machine without this knowledge could pose an infection control risk to all residents.A review of the policy and procedure (P&P) titled Dishwashing, undated, the P&P stipulated, Use the machine at a range of 120 degrees F to 140 degrees F. The chlorine should read 50-100 ppm on dish surfaces in final rinse.A review of the facility's P&P titled, Sanitation, dated 2023, the P&P indicated, No Food & Nutrition Services employee shall operate any major piece of equipment without knowing how to operate it correctly.A review of the facility's procedure titled Competencies for Food and Nutrition Services Employees, undated, the procedure indicated food and nutrition services employees must show competence in following all manufacturer's instructions for the proper use and care of equipment.

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, and record review the facility failed to ensure an effective system was in place to accurately identify and communicate residents' food allergies, preferences and substitutes for a census of 87 residents when the facility's tray tickets listed residents' allergies under the dislikes section rather than under a clearly defined allergies designation, and preferences were not assessed, documented on meal tickets or honored for three residents (Resident 35, Resident 86, and Resident 89). This failure placed residents at risk for exposure to allergens due to staff's inability to reliably identify and accommodate allergy restrictions, and left residents frustrated due to their preferences not being honored. During an interview on 3/23/26 at 9:15 a.m. Resident #35 stated he did not get what he needed for breakfast. He stated he told someone and he still didn't get it. He stated he needed raisin bran cereal with two non-sugar sweeteners and more milk. He said they kept bringing him oatmeal and he kept telling them he wanted raisin bran and they never brought. He stated no one offered him anything else to eat and he got tired of asking. During a document review and interview on 03/24/2026 7:59 AM Resident #35 was eating breakfast of pancakes and sausage. He stated he did not get Raisin Bran cereal and he wanted to eat it everyday. A review of his meal ticket and under preferences it did not include Raisin Bran. During a document review and interview on 3/24/26 at 8:18 a.m., Resident #86 stated her breakfast was not what she liked. A review of her meal ticket indicated nothing under preferences or dislikes. During an observation and interview on 3/25/26 at 7:55 a.m., Resident #35 did not receive Raisin Bran for breakfast. During an observation on 3/25/26 at 2:30 p.m. the lunch tray preference cards on the lunch trays for Resident #35 and Resident #86 did not have any preferences of dislikes documented. Resident #35 was admitted [DATE] with a BIMS (Brief Interview of Mental Status-- an assessment tool) a score of 15, indicating intact cognition. Resident #86 was admitted [DATE] with a BIMS score of 8, indicating moderate cognitive impairment. During a record review of the facility's 85 lunch tray tickets dated 3/24/26, all tray tickets reviewed indicated Allergies: NONE. During an interview on 3/26/26 at 8:29 a.m. with Resident 89, Resident 89 stated her tray ticket lists Macadamia Nut Oil under dislikes, but this is actually a lifeˆthreatening allergy for her. During an interview on 3/26/26 at 5:30 p.m., with the Certified Dietary Manager (CDM), the CDM stated the dietary software used by the facility does not allow allergies to print directly on the tray tickets. The CDM further stated when allergies are not accurately displayed, dietary staff may mistake a true allergy for a preference. As a result, a resident could be given an unsafe food item, creating a significant risk for an adverse allergic reaction, including potentially lifeˆthreatening outcomes. (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 3/27/26 at 10:45 a.m., with the Director of Nursing (DON), the DON stated residents' food allergies should be indicated on the tray tickets. The DON further stated if a resident's allergies are not clearly indicated on the tray tickets, staff may unknowingly serve a food containing the allergen which poses a severe safety risk, including the potential for an allergic reaction that could lead to serious harm or death. During an e-mail correspondence on 4/7/26 at 11:04 a.m. with Medical Records, Medical Records stated the facility does not currently have a policy on Allergies.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to store, prepare, distribute, and serve food under sanitary conditions and in accordance with professional standards for food service safety for a census of 87, when:Several food items were found in the walk-in refrigerator past their use by dates;Several food items were found in the dry storage area past their use by dates;The scoop was left in the large bin container which stored the flour;Facility provided snacks were found in the resident refrigerator past their use by date; andFacility provided snacks were found in the resident refrigerator without date labels.These failures had the potential to contribute to the spread of foodborne illnesses among a vulnerable resident population.1. During a concurrent observation and interview on 3/23/26 beginning at 8:34 a.m. with the Registered Dietitian (RD), the following items were found inside the Walk-In Refrigerator with the following marked dates: a 32 ounce container of Liquid Whole Eggs with a use by date of 3/22; a half gallon container of soy sauce with a use by date of 3/18; an opened plastic bag containing lettuce with a use by date of 3/18; and an opened plastic bag containing red seedless grapes which was unlabeled. The RD confirmed all items were past their use by dates and the grapes were unlabeled and proceeded to remove all items and threw them directly into the garbage can.2. During the initial kitchen tour on 3/23/26 at 8:48 a.m., the following items were observed to be in the facility's dry storage area with the following marked dates: Two plastic bag containers of hamburger buns, containing 12 hamburger buns in each bag, with a date of 3/9; a large plastic container filled with approximately 80 to 100 individually packaged saltine crackers with a use by date of 1/20/25; a large plastic container filled with individually packaged diet cookies with a date of 12/15/25; a 1.8 liter container of Kikkoman Sweet [NAME] Seasoning with an open date of 7/15/25 and a use by date of 10/15/25; and a one gallon container of Honey with a use by date of 6/15/25.3. During an observation on 3/23/26 at 9:08 a.m., a blue scoop was observed stored inside the large plastic container used for holding flour.4. During an observation conducted on 3/24/26 at 8:20 a.m., a container holding individually wrapped, facilityˆprepared peanut butter and jelly sandwiches and meat and cheese sandwiches, cut into triangles, was observed stored in the resident refrigerator labeled with printed dates of 3/20/26. In addition, two burgundy containers containing a puddingˆlike substance were observed stored in the same refrigerator, each covered with a gray lid and labeled with handwritten dates of 3/20/26.5. During an observation conducted on 3/24/26 at 8:20 a.m., a container holding individually wrapped, facilityˆprepared peanut butter and jelly sandwiches and meat and cheese sandwiches, cut into triangles, was observed stored in the resident refrigerator without any date labels indicating when the items had been prepared. In addition, two clear, scalloped plastic dessert bowls containing a piece of bread or cake topped with sliced strawberries and a dollop of white cream, and one clear, scalloped plastic dessert bowl containing a single serving of a dark chocolate cake or brownie, were observed stored in the resident refrigerator without any date labels indicating when the items had been prepared.During an interview on 3/26/26 at 5:30 p.m. with the Certified Dietary Manager (CDM), the CDM stated that expired food items and unlabeled foods have been a persistent issue in the kitchen. When shown photos of the facilityˆprovided snacks, the CDM acknowledged the outdated snacks found in the resident refrigerator should have been discarded no later than three days after preparation. The CDM also confirmed the unlabeled facilityˆprovided snacks should have been discarded immediately because staff could not verify their freshness or safety. The CDM further stated these practices increased the risk of residents being served expired, spoiled, or unsafe foods, potentially resulting in foodborne illness.During an interview on 3/27/26 at 10:45 a.m. with the Director of Nursing (DON), the DON stated expired food items, unlabeled foods, and improperly dated facilityˆprovided snacks pose a significant safety concern for residents. The DON explained that expired or outdated food should not be available to residents and must be discarded because it may be unsafe to consume. The DON (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	further stated that undated snacks also must not be kept, as staff cannot verify whether the items remain fresh or within safe timeframes. The DON stated these practices increase the risk of residents being served spoiled or unsafe foods, potentially resulting in foodborne illness, resident decline, or other adverse health outcomes.A review of the facility's policy and procedure (P&P) titled Labeling and Dating for Safe Storage of Food, revised 4/23, the P&P stipulated, All products should be dated upon receipt. All products should be dated when opened. Use Use-By dates on all food once opened and stored under refrigeration.A review of the facility's P&P titled Refrigerated Leftover Storage, revised 8/21, the P&P stipulated, .Date container with use by date (lids may be misplaced).Do not save fresh fruits -cut, puddings or custards, and sandwiches. The P&P also indicated food items such as breads, cakes, and luncheon and deli meats can be stored for 1 to 3 days.A review of the facility's policy and procedure (P&P) titled Storage of Food and Supplies, dated 2017, indicated that dry bulk foods, such as flour, must be stored in plastic containers with tightˆfitting covers, and scoops are not to be left inside the containers. The P&P also required that all food items be dated with the month, day, and year, and that food products be used according to the timeframes outlined in the Dry Food Storage Guidelines, which specify that bread may be stored for five to seven days after receipt.

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a policy regarding use and storage of foods brought to residents by family and other visitors. Based on observation, interview, and record review, the facility failed to store resident food in a safe and sanitary manner for a census of 87 when staff stored several perishable food items unlabeled and undated in the facility pantry designated for resident food.This failure had the potential to cause foodborne illnesses in a vulnerable resident population.During an observation on 3/24/26 at 8:23 a.m. in the clean utility room, which contained cabinets designated for resident personal food items, one clear plastic scalloped^edge bowl containing three large porous pieces of bread sat directly on the cabinet shelf. The bread remained unprotected and exposed to the environment because the container was uncovered. At the same time and location, one large red^and^white commercially wrapped food item rested on the same shelf approximately two inches from the uncovered bread. The paper wrap, marked in large black lettering JACK CHEESEBURGER, did not include a room number or a date indicating when staff received it.During an interview on 3/24/26 at 8:28 a.m., with Unlicensed Staff H (US H), US H stated only foods for residents were to be stored in the clean utility room. US H also confirmed the bread and cheeseburger were not labeled or dated.During an interview on 3/26/26 at 5:30 p.m., with the Certified Dietary Manager (CDM), the CDM stated he expected staff to label all resident food items according to facility policy.During a review of the facility policy and procedure titled, Food For Residents From Outside Sources, dated 2018, the policy stipulated, .If opened, the food must be sealed, dated to the date opened.During a review of the policy titled Bringing In Food For A Resident, dated 2018, the policy stipulated, Food or beverages should be labeled and dated to monitor for food safety.Foods in unmarked or unlabeled containers will be marked with the current date and the resident's name.

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F 0841 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Designate a physician to serve as medical director responsible for implementation of resident care policies and coordination of medical care in the facility. Based on interview and record review the facility failed to ensure all responsibilities of the Medical Director were effectively performed to ensure resident attained and maintained the highest practicable physical, mental and psychosocial well-being when the Medical Director did not fulfill his responsibility for the coordination of medical care in the facility. This failure resulted in Gradual Dose Reductions (GDR) not being addressed and communication between the Medical Director and care teams being ineffective which could result in delayed resident care, unnecessary medication use, and potentially poor resident outcomes. During a phone interview, on 3/24/26 at 11:19 a.m., with Guardian A (legal decision maker for Resident #4 and Resident #14), she stated she felt like she had to pester Medical Director with repeated phone calls and requests to speak with him about the medical care for Resident #4 and Resident #14. She stated he would seldom call her back. She stated he was unresponsive and it made her angry because she could not speak to him on behalf of the residents she was responsible for. During a phone interview on 3/25/26 at 3:16 p.m., Family Member of Resident #78 stated she had tried to speak with Medical Director but could never get through to him. During an interview and concurrent record review on 3/26/26 at 8:26 a.m., DON stated monitoring of the Anti-Psychotic Medication Program was conducted monthly with the Consultant Pharmacist, Medical Director and herself. The Gradual Dose Reduction (GDR) documentation for the facility for the last 3 months was reviewed and indicated no documented response by the Medical Director for recommendations by the Consultant Pharmacist for mandated Gradual Dose Reductions for Resident #4, Resident #86 and Resident #78. DON stated the Medical Director should have approved the GDR recommendations from the Consultant Pharmacist. She stated there was no monitoring of the GDR medications for facility residents by the Medical Director. She stated he was consistently difficult to get him to respond to emails, phone calls and requests to perform the GDR review. She stated he was only in the facility once a month for only a couple of hours. She stated he did not attend committee meetings in person and rarely by phone. She stated he was actually in the facility he would just initial documents for attendance and reviews and spend no time reviewing or discussing any facility related issues with her. During a phone interview on 3/26/2026 at 9:59 a.m. Consultant Pharmacist stated her responsibilities included review and recommendations for any medications that included GDRs, labs, and pain medication use. She stated she collaborated with Administrator and DON to monitor Antipsychotic medication through the GDR review and participate in the Quality Committee presentation of that information. She stated Anti-psychotic medication use in the facility was Probably a little above the national level. She stated the facility did a good job getting Pharmacy Recommendation done, but we don't always hear back from physician. She stated the Medical Director was non-compliant. She stated, The biggest challenge is the medical director and his timely responses. During a phone interview on 3/26/2026 at 3:15 p.m., Medical Director stated his responsibility as the facility Medical Director was Everything medical in the building, that included attending meetings, administrative duties and working on issues with Administrator and DON. He stated he reviewed the care that residents were supposed to receive and if there were on appropriate medications. He stated he usually attended committee meetings by phone. He stated once a month he reviewed GDR recommendations via documents sent to him. He stated when he was in the facility, he would review the paper forms and always sign the paper documentation for GDR recommendations. MD could not (continued on next page)

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F 0841 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	relay what projects the QAPI team was working on. During an interview with Administrator on 3//27/27 at 9:40 a.m., she stated working with Medical Director was challenging. She stated he did not consistently review the Pharmacy Recommendations for recommendations for GDRs. During an interview on 3/27/26 at 11:10 a.m. with the Director of Nursing(DON), and the Administrator (ADM) in the ADM's office, the ADM stated the MD attended maybe three QAPI meetings a year, usually by conference call, and that the ADM or DON called the MD following the QAPI meetings to update him but he did not offer any additional input or suggestions. The ADM further stated the MD signed the attendance logs when he came into the facility and she had no way to prove he attended by conference call. The ADM continued stating the MD was disconnected, both the ADM and DON stated they did not feel supported by the MD. A review of a document titled SKILLED NURSING FACILITY MEDICAL DIRECTOR AGREEMENT, signed 11/4/25, indicated DUTIES AND RESPONSIBILITIES As Medical Direcctor, Physician shall be responsible for standards, coordination, surveillance, and planning for improvement of medical care in the Facility. Apprising the Administrator as to recommendations, proposed plans for implementation, and continuing assessments of, the clinical care of patients, through dated and signed reports. A review of a facility Policy and Procedure titled Gradual Dose Reduction of Psychotropic Drugs, Revise 3/17/25 indicated Resident who use psychotropic drugs receive gradual dose reductions and behavioral interventions unless clinically contraindicated, in an effort to be managed at a lower dose or to discontinue these drugs. Opportunities during the care process to consider whether the medications should be continued, reduced, discontinued, or other wise modified include: i. During the monthly medication regimen review by the pharmacist. Ii. When the physician or prescribing practitioner evaluates the resident's progress. Iii. During the quarterly MDS review by the interdisciplinary team. A review of a facility policy titled, 2026 QAPI Plan for Crescent City Care Center, undated, indicated, The QAPI committee, which includes the medical director, is ultimately responsible for assuring compliance with the federal and state requirements and continuous improvement in quality of care and customer satisfaction.

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Keep all essential equipment working safely. Based on observation, interview, and record review, the facility failed to ensure that essential kitchen equipment was in safe operating condition for a census of 87 residents when:1. The low temp dishwashing machine was operated at 108 degrees Fahrenheit multiple times; and2. A food thermometer was not readily available for use.These failures had the potential to compromise the facility's ability to maintain effective sanitation practices for all residents and increase the risk of serving food that had not been verified to be at a safe temperature.1. During an observation on 3/25/26 at 10:37 a.m., the Dishwasher (DW) operated the low temp dishwasher multiple times, and the temperature gauge showed 108 degrees to 110 degrees Fahrenheit.2. During a concurrent interview and observation on 3/25/26 at 10:59 a.m. with the [NAME] (CK I), CK I was calibrating the food thermometers per facility policy and observed the thermometer was not reading the required temperature of 212 degrees Fahrenheit as it was immersed in boiling water. The CK I confirmed the temperature was reading at 203 degrees Fahrenheit.During an observation on 3/25/26 at 11:30 a.m., the food thermometer continued to read at 203 degrees Fahrenheit.During an observation on 3/25/26 at 11:39 a.m., the CK I brought in a different food thermometer which read at 208 degrees Fahrenheit.During an interview on 3/26/26 at 5:30 p.m., with the Certified Dietary Manager (CDM), the CDM stated the low temp dishwasher should be operated between 120 to 140 degrees Fahrenheit. The CDM also stated it is important to have working thermometers in the kitchen to ensure food was cooked and served at correct temperatures.During an interview on 3/27/27 at 10:45 a.m., with the Director of Nursing (DON), the DON stated any staff who operated the dishwashing machine should know the correct operating temperature and how to check for proper sanitation. The DON also stated operating the dishwashing machine without knowledge of how to operate it properly could pose an infection control risk to all residents.During a review of the facility's policy and procedure (P&P) titled Dishwashing, undated, the P&P stipulated, Use the machine at a range of 120 degrees F to 140 degrees F. The chlorine should read 50-100 ppm on dish surfaces in final rinse.During a review of the facility's procedure titled, Weekly Thermometer Calibration Chart, dated 2023, the procedure stipulated, all thermometers should be calibrated once a week and boiling water may also be used in the same manner to calibrate the thermometer, with the thermometer to read 212 degrees Fahrenheit.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to honor the rights of three residents (Resident 81, Resident 34 and Resident 54) out of twelve residents sampled for Advanced Directives (ADR), when they neglected to provide the Resident's and/or their representatives with a consultation upon admission to the facility. This failure had the potential to result in the resident's wishes for life sustaining treatment during an emergency not being honored. A review of Resident 81's admission record indicated she was admitted on [DATE] with the diagnoses of history of breast cancer, repeated falls, osteoarthritis and osteoporosis (diseases causing decrease in bone density and pain in joints), and Bipolar Disorder (a chronic mental health condition characterized by intense, alternating mood swings between extreme high energy (mania or hypomania) and deep depression). A review of Resident 81's clinical record indicated no POLST (Physicians orders for Life Sustaining Treatment) or ADR (Advanced Directives) were on record.A review of Resident 34's admission record indicated he was admitted on [DATE] with the diagnoses of Parkinson's Disease (a progressive disease of the nervous system marked by tremor, muscular rigidity, and slow, imprecise movements), dysphagia (difficulty swallowing) and unspecified dementia (a progressive state of decline in mental abilities).A review of Resident 34's admission record indicated no POLST or ADR were on record.A review of Resident 54's admission record indicated she was admitted on [DATE] with diagnoses of Encephalopathy (any disease or dysfunction of the brain that alters its structure or function, often causing altered mental state, confusion, personality changes, or dementia), and repeated falls with unsteadiness on feet.A review of Resident 54's clinical record indicated no POLST or ADR were on record.During an interview on 3/26/26 at 12:31 p.m. with Medical Records, Medical Records stated they could not find the POLST or ADR records for Resident 81, 34 and 54, and had asked the Social Services Director (SSD) to make notes about why these records were not available.A review of Resident 81's clinical record indicated she had signed a POLST declination form on 1/24/23 and was not offered an ADR at that time and the SSD was to follow up Quarterly.A review of SSD Progress Notes for Resident 81 indicated no ADR consultation had been provided until 3/26/26 during the survey.A review of SSD Progress notes for Resident 34 indicated no ADR consultation had been provided until 3/26/26 during the survey.A review of SSD Progress Notes for Resident 54 indicated no ADR consultation had been provided until 3/26/26 during the survey.During an interview on 3/27/26 at 8:53 a.m. with the Director of Nursing (DON), the DON stated, ADR and/or POLST should be completed on admission, and the Resident and/or Resident Representative should have had consultation. The DON further stated the risk was not honoring the Residents' wishes if there was a life threatening event.A review of a facility policy, titled, Residents Rights Regarding Treatment and Advanced Directives, revised 12/29/22, indicated, On admission the facility will determine if the resident has executed an advanced directive, and if not, determine whether the resident, if cognitively able to do so, would like to formulate and advanced directive. In the event the resident is unable to formulate an ADR due to cognitive impairment or deemed by the medical doctor that the resident is incapable of making decisions on his or her own, the facility will provide information and education to the resident representative.

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure two allegations of abuse were reported to the Department within the required timeframe for three of 38 sampled residents (Resident 12, Resident 84 & Resident 99) when:The facility did not report an allegation of abuse involving Resident 99, and;The facility did not report a resident-to-resident altercation between Resident 12 and Resident 84.These failures had the potential to result in delayed identification and intervention regarding abuse, increased risk to resident safety, and noncompliance with regulatory reporting requirements, potentially compromising the well-being and protection of vulnerable residents within the facility. A review of Resident 99's admission Record (facility demographic) indicated Resident 99 was admitted to the facility on [DATE] and passed away on 3/13/26. A review of the Social Services Progress Note dated 2/03/26 at 9:08 a.m., indicated the facility was made aware of an allegation relayed by Life Partner 1 that Resident 99 reported 2 staff members were arguing, got into her face, and spit in her face. A review of Resident 99's electronic medical record (EMR) did not indicate a completed investigation was conducted after the allegation was made. Documentation of an interdisciplinary team (IDT) meeting reportedly scheduled to occur on or about 2/04/26 regarding the allegation was not found in the EMR. During an interview on 3/25/26 at 3:35 p.m., Life Partner 1 stated that Resident 99 told him staff had gotten into her face and spit on her. Life Partner 1 stated that at the time of the allegation, Resident 99 was still able to understand what was happening and clearly communicate concerns, and he believed what she told him. Life Partner 1 stated he reported this concern to facility staff and administration. During an interview on 3/25/26 at 4:25 p.m., the Administrator (ADM) stated that no investigation had been conducted regarding the abuse allegation made by Resident 99. The ADM stated she did not believe the incident occurred and believed Resident 99 may have been experiencing confabulations or delusions. The ADM also stated she was unable to locate documentation of the IDT meeting reportedly held regarding the allegation. During an interview on 3/25/26 at 5:05 p.m., the ADM and Infection Prevention Nurse (IP) stated they would begin identifying staff members who had cared for Resident 99 on the date of the alleged incident and would attempt to obtain additional information, including contacting the ambulance company. During an interview on 3/26/26 at 9:04 a.m., the ADM stated she submitted the SOC 341 (a state form used by mandated reporters to report suspected abuse, neglect, or exploitation of elders or dependent adults) the previous night during the survey regarding the alleged incident and was in the process of gathering staff information related to the event. A review of the facility policy titled, Abuse, Neglect and Exploitation, revised 12/19/22, indicated under Section V.A., An immediate investigation is warranted when suspicion of abuse, neglect or exploitation, or reports of abuse [occur]. The same policy indicated that investigating included (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	identifying and interviewing all involved persons and providing complete and thorough documentation of the investigation. Findings: A record review on March 31, 2026, showed Resident 12's clinical record contained a nursing note dated 3/18/26 by LVN F stating: verbal altercation R/t miscommunication between [Resident 12] and his roommate [Resident 84]. Will monitor X 72 hrs (hours) for aggressive behavior towards each other. Nursing staff made aware and notified the administrator. A review of Resident 12's admission record indicated he was initially admitted in October 2025 with a diagnosis of chronic kidney disease. A review of Resident 12's Minimum Data Set (MDS) a federally mandated resident assessment tool, indicated Resident 12 had no memory impairment. A review of Resident 84's admission record indicated he was initially admitted in May 2024 with a diagnosis of encounter for surgical aftercare following surgery on the nervous system. A review of Resident 84's MDS indicated Resident 84 had no memory impairment. A review of IQIES (data system) entries from March 18, 2026, through March 31, 2026, confirmed the altercation was not reported to the Department. An interview on 3/24/26 at 3:45 p.m., with the Director of Nursing (DON), the DON stated, All altercations are reported to [the Administrator]. She makes the decision as to if an altercation is to be reported or not. Resident #84 grabbed Resident #12's arm while Resident #12 was walking out of the room. The DON further acknowledged that no assessment or 72ˆhour monitoring checks were completed. An interview on 3/25/26 at 12:53 p.m. with the Administrator (ADM), the ADM stated, I didn't report it because the [SOS 341] form says to report if it 'reasonably appears to be abuse or neglect.' I thought it unsubstantiated. The Administrator confirmed that allegations of abuse are required to be reported to the Department within two hours and acknowledged the 3/18/26 allegation was not reported until 3/24/26. A review of the facility's policy titled Abuse, Neglect and Exploitation, revised 12/22, indicated that reports of physical abuse must be made to the Department within two hours.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 interview and record review, the facility failed to develop and implement comprehensive, person-centered nursing care plans for two of two sampled residents (Resident 26 and Resident 43), related to:Lack of post-fall care plan interventions for Resident 26,Repeated medication refusals by Resident 26, and;Resident 43's fluctuating psychosocial (define) and behavioral patterns, including prolonged bed stay and limited activity participation.These findings may have resulted in Resident 26 being placed at increased risk for additional falls, injuries, or even death. The lack of appropriate interventions could have contributed to ongoing medication refusals, which may have worsened Resident 26's chronic health issues. Additionally, these deficiencies may have led to physical deterioration for Resident 43, such as muscle weakness, joint stiffness, pressure sores, and a heightened risk of infection due to prolonged bed rest.A review of Resident 26's admission Record (facility demographic) indicated he was admitted to the facility on [DATE] with medical diagnoses which included dementia (significant decline in memory and thinking abilities that disrupts daily activities), history of falls, and difficulty walking.A review of Resident 26's risk assessment dated [DATE] indicated he was given a score of 21, which indicated he was at high risk for falls.1). Record review of a nursing progress note dated 3/19/26 at 2:20 a.m., indicated Resident 26 was found on the floor next to the bathroom door. According to this note, Resident 26 was unable to state how the fall occurred.Record review of an interdisciplinary care conference note dated 3/19/26 at 9:04 a.m. indicated the fall was likely related to confusion and unassisted ambulation. Interventions identified during the meeting included: reminding Resident 26 to use the call light, keeping the call light within reach, ensuring non-skid footwear, providing staff supervision, and ensuring the tab alarm was activated.Record review of Resident 26's updated care plan initiated on 3/19/26 indicated interventions that were general in nature and did not clearly reflect the specific interventions identified during the interdisciplinary team meeting.2).Record review of Resident 26's medication administration record (MAR) indicated she regularly declined her prescribed Seroquel (a prescription medication used to treat mental health conditions). According to Resident 26's MAR, between 3/01/25 and 3/25/25, Resident 26 refused the medication 11 times in the morning (8 a.m.) and 16 times in the evening (6 p.m.), which indicated he received Seroquel less than half of the time it was ordered. Record review of Resident 26's nursing care plans did not indicate a care plan was created to address Resident 26's repeated medication refusals. As a result, there were no interventions describing approaches to encourage medication acceptance, alternative interventions, physician notifications of refusals and follow-up, and evaluation of effectiveness of the medication.During an interview on 3/26/26 at 1:05 pm, LN C confirmed that Resident 26's MAR accurately reflected that Resident 26 had refused the 8 a.m. and 6 p.m. Seroquel doses most of the time.During an interview on 3/26/26 at 2:25 pm, CNA G stated that due to workload demands and staffing challenges, it was difficult to consistently monitor residents and identify changes in condition.During an interview on 3/26/26 at 2:05 pm the Assistant Director of Nursing (ADON), stated that after further review, she found interdisciplinary notes indicating the facility had begun to address medication refusal for Resident 26; however, these interventions were not clearly reflected in the care plan at the time of survey. The ADON was unable to find in Resident 26's medical record that the physician was made aware of the refusals.3).Record review of Resident 43's admission Record indicated she was admitted to the facility on [DATE] with medication diagnoses which included Dementia, Major Depression (a mental health disorder characterized by persistent feelings of sadness and loss of interest in activities), and Diabetes Mellitus (a condition characterized by high levels of sugar in the blood).Record review of Resident 43's Minimal Data Set (MDS, an assessment tool) dated 2/3/26 indicated his Brief Interview of Mental Status (BIMS, a cognition [the mental action or process of (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	acquiring knowledge and understanding through thought, experience, and the senses] assessment) score was 8, which indicated his cognition was moderately impaired (A score of 1-7 indicates the cognition is severely impaired, 8-12 indicates the cognition is moderately impaired, and 13-15 indicates the cognition is intact). This document also indicated Resident 43's Family Member XX was Resident 43's responsible party.During observations made at different times from 3/22/26 through 3/26/26, Resident 43 was noted to be transferred out of bed only twice in four days.During an interview on 3/24/26 at at 9:43 a.m., the MDS coordinator stated Resident 43 went through cycles where she remained in bed for extended periods and other times was up, wandering into rooms, and requiring a wander guard (a wearable electronic security system used in nursing homes and memory care units to prevent at-risk residents from elopement) due to wandering and exit seeking behaviors. The MDS Coordinator acknowledged this cyclical pattern and confirmed Resident 43's care plan did not clearly reflect individualized interventions to address it.Record review of Resident 43's active care plans indicated one of her interventions for psychosocial well-being and activity participation was for staff to take Resident 43 outside on beautiful sunny days.During an interview on 3/25/26 at 4 p.m., the Assistant Director of Nursing and IP stated that Resident 43's behavior of staying in bed for extended periods of time was considered her baseline, and that she had reportedly been up for meals twice during the week but returned to bed afterward.During an observation on 3/26/26 at 2:06 p.m., the weather was sunny and pleasant; however, Resident 43 was not observed outside, and the care plan intervention to take the resident outside on beautiful sunny days was not observed implemented.During an interview on 3/25/26 at 4:45 p.m., the Assistant Activities Director stated Resident 43 was often in bed and did not want to get up even with encouragement, and although she attended some activities, she was mostly in bed.During a phone interview on 3/25/26 at 4:14 p.m., Resident 43's Family Member #2 stated this pattern was not unusual for Resident 43 and described periods when the resident remained in bed and other periods when she was more active and attended activities.A review of the facility policy titled, Fall Prevention Program, developed on 12/19/22 and revised on 12/28/23, indicated, Interventions will be monitored for effectiveness .The plan of care will be revised as needed. The same policy indicated that when a resident experiences a fall, the facility will, review the resident's care plan and update as indicated.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 ensure three of six sampled residents (Resident 26, Resident 54 and Resident 81) remained free of accidents when they did not received adequate supervision to prevent falls, resident-centered nursing care plans were not developed prior or after the falls, post-fall assessments or neurological checks (rapid nursing assessments to detect brain injuries or spinal issues after a fall) were not completed, and interdisciplinary team meetings (IDT) were not held to identify the root cause of the falls.These failures could have resulted in serious harm or injury to the residents, including increased risk of falls, potential physical trauma, prolonged recovery times, and diminished quality of life. Additionally, the lack of proper supervision, individualized care planning, and post-fall assessments may have prevented the facility from identifying and addressing the underlying causes, thereby increasing the likelihood of future incidents. Resident 26 Record review of Resident 26's admission Record (facility demographic) indicated he was admitted to the facility on [DATE] with medical diagnoses which included dementia (general term for decline in memory, thinking, and reasoning skills severe enough to interfere with daily life), history of falls, and difficulty walking. Record review of a fall risk assessment for Resident 26 dated 3/19/26 indicated he was given a score of 21, which indicated he was at high risk for falls. Record review of a nursing progress note dated 3/19/26 at 2:20 a.m. indicated Resident 26 was found on the floor next to the bathroom door. According to this note, Resident 26 was unable to state how the fall occurred. This progress note also indicated Resident 26 sustained a small bump to the right side of the head, neurological checks were initiated, and the physician and administrator were notified. Record review of Resident 26's progress notes following the fall did not identify evidence of a comprehensive post-fall assessment including range of motion, mobility or transfer assessment, evaluation for possible musculoskeletal injury or detailed pain-focused interventions. Record review of Resident 26's Medication Administration Record (MAR) indicated Tylenol (a medication used to treat mild to moderate pain) 500 milligrams (mg, a unit of measurement) was administered after the fall; however, the MAR did not indicate a pain score, description of pain, location of pain, or other detailed pain assessment at the time the medication was given. The MAR also did not indicate reassessment of Resident 26's pain following administration to determine whether the medication was effective. Record review of an occupational therapy note dated 3/19/26 at 2:29 p.m. stated the resident remained at prior level of function; however, the note did not include documentation of functional reassessment, such as standing ability, strength, coordination, or mobility following the fall. Record review of progress notes dated 3/23/26 at 7:24 p.m., indicated Resident 26 was transferred to the hospital due to complaints of back pain following the fall on 3/19/26. Record review of hospital records dated 3/24/26 at 3:14 a.m., indicated Resident 26 was diagnosed (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	with a T12 (middle section of vertebral column) compression fracture and returned to the facility with a Thoracic-Lumbar-Sacral Orthosis (TLSO, a brace that wraps around the torso) brace. During an interview on 3/25/26 at 2:25 pm, CNA G stated she assisted Resident 26 with breakfast but had not returned to the resident's room due to workload demands. CNA G stated staffing levels made it difficult to consistently monitor residents and identify changes in condition. During an interview on 3/25/26 at 1:05 pm, LN C stated the last time he saw Resident 26 prior to the change in condition regarding the fall was during morning medication administration at approximately 8 a.m. During an interview on 3/25/26 at 3:55 pm, the Assistant Director of Nursing stated that she observed Resident 26 exhibiting abnormal responsiveness when delivering lunch to the resident's room. The Assistant Director of Nursing stated she attempted to stimulate Resident 26, including performing a sternal rub, which elicited minimal response. She added that at that point, emergency medical services were contacted. A review of the facility policy titled, Fall Prevention Program, developed on 12/19/22 and revised on 12/28/23, indicated that when a resident experienced a fall, the facility would, assess the resident .complete a post-fall assessment, and, review the resident's care plan and update as indicated. The same policy indicated that staff would, monitor for changes in resident's cognition, gait, ability to rise/sit, and balance. Resident 54 A review of Resident 54's admission record indicated she was admitted to the facility on [DATE] with diagnoses of encephalopathy (any disease or dysfunction of the brain that alters its structure or function, often causing altered mental state, confusion, personality changes, or dementia) and dementia (a progressive state of decline in mental abilities), and repeated falls with unsteadiness on feet. A review of Resident 54's Minimum Data Set (MDS, an admission assessment) indicated she was unable to complete her Brief Interview of Mental Status assessment (BIMS, an assessment tool used by facilities to screen and identify memory, orientation, and judgement status of the resident). A review of Resident 54's nursing care plan initiated on 12/21/25 and revised on 3/03/26 indicated she was at risk for falls and interventions were minimal/standard/generalized and indicated interventions to anticipate resident's needs, keep call light in reach and maintain a safe environment. A review of Progress Notes, Alert Charting dated 2/27/26 at 3:12 pm indicated Resident 54 was showing new behaviors and confusion, and the Falls Care Plan was not updated. A review of Resident 54's SBAR report dated 3/06/26 at 6:53 a.m. indicated she had an unwitnessed fall on 3/06/26 while ambulating to the other side of the room per her roommate report and sustained a superficial cut above her right eye. A review of Physician Progress indicated the Medical Director (MD) had seen Resident 54 on 3/06/26 at 7:11 p.m., the same day and time she was in the ED after sustaining the fall with no mention of the fall or injury. Physician progress note indicated a, quiet first month. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 54's General Acute Care Hospital (GACH) report dated 3/06/26 indicated Resident 54 had been found on the ground next to her bed by facility staff and minimal additional information was provided by facility staff. CT Pelvis (imaging of the Residents pelvis and hips), imaging showed a fracture of her right femoral neck. A review of Resident 54's Care Plan indicated the Care Plan was updated the day of the fall 3/06/26 with no new interventions. The interventions in the care plan remained general/non-individualized and indicated to alert the provider, assess for injuries from fall and educate on the importance of maintaining a safe environment. A review of Resident 54's Clinical admission progress note indicated she returned to the facility on 3/09/26 at 3:21 p.m. with a surgical incision to right hip and was disoriented and required queues. The Falls Care Plan was not updated upon her return. A review of Resident 54's nursing progress notes dated 3/10/26, 4 days after the fall, indicated she had a black eye from the fall and continued to try and get out of bed and required one-to-one supervision. The Falls Care plan was not updated to reflect the need for one-to-one supervision. A review of Resident 54's progress notes did not indicate an IDT meeting was held to discuss the root cause of the fall that occurred on 3/06/26. Resident 81 A review of Resident 81's admission record indicated she was admitted to the facility on [DATE] with diagnoses of Myopathies (a group of diseases that primarily affect skeletal muscle structure, metabolism, or function, resulting in weak, stiff or painful muscles), unsteadiness on feet, falls, osteoarthritis (degeneration of join cartilage and the underlying bone, most common from middle age onward, causing pain and stiffness, especially in the hip, knee, and thumb joints), and osteoporosis (a disease characterized by weakened, porous bones, leading to a high risk of fractures) with multiple fractures. A review of Resident 81's MDS dated [DATE] indicated Resident 81 had a BIMS of 12 indicating moderate cognitive impairment. A review of Resident 81's MDS dated [DATE] Section GG Functional Abilities indicated Resident 81 could walk with a walker and had full ROM (range of motion) in her upper or lower extremities. A review of Resident 81's Progress Notes, Alert Note dated 4/25/25 at 5:45 p.m., indicated Resident 81 was found on the floor in her room and stated she had fallen and hit her head and her left arm and reported pain of 10/10. Resident 81 requested to go to the hospital. A review of Resident 81's Progress Notes, Alert Note dated 4/25/25 at 11:32 p.m., indicated Resident 81 returned from the hospital with a diagnosis of left closed fracture of her left humerus and the MD was notified. No hospital report was available. A review of Resident 81's GACH emergency department (ED) visit report dated 5/12/25 indicated Resident 81 fell at the facility on 4/25/25 while trying to make her bed, tripped over her shoes, and fell on her left side. The X-Ray reports indicated the left closed impacted left proximal humerus fracture. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 81's Fall IDT Reports indicated IDT fall meetings were held 2/12/23, 4/8/23 and 8/25/25. There was no indication in the progress notes that an IDT meeting was held after Resident 81's Fall on 4/25/25. A review of Resident 81's Care Plan indicated one intervention was added for falls on 4/25/25 and indicated to assess for pain. A review of Resident 81's Falls Risk Evaluation dated 8/25/25 indicated she was at risk for falls related to Psychotropic Medications (chemical substances that alter brain function, affecting mood, perception, thoughts, or behavior), Narcotics (often referred to as opioids, are natural or synthetic substances that reduce pain, induce sleep, and create euphoric effects by binding to opioid receptors in the brain), Antihypertensive (medications for high blood pressure), Antiseizure (medications to treat seizure disorders), and Cathartic (induce, prompt, or increase bowel movements, often acting as strong laxatives medications). The Care plan was not updated following this assessment. A review of Resident 81's Care Plan indicated goals and interventions related to fall risk due to medications were not added until 3/26/26 during the survey. A review of Resident 81's MDS dated [DATE] section GG indicated she could no longer walk and that ROM in shoulders was not impaired. During an interview on 3/27/26 at 8:53 a.m., the Director of Nursing stated when a fall occurred, they should document immediately what was done, IDT review for root cause analysis, and review the care plan and update or change to more appropriate falls interventions. DON further stated it did not meet her expectation to keep the same interventions on the care plan as residents could continue to fall and care plans should be individualized and updated as needed, especially after an injury. A review of a facility document titled, Fall Prevention Program, revised on 12/28/23, indicated, The interdisciplinary team will initiate interventions on the Resident's care plan, in accordance with their level of risk. Fall interventions include but are not limited to universal environmental interventions; clear pathway; bed is locked and in low position; call light and frequently used items in reach; adequate lighting; assistive devices in good repair; monitor for changes in cognition, gait, ability to rise/sit, and balance, shoes or non-slip soles, eye glasses, monitor vitals signs. Provide interventions that address unique risk factors measured by the risk assessment tool: medications, psychological, cognitive status, or recent changes in functional status. Provide additional interventions including but not limited too; assistive devices, increased rounds, sitter if indicated, medication review; low bed, alternate call system access, scheduled ambulation or toileting assistance, family and caregiver or resident education, therapy services referral. When a resident experiences a fall the facility will; assess the resident; complete a post fall assessment, complete an incident report, notify physician and family, review the resident's care plan, document all assessments and actions, obtain witness statements in the case of injury.

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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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to ensure that residents' nutritional needs were recognized and evaluated upon admission for four out of six sampled residents (Resident 20, Resident 31, Resident 78, and Resident 79) when the clinical record for each resident lacked evidence of a nutritional assessment completed at or shortly after admission as required to identify weight history, diet orders, allergies, swallowing risks, and nutritionˆrelated diagnoses.This failure resulted in delayed evaluation of dietary requirements, risk factors, and nutritional status for four residents and placed them at risk for unmet nutritional needs, delayed therapeutic diet implementation, and decline in nutritional status.A review of Resident 20's admission record indicated he was last admitted on [DATE] with diagnoses including Type 2 Diabetes Mellitus with Foot Ulcer and Orthopedic Aftercare Following Surgical Amputation.A review of Resident 20's initial nutritional assessment indicated the assessment was completed on 9/1/25.A review of Resident 31's admission record indicated he was last admitted on [DATE] with the diagnosis of cellulitis (a skin infection that causes swelling and redness) of the left lower limb.A review of Resident 31's initial nutritional assessment indicated the assessment was completed on 2/7/26.A review of Resident 78's admission record indicated she was last admitted on [DATE] with diagnoses including Nonrheumatic Aortic Valve Stenosis and Unspecified Protein-Calorie Malnutrition.A review of Resident 78's initial nutritional assessment indicated the assessment was completed on 1/31/2026.A review of Resident 79's admission record indicated he was last admitted on [DATE] with diagnoses including Osteomyelitis and Morbid (Severe) Obesity due to excess calories.A review of Resident 79's initial nutritional assessment indicated the assessment was completed on 2/2/26.During an interview on 3/26/26 at 5:30 p.m. with the Certified Dietary Manager (CDM), the CDM stated the Registered Dietitian (RD) conducts nutrition assessments for residents on admission, quarterly, and more frequently when there are significant weight changes. The CDM explained that timely nutritional assessments are important because they identify weight fluctuations, dietary needs, and texture requirements, allowing the facility to adjust meals appropriately. The CDM stated that if these assessments are delayed, residents may not receive needed dietary interventions, increasing the risk of inadequate intake, unaddressed weight loss, and malnutrition.During an interview on 3/27/26 at 10:45 a.m. with the Director of Nursing (DON), the DON stated the RD completes an initial nutrition assessment on admission or within the first week, conducts quarterly assessments, and performs weekly reviews for residents experiencing weight variances. The DON stated she was unsure of exact policy requirements but understood that timely completion of these assessments is necessary to monitor nutritional status. The DON further stated that delayed nutritional assessments place residents at risk for not eating adequately, experiencing weight loss, and experiencing associated health decline if nutritional needs are not promptly identified and addressed.ˆA review of the facility's policy and procedure (P&P) titled, Initial Resident Visitation/Nutritional Screening, dated 9/21, the P&P indicated, The CDM, DTR, or other clinically qualified nutrition professional, or designated associate should visit each resident within approximately 72 hours or in the first week following admission and complete a dietary interview and prescreen.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure pain was adequately assessed, monitored, and managed for two of 38 sampled residents (Resident 26 & Resident 64) who suffered from high levels of pain.These findings may have resulted in the residents experiencing untreated or undertreated pain, delayed recognition of injury, decreased comfort, and reduced functional ability.A review of Resident 26's admission Record (facility demographic) indicated she was admitted to the facility on [DATE] with diagnoses which included dementia (a significant decline in memory and thinking abilities that disrupt daily activities), history of falls, and difficulty walking. Record review of a nursing progress note dated 3/19/26 at 2:20 a.m. indicated Resident 26 was found on the floor next to the bathroom door. A small bump was noted to the right side of the head, and Resident 26 was unable to state how the fall occurred. Record review of Resident 26's Medication Administration Record (MAR) dated 3/19/26 at 6:16 a.m., indicated Tylenol (a medication used to treat mild to moderate pain) 500 milligrams (mg, a unit of measurement) was administered following the fall. The MAR included a once-per-shift pain monitoring section, which indicated a pain score of 0 for both 3/19/26 and 3/20/26; however, the MAR did not include a location for documentation of pain location, description, or characteristics of pain, nor did it include a place to document reassessment of pain or effectiveness of the medication after administration. Record review of nursing progress notes dated 3/19/26 at 1:05 p.m. indicated Resident 26, denies any pain. Record review of nursing progress notes dated 3/20/26 did not indicate a documented pain assessment. Record review dated 3/21/26 indicated Resident 26 was offered Tylenol 1000 mg by mouth (PO, by mouth) three times and declined; however, the documentation did not indicate a pain level, pain location, or follow-up assessment, and did not indicate use of non-pharmacological pain interventions. Record review of the MAR dated 3/19/26 through 3/26/26 further indicated multiple refusals of scheduled Tylenol doses, with documentation of refusals or medication being spit out; however, the record did not indicate follow-up pain assessment, reassessment, or adjustment of the pain management plan in response to these refusals. Record review of an interdisciplinary care conference note dated 3/19/26 at 9:04 a.m. indicated Resident 26's fall was reviewed; however, the documentation did not indicate Resident 26's pain level or specific pain management interventions. Record review of a physician progress note dated 3/20/26 at 4:17 p.m. (late entry) did not indicate a documented pain assessment or plan related to the fall were developed for Resident 26. Record review of Resident 26's Medication Administration Record (MAR) indicated the resident had physician orders for Tramadol (a prescription medication to treat moderate to severe pain) 50 mg by mouth three times daily for pain and Tylenol Extra Strength 500 mg, two tablets by mouth every eight hours for pain. Despite these orders, record review of Resident 26's MAR indicated his pain level was only assessed twice following the fall, on 3/23/24 and 3/24/26. The documentation indicated his pain level was six both times (pain scale from 0 to 10, with 0 indicating no pain and 10 the worst pain experienced during a person's lifetime). (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of a physician progress note dated 3/24/26 at 6:33 p.m. indicated, [Resident 26] seems to express pain as anger and frustration. This suggested Resident 26 may have demonstrated pain through behavioral expressions rather than clearly verbalizing discomfort. This increased the importance of staff conducting comprehensive pain assessments and reassessments following Resident 26's fall and changes in condition. Record review of a nursing progress note dated 3/23/26 at 7:24 p.m. indicated Resident 26 was transferred to the hospital due to complaints of back pain following the fall on 3/19/26. Record review of hospital records dated 3/24/26 at 3:14 a.m. indicated Resident 26 was diagnosed with a T12 compression fracture and returned to the facility with a thoracic-lumbar-sacral orthosis (TLSO, a brace designed to stabilize the thoracic [middle section of the vertebral column] and lumbar spine [lower section of the vertebral column] after surgery or injury) brace. Record review of Resident 26's active nursing care plans indicated a care plan was developed for pain related to fracture of the right femur (thigh bone); however, the care plan did not indicate individualized non-pharmacological interventions (non-medication approaches such as repositioning, comfort measures, or other supportive care) to control or help relieve pain. Record review of physician orders for month of March 2026 did not indicate an order for breakthrough pain medication beyond routine scheduled medications. During an interview on 3/26/26 at 1:00 p.m., the Infection Prevention Nurse (IP) stated the facility's electronic medical record (EMR) did not include a designated location for staff to document pain reassessment following administration of pain medication. The IP further stated the MAR did not include a section for staff to document non-pharmacological pain interventions. During an interview on 3/26/26 at 1:55 pm, the Assistant Director of Nursing (ADON) stated she was unable to find documentation indicating consistent reassessment of pain or evidence of a revised pain management plan following Resident 26's fall and subsequent injury. A review of the facility policy titled, Pain Management, developed on 12/19/22 and revised on 3/17/25, indicated that the facility would, evaluate the resident for pain and the cause(s). when a significant change in condition or status occurs. The same policy indicated that staff would, observe for nonverbal indicators which may indicate the presence of pain, including, irritability, and other behavioral changes. The policy further indicated that staff would, reassess resident's pain management regularly for effectiveness, and revise the pain management regimen and plan of care when pain was not adequately controlled. A review of Resident 64's admission record indicated he was admitted on [DATE] with medical diagnoses including person injured in a motor vehicle accident (MVA), multiple fractures of ribs, pain in unspecified joint, pain in both shoulders and dysphagia (difficulty swallowing). A review of Resident 64's Minimum Data Set (MDS-A resident assessment tool) dated 2/04/26 indicated he had a Brief Interview of Mental Status (BIMS, an assessment tool used by facilities to screen and identify memory, orientation, and judgement status of the resident) score of 13, which indicated no cognitive (mental processes related to acquiring knowledge and understanding through thought, experience, and the senses) impairment. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 64's general acute care hospital (GACH) Discharge summary dated [DATE] indicated he had weakness and debility after polytrauma (multiple trauma) from a motor vehicle accident in which he sustained fractures of his left tibia and humerus (bones in left arm and leg), right femur (right thigh bone), right clavicle (collar bone), multiple rib fractures, and C5-C7(vertebrae of the neck) cervical fractures. This document also indicated Resident 64 had acute pain which was treated with Morphine (controlled medication to treat moderate to severe pain) while hospitalized . A review of Resident 64's Care Plan indicated he had arthritis (joint pain) with chronic pain. This care plan indicated broad non-individualized interventions for pain were initiated on 7/30/25 to administer analgesics as ordered and monitor for effectiveness. A review of Resident 64's physician orders indicated that Resident 64's pain had been treated with the same pain medication regimen since his arrival at the facility. This consisted of Lidocaine external patch (a local anesthetic to numb the skin) every 12 hours, Gabapentin (a medication to treat nerve pain) 100 milligrams (mg) three times a day, Tylenol (a medication used to treat mild to moderate pain) 1000 mg every eight hours, and Tramadol (a controlled medication to treat moderate to severe pain) 50 mg every eight hours for breakthrough pain. A review of Resident 64's electronic medication and treatment record indicated he asked for Tramadol every day from 3/11 through 3/26 and his pain level remained a seven on a scale between one being the lowest and ten being the highest, despite his scheduled medications. A review of Physicians Progress Notes from admission to present indicated no mention of response to pain management modalities or plan of care for chronic pain. During a concurrent interview and record review on 3/24/26 at 12:55 p.m. with the Social Services Director (SSD), a list of residents who had missed medical appointments was reviewed. The list indicated that Resident 64 had missed a nerve conduction study (a diagnostic tool that measures how fast and strong electrical signals travel through nerves, usually to detect damage or disease) scheduled at an acute care hospital on 3/18/26 and it had not yet been rescheduled. During an interview on 3/23/26 at 9:30 a.m., with Resident 64 in his room, he stated he had sustained 24 broken bones in his accident and that his pain was constant. Resident 64 further stated he took Tramadol for pain, but it did not help and he was in pain all the time. During an interview on 3/25/26 at 2:20 p.m., with Unlicensed Staff G (US G), she stated Resident 64 had a lot of pain and he knew when his medications were due and was waiting at the medication cart every time he could request it. During an interview on 3/25/26 at 3:19 p.m., with Licensed Nurse E (LN E), she stated she believed many residents at the facility who were assigned to the Medical Director (MD) were undermedicated for pain, and that Resident 64 took his Tramadol every time it was due. During an interview on 3/27/26 at 8:53 a.m., with the Director of Nursing (DON), she stated she was thankful to have new physicians on board who were willing to address pain in a more individualized way because uncontrolled pain could lead to more pain, overall decline, and could affect the well-being of residents. A review of a facility document titled, Pain Management, revised on 3/17/25, indicated, The facility (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	will recognize when a Resident is experiencing pain and identify circumstances when the pain can be anticipated and, to Evaluate the resident for pain and the causes upon admission, during ongoing scheduled assessments, and when a significant change in condition occurs, and manage or prevent pain, consistent with the comprehensive assessment and plan of care, current professional standards of practice and the resident's goals and preferences.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record reviews, the facility did not engage in a program to prevent or minimize adverse consequences related to medication therapy for five Residents (Resident #86, Resident #4, Resident #78, Resident #5, and Resident #81), when there was a lack of documented engagement and response between Pharmacy, Nursing and Medical Director for the Monthly Medication Review. This failure had the potential to lead to ineffective management of resident medications and ineffective communication among the resident care team. During a concurrent interview and record review on 3/25/26 at 4:15 p.m., with DON (Director of Nursing), the Gradual Dose Reduction (GDR) Request Binder document indicated the following Pharmacist Recommendations: Resident #4 GDR requests on 5/25, 6/25, 2/26 were not documented as either agree or disagree by Medical Director. Resident #86 GDR requests 5/25, 6/25, 7/25, 9/25 with discontinuation of medications, were not documented either agree or disagree by Medical Director. Resident #78 GDR requests 4/25 discontinuation of medication related to side effect of rash, order an Abnormal Involuntary Movement Scale Test (AIMS)(A 12-item, clinician-rated, 5-minute examination), were not documented as either agree or disagree by Medical Director. The DON stated that Medical Director did not document anything and there were no notes in any of these resident charts. DON stated for Resident #4 there were no labs ordered as recommended by the pharmacist a lab level. She stated for Resident #86 in August and September of 2025, repeated pharmacist recommendations GDRS and discontinuation of medications and a reminder to monitor lab values and medication to the medical director were not responded to as either acknowledged and accepted or refused. DON stated all of it should have happened and it was a requirement of the Medical Director. DON stated it should have happened and it did not, and as a result the residents were not being monitored by the Medical Director. A request to the facility for the original documents was made and the documents were not received by the end of survey. During an interview and concurrent record review on 3/26/26 at 8:26 a.m., DON stated monitoring of the Anti-Psychotic Medication Program was conducted monthly with the Consultant Pharmacist, Medical Director and herself. The Gradual Dose Reduction (GDR) documentation for the facility for the last 3 months was reviewed and indicated no documented response by the Medical Director for recommendations by the Consultant Pharmacist for mandated Gradual Dose Reductions for Resident #4, Resident #86 and Resident #78. DON stated the Medical Director should have approved the GDR recommendations from the Consultant Pharmacist. She stated there was no monitoring of the GDR medications for facility residents by the Medical Director. She stated he was consistently difficult to get him to respond to emails, phone calls and requests to perform the GDR review. During a phone interview on 3/26/2026 at 9:59 a.m. Consultant Pharmacist stated her responsibilities included review and recommendations for any medications that included GDRs, labs, and pain medication use. She stated she collaborated with Administrator, Medical Director and DON to monitor Antipsychotic medication through the GDR review. She stated Anti-psychotic medication use in the facility was Probably a little above the national level. She stated for the Gradual Dose Recommendations (GDR) we don't always hear back from physician. She stated we want the lowest effective dose for anything. She stated, The biggest challenge is the medical director and his timely responses. During a phone interview on 3/26/2026 at 3:15 p.m., Medical Director stated he reviewed the care that residents were supposed to receive and if there were appropriate medications. He stated once a month he reviewed GDR recommendations via documents sent to him. He stated when he was in the (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	facility, he would review the paper forms and always sign the paper documentation for GDR recommendations. MD stated he could not explain why some GDR's had not been signed or the response/rationale documented. During an interview with Administrator on 3//27/27 at 9:40 a.m., she stated working with Medical Director was challenging. She stated he did not consistently review the Pharmacy Recommendations for recommendations for GDRs. Resident #86 was admitted [DATE] with diagnoses that included unspecified Psychosis not due to a substance or know physiological reason. Resident #78 was admitted [DATE] with diagnoses that included bipolar disorder (A chronic mental health condition). Resident # 4 was admitted [DATE] with diagnoses of Psychosis with Schizophrenia. A review of Resident 5's admission record indicated Resident 5 was admitted on [DATE] with the diagnoses of Alcohol induced persisting dementia, Bipolar Disorder and Major Depressive disorder. A review of Resident 5's GDR for Seroquel dated 10/17/25 indicated it was declined without rationale from primary physician. A review of Resident 81's admission record indicated Resident 81 was admitted on [DATE] with diagnoses of Anxiety, PTSD, and Bipolar 2 Disorder. A review of Resident 81's GDR requests indicated a GDR for both Depakote Sprinkles and Aripiprazole was declined on 10/17/25 without physician rationale. A review of a document titled SKILLED NURSING FACILITY MEDICAL DIRECTOR AGREEMENT, signed 11/4/25, indicated DUTIES AND RESPONSIBILITIES As Medical Director, Physician shall be responsible for standards, coordination, surveillance, and planning for improvement of medical care in the Facility. Apprising the Administrator as to recommendations, proposed plans for implementation, and continuing assessments of, the clinical care of patients, through dated and signed reports. A review of a facility Policy and Procedure titled Gradual Dose Reduction of Psychotropic Drugs, revised 3/17/25 indicated Resident who use psychotropic drugs receive gradual dose reductions and behavioral interventions unless clinically contraindicated, in an effort to be managed at a lower dose or to discontinue these drugs. Opportunities during the care process to consider whether the medications should be continued, reduced, discontinued, or otherwise modified include: i. During the monthly medication regimen review by the pharmacist. Ii. When the physician or prescribing practitioner evaluates the resident's progress. Iii. During the quarterly MDS review by the interdisciplinary team. A review of a facility policy titled, Psychotropic Medications, revised 3/17/25, indicated, Prior to initiating or increasing Psychotropic Medications, the resident, family, and or representative must be informed of the benefits, risks, and alternatives for the medication, including black box warnings for antipsychotic medication in advance of such initiation or increase. The Resident has the right to accept or decline the initiation or increase of a psychotropic medication. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of a facility policy titled, Gradual Dose Reduction, revised 3/17/25, indicated, For any individual who is receiving a psychotropic medication, a GDR may be considered clinically contraindicated for reasons that include but are not limited to the following: The continued use is in accordance with relevant standards of practice and the physician has documented the clinical rationale for why an attempted dose reduction would likely impair the residents function or exacerbate the underlying medical or psychiatric disorder.

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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 ensure infection prevention and control practices were implemented as required for six of six sampled residents (Resident #7, Resident #12, Resident #41, Resident #45, Resident #69) when:Ten missed hand hygiene opportunities were identified during medication pass observations, in which licensed nursing staff did not perform hand hygiene before or after resident contact and before medication preparation or administration, and;A Licensed Nurse failed to change gloves after contact with soiled materials during a tubeˆfeeding medication pass, when she handled a soiled towel and then proceeded to administer medications without removing gloves and performing hand hygiene.These deficient practices had the potential to contribute to the spread of infections among a vulnerable resident population.During medication administration observation on 3/25/26 at 7:28 a.m., Licensed Nurse C (LN C) missed four hand hygiene opportunities when he did not use hand sanitizer before entering Resident 41's room and later picked up two medication cups placing his fingers inside, contaminating the cups. During medication administration observation on 3/25/26 at 7:43 a.m., Licensed Nurse G (LN G) missed four hand hygiene opportunities when: 1)She did not use hand sanitizer before she collected medications for Resident 45, 2). She did not use hand sanitizer before entering Resident 45's room, 3). She did not use hand sanitizer before she collected medications for Resident 69, and 4). She did not use hand sanitizer before entering Resident 69's roomDuring medication administration observation on 3/25/26 at 9:04 a.m., the Infection Preventionist (IP, a nurse responsible for educating staff on infection control) missed two hand hygiene opportunities when she did not use hand sanitizer while entering Resident 7's room and exiting after medication administration. During a tubeˆfeeding medication administration observation on 3/25/26 at 11:10 a.m., in Resident 12's room, LN G prepared medications properly, arranged them on a tray, entered the resident's room, cleaned the resident, removed a soiled towel and placed the soiled towel into a plastic bag. LN G then proceeded to administer medications without changing gloves or performing hand hygiene.During an interview with LN G on 3/26/26 at 3:02 p.m., she stated, I should have changed my gloves. It is important because the gloves could have been contaminated with body fluids or bacteria that then [the resident] would get exposed to.A review of the facility's policy titled, General Dose Preparation and Medication Administration, last revised on 11/24, indicated that, appropriate hand hygiene should be performed before and after direct resident contact, and medications should not come into contact with any surface except the medication cup.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to thoroughly investigate an abuse allegation involving staff and one of one sampled resident (Resident 99).This failure had the potential to delay the implementation of necessary protective measures and oversight to safeguard the health and safety of Resident 99 and other residents of the facility.A review of Resident 99's admission Record (facility demographic) indicated Resident 99 was admitted to the facility on [DATE] and passed away on 3/13/26.A review of the Social Services Progress Note dated 2/03/26 at 9:08 a.m., indicated the facility was made aware of an allegation relayed by Life Partner 1 that Resident 99 reported two staff members were arguing, got into her face, and spit in her face.A review of Resident 99's electronic medical record (EMR) did not indicate the allegation was timely reported to the California Department of Public Health (CDPH) or that immediate follow-up actions were initiated at the time the allegation was made.During an interview on 3/25/26 at 3:35 p.m., Life Partner 1 stated that Resident 99 told him staff had gotten into her face and spit on her. Life Partner 1 stated he reported this concern to facility staff and administration.During an interview on 3/25/26 at 4:25 p.m., the Administrator (ADM) stated she did not believe the incident had occurred and believed Resident 99 may have been experiencing confabulations or delusions. The ADM stated she did not report the allegation to the California Department of Public Health (CDPH) when it was initially made.During an interview on 3/26/26 at 9:04 a.m., the ADM stated she submitted the SOC 341 (a state form used by mandated reporters to report suspected abuse, neglect, or exploitation of elders or dependent adults) the previous night during the survey, regarding the alleged incident and was in the process of gathering staff information related to the event.A review of the facility policy titled, Abuse, Neglect and Exploitation, revised 12/19/22, indicated, An immediate investigation is warranted when suspicion of abuse, neglect or exploitation, or reports of abuse [occur]. The same policy indicated under Section VII.1.a-b that all alleged violations must be reported immediately, but not later than two hours if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury.

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	056296	A. Building B. Wing	03/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Crescent City Care Center	1280 Marshall Street Crescent City, CA 95531

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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 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure the transfer and discharge of Sampled Resident #94 was documented in the resident's medical record, and appropriate information was communicated to the receiving health care institution and Ombudsman (advocacy agency). This failure had the potential to cause miscommunication, inadequate care and lack of advocacy. During an interview and record review with Medical Records (MR) on 3/25/26 at 12:50 p.m., MR stated Resident #94 was admitted [DATE] and discharged on 12/29/15. She stated the Social Services note indicated he was transferred to the hospital. She stated there was no physician order to transfer, no nursing progress note, no notification to the Ombudsman, and no documentation of where the personal belongings of the resident went. She stated there should be an order from the physician.During an interview and concurrent record review on 3/25/26 at 1 p.m. DON (Director of Nursing) stated for resident transfer or discharges to the hospital there should have been a nursing progress note that stated why the resident was transferred, there should have been documented notification to the Physician, Responsible Party, and Ombudsman, a Change of Condition in the Minimum Data Set (MDS), final disposition of personal items documented on the inventory sheet, Social services plan for house or home health, and education. She stated the only documentation she could find in the medical record was a Social Services note that indicated the Resident was transferred to the hospital. She stated nothing was documented and it should have been. She stated it was like he disappeared and we missed this one. During an interview and concurrent record review with Social Services on 3/26/26 at 1:20 p.m., she stated she was not the Social Services person at the time of Resident #94's transfer/discharge. She stated there should have been an inventory disposition sheet document for Resident #94's personal items. She stated there was no notification documentation to the Ombudsman for Resident #94 and there should have been. A request for a facility policy about documentation and notification was made and not received by the end of the survey.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure Resident #12's enteral feeding (liquid nutrition delivered directly into the stomach or small intestine via a tube for individuals unable to eat enough by mouth to meet their nutritional needs) was administered according to the physician's order and failed to ensure the glucose solution used with the resident's enteral feeding setup was properly labeled. These failures had the potential to result in improper nutrition delivery, contamination, and adverse health outcomes. Findings:A review of Resident #12's admission record indicated he was admitted on [DATE] with a diagnosis of chronic kidney disease. An observation on 3/23/26 at 8:43 a.m., noted Resident #12's enteral feeding pump running. The Glucerna bottle label showed a start time beginning with 8, but the complete time was unreadable due to smudging. The bottle label indicated a rate of 85 mL/hr hr (milliliters/hr, the amount of fluid infusing during one hour), while the pump was running at 90 mL/hr.A record review on 3/23/26 of Resident 12's chart showed the physician's order for Continuous Enteral Feeding at 90mL/hr x 20 hrs. An observation on 3/26/26 at 7:32 a.m. noted Resident #12's enteral feeding pump was running. The Glucerna bottle was not labeled for resident, time, date or rate of medication. An interview with the Director of Nursing (DON) on 03/26/2026 at 8:38 AM, the DON stated. It's not? Not on the back? Without the bottle being labeled, we don't know if the food is good. It could create gastric issues, an infection, any number of issues.An interview with LN F on 03/26/2026 at 3:17 PM, LN F stated, night shift is who hung the enteral feeding and it will say on the bottle when it was hung. After being shown a photo of the unlabeled bottle, LN F stated, Oh, no. no. this is not good. We have no idea when it was hung. It could be old and building bacteria. It could create an infection.A review of the facilities policy and procedure titled, Care and Treatment of Feeding Tubes, revised 12/19/22 stated, Feeding tubes will be utilized according to physician orders .A review of the facilities policy and procedure titled, Storage and Expiration Dating of Medications and Biologicals, revised 6/30/25, stated infusion labels must include the medication name, volume, infusion rate.date and time of administration, initials of person administrating.

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure behavioral and mental health services for one of two Sampled Residents (Resident #49). This failure had the potential to affect Resident 49's wellbeing and the potential to cause further trauma. A review of Resident 49's admission record indicated he was admitted on [DATE] with diagnoses of Major Depressive Disorder (a serious mental health condition characterized by persistent sadness, loss of interest in activities, and low energy) and Delusional Disorder (a chronic, rare psychotic condition defined by holding one or more fixed, false, and non-bizarre beliefs).A review of Resident 49's Minimum Data Set (MDS-a resident assessment tool) dated 3/4/26 indicated Resident 49 had a BIMS score of 15 indicating no cognitive impairment.A review of Resident 49's Trauma Informed Care Screener dated 2/20/26 indicated he had experienced a traumatic event.A review of Resident 49's Order Summary dated 3/27/26 indicated Resident 49 had no orders/referral for Psychiatric or mental health services and had been prescribed Wellbutrin (an antidepressant medication) for verbalization of sadness. A review of Resident 49's clinical record indicated no Psychiatric or mental health consult had occurred.A review of Resident 49's current Care Plan dated 1/5/26 indicated Resident 49 had disturbed thought processes related to delusional ideas, psychosis, depression and had actual or suspected history of personal trauma. It further indicated that Resident 49 was at risk for behaviors if triggered by past traumas and an intervention was added to be referred to Psychiatry or a mental health provider.During an interview on 3/24/26 at 8:45 a.m. with Resident 49 in his room, Resident 49 stated he experienced a home invasion just before Christmas last year and felt he had some PTSD. Resident 49 further stated he had spoken to a psychiatrist while in the hospital and they didn't believe his trauma was real which made it difficult for him to talk about what had happened.During an interview on 3/27/26 at 8:53 a.m. with the Director of Nursing (DON) in her office, DON stated Psychiatric services should be provided if indicated on the Care Plan, and trauma informed care was very important for the population at the facility.A review of a facility policy titled, Trauma Informed Care, dated 12/19/22, indicated, The facility will collaborate with resident trauma survivors, and as appropriate, the resident's family,friends, the primary care physician, and any other health care professionals (such as psychologists and mental health professionals) to develop and implement individualized care plan interventions.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation and interview, the facility failed to ensure that medications were stored in a secure manner when 1. medications were left unattended on a medication cart, 2. loose pills were found at the bottom of multiple medication carts, 3. an open date on a medication was illegible, 4. a Licensed Nurse did not know how to dispose of wasted medications, 5. medication carts were observed unlocked and unattended on two occasions, and 6. an emergency medication kit (EˆKit) was observed open and accessible. This deficient practice has the potential to affect all residents who rely on the integrity and safety of the facility's medication supply when residents, staff and visitors could access unattended medications which could result in accidental ingestions of medications and medications getting lost and misplaced and not available for residents who need them. Findings:During an observation on 03/25/2026 at 9:15 AM Licensed Nurse (IP) was at med cart, reviewing medication packets, when IP located a packet requiring disposal, and left it on top of her medication cart while entering a resident's room to administer medications, leaving the cart and medications unattended. During an observation on 03/26/2026 at 11:00 AM with the Director of Nursing (DON), the emergency medication kit (e-kit) with intravenous medications was observed unlocked, with no log or documentation of who opened it or when it was accessed. The DON confirmed they were unaware of why, when or by whom it was opened. The inventory review showed that two 500mL normal saline bags were missing. The e-kit was delivered to the facility on 2/22/26. During Medication Cart review on 3/26/26 beginning at 2:42 PM, loose pills were found inside the carts:- 6 loose pills in the South cart- 2 loose pills in the East cart- 4 loose pills in the [NAME] cartWhile reviewing South cart, a medication had an illegible open date. LN B stated, I cannot tell what date this it. I can't tell if it's a seven or a three, While reviewing [NAME] cart, LN F stated, I don't know where to dispose of [the loose pills].An observation on 03/26/2026 at 4:53 PM noted a medication cart, positioned in the hallway, facing outward, unlocked and unattended, while LN C was inside a resident room giving medications. When the LN returned, he locked the cart after observing the surveyor watching it. LN C confirmed the cart had been unattended and stated, Anybody could have accessed the meds. If someone took someone else's meds, the other resident would be without, someone could get ill, or worse. no, this is bad.A review of the facilities policy and procedure titled, General Dose Preparation and Medication Administration revised 11/24, revealed section 2.8: facility staff should not leave medications or chemicals unattended; and section 7: Facility should ensure that medication carts are always locked when out of sight or unattended.A review of the facilities policy and procedure titled, Emergency Medication Supplies (Emergency Kits), revision date 11/315/24 states, The emergency kit is sealed and stored in a secure area to prevent unauthorized access.

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F 0774 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Help the resident with transportation to and from laboratory services outside of the facility. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure Resident 64 could attend a much-needed medical appointment when no transportation was arranged causing the appointment to be cancelled and subsequently never rescheduled. This failure directly affected Resident 64's access to care and a pain management program.A review of Resident 64's admission record indicated he was admitted on [DATE] with the diagnoses of person injured in an MVA (motor vehicle accident), multiple fractures of ribs, pain in unspecified joint, pain in both shoulders, muscle spasm, and dysphagia (difficulty swallowing).A review of Resident 64's Minimum Data Set (MDS-a resident assessment tool) dated 2/4/26 indicated he had a BIMS (Brief Interview for Mental Status-an assessment tool used by facilities to screen and identify memory, orientation, and judgement status of the resident) score of 13 with no cognitive impairment.A review of Resident 64's Social Services Progress Notes indicated no documentation concerning the missed appointment.During an interview on 3/23/26 at 9:30 a.m. with Resident 64 in his room, Resident 64 stated he had constant pain after his accident and had missed an appointment for pain management due to facility transportation issues that had been going on for a year.During a concurrent interview and record review on 3/24/26 at 12:55 p.m. with the Social Services Director (SSD), a list of residents who had missed medical appointments was reviewed. The list indicated that Resident 64 had missed a Nerve Conduction Study scheduled at (name of hospital) on 3/18/26 and that was not yet rescheduled. The SSD stated she had not made any progress notes about the missed appointments and that they were cancelled due to the facility van not being operable and the facility waiting for new registration tags. During an interview on 3/26/26 at 11:04 a.m. with the SSD in her office, SSD stated it was not ok for Residents to miss their medical appointments due to lack of transportation. SSD further stated this could interfere with proper care, affect the level of care they receive at the facility and could lead to further decline and even affect their mood.During an interview on 3/27/26 at 8:53 a.m. with the Director of Nursing (DON), DON stated her expectation was that the SSD arrange for transportation by alternate means if the van was not available. DON further stated missed pain management appointments did not meet her expectation because chronic pain needed to be treated effectively.A review of a facility policy titled, Transportation, revised 1/22/24, indicated, Social Services will help the resident as needed to obtain transportation.A review of a facility document titled, Social Services, revised 12/19/22, indicated, The facility, regardless of size, will provide medically related social services to each resident, to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being.