STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056328	A. Building B. Wing	03/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Premier Care Center for Palm Springs	2990 East Ramon Road Palm Springs, CA 92264

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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 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure care and treatment was provided, for 12 of 93 residents (Residents 113, 4, 12, 9, 69, 5, 89, 116, 87, 109, 84, and 119), when:1.For Resident 113, the facility did not conduct on-going assessment of the resident's bowel movement/constipation (difficulty passing stool) and implement interventions to address constipation according to the physician's order and facility's policy and procedure, when Resident 113 did not have bowel movement from February 4, 2026, to February 10, 2026 (seven days). In addition, the facility staff did not act on several daily alert notifications from February 6, 2026, to February 11, 2026, indicating Resident 113 not having a bowel movement (BM) for more than three days.2. For Residents 4, 12, 9, 69, 5, 89, and 116, the facility did not implement interventions to address constipation when the residents did not have bowel movement for three days or more, despite alert notifications in the facility's electronic health record, indicating no bowel movement for three days or more.On March 9, 2026, at 5:58 p.m., the Administrator (ADM) and the Director of Nursing (DON) were verbally notified of the Immediate Jeopardy (IJ - situation in which the provider's non-compliance with one or more requirements of participation has caused or likely to cause serious injury, harm, impairment, or death to a resident), due to the facility's failure to assess/evaluate and provide the appropriate interventions to address Residents 113, 4, 5, 9, 12, 69, 89, and 116's no bowel movement of three days or more. The facility was notified an extended survey would be conducted due to substandard quality of care issues.These failures resulted in a delay in the care and treatment of Resident 113's constipation, subsequently leading to Resident 113's death on February 13, 2026, secondary to bowel ischemia (a condition that happens when narrowed or blocked arteries restrict blood flow to the small intestine). In addition, these failures had the potential for Residents 4, 5, 9, 12, 69, 89, and 116 to develop complications related to constipation such as fecal impaction (a solid, immovable mass of stool becomes trapped in the rectum or colon, which can lead to severe abdominal pain, nausea, and vomiting), bowel obstruction (a partial or complete blockage of the intestines that may require emergency medical attention), hemorrhoids (swollen blood vessels in the rectum or anus caused by straining, leading to pain, itching, and bleeding).On March 10, 2026, at 11:14 a.m., the ADM presented an acceptable IJ removal plan which included the following:-On March 6, 2026, at 8 p.m., the DON and designee conducted a facility-wide bowel movement audit using the PCC (Point Click Care - electronic health record) alerts and bowel flowsheets to review the bowel record of all residents, to identify residents who had no bowel movement three days or more;-18 out of 90 residents were identified as having no BM for more than three days. Licensed Nurses (LN) conducted interviews and assessments of identified residents with no BM for more than three days and documented in the residents' progress notes. Immediate interventions were implemented as ordered by the physician, including administration of PRN (as needed) medications for constipation;-On March 6, 2026, and March 9, 2026, the DON and designees reviewed all residents' bowel management regimens and PRN medications for constipation to ensure every resident had an active and appropriate bowel management program in place;-On March 9, 2026, the DON and Registered Nurse (RN) designees conducted interviews and assessments of all residents to evaluate bowel status, including any signs and symptoms of (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 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	constipation;-On March 9, 2026, care plans were reviewed and updated to reflect individualized bowel management interventions as ordered;-On March 6 to 10, 2026, LNs received in-service training from the DON regarding the facility's bowel management program, consistent bowel monitoring and documentation, recognition of constipation risk factors, use of the PCC alerts, and timely administration of PRN medications according to the physician's orders;- On March 6 to 10, 2026, Certified Nurse Assistants (CNA) received in-service training from the Director of Staff Development (DSD) regarding the facility's bowel management program, monitoring of bowel movements, reporting to the LN any resident who had no BM for three days or more, accurate and timely documentation in the POC (Point of Care - electronic charting for CNAs) of real time entries;-Starting March 9, 2026, the facility will utilize the PCC-Alert to identify residents who have not had a BM for more than three days. Daily review of the PCC-Alert will be conducted by the RN Supervisor or designee. Residents identified on the alert report will be assessed and determine if the interventions are required. If PRN medications are administered and the resident continues to have no BM, the nursing staff will notify the physician for further evaluation and additional orders;-Starting March 6 to 10, 2026, the facility will implement bowel medication regimen if appropriate, as recommended by the Medical Director, and as approved by the Attending Physician;-Starting March 9, 2026, the MDS (Minimum Data Set - a resident assessment tool) Coordinator and designee will develop and routinely update care plans for At risk for Constipation to reflect each resident's bowel management needs;-Starting March 9, 2026, the charge nurses will conduct shift to shift endorsement to review residents identified on the bowel monitoring list, including those with no documented BM; and-Starting March 10, 2026, the facility IDT (Interdisciplinary Team - a group of healthcare professionals) will review the PCC - Alert Dashboard during the morning stand-up meeting to identify any residents triggered for no BM for more than three days. The IDT will follow up accordingly to ensure appropriate interventions are implemented.On March 10, 2026, at 6:05 p.m., the Immediate Jeopardy was removed in the presence of the ADM and the DON, upon verification of the implementation of the IJ removal plan, while onsite in the facility.3. For Resident 87, the facility did not conduct an assessment when the resident had blood sugar (BS) levels above 400 mg/dl (milligram/deciliter - unit of measurement), and implement interventions including notifying the physician when the BS was above 400 mg/dl, according to the physician's orders.This failure had the potential for a delay in the care and treatment to manage elevated BS and could contribute to the development of complications related to uncontrolled BS, such as damage to the blood vessels and nerves, leading to heart disease, stroke, kidney failure, blindness, and nerve damage;4. For Resident 109, the facility did not address the resident's multiple open areas on the bilateral lower extremities due to scratching. This failure had the potential for a delay in the care and treatment and could cause infection on the affected area; 5. For Resident 84, the facility did not provide on-going monitoring and assessment of bilateral lower extremity edema (swelling). In addition, the facility did not provide re-evaluation of the wound on the right great toe for continued wound treatment from February 16 to 26, 2026.These failures have the potential for a delay in the care and treatment and could affect the overall health condition of the resident; and6. For Resident 119, the facility did not conduct an assessment when the resident had blood sugar (BS) levels above 400 mg/dl (milligram/deciliter - unit of measurement), and implement interventions including notifying the physician when the BS was above 400 mg/dl, according to the physician's orders.This failure had the potential for a delay in the care and treatment to manage elevated BS and could contribute to the development of complications related to uncontrolled BS, such as damage to the blood vessels and nerves, leading to heart disease, stroke, kidney failure, blindness, and nerve damage. Findings: 1.On March 6, 2026, during a review of a closed record (record of a discharged resident) for Resident 113 was conducted. Resident 113's Face Sheet (includes demographic information of the resident), indicated the resident was admitted to the facility on [DATE], with diagnoses which included aftercare post surgery (after surgery) for fracture (broken) of the left femur (thigh bone). (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	A review of Resident 113's Physician Orders for Life-Sustaining Treatment (POLST), dated January 31, 2026, indicated the resident was DNR (Do Not Attempt Resuscitation [the action or process of reviving someone from unconsciousness or apparent death]) and Selective Treatment (use of medical treatment, IV (intravenous – though the vein), and IV fluids as indicated). A review of Resident 113's History and Physical, dated February 1, 2026, indicated, .Has capacity to make medical decisions. A review of Resident 113's Order Summary Report, included the following medications which could cause constipation: -HYDROcodone-Acetaminophen (narcotic pain medication) Oral Tablet 5-325 MG (milligram – unit of measurement).Give 1 (one) tablet by mouth every 6 (six) hours for pain management, date ordered January 31, 2026; -Ferrous Sulfate (iron supplement) Oral Tablet 325 MG.Give 1 (one) tablet by mouth one time a day for supplement, date ordered January 30, 2026; -Citalopram Hydrobromide (medication to treat depression) Oral 20 MG.Give 1 (one) tablet by mouth one time a day for depression m/b (manifested by) verbalization of sadness over health, date ordered January 30, 2026; -QUEtiapine Fumarate (medication to treat mental illness) Oral Tablet 25 MG.Give 1 (one) tablet by mouth at bedtime for psychosis (mental illness), date ordered January 30, 2026; -Cymbalta (medication to treat depression and pain) Oral Capsule 100 MG Give 1 (one) capsule by mouth two times a day for pain, date ordered February 4, 2026; and -Trazodone HCl (medication to treat depression) Oral Tablet 50 MG.Give 0.5 tablet by mouth at bedtime for depression m/b inability to sleep, date ordered February 10, 2026. A review of Resident 113's Order Summary Report, included the following medications for bowel management: -Docusate Sodium (stool softener) Capsule 100 MG Give 1 (one) capsule by mouth two times a day for Bowel Hygiene, date ordered January 30, 2026; -Milk of Magnesium (MOM - an over-the-counter medication containing magnesium hydroxide, used primarily as a saline laxative [fast-acting, salt-based agent used for short-term constipation relief and bowel cleansing] to relieve constipation and as an antacid to treat heartburn or indigestion) Give 30 ml (milliliter – unit of measurement) by mouth every 24 hours as needed for Bowel Care **if no BM in 3 (three) days, date ordered January 30, 2026; -Bisacodyl (a fast-acting stimulant laxative used for short-term relief of occasional constipation and to empty the bowels before medical procedures) Suppository (a solid medical preparation in a roughly conical or cylindrical shape, designed to be inserted into the rectum or vagina to dissolve) 10 MG Insert 1 (one) suppository rectally every 24 hours as needed for Bowel Care **If MOM not effective, date ordered January 30, 2026; and (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	-Fleet Enema (an over-the-counter, pre-lubricated, single-use rectal saline laxative used for fast relief of occasional constipation, fecal impaction, or bowel cleansing before medical procedures) 7-19 GM/118 ml (gram/milliliter).Insert 1 (one) unit rectally every 24 hours as needed for Bowel Care ***if MOM and Bisacodyl ineffective, date ordered January 30, 2026. A review of Resident 113's Minimum Data Set, dated February 6, 2026, indicated Resident 113 had a BIMS (Brief Interview of Mental Status) score of 13 (cognitively intact - has normal mental functioning, including intact memory, reasoning, attention, and decision-making abilities), and required assistance in ADLs (Activities of Daily Living). A review of Resident 113's Documentation Survey Report, for the month of February 2026, indicated bowel movements on the following dates: -February 1, 2026, at 10:57 a.m.; small, putty like (sticky, or clay-colored stool) stool; -February 3, 2026, at 10;36 p.m.; medium, putty like stools; -February 11, 2026, at 9:08 p.m.; large, formed/soft stools; and -February 12, 2026, at 2:30 p.m.; medium, formed/soft stools. Further review of the above document indicated Resident 113 did not have BM from February 4 to 10, 2026 (seven days). A review of Resident 113's care plan, dated February 2, 2026, indicated, .Anti-psychotic medication use r/t (related to) psychosis m/b (manifested by) hallucinations (the apparent perception of something not present).at risk for side effects.Document side-effects.constipation. A review of Resident 113's care plan, dated February 12, 2026, indicated, .Has risks for constipation r/t (related to) Decreased mobility, Medications side effects.goal.Will have abnormal bowel movement at least daily through the review date.Administer medications as ordered.Monitor medications for side effects of constipation. Keep physician informed of any problems.Record bowel movement pattern each day. Describe amount, color and consistency. A review of Resident 113's care plan, dated February 12, 2026, indicated, .At risk for depression.medication side effects.Observe for side effects of anti-depressant (medication to treat depression) medication.constipation, fecal impaction. A review of Resident 113's Medication Administration Record, for the month February 2026, indicated there was no documented evidence MOM, Bisacodyl, and fleet enema were administered to the resident when there was no BM for three days or more. Further review of Resident 113's record indicated there was no documented evidence the physician was notified to address the resident's no BM for seven days (February 4 to 10, 2026). A review of Resident 113's physician's notes, documented by the Nurse Practitioner (NP), dated February 13, 2026, at 9:35 a.m., indicated, .02.13 (February 13, 2026) - No acute events overnight. Seen with PT (Physical Therapy) during encounter. Patient reports vague abdominal discomfort during PT. Patient denies pain, nausea, vomiting.Physical Exam.Abdomen.Anterior palpation (the medical (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	technique of using fingers or hands to feel the front surface of the body (e.g. [Latin word meaning for example], abdomen, chest, neck) to assess for tenderness, organ size, texture, masses, or temperature) – Normal, No guarding (voluntary or involuntary contraction of abdominal muscles in response to underlying inflammation), No rebound (Pain that occurs upon the sudden release of pressure on an abdominal area). No abdominal tenderness.Assessment/Plan.lower abdominal pain.UA (urinalysis – urine test) and KUB (Kidney, Ureter, and Bladder X-ray - a diagnostic imaging test used to visualize the urinary system, specifically for detecting kidney stones, infections, or abdominal pain.It acts as a rapid assessment tool for gastrointestinal [digestive tract, is a continuous muscular pathway extending from the mouth to the anus, specialized for breaking down food, absorbing nutrients, and excreting waste] and urinary issues) . A review of Resident 113's Physician and Telephone Orders, dated February 13, 2026, indicated, STAT (used in clinical settings to indicate that a test, medication, or procedure is urgent and must be prioritized and completed right away, typically within 30 minutes) orders for the following: -CBC (complete blood count - a routine blood test that measures the cells circulating in the blood: white blood cells [WBC - infection fighting], red blood cells [RBC -oxygen carrying], and platelets [PLT – clotting]. It is used to diagnose conditions like anemia [a medical condition characterized by a lower-than-normal level of healthy red blood cells or hemoglobin in the blood, reducing the blood's capacity to carry oxygen to tissues] infection, and leukemia [a cancer of the blood-forming tissues, including bone marrow, characterized by the rapid, uncontrolled production of abnormal white blood cells], monitor overall health, or check treatment progress); -U/A (urinalysis - routine test used to analyze urine for signs of infection) with C & S (culture and sensitivity - a diagnostic laboratory test used to identify a pathogenic organism [bacteria, fungus] causing an infection [culture] and determine which specific antibiotics or medications will effectively treat it); and -KUB. A review of Resident 113's Radiology Report, dated February 13, 2026, at 12:44 p.m., indicated, .Xray Abdomen.Results: Dilated loops of bowel (segments of the small or large intestine that have abnormally widened, often indicates a serious condition, such as a physical blockage or failure of muscles to push content forward) colonic fecal residual (the presence of waste material (feces) that remains in the colon or rectum instead of being evacuated during a bowel movement) is noted.Gastric Distention (the abnormal stretching, swelling, or enlargement of the stomach caused by trapped gas, liquids, food, or air swallowing).Conclusion: Ileus (temporary stoppage of normal intestinal muscle contractions [peristalsis], causing a functional or nonmechanical bowel obstruction. A state where the intestines cannot move waste or food through the digestive tract due to paralyzed muscles, rather than a physical blockage) type pattern favored, obstruction not excluded. Recommend CT (computed tomography - scan is a noninvasive, painless medical imaging procedure that uses rotating X-rays and computers to create detailed, 3D, cross-sectional images (slices) of bones, blood vessels, and soft tissues) or follow up as clinically warranted. A review of Resident 113's Progress Notes, dated February 13, 2026, at 1:06 p.m., indicated, .Bladder distended, hard, firm and distended pain on palpation. NP (name of NP) notified with order insert foley Cath (catheter - a flexible, indwelling plastic or rubber tube inserted through the urethra into the bladder to continuously drain urine) draining to tea colored urine.Patient was relieved of pain after. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	A review of Resident 113's Progress Notes, dated February 13, 2026, at 2:11 p.m., indicated, .Received new order from, (name of physician), May transfer to (name of immediate care (IC) facility - synonymous with urgent care; a walk-in medical clinic that provides prompt treatment for non-life-threatening illnesses and injuries, such as sprains, cuts, cold/flu, and infections) on 2-13-26 (February 13, 2026) for CT of the ABD (abdomen). A review of Resident 113's IC facility visit notes, dated February 13, 2026, at 3 p.m., indicated, .2d (two days) lower abdominal pain at SNF (Skilled Nursing Facility), she is s/p (status post - used to describe a patient's condition after a specific procedure, surgery, or significant medical event) L (left) hip surgery and is on pain medications. She says she had BM today and passed gas but on exam her abdomen is distended and there were no bowel sounds after 1 (one) minute. Sounds initially like SBO (small bowel obstruction - a partial or complete blockage of the small intestine that prevents food, fluids, and gas from moving through the digestive tract; a serious condition often causing severe abdominal pain, vomiting, and bloating) but on rectal exam she has severe fecal impaction (a serious medical condition characterized by a large, hard, dry mass of stool stuck in the rectum or colon due to chronic, untreated constipation) so the stool is making it to the rectum (the final section of the large intestine, terminating at the anus). Attempted some disempaction (sic) (the medical process of removing hardened, impacted stool from the rectum or colon, usually caused by severe, chronic constipation), will get CT scan per SNF request. Abdominal xray showed air fluid levels, so the radiologist who read it requested CT to assess for SBO.1545 (3:45 p.m.): After some fecal disempaction (sic), she now has bowel sounds and softer abdomen. Will try to disempact (sic) more before sending pt (patient) to CT scan. 1550 (3:50 p.m.): WBC (white blood cell count - colorless, immune cells produced in the bone marrow that circulate in the blood and tissues to fight infection, viruses, and foreign substances) also elevated at 19.1 (normal range 5 to 10).1555 (3:55 p.m.): Foley replaced, the urine remains cloudy so will give IV (intravenous – through the vein) Rocephin (medication to treat infection).for possible UTI (urinary tract infection). This could explain the elevated WBC.Vital Signs.3:10 p.m.Pulse/min (minute) 128 (normal range 60 to 100 beats).Pain level 8/10 (indicative of severe pain).Physical Exam.Abdomen.Auscultation (he medical practice of listening to internal body sounds—primarily heart, lungs, and intestines—to assess organ function and detect abnormalities) – absent bowel sounds. Abdominal tenderness – LLQ (left lower quadrant - left lower part of the abdomen).Assessment.Fecal impaction.Patient Plan.After the CT scan you can go back to (name of SNF), we will call when we get the results. If you get worse before you get the CT results you may need to go to ER (emergency room). You had a lot of stool in your rectum (fecal impaction) which we removed. This could be the cause of your pain. A review of Resident 113's CT scan results, dated February 13, 2026, electronically signed at 8 p.m., indicated, .Abdomen.Atherosclerotic disease of the abdominal aorta (a progressive buildup of plaque in the largest artery in your body, called your aorta [largest artery in the body that supplies oxygenated blood to the abdominal organs and lower extremities].Impression.Distended and patulous (an anatomical structure that is abnormally wide open, distended, or gaping when it should be closed or resting) air-filled distal esophagus with ingested material (an esophageal foreign body or food impaction located in the lower portion of the esophagus) within it. The patient is at risk for aspiration (the accidental breathing in of food, liquid, or foreign material into the airway/lungs).Large quantity of ingested material in the stomach.Portal venous air (a rare, serious radiologic (a medical specialty that utilizes imaging technologies) sign defined by the presence of gas (air) within the portal vein (a vein conveying blood to the liver from the spleen, stomach, pancreas, and intestines) and its branches, typically leading to the liver is noted best seen on series 2 image 39 raising concern for bowel ischemia. Surgical consultation is highly advised.Large quantity of stool throughout the colon. Consider constipation. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On March 6, 2026, at 7:03 p.m. a follow up concurrent interview and review of Resident 113's record was conducted with the DON. The DON stated the following: -The Registered Nurse (RN) told the NP that Resident 113 had abdominal distention and the NP, who was in the facility, ordered for stat KUB, UA, and CBC; -The NP ordered for CT scan to be done at the IC facility after the KUB results indicated ileus and to rule out bowel obstruction; -Resident 113's bowel movement record indicated the resident did not have BM from February 4 to 10, 2026; -Resident 113 was on routine narcotic pain medication and had orders for Docusate sodium, and PRN medication of MOM, Bisacodyl suppository, and fleets enema if no BM for three days or more. The DON stated there was no PRN MOM, Bisacodyl, and fleets enema administered to Resident 113 when there was no BM for three days or more. The DON stated the LN should have administered PRN bowel regimen medications to address Resident 113's constipation, and notify the physician if not effective; -The LN would get alert notification from PCC dashboard to alert staff if there was no BM for three days or more. Reviewed the PCC dashboard with the DON and indicated there were daily alert notifications starting from February 6 to 11, 2026, indicating Resident 113 was not having BM for three days or more and to give PRN constipation protocol; and -She was uncertain why the nurse did not address the alert notification from the PCC dashboard. The DON stated the LN should have addressed the alert notification of no BM for three days or more for Resident 113. On March 9, 2026, at 12:08 p.m., a concurrent interview and review of Resident 113's record was conducted with the medical doctor (MD) and the NP. The MD and the NP stated the following: -The MD stated he was the primary physician for Resident 113 while the resident was in the SNF, and he and the NP are in the SNF five days a week; -If urgent labs (laboratory tests) and radiologic procedures are being ordered, they would send the resident to the IC facility (about a mile away from the SNF) as the lab and radiology vendor would take a long time for the test to be done; -The MD and the NP made rounds in the morning (around 9 a.m. to 11 a.m.) of February 13, 2026, and Resident 113 complained of abdominal pain. The MD stated Resident 113 is high risk to develop constipation as the resident was on routine narcotic pain medication; -Reviewed with the MD and NP their notes from Resident 113's electronic record, and the assessment documented indicated abdominal distention, with no documentation of auscultation (guided listening to bowel sounds using a stethoscope) and percussion (a physical examination technique used to assess for fluid [ascites - abnormal buildup of fluid in the peritoneal cavity], organomegaly [enlarged liver/spleen], or masses by producing sound waves through light tapping of the abdomen). The NP stated they did not check Resident 113's bowel sounds as the resident reported the abdominal discomfort while doing physical therapy; (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	-KUB was done at the facility and was reported on 12:44 p.m., with result of ileus and obstruction not excluded, and a CT was recommended. The MD stated CT scan of the abdomen was done at the IC facility; -The MD stated that he was uncertain if they were made aware Resident 113 had no bowel movement from February 4 to February 10, 2026, and only became aware of the recent bowel movement prior to the resident's complaint of abdominal pain on February 13, 2026. The MD noted that the recommended interventions for KUB and CT scan would have remained unchanged, regardless of earlier knowledge regarding the absence of bowel movements over several days; -The MD stated Resident 113 had medications to address constipation and should have been given if the resident did not have BM for a couple of days; -The MD stated if a resident was sent to the IC facility for a procedure, the IC physician would assess the resident's condition and do the appropriate interventions including the SNF MD recommendation. The MD stated the IC facility conducted the CT scan after Resident 113 was disimpacted for fecal impaction. The MD stated usually CT scan should have been done before doing the disimpaction to prevent any manipulation if there is presence of nonviable tissue (tissue or cells that are no longer alive or able to function normally), as it could get worse; - The MD stated the result of the CT scan for Resident 113 indicated bowel ischemia. The MD stated bowel ischemia could be acute or chronic, and if there is damaged tissue already, it could become necrotic (the death of body tissue, often due to lack of blood supply, trauma, or infection) because of decreased blood supply to the tissue. The MD stated rectal fecal impaction would not normally cause bowel ischemia, but if the stool gets backed up and caus

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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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure food was prepared, stored, served, or distributed in accordance with professional standards of food service safety, for 92 of 93 residents who received food from the facility kitchen, when the following were found, readily available for use:1. Several bottles of opened herbs and spices were found not labeled with open dates;2. One opened one-gallon container of buttermilk ranch dressing and one opened one-gallon container of egg mayonnaise were found inside refrigerator # (number) 1 without open dates;3. One package of roast beef was found stored in the walk-in refrigerator, past its use-by date; and4. One opened one-gallon container of sesame oil was not labeled with an open date.These failures had the potential to cause food-borne illness in a highly susceptible population of 92 out of 93 residents who consume food from the facility kitchen. Findings:On March 2, 2026, at 9:45 a.m., an initial tour of the facility's kitchen was conducted with the Assistant Dietary Supervisor (ADS), the following were observed:1. The following opened bottles of herbs and spices were on the spice rack, and not labeled with open dates:- Mediterranean style ground oregano 13 oz (ounce- unit of weight measurement) bottle;- Ground cumin 396 gram (unit of weight measurement) bottle;- Dill weed 5 oz bottle;- Ground ginger 1 lb (pound- unit of weight measurement) bottle;- Rubbed sage 4 oz bottle;- Ground cayenne pepper 14 oz bottle; and- Ground rosemary 12 oz bottle.In a concurrent interview, the ADS confirmed the items had no open dates, and was unsure if they should be labeled with open dates. 2. Inside Refrigerator # 1:- A one-gallon container of buttermilk ranch dressing was not labeled with an open date; and- A one- gallon container whole egg mayonnaise was not labeled with an open date.In a concurrent interview, the ADS stated the ranch dressing and mayonnaise should be good for one month after the open date, and these items did not have an open date, therefore staff would not know when to discard them. 3. On March 2, 2025, at 11 a.m., the walk-in refrigerator was observed with the ADS. In the middle shelf of the black metal rack by the right wall of the walk-in refrigerator, was a large black plastic tub. Inside the tub was one package of Roast Beef Split Top Round, labeled with op 2/24/26 February 24, 2026, and Ub 2/28/26 (February 28, 2026).In a concurrent interview, the ADS stated the label indicating op meant for open date, and Ub meant for the use-by date. The ADS further stated the roast beef was past its use-by date and should have already been discarded.4. On March 2, 2025, at 11:10 a.m., the dry storage room was observed with the ADS. At the bottom shelf on the steel metal rack by the right wall near the door, was an opened one-gallon bottle of [NAME] Kee pure sesame oil, labeled R: 2-4-26. There was no open date indicated on the bottle.In a concurrent interview, the ADS stated the label R meant for a received date of February 4, 2026. The ADS stated the bottle should have been labeled with an open date.On March 6, 2026, at 4:56 p.m., the Registered Dietitian (RD) was interviewed. The RD stated the herbs and spices should have had open dates, as well as the buttermilk ranch dressing, mayonnaise, and sesame oil. The RD stated the beef roast, already past it's use-by date, should have been discarded.A review of the facility's policy and procedure titled, LABELING AND DATING OF FOODS, dated 2023, indicated, .All food items in the storeroom, refrigerator, and freezer need to be labeled and dated based on established procedures for either food safety or product rotation.OD= Open Date.UB= Use By Date.The individual opening or preparing a food shall be responsible for date marking at the time of processing and/or storage.For foods that are commercially processed, ready to eat and intended to be stored cold greater than 24 hours will be marked by a Use By date.The Use By date signifies the date in which food must be consumed or discarded. The dating once opened but require refrigeration are included on the Dry Goods Storage Guidelines .A review of the facility's document titled, DRY GOODS STORAGE GUIDELINES, dated 2023, indicated, .This storage length is to be followed unless you have manufacturer's recommendation indicating otherwise.Herbs.Opened on shelf.1 year.Spices, (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	ground.Opened on Shelf.2 years.Salad dressing, bottled.Opened-Refrigerated.1 month.Mayonnaise.Opened-Refrigerated.2 months.Oil, vegetable (including sesame oil).Opened on Shelf.3 months.

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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 ensure an individualized comprehensive care plan was developed, for seven of 23 residents reviewed (Residents 8, 25, 109, 119, 32, 89, and 116), when:1.For Resident 8, a care plan was not developed to address targeted behavior of hallucinations (a false perception or sensory experience -such as seeing, hearing, smelling, tasting, or touching something that is not actually present), depression (common, serious, and treatable mental health disorder characterized by persistent feelings of extreme sadness, emptiness, hopelessness, and a loss of interest in activities), and anxiety (a common, often normal, feeling of intense fear, dread, and nervousness);2.For Residents 25, 109, and 119, a care plan was not developed to address dental issues; and3. For Residents 32, 89, and 116, a care plan was not developed to address the use of oxygen.These failures could result in facility staff being unaware of the plan of care established to address the residents' condition.Findings: 1. On March 5, 2026, Resident 8's record was reviewed. Resident 8's Face Sheet, indicated the resident was admitted to the facility on [DATE], with diagnoses which included dementia (memory loss), psychosis (mental disorder), depression, and anxiety. A review of Resident 8's History and Physical, dated January 8, 2026, indicated the resident does not have a capacity to make decisions. A review of Resident 8's Minimum Data Set (MDS – a resident assessment tool), dated January 14, 2026, indicated the resident had a BIMS (Brief Interview for Mental Status) score of 6 (severe cognitive impairment). A review of Resident 8's Order Summary Report, included the following physician's order: -LORazepam Oral Tablet 0.5 MG (milligram – unit of measurement).Give 1 (one) tablet by mouth every 6 (six) hours as needed for ANXIETY M/B (manifested by) VERBALIZATION OF ANXIOUSNESS, date ordered January 7, 2026; -Mirtazapine Oral Tablet 15 MG.Give 1 (one) tablet by mouth at bedtime for DEPRESSION M/B VERBALIZATION OF SADNESS, date ordered January 7, 2026; - SEROquel (medication to treat psychosis) Oral Tablet 25 MG.Give 1 (one) tablet by mouth two times a day for PSYCHOSIS M/B AUDITORY AND VISUAL HALLUCINATIONS, date ordered January 7, 2026. Further review of Resident 8's record indicated there was no documented evidence an individualized care plan was developed to address targeted behaviors of anxiousness, verbalization of sadness, and auditory and visual hallucinations. On March 6, 2026, at 9:38 a.m., a concurrent interview and record review was conducted with the Director of Nursing (DON). The DON stated there was no individualized care plan developed to address Resident 8's behaviors. The DON stated the facility should have developed an individualized care plan for the targeted behaviors for the staff to be aware what interventions to implement when the resident would have those behaviors. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2a. On March 3, 2026, at 4:13 p.m., Resident 25 was observed alert, sitting at bedside. Resident 25 was observed without any teeth or dentures to upper or lower gums. In a concurrent interview, Resident 25 stated she had denture impressions done at her last dentist appointment in the fall of 2025. Resident 25 stated the facility did not provide further updates or follow ups on her dentures. Resident 25 stated the staff will cut up her food, then she will moisten her food with her tongue and gums before swallowing. On March 3, 2026, Resident 25's medical record was reviewed. Resident 25 was admitted to the facility on [DATE], with diagnoses which included hemiplegia and hemiparesis following cerebral infarction affecting left dominant side (weakness or paralysis on the left side of body caused by a stroke) and dysphagia (difficulty swallowing). A review of Resident 25's Initial admission Record, dated April 25, 2025, indicated, .oral assessment.natural teeth: present.artificial teeth: no.upper: no.lower: no. A review of Resident 25's MDS, dated April 30, 2025, indicated the following: - .holding food in mouth/cheeks.residual food in mouth after meals.; and -Oral/Dental Status.dental: none of above were present. A review of Resident 25's MDS, dated January 9, 2026, indicated Resident 25 had a BIMS (Brief Interview of Mental Status-a cognitive assessment tool) score of 15 (cognitively intact). Further review of Resident 25's record indicated there was no documented evidence an individualized care plan was developed to address dental concerns or potential risks with difficulty chewing and swallowing food. On March 5, 2026, at 12:32 p.m., an interview was conducted with Certified Nurse Assistant (CNA) 3. CNA 3 stated residents that do not have teeth will use an oral mouth sponge for oral hygiene. CNA 3 stated residents that do not have dentures are placed on a soft diet. CNA 3 stated the facility has a dentist that comes to the facility to assess the residents' teeth. CNA 3 stated Resident 25 reported her dentures were hurting her. On March 6, 2026, at 3:15 p.m., a concurrent interview and record review was conducted with the Social Services Director (SSD). The SSD stated the initial social services assessment was completed after the resident's admission, then a follow up assessment was being done quarterly. The SSD stated the nursing staff will identify residents requiring dental services and report to the SSD or oral assessment conducted during social service assessment. The SSD stated Resident 25 reported that her dentures were loose and did not fit properly. A concurrent review of Resident 25's medical record with the SSD verified that the Initial Social Services Assessment, did not include information regarding Resident 25's oral cavity status. The SSD stated Resident 25 had a dental appointment with denture impressions done on October 2, 2025. The SSD stated Resident 25 did not receive her dentures as of this time. The SSD stated Resident 25 should have been updated or had a dental follow-up appointment within 2 weeks of the initial dental appointment. The SSD stated it was not acceptable for Resident 25 to have a follow-up appointment five months later. The SSD stated Resident 25 was at risk for choking and poor nutritional intake. The SSD stated there was no care plan developed to address Resident 25's dental issues, and the facility should have developed one. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2b. On March 3, 2026, at 10:33 a.m., Resident 109 was observed sitting upright in bed, awake and alert. Resident 109 was observed with missing, chipped, and blackened teeth to his entire oral cavity. In a concurrent interview with Resident 109, he stated his teeth have been this way for years and has not had a dentist appointment since he was admitted to the facility. On March 4, 2026, Resident 109's medical record was reviewed. Resident 109 was admitted to the facility on [DATE], with diagnoses which included hemiplegia and hemiparesis following cerebral infarction affecting right dominant side (weakness or paralysis on the right side of body caused by a stroke) and cognitive communication deficit (having trouble communicating). A review of Resident 109's Initial admission Record, dated March 1, 2025, indicated, .oral assessment.natural teeth present: yes.carious: no.missing: no.broken: no.able to function without natural teeth: yes. A review of Resident 109's MDS, dated December 3, 2025, indicated the following: -BIMS (Brief Interview of Mental Status-a cognitive assessment tool) score of 13 (cognitively intact); and -Oral/Dental Status; no dental issues. Further review of Resident 109's record indicated there was no documented evidence an individualized care plan was developed to address dental concerns or potential risks related to carious teeth. On March 5, 2026, at 1:28 p.m., a concurrent observation and interview was conducted with Certified Nurse Assistant (CNA) 6. CNA 6 stated the CNA was responsible for providing oral hygiene to residents every day before breakfast and at bedtime. A concurrent observation of Resident 109 was conducted with CNA 6. CNA 6 stated Resident 109's teeth were chipped and had blackened areas on multiple teeth on the top and bottom of his mouth. CNA 6 stated he had observed Resident 109's teeth like this before. CNA 6 stated he should have reported his observations to the charge nurse. On March 6, 2026, at 2:55 p.m., a concurrent observation and interview was conducted with Licensed Vocational Nurse (LVN) 1. LVN 1 stated the LN was responsible to assess the resident oral status upon admission, then weekly and when a change of condition occurred. LVN 1 stated the CNA was responsible for assessing the resident's oral cavity daily when providing oral hygiene care and report to the charge nurse when any concerns were observed. A concurrent observation of Resident 109 was conducted with LVN 1. LVN 1 stated Resident 109 had missing and broken teeth, as well as buildup of blackened areas on multiple teeth on the top and bottom of his mouth. LVN 1 stated she had noticed Resident 109's teeth like this since admission. LVN 1 stated Resident 109 oral cavity status should have been documented upon admission. On March 6, 2026, at 3:36 p.m., a concurrent interview and record review were conducted with the Social Services Director (SSD). The SSD stated the initial social services assessment was completed after admission, then a follow up assessment was done quarterly. The SSD stated for residents requiring dental services will be identified by the nursing staff and reported to the SSD or the during social service assessment, the SSD will visually assess the resident's oral cavity. A concurrent review of Resident 109's medical record, the SSD verified that the Initial Social Services Assessment did not include information regarding Resident 109's oral cavity status. A concurrent observation of (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident 109 was conducted with the SSD. The SSD stated Resident 109's teeth were broken, had missing teeth, and had decay like areas to multiple teeth on the top and bottom of his mouth. The SSD stated Resident 109 should have had a dental consultation for further evaluation following the Initial Social Services Assessment. The SSD stated the facility should have developed an individualized care plan for Resident 109's dental concerns and risks for the staff to be aware of what interventions to implement. 2c. On March 3, 2026, at 11:23 a.m., Resident 119 was sitting upright in bed, alert and awake. Resident 119 was observed without any teeth or dentures to upper or lower gums. In a concurrent interview, Resident 119 stated she has her dentures with her but does not feel comfortable to wear due to loose fitting. Resident 119 stated she received her dentures in November 2025 and was told that Medicare would not cover a second set of dentures. Resident 119 stated she informed the Social Services Director regarding her loose-fitting dentures. Resident 119 stated she was not asked if she wanted to follow up with a dentist. On March 5, 2026, Resident 119's medical record was reviewed. Resident 119 was admitted to the facility on [DATE], with diagnoses which included type 2 diabetes mellitus (a long-lasting health condition where the body cannot properly use or make enough insulin (a hormone produced to lower blood sugar levels), leading to high blood sugar levels). A review of Resident 119's N Adv- Clinical Admission, dated February 28, 2026, indicated, .has own teeth.dental appliance lower: blank.dental appliance upper: blank.examination of oral/dental status: not checked. broken or loosely fitting full or partial denture (chipped, cracked, uncleanable, or loose): blank.oral cavity: oral cavity clean.oral care: not performed (resident is independent). A review of Resident 119's N Adv-Skilled Evaluation, dated March 2, 2026, indicated, .has own teeth. dental appliance lower: blank.dental appliance upper: blank.examination of oral/dental status: not checked. broken or loosely fitting full or partial denture (chipped, cracked, uncleanable, or loose): blank.oral cavity: oral cavity clean.oral care: blank. A review of Resident 119's History and Physical Examination, dated March 2, 2026, indicated the resident has capacity to understand and make decisions. A review of Resident 119's MDS, dated March 4, 2026, indicated the following: -BIMS (Brief Interview of Mental Status) score of 15 (cognitively intact); and -Dental: broken or loosely fitting full or partial denture (chipped, cracked, uncleanable, or loose): No. No natural teeth or tooth fragment (s) (edentulous): No. Further review of Resident 119's record indicated there was no documented evidence an individualized care plan was developed to address dental concerns or potential risks related to chewing and swallowing food. On March 5, 2026, at 12:41 p.m., an interview was conducted with Certified Nurse Assistant (CNA) 3. CNA 3 stated the CNA was responsible for preparing the resident for meals as follows: have resident sitting upright, provide oral and hand hygiene. CNA 3 stated the day shift CNA was responsible for applying the resident's dentures before breakfast. CNA 3 stated if a resident was observed without dentures, the CNA would ensure the meal would not cause choking. CNA 3 stated she should notify (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the charge nurse if the resident's diet needed to be changed or if the resident required a speech therapist evaluation. CNA 3 stated she should have asked Resident 119 about her dentures prior to breakfast and lunch and reported to the charge nurse. On March 6, 2026, at 3:11 p.m., a concurrent interview and record review was conducted with the Social Services Director (SSD). The SSD stated the initial social services assessment was completed after admission, then a follow up assessment was done quarterly. The SSD stated for residents requiring dental services will be identified by the nursing staff and reported to the SSD or the during social service assessment, the SSD will visually assess the resident's oral cavity. The SSD stated Resident 119 reported that her dentures were loose and did not fit properly. A concurrent review of Resident 119's medical record verified that the Initial Social Services Assessment did not include information regarding Resident 119's oral cavity status or dentures concern. The SSD stated Resident 119 was at risk for choking and losing weight due to not eating properly. The SSD stated the facility should have developed an individualized care plan for Resident 119's dental concerns and risks for the staff to be aware of what interventions to implement. 3a. On March 2, 2026, at 11:25 a.m., a concurrent observation and interview with Resident 32 was conducted in her room. Resident 32 was observed receiving oxygen via nasal cannula at two liters per minute (L/min). Resident 32 stated she used oxygen continuously. A review of Resident 32's Face Sheet, indicated the resident was admitted to the facility on [DATE], with diagnosis which included shortness of breath. A review of Resident 32's History and Physical Examination, dated February 19, 2026, indicated Resident 32 had the capacity to understand and make decisions. A review of Resident 32's Order Summary Report, included a physician's order, dated March 2, 2026, which indicated an order for oxygen at two L/min via nasal cannula. Further review of Resident 32's record indicated there was no documented evidence a care plan was developed for the use of oxygen. On March 5, 2026, at 3:50 p.m., a concurrent interview and record review with Licensed Vocational Nurse (LVN) 4 was conducted. LVN 4 stated it was the licensed nurse's responsibility to initiate a care plan as soon as possible, when there was a physician's order or a change of condition identified. LVN 4 stated there was no care plan for oxygen use for Resident 32. LVN 4 stated there should have been a care plan for oxygen use for Resident 32. LVN 4 stated it was important to have a care plan to guide resident care and monitoring. On March 5, 2026, at 4:30 p.m., a concurrent interview and record review with the Director of Nursing (DON) was conducted. The DON stated it was the licensed nurse's responsibility to initiate a care plan upon admission and within twenty-four hours of orders received or conditions identified. The DON stated there was no care plan for oxygen management for Resident 32. The DON stated a care plan should have been initiated for oxygen management. The DON stated it was important to have a care plan to guide resident care. 3b. On March 3, 2026, at 4:30 p.m., an observation in Resident 89's room was conducted. Resident 89 was observed receiving oxygen via nasal cannula at two liters per minute (L/min). (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 89's Face Sheet, indicated the resident was admitted to the facility on [DATE], with diagnosis which included atherosclerotic heart disease (plaque in arteries). A review of Resident 89's MDS, dated February 9, 2026, indicated a Brief Interview for Mental Status (BIMS - a tool to assess cognition) score of 9 (moderately impaired cognition). A review of Resident 89's physician's orders, dated February 2, 2026, indicated an order for oxygen at two L/min via nasal cannula. A review of Resident 89's care plan, dated February 27, 2026, indicated, .Focus.At risk for Shortness of Breath.Goal.no complications related to SOB (shortness of breath).Interventions.oxygen as ordered. On March 5, 2026, at 3:52 p.m., a concurrent interview and record review with LVN 4 was conducted. LVN 4 stated it was the licensed nurse's responsibility to initiate a care plan as soon as possible, when there was a physician's order or a change of condition identified. LVN 4 stated the care plan for oxygen use was not entered timely for Resident 89. LVN 4 stated the care plan for oxygen use should have been initiated when the order was received. LVN JF stated it was important to have a care plan to guide resident care and monitoring. On March 5, 2026, at 4:32 p.m., a concurrent interview and record review with the DON was conducted. The DON stated it was the licensed nurse's responsibility to initiate a care plan upon admission and within twenty-four hours of orders received or conditions identified. The DON stated the care plan for oxygen use was not entered timely for Resident 89. The DON stated a care plan for oxygen use should have been initiated timely. The DON stated it was important to have a care plan to guide resident care. 3c. On March 2, 2026, at 4:28 p.m., a concurrent observation and interview with Resident 116 was conducted in her room. Resident 116 was observed to be receiving oxygen via nasal cannula at two liters per minute (L/min). Resident 116 stated she used oxygen continuously. A review of Resident 116's Face Sheet, indicated the resident was admitted to the facility on [DATE], with diagnosis which included atherosclerotic heart disease (plaque in arteries). A review of Resident 116's MDS, dated March 4, 2026, indicated a BIMS score of 13 (cognitively intact). A review of Resident 116's physician's orders, dated March 3, 2026, indicated an order for oxygen at two L/min via nasal cannula. Further review of Resident 116's record indicated there was no documented evidence a care plan for oxygen management and use for oxygen was developed for Resident 116. On March 5, 2026, at 3:54 p.m., a concurrent interview and record review with LVN 4 was conducted. LVN 4 stated it was the licensed nurse's responsibility to initiate a care plan as soon as possible, when there was a physician's order or a change of condition identified. LVN 4 stated there was no care plan for oxygen management and use for oxygen for Resident 116. LVN 4 stated there should have been a care plan for oxygen management and use. LVN 4 stated it was important to have a care plan to guide resident care and monitoring. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On March 5, 2026, at 4:34 p.m., a concurrent interview and record review with the DON was conducted. The DON stated it was the licensed nurse's responsibility to initiate a care plan upon admission and within twenty-four hours of orders received or conditions identified. The DON stated there was no care plan for oxygen management and use for oxygen for Resident 116. The DON stated a care plan should have been initiated for oxygen management and use. The DON stated it was important to have a care plan to guide resident care. A review of the facility's policy and procedure titled, Care Plan and Care Plan Update, dated January 15, 2026, indicated, .resident receives quality care and services.in accordance with.plan of care.Care plan will be initiated based on identified problem and medical change of condition. A review of the facility's policy and procedure titled, Care Planning, reviewed on January 15, 2026, indicated, .It is the policy of this facility that the interdisciplinary team (IDT – a group of healthcare professionals) shall develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.A comprehensive care plan is developed within seven (7) days of completion of the Resident Minimum Data Set (MDS – a resident assessment tool) and will be updated as needed.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the facility's policy and procedure on oxygen use was followed, for three of three residents reviewed under oxygen (Residents 32, 89, and 116, when:1. For Residents 32 and 89, the nasal cannula (a medical device used to deliver supplemental oxygen) was not changed every seven days; and2. For Resident 116, the nasal cannula was undated when it was initially used.These failures had the potential to result in risk for infection for Residents 32, 89, and 116.Findings:1a. On March 2, 2026, at 11:25 a.m., a concurrent observation and interview with Resident 32 was conducted in her room. Resident 32 was observed receiving oxygen via nasal cannula at two liters per minute (L/min). The nasal cannula was labeled with a date indicating 2/22/26 (February 22, 2026) in black permanent marker on the tube near the connector site. Resident 32 stated she used oxygen continuously.A review of Resident 32's Face Sheet, indicated the resident was admitted to the facility on [DATE], with diagnosis which included shortness of breath.A review of Resident 32's History and Physical Examination, dated February 19, 2026, indicated Resident 32 had the capacity to understand and make decisions.A review of Resident 32's physician's orders, dated March 2, 2026, indicated an order for oxygen at two L/min via nasal cannula.On March 2, 2026, at 4:37 p.m., a concurrent observation and interview with Licensed Vocational Nurse (LVN) 1 was conducted. LVN 1 stated Resident 32's nasal cannula tubing was labeled with the date of 2/22/26 written in black permanent marker. LVN 1 stated the nasal cannula had not been changed weekly in accordance with facility's policy and procedure. LVN 1 stated oxygen tubing should be changed weekly. LVN 1 further stated not changing the nasal cannula weekly could place the residents at risk of infection. On March 3, 2026, at 4:55 p.m., an interview with the Infection Preventionist (IP) was conducted. The IP stated the licensed nurses were responsible for changing nasal cannulas weekly. The IP stated Resident 32's nasal cannula should have been changed weekly. The IP stated it was important to change the nasal cannula weekly to prevent infection.1b. On March 3, 2026, at 4:30 p.m., an observation in Resident 89's room was conducted. Resident 89 was observed receiving oxygen via nasal cannula at two L/min. The nasal cannula was labeled 2/22/26 (February 22, 2026) in black permanent marker on the tube near the connector site.A review of Resident 89's Face Sheet, indicated the resident was admitted to the facility on [DATE], with diagnosis which included atherosclerotic heart disease (plaque in arteries).A review of Resident 89's Minimum Date Set (MDS - an assessment tool), dated February 9, 2026, indicated a Brief Interview for Mental Status (BIMS - a tool to assess cognition) score of 9 (moderately impaired cognition).A review of Resident 89's physician's orders, dated February 2, 2026, indicated an order for oxygen at two L/min via nasal cannula.On March 2, 2026, at 4:40 p.m., a concurrent observation and interview with LVN 6 was conducted. LVN 6 stated Resident 89's nasal cannula tubing was labeled with the date of 2/22/26 written in black permanent marker. LVN 6 stated the nasal cannula had not been changed weekly in accordance with facility's policy and procedure. LVN 6 stated oxygen tubing should be changed weekly. LVN 6 further stated not changing the nasal cannula weekly could place the resident at risk for infection. On March 3, 2026, at 4:59 p.m., an interview with the IP was conducted. The IP stated the licensed nurses were responsible for changing nasal cannulas weekly. The IP stated Resident 89's nasal cannula should have been changed weekly. The IP stated it was important to change the nasal cannula weekly to prevent infection.2. On March 2, 2026, at 4:28 p.m., an observation and interview with Resident 116 was conducted in her room. Resident 116 was observed to be receiving oxygen via nasal cannula at two L/min. The nasal cannula was not labeled with a date. Resident 116 stated she used oxygen continuously.A review of Resident 116's Face Sheet, indicated the resident was admitted to the facility on [DATE], with diagnosis which included atherosclerotic heart disease (plaque in arteries).A review of Resident 116's physician orders, dated March 3, 2026, indicated an order for oxygen at two L/min via nasal cannula.A review of Resident 116's MDS, dated March 4, (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2026, indicated a BIMS score of 13 (cognitively intact).On March 2, 2026, at 4:39 p.m., a concurrent observation and interview with LVN 1 was conducted. LVN 1 stated Resident 116's nasal cannula tubing did not have date indicating when it was changed. LVN 1 stated the nasal cannula should have been dated in accordance with facility's policy and procedure. LVN 1 further stated not dating the nasal cannula did not provide staff information when the nasal cannula was changed and it placed the resident at risk of infection. On March 3, 2026, at 4:57 p.m., an interview with the IP was conducted. The IP stated the licensed nurses were responsible for changing nasal cannulas weekly and labeling the nasal cannula with the date. The IP stated Resident 116's nasal cannula should have been labeled with the date. The IP stated it was important to date the nasal cannula to prevent infection.A review of the facility's policy and procedure titled, Oxygen, Use of, dated January 15, 2026, indicated, .to promote resident safety in administering oxygen.O2 (oxygen) cannula or mask will be changed at least every 7 (seven) days.Tubing.will be dated in an identifiable fashion.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure pharmacy services were implemented according to the facility's policy and procedure, when:1.One vial of shingles (a painful viral infection causing a blistering rash, usually in a stripe on one side of the body or face) vaccine labeled for Resident 19, dispensed by pharmacy on February 19, 2026, and stored in the medication refrigerator available for use, despite complete dose of shingles vaccine received by Resident 19 prior to February 19, 2026. This failure had the potential for duplicate administration of shingles vaccine to Resident 19 and could cause adverse effect of the medication; and2.PRN (as needed) narcotic medications were administered and documented in accordance with the physician orders and the facility policy and procedure for Residents, 12, 24, and 23.This failure had the potential to compromise pain management, delayed evaluation of medication effectiveness, increased risk of duplicate dosing, and possible drug diversion. Findings: 1.On March 5, 2026, at 10:13 a.m., during medication room inspection conducted with the Infection Preventionist (IP), one via of shingles vaccine labeled for Resident 19 was found stored inside the medication refrigerator. The medication label indicated the pharmacy dispensed the shingles vaccine on February 19, 2026.A concurrent review of Resident 19's record was conducted with the IP. A review of Resident 19's Face Sheet, indicated the resident was admitted to the facility on [DATE], with diagnoses which included diabetes mellitus (abnormal blood sugar).A review of Resident 19's physician order, dated February 16, 2026, indicated, Shingrix (brand of shingles vaccine) Intramuscular (inject to the muscles) Suspension Reconstituted 50 MCG/0.5ML (microgram/milliliter - unit of measurement).Inject 50 mcg intramuscularly.A review of Resident 19's Immunization Report, indicated shingles vaccine administered on February 16, 2026.A review of Resident 19's immunization history through CAIR (California Immunization Registry - a secure, confidential, statewide computerized immunization system for California residents) website, indicated Resident 19 had received second dose of shingles vaccine on February 16, 2026.In a concurrent interview with the IP, the IP stated the vial of shingles vaccine for Resident 19 should be discarded and not stored in the medication refrigerator readily available for use to avoid error of administering the vaccine to Resident 19 and use for other residents.A review of the facility's policy and procedure titled, Medication Destruction for non-controlled medications, dated May 2022, indicated, .Unused, unwanted and non-returnable medications should be removed from their storage and secured until destroyed.On March 5, 2026, at 10:32 a.m., during an inspection of Medication Cart A conducted with the IP, the following were observed:2a. Resident 12's Hydrocodone-Acetaminophen (controlled pain medication) 5-325 mg (milligram - unit of measurement) was observed in the narcotic box.A review of Resident 12's physician order, dated December 10, 2025, indicated, HYDROcodone-Acetaminophen.1 (one) tablet every 6 (six) hours as needed for pain.Resident 12's Controlled Medication Count Sheet, for Hydrocodone-Acetaminophen and Medication Administration Record (MAR), for the month of January 2026, was reviewed with the IP.Resident 12's Controlled Medication Count Sheet, indicated Hydrocodone-Acetaminophen was signed out and was not documented on Resident 12's MAR as administered on the following dates:-January 9, 2026, at 9:15 a.m.; and-January 12, 2026, at 11:26 a.m.In a concurrent interview with the IP, the IP stated narcotic medications signed out from the count sheet should be documented as administered in the resident's MAR.2b. Resident 24's Lorazepam (Ativan - medication to treat anxiety) 1 (one) mg was observed in the narcotic box.A review of Resident 24's physician order, dated February 27, 2026, indicated, Ativan Oral Tablet 1 MG.1 tablet.every 8 (eight) hours as needed.Resident 24's Controlled Medication Count Sheet, for Lorazepam and Medication Administration Record (MAR), for the month of February 2026, was reviewed with the IP.Resident 24's Controlled Medication Count Sheet, indicated Lorazepam was signed out and was not documented on Resident 24's MAR as administered on the following (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	dates:-February 28, 2026, at 9:53 p.m.In a concurrent interview with the IP, the IP stated narcotic medications signed out from the count sheet should be documented as administered in the resident's MAR.2c. On March 5, 2026, at 1:23 p.m., an inspection of Medication Cart C was conducted with Licensed Vocational Nurse (LVN) 2.Resident 23's Lorazepam 0.5 mg and Hydrocodone-Acetaminophen 10-325 mg were observed stored inside the narcotic box.A review of Resident 23's physician's order included the following:- LORazepam Oral Tablet 0.5 MG.1 (one) tablet.every 6 (six) hours as needed.; date ordered February 4, 2026; and- HYDROcodone-Acetaminophen.10-325 mg.1 (one) tablet.every 6 (six) hours as needed.; date ordered February 16, 2026.Resident 23's Controlled Medication Count Sheet, and Medication Administration Record (MAR), for the month of February 2026, for Lorazepam and Hydrocodone-Acetaminophen were reviewed with the IP.Resident 24's Controlled Medication Count Sheet, indicated Lorazepam was signed out and was not documented on Resident 24's MAR as administered on February 16, 2026, at 2:10 a.m.Resident 24's Controlled Medication Count Sheet, indicated Hydrocodone was signed out and was not documented on Resident 24's MAR as administered on February 19, 2026, at 9:19 a.m.In a concurrent interview with LVN 2, LVN 2 stated narcotic medications signed out from the count sheet should be documented as administered in the resident's MAR.On March 5, 2026, at 3:37 p.m., during an interview with the Director of Nursing (DON), the DON stated narcotic medications signed out from the narcotic count sheet should be documented as administered in the residents' MAR to prevent drug diversion.A review of the facility's policy and procedure titled, Medication Administration, dated January 15, 2026, indicated, .All current drugs and dosage schedules must be recorded on the resident's medication administration record (MAR).as appropriate.The staff administering the medication must record such information on the resident's MAR before administering the next resident's medication.Should a drug be.given other than at the scheduled time it should be appropriately documented on the MAR.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure medications were stored properly according to the facility's policy and procedure, when:1.One vial of IV (intravenous- through the veins) medication was stored together with oral medications;2.Eye drop medications were stored together with oral medications. These failures had the potential for the medications to be administered through the wrong route; and3.Discontinued or completed treatment medications were stored in the Treatment Carts readily available for use. In addition, one opened box of iodine prep pads, which expired in February 2025, was stored in the treatment cart readily available for use.These failures had the potential for the medications to be administered to the residents without physician's orders and could have adverse effect on the residents. In addition, expired topical antiseptics (used to disinfect skin and prevent infection) have the potential to have lesser efficacy and could contribute to adverse side effects. Findings:1.On [DATE], at 10:32 a.m., during an inspection of Medication Cart A conducted with the Infection Preventionist (IP), one vial of ondansetron (medication to treat nausea and vomiting) Injection administered through I V, labeled for Resident 128 was observed stored together in a container with the following medications:-Three (3) bottles of nitroglycerin (medication to treat chest pain) tablets for three (3) different residents;-One opened botte of stool softener; and-One opened bottle of Tylenol (medication to treat fever and pain).In a concurrent interview with the IP, the IP stated the IV ondansetron should be in the IV cart and not stored together with the oral medications.2. On [DATE], at 1:23 p.m., during an inspection of Medication Cart C conducted with Licensed Vocational Nurse (LVN) 2, one container located on the first drawer of the medication cart had multiple oral medications labeled for different residents stored together with multiple eye drop medication labeled for different residents.In a concurrent interview with LVN 2, she stated oral medications and eye drops should be stored separately.A review of the facility's policy and procedure titled, Storage of Medications, dated [DATE], indicated, .Medications and biological are stored safely, securely, and properly.Orally administered medications are kept separate from externally used medications and treatments.Eye medications are stored separately per facility policy.3. On [DATE], at 12:42 p.m., during inspection of the Treatment Carts 1 and 2 conducted with the Treatment Nurse (TN), the following were found:-one open box of Lidocaine (used on different parts of the body to cause numbness or loss of feeling) solution 4%, labeled for Resident 7, with pharmacy dispensed date of [DATE], and date opened on February 5, 2026. The label indicated instructions for the medication to be applied to the left buttocks every Thursday for wound management for 21 days. In a concurrent interview and review of Resident 7's record conducted with the TN. The TN stated Resident 7's Lidocaine had a physician's order, dated [DATE], for 21 days (stop date on February 12, 2026). The TN stated the wound physician would request to use the Lidocaine medication to be applied prior to wound debridement. The TN stated the Lidocaine order should have been re-evaluated if needed to renew the physician's order. The TN stated the Lidocaine medication should not be readily available in the treatment cart if there is no current order;-one opened tube of Bethamethasone Diproprionate (a high-potency topical corticosteroid used to reduce itching, redness, and swelling from skin conditions) cream 0.05%, labeled for Resident 11, with pharmacy dispensed date of February 27, 2026. The label indicated instructions for the medication to be applied to face, chest, and arms for 14 days. Another tube of cream labeled for Resident 11 indicated Bethamethasone Valerate (a prescription-strength topical corticosteroid used to treat skin conditions by reducing inflammation, itching, and redness) 0.1%, with pharmacy date dispensed of [DATE]. In a concurrent interview and review of Resident 11's record conducted with the TN, the TN stated the physician's order for Resident 11's Bethamethasone Dirpropionate was discontinued on (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	[DATE], and was changed to Bethamethasone Valerate. The TN stated the discontinued Bethamethasone Dipropionate should be removed from the treatment cart and not be readily available for use;-one opened tube of Calcipotrien (a prescription synthetic Vitamin D3 derivative used to treat plaque psoriasis [a chronic, non-contagious autoimmune condition causing rapid skin cell turnover, resulting in thick, inflamed red or purple patches with silvery scales] by slowing skin cell growth, reducing scaling, and decreasing redness) 0.005%, labeled for Resident 99, with pharmacy dispensed date of [DATE]. The label indicated instructions for the medication to be applied to affected areas every 12 hours as needed for flares/itch for 14 days (stop date [DATE]). In a concurrent interview and review of Resident 99's record conducted with the TN, the TN stated Resident 99's Calcipotrien was already discontinued with a completed date of [DATE], should be discarded from the Treatment Cart and not readily available for use; and-one opened tube of Nystatin Cream (a medicated cream or ointment that treats fungal or yeast infections in your skin), labeled for Resident 67, with pharmacy dispensed date of February 17, 2026. The label indicated instructions for the cream to be applied to Resident 67 to left armpit for 14 days (stop date [DATE]). In a concurrent interview and review of Resident 67's record conducted with the TN, the TN stated Resident 67's skin issues were already resolved and the treatment order was not needed to be renewed, and the cream should have been removed from the cart and readily available for use;- one opened bottle of Ciclopirox solution (used to treat infections caused by fungus) 8%, labeled for Resident 71, with pharmacy date dispensed of [DATE]. The label indicated instructions for the solution to be applied to both toenails for 14 days (stop date of February 13, 2026). In a concurrent interview and review of Resident 71's record conducted with the TN, the TN stated Resident 71's Ciclopirox solution should be discarded from the Treatment Cart and not be readily available for use; and-one opened box containing multiple Iodine Prep pads (single-use, sterile antiseptic wipes saturated with a 10% povidone-iodine solution, designed for topical antiseptic use to prevent infection in minor cuts, scrapes, and burns) with expiration date of February 2025. In a concurrent interview, the TN stated the iodine prep pads were expired and should be removed from the treatment cart and not be readily available for use.A review of the facility's policy and procedures titled, Discontinued Medications, dated [DATE], indicated, .when medications are discontinued by the prescriber.Medications are removed from the medication cart or active supply immediately upon receipt of an order to discontinue (to avoid inadvertent administration).

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F 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide routine and 24-hour emergency dental care for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure dental care services and follow up treatment were provided, for three of five residents reviewed for dental (Residents 25, 109, and 119), when:1.For Resident 25, there was no follow up dental consult after denture impressions were obtained on October 5, 2025;2.For Resident 109, there were no dental services/consult provided for broken, missing, and carious teeth; and3.For Resident 119, there were no dental services/consult provided for missing teeth or ill-fitting dentures. These failures had the potential to result in untreated dental conditions, pain, infection, poor nutrition, and further decline in overall health. Findings:1. On March 3, 2026, at 4:13 p.m., Resident 25 was observed alert, sitting at bedside. Resident 25 was observed without any teeth or dentures to upper or lower gums. In a concurrent interview, Resident 25 stated she had denture impressions done at her last dentist appointment in the fall of 2025. Resident 25 stated the facility did not provide further updates or follow ups on the status of her dentures. Resident 25 stated the staff will cut up her food, then she will moisten her food with her tongue and gums before swallowing.On March 3, 2026, at 4:38 p.m., Resident 25's medical record was reviewed. Resident 25 was admitted to the facility on [DATE], with diagnoses which included hemiplegia and hemiparesis following cerebral infarction affecting left dominant side (weakness or paralysis on the left side of body caused by a stroke) and dysphagia (difficulty swallowing).A review of Resident 25's Initial admission Record, dated April 25, 2025, indicated, .oral assessment.natural teeth: present.artificial teeth: no.upper: no.lower: no.A review of Resident 25's Minimum Data Set (MDS - an assessment tool), Section K: Swallowing/Nutritional Status, dated April 30, 2025, indicated, .holding food in mouth/cheeks.residual food in mouth after meals.A review of Resident 25's physician orders indicated the following:- CCHO (controlled carbohydrate), NAS (no added salt) diet, Easy to Chew-Level 7 texture (regular, easy to chew), THIN LIQUIDS consistency, date ordered on August 6, 2025.A review of Resident 25's Dental Documents, dated October 2, 2025, indicated, Exam: Submit TAR (Treatment Authorization Request) FUD (Full Upper Dentures)/FLD (Full Lower Dentures), new.A review of Resident 25's MDS, dated January 9, 2026, indicated Resident 25 had a BIMS (Brief Interview of Mental Status-a cognitive assessment tool) score of 15 (cognitively intact).Further review of Resident 25's record indicated there was no documented evidence the status of the resident's dentures was followed with the dental provider.On March 5, 2026, at 12:32 p.m., an interview was conducted with Certified Nurse Assistant (CNA) 3. CNA 3 stated residents that do not have teeth will use an oral mouth sponge for oral hygiene. CNA 3 stated residents that do not have dentures are placed on a soft diet. CNA 3 stated the facility has a dentist that comes to the facility to assess the residents' teeth. CNA 3 stated Resident 25 reported her dentures were hurting her.On March 6, 2026, at 3:15 p.m., a concurrent interview and record review was conducted with the Social Services Director (SSD). The SSD stated the initial social services assessment was completed after the resident's admission, then a follow up assessment was being done quarterly. The SSD stated the nursing staff will identify residents requiring dental services and report to the SSD or oral assessment conducted during social service assessment. The SSD stated Resident 25 reported that her dentures were loose and did not fit properly. A concurrent review of Resident 25's medical record with the SSD verified that the Initial Social Services Assessment, did not include information regarding Resident 25's oral cavity status. The SSD stated Resident 25 had a dental appointment with denture impressions done on October 2, 2025. The SSD stated Resident 25 did not receive her dentures as of this time. The SSD stated Resident 25 should have been updated or had a dental follow-up appointment within 2 weeks of the initial dental appointment. The SSD stated it was not acceptable for Resident 25 to have a follow-up appointment five months later. The SSD stated Resident 25 was at risk for choking and poor nutritional intake.2. On March 3, 2026, at 10:33 a.m., Resident 109 was observed sitting upright in bed, awake and alert. Resident 109 was observed with (continued on next page)

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F 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	missing, chipped, and blackened teeth to his entire oral cavity. In a concurrent interview with Resident 109, he stated his teeth have been this way for years and has not had a dentist appointment since he was admitted to the facility. On March 4, 2026, Resident 109's medical record was reviewed. Resident 109 was admitted to the facility on [DATE], with diagnoses which included hemiplegia and hemiparesis following cerebral infarction affecting right dominant side (weakness or paralysis on the right side of body caused by a stroke) and cognitive communication deficit (having trouble communicating).A review of Resident 109's Initial admission Record, dated March 1, 2025, indicated, .oral assessment.natural teeth present: yes.carious: no.missing: no.broken: no.able to function without natural teeth: yes.A review of Resident 109's MDS, dated December 3, 2025, indicated the following:-BIMS (Brief Interview of Mental Status-a cognitive assessment tool) score of 13 (cognitively intact); and-Oral/Dental Status; no dental issues.A review of Resident 109's physician's order indicated there was no order for dental consult.On March 5, 2026, at 1:28 p.m., a concurrent observation and interview was conducted with Certified Nurse Assistant (CNA) 6. CNA 6 stated the CNA was responsible for providing oral hygiene to residents every day before breakfast and at bedtime. A concurrent observation of Resident 109 was conducted with CNA 6. CNA 6 stated Resident 109's teeth were chipped and had blackened areas on multiple teeth on the top and bottom of his mouth. CNA 6 stated he had observed Resident 109's teeth like this before. CNA 6 stated he should have reported his observations to the charge nurse.On March 6, 2026, at 2:55 p.m., a concurrent observation and interview was conducted with Licensed Vocational Nurse (LVN) 1. LVN 1 stated the LN was responsible to assess the resident oral status upon admission, then weekly and when a change of condition occurred. LVN 1 stated the CNA was responsible for assessing the resident's oral cavity daily when providing oral hygiene care and report to the charge nurse when any concerns were observed. A concurrent observation of Resident 109 was conducted with LVN 1. LVN 1 stated Resident 109 had missing and broken teeth, as well as buildup of blackened areas on multiple teeth on the top and bottom of his mouth. LVN 1 stated she had noticed Resident 109's teeth like this since admission. LVN 1 stated Resident 109 oral cavity status should have been documented upon admission and the physician should have been notified for a dental consult order.On March 6, 2026, at 3:36 p.m., a concurrent interview and record review were conducted with the Social Services Director (SSD). The SSD stated the initial social services assessment was completed after admission, then a follow up assessment was done quarterly. The SSD stated for residents requiring dental services will be identified by the nursing staff and reported to the SSD or the during social service assessment, the SSD will visually assess the resident's oral cavity. A concurrent review of Resident 109's medical record, the SSD verified that the Initial Social Services Assessment did not include information regarding Resident 109's oral cavity status. A concurrent observation of Resident 109 was conducted with the SSD. The SSD stated Resident 109's teeth were broken, had missing teeth, and had decay like areas to multiple teeth on the top and bottom of his mouth. The SSD stated Resident 109 should have had a dental consultation for further evaluation following the Initial Social Services Assessment.3. On March 3, 2026, at 11:23 a.m., Resident 119 was sitting upright in bed, alert and awake. Resident 119 was observed without any teeth or dentures to upper or lower gums. In a concurrent interview, Resident 119 stated she has her dentures with her but does not feel comfortable to wear due to loose fitting. Resident 119 stated she received her dentures in November 2025 and was told that Medicare would not cover a second set of dentures. Resident 119 stated she informed the Social Services Director regarding her loose-fitting dentures. Resident 119 stated she was not asked if she wanted to follow up with a dentist.On March 5, 2026, Resident 119's medical record was reviewed. Resident 119 was admitted to the facility on [DATE], with diagnoses which included type 2 diabetes mellitus (a long-lasting health condition where the body cannot properly use or make enough insulin (a hormone produced to lower blood sugar levels), leading to high blood sugar levels).A review of Resident 119's N Adv- Clinical Admission, dated February 28, 2026, indicated, .has own teeth.dental appliance lower: blank.dental appliance upper: blank.examination of oral/dental (continued on next page)

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F 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	status: not checked. broken or loosely fitting full or partial denture (chipped, cracked, uncleanable, or loose): blank.oral cavity: oral cavity clean.oral care: not performed (resident is independent).A review of Resident 119's N Adv-Skilled Evaluation, dated March 2, 2026, indicated, .has own teeth. dental appliance lower: blank.dental appliance upper: blank.examination of oral/dental status: not checked. broken or loosely fitting full or partial denture (chipped, cracked, uncleanable, or loose): blank.oral cavity: oral cavity clean.oral care: blank.A review of Resident 119's History and Physical Examination, dated March 2, 2026, indicated the resident has capacity to understand and make decisions.A review of Resident 119's MDS, dated March 4, 2026, indicated the following:-BIMS (Brief Interview of Mental Status) score of 15 (cognitively intact); and- Dental: broken or loosely fitting full or partial denture (chipped, cracked, uncleanable, or loose): No. No natural teeth or tooth fragment (s) (edentulous): No.On March 5, 2026, at 12:41 p.m., an interview was conducted with Certified Nurse Assistant (CNA) 3. CNA 3 stated the CNA was responsible for preparing the resident for meals as follows: have resident sitting upright, provide oral and hand hygiene. CNA 3 stated the day shift CNA was responsible for applying the resident's dentures before breakfast. CNA 3 stated if a resident was observed without dentures, the CNA would ensure the meal would not cause choking. CNA 3 stated she should notify the charge nurse if the resident's diet needed to be changed or if the resident required a speech therapist evaluation. CNA 3 stated she should have asked Resident 119 about her dentures prior to breakfast and lunch and reported to the charge nurse.On March 6, 2026, at 3:11 p.m., a concurrent interview and record review was conducted with the Social Services Director (SSD). The SSD stated the initial social services assessment was completed after admission, then a follow up assessment was done quarterly. The SSD stated for residents requiring dental services will be identified by the nursing staff and reported to the SSD or the during social service assessment, the SSD will visually assess the resident's oral cavity. The SSD stated Resident 119 reported that her dentures were loose and did not fit properly. A concurrent review of Resident 119's medical record verified that the Initial Social Services Assessment did not include information regarding Resident 119's oral cavity status or dentures concern. The SSD stated Resident 119 was at risk for choking and losing weight due to not eating properly.A review of the facility's policy and procedure titled, Dental Services-Access to Routine and Emergency Dental Services Repairing and Replacing Dentures, reviewed January 15, 2026, indicated, .It is the policy of this facility to ensure .residents who require dental services on a routine or emergency basis have access to such services without barrier.it is likewise the policy of the facility .the facility to repair or replace the dentures of a resident.Routine dental services means an annual inspection of the oral cavity for signs of disease, diagnosis of dental disease, dental radiograph as needed, dental cleaning, fillings (new and repairs), minor partial or full denture adjustments, smoothing of broken teeth.taking impressions for dentures and fitting dentures.the facility will ensure that the needed dental services are available.in the event that a facility resident requires emergency dental services, for the replacement of dentures.the facility will.promptly refer the resident for dental services.assist the resident in making the necessary dental appointments when necessary or requested.

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have a plan that describes the process for conducting QAPI and QAA activities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility's Administrator and governing body failed to ensure a Quality Assurance Performance Improvement (QAPI - as systematic, interdisciplinary, comprehensive, and data-driven approach to maintain and improve safety, quality of care, and quality of life of the residents) plan was in place to address the facility's systemic process issues related to addressing constipation through the facility's bowel management program.This failure resulted in a deficiency identified during the facility's recertification survey when an Immediate Jeopardy (IJ - a situation in which entity noncompliance has placed the health and safety of recipients in its care at risk for serious injury, serious harm, serious impairment, or death) was called on [DATE] at 5:58 p.m., regarding the not implementing the bowel management program and the physician's order to address constipation.Findings:A recertification survey was conducted between [DATE], to [DATE]. During the survey, systemic issues were identified regarding not addressing the resident's constipation according to the physician's order and the facility's policy and procedure related to bowel management program (Cross reference to F684).On [DATE], at 10:12 a.m., Resident 113's record was reviewed. A review of the record indicated the facility failed to implement interventions to address constipation according to the facility's policy and procedure and physician's orders, which led to Resident 113's death on February 13, 2026, secondary to mesenteric ischemia. After further investigation was conducted and following the process for IJ determination and approval from the State Agency (SA) Supervisor, the survey team declared an IJ on [DATE], at 5:58 p.m., in the presence of the Administrator and Director of Nursing (DON). The facility was also notified of an Extended Survey due to Substandard Quality of Care (SQC).On [DATE], at 7:21 p.m., an interview with the Administrator (ADM)was conducted. The ADM stated the facility's QAPI committee meets quarterly to discuss concerns or issues in the facility regarding provision of quality care and safety, and comprises the ADM, the Director of Nursing (DON), the Medical Director, governing body, IP, medical records, the Minimum Data Set (MDS) coordinator, Certified Nursing Assistant (CNA), Licensed Nurses (LN), Registered Nurse (RN), housekeeping supervisor. The Administrator stated he was unaware of any issues regarding the facility's bowel management program until the concern was discovered by the survey team. The ADM stated the QAPI committee have not identified issues with the facility's bowel management program related to constipation. A review of the facility's policy and procedure titled, Quality Assurance and Performance Improvement (QAPI) Plan, dated [DATE], indicated, .identifying and providing needed care and services that are person centered in accordance with.professional standards of practice.QAPI team will.determine if gaps or patterns exist in our systems of care that could result in quality problems.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure infection control practices were implemented according to facility policy and procedure and standards of practice for three of 93 residents (Residents 49, 37, and 77) when:1.A hospice Registered Nurse (RN) was observed not using appropriate personal protection equipment (PPE - equipment [gowns, gloves, masks, goggles] worn to protect from spreading infection) while providing care to Resident 49 who required enhanced barrier precaution (EBP - an infection control strategy for nursing homes to reduce the spread of multidrug-resistant organisms [MDROs] by requiring the use of gowns and gloves during high-contact resident care), placed his personal bag on top of Resident 49's bed, did not disinfect the resident's shared equipment used to check vital signs prior to and after use, and did not perform hand hygiene after providing care to Resident 49; and2.During medication pass observation, the licensed nurse did not clean and disinfect a shared blood pressure (BP-pressure of blood in blood vessels) cuff according to the manufacturer's recommended contact time (the required duration the equipment must remain wet with the disinfectant to effectively kill microorganisms [germs]).These failures had the potential to expose vulnerable residents to cross-contamination and increased the risk for infections. Findings: 1.On March 3, 2026, at 10:45 a.m., an Enhanced Barrier Precaution (EBP- an infection control strategy for nursing homes to reduce the spread of multidrug-resistant organisms [MDROs] by requiring the use of gowns and gloves during high-contact resident care), was observed outside of Resident 49's room, with visible PPE (personal protective equipment) supplies stocked. On March 3, 2026, at 10:47 a.m., a review of the EBP signage indicated, .Enhanced Barrier Precautions .Providers and Staff Must .Wear gloves and a gown for High-Contact Care Activities ., with images of a stop sign, gloves and a gown along the sides of the written instructions for enhanced barrier precautions. On March 3, 2026, at 10:55 a.m., an observation of a Hospice RN entered Resident 49's room. The Hospice RN did not put on a gown and gloves. The Hospice RN was observed placing his nursing bag on Resident 49's bed. The Hospice RN was observed removing a stethoscope (handheld medical tool used by healthcare providers to listen to sounds inside the body), blood pressure cuff (an inflatable sleeve used to compress the arm's artery) and pulse ox (a small, non-invasive device clipped onto a finger, toe, or earlobe to measure the oxygen saturation level in your blood) from his nursing bag. The Hospice RN did not disinfect the equipment prior to use. The Hospice RN was observed applying the pulse oximeter to Resident 49's finger, then applying the blood pressure cuff to Resident 49's right arm, then applied the stethoscope to his ears and was auscultating (listen to) Resident 49's chest. The Hospice RN was observed placing the equipment back into his nursing bag without disinfecting. The Hospice RN was observed touching Resident 49's foley catheter tubing and drainage bag (a flexible, hollow tube inserted into the bladder to drain urine into a collection bag), without wearing gloves. The Hospice RN was observed exiting Resident 49's room without sanitizing hands. On March 3, 2026, at 11:04 a.m., a concurrent interview and record review was conducted with the Hospice RN. The Hospice RN stated all orders are communicated to the facility by the hospice agency. The Hospice RN stated if the facility has any additional orders, then the orders should match. A concurrent record review of the EBP signage outside of Resident 49's room was conducted. The Hospice RN stated he was not sure why Resident 49 was on EBP precautions. The Hospice RN stated the EBP precautions may be related to Resident 49's suprapubic catheter (a medical device used to (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents are free from unnecessary use of psychotropic (therapeutic drugs that affect brain function, altering mood, perception, cognition, and behavior to treat mental health disorder) medications, for one of five residents reviewed for unnecessary medications (Resident 8), when:1.The reason for PRN (as needed) Lorazepam (medication to treat anxiety) was documented and non-pharmacologic interventions were provided to Resident 8 prior to administration of PRN Ativan; and2.There was no informed consent obtained by the physician from the resident/resident representative regarding the use of Mirtazapine (medication to treat depression).These failures had the potential for Resident 8 to receive unnecessary psychotropic medications and could develop adverse effects from the use of psychotropic medications.Findings:On March 5, 2026, Resident 8's record was reviewed. Resident 8's Face Sheet, indicated the resident was admitted to the facility on [DATE], with diagnoses which included dementia (memory loss), psychosis (mental disorder), depression (a serious, common medical mood disorder characterized by persistent sadness, loss of interest in activities, and low energy), and anxiety (a medical condition characterized by persistent, excessive, and uncontrollable worry, fear, or apprehension regarding future threats or situations).A review of Resident 8's History and Physical, dated January 8, 2026, indicated the resident does not have a capacity to make decisions.A review of Resident 8's Minimum Data Set (MDS - a resident assessment tool), dated January 14, 2026, indicated the resident had a BIMS (Brief Interview for Mental Status) score of 6 (severe cognitive impairment).A review of Resident 8's Order Summary Report, included the following physician's order:- (AA - anti anxiety) DOCUMENT NON-PHARMACOLOGICAL INTERVENTIONS DONE Q (every) SHIFT., date ordered January 7, 2026;- LORazepam Oral Tablet 0.5 MG (milligram - unit of measurement).Give 1 (one) tablet by mouth every 6 (six) hours as needed for ANXIETY M/B (manifested by) VERBALIZATION OF ANXIOUSNESS, date ordered January 7, 2026;- Mirtazapine Oral Tablet 15 MG.Give 1 (one) tablet by mouth at bedtime for DEPRESSION M/B VERBALIZATION OF SADNESS, date ordered January 7, 2026;A review of Resident 8's Medication Administration Record, for the month of January and February 2026, indicated Lorazepam was administered to the resident without documentation of reason or presence of behavior:-January 25, 2026, at 4:54 p.m.;-February 11, 2026, at 6:24 p.m.;-February 12, 2026, at 8:04 p.m.;-February 13, 2026, at 5:04 p.m.; and-February 17, 2026, at 4:30 p.m.Further review of Resident 8's record indicated there was no documented evidence of the reason for administering PRN Lorazepam to Resident 8 on the above dates. In addition, there was no documented evidence non-pharmacological interventions were provided prior to administration of PRN Lorazepam.A review of informed consents for the use of psychotropic medications for Resident 8 indicated there was no documented evidence an informed consent for the use Mirtazapine was obtained by the prescribing physician prior to the administration.On March 6, 2026, at 9 a.m., a concurrent observation and interview with Resident 8 was conducted. Resident 8 was observed sitting on a rollator walker (a mobile, four-wheeled (sometimes three-wheeled) mobility aid equipped with handlebars, hand-operated brakes, and a built-in seat, designed to provide stability, support, and resting capability for individuals with limited mobility) near the nurses' station calmly waiting for other residents and staff to pass by her and would carry on a conversation with them. In a concurrent interview, Resident 8 stated she was feeling ok.On March 6, 2026, at 9:38 a.m., a concurrent interview and record review was conducted with the Director of Nursing (DON). The DON stated Mirtazapine was administered starting January 7, 2026. The DON stated a new consent form was completed for Resident 8's use of Mirtazapine on February 3, 2026, but could not find documentation informed consent was obtained for the use of Mirtazapine when it was ordered on January 7, 2026. The DON stated there was no documentation reason for administering PRN (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Lorazepam to Resident 8, including non-pharmacologic interventions prior to administration. The DON stated the licensed nurse should assess the resident and determine the cause of anxiety, provide non-pharmacologic interventions before giving PRN Lorazepam if ineffective.A review of the facility's policy and procedure titled, Behavioral Health Services, reviewed January 15, 2026, indicated, .It is the policy of this facility to provide residents with necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.The plan of care will include non-pharmacological interventions and individualized, person-centered care approaches as well as trauma-informed approaches in accordance with resident's customary routine, with input from the resident and/or resident representative.The physician in collaboration with the IDT (Interdisciplinary Team - a group of healthcare professionals) team, will determine the appropriate psychiatric or psychological treatment or rehabilitative services needed. Treatment will be provided as ordered by the physician.A review of the facility's policy and procedure titled, Informed Consent, reviewed January 15, 2026, indicated, .It is the policy of this facility that resident rights are not violated and a copy of these rights and pertinent policies are made available to the resident and to any representative of the resident.Physician's orders related to the use of psychotherapeutic drug and physical restraints should not be initiated until an informed consent is obtained.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the necessary process when a resident is to be discharged was implemented according to the facility's policy and procedure, for two of three residents reviewed under closed records (Resident 114 and 112), when:1.For Resident 114, a written notice of proposed transfer (a written notification which included the contact information for the Long-Term Ombudsman [a trained advocate-either a staff member or volunteer-who investigates complaints and resolves problems regarding the health, safety, welfare, and rights of individuals living in nursing homes, assisted living, and board and care facilities] and appeal rights) was provided to the resident timely. This failure had the potential for Resident 114 to be not aware of his appeal rights for inappropriate discharge; and2.For Resident 112, the inventory of the resident's belongings was not completed when the resident was transferred to the general acute hospital (GACH) on December 30, 2025. This failure had the potential for Resident 112 or representative not to receive the personal belongings left at the facility when the resident was discharged .Findings: 1.On March 6, 2026, Resident 114's record was reviewed. Resident 114's Face Sheet, indicated the resident was admitted to the facility on [DATE], with diagnoses which included urinary tract infection and chronic obstructive pulmonary disease (COPD – a condition involving constriction of the airways and difficulty or discomfort in breathing). A review of Resident 114's History and Physical, dated November 16, 2025, indicated the resident has capacity to understand and make decisions. A review of Resident 114s' Minimum Data Set (MDS – a resident assessment tool), dated November 17, 2025, indicated the resident has a BIMS (Brief Interview for Mental Status) score of 14 (cognitively intact). A review of Resident 114's Progress Notes, indicated the following: -January 12, 2026, at 11:54 a.m., .IDT (Interdisciplinary Team – a group of healthcare professionals) members met with this resident and his son (name of family member) over the phone to discuss current POC (Plan of Care), d/c (discharge) plans. Per resident and son the plans are to return home with HH (Home Health) and caregiver support 5x (five times) day.NOMNC (Notice of Medicare Non-Coverage) was also issue for LCD (Last Covered Day) of 1/0/26 (January 20, 2026) and to d/c home on 1/21/26 (January 21, 2026). -January 17, 2026, at 1:35 p.m., .PATIENT discharged HOME WITH ALL BELONGING AND MEDICATIONS. PATIENT DISCHARGE INSTRUCTIONS COMPLETED WITH PATIENT and FRIEND AT BEDSIDE. A review of the NOMNC form for Resident 114, indicated the form was signed by the resident on January 12, 2026. A review of Resident 114's, Notice of Proposed Transfer/Discharge, indicated the form was completed by the facility staff on January 19, 2026 (2 days after the resident was discharged), was not signed by the resident, and was mailed to the resident's family member. (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On March 6, 2026, at 4:45 p.m., a concurrent interview and record review was conducted with the Social Services Director (SSD). The SSD stated the following: -Discharge planning starts on admission and the IDT would meet to discuss the resident's progress and plan for discharge within 48 to 72 hours prior to the proposed discharge date ; -The Notice of Proposed Transfer is being provided to the residents or resident representative to all residents who were discharged back to the community or transferred to the GACH; -If the facility determines the discharge date , they will issue to the resident or resident representative the NOMNC and Notice of Proposed Transfer at the same time; and -Resident 114's NOMNC was issued on January 12, 2026, and there was no Notice of Proposed Transfer/Discharge provided to the resident not until it was mailed to the resident's family member on January 19, 2026 (2 days after the resident was discharged to home). The SSD stated the Notice of Proposed Transfer/Discharge should have been provided to Resident 114 at least three days prior to discharge. A review of the facility's policy and procedure titled, Notification of Proposed Transfer and Discharge, reviewed January 15, 2026, indicated, .It is the policy of the facility to provide residents and their representatives a written notice of transfer/discharge. The notice must clearly state the reason for the transfer/discharge, the effective date, the location of the transfer/discharge, and information about the resident's appeal rights, including contact information for the Long-Term Ombudsman and Disability Rights California.The facility will provide written notice of a proposed transfer/discharge to the resident and their representative(s) at least 48 hours before the effective date, unless it is an emergency transfer. 2. On March 5, 2026, Resident 112's record was reviewed. Resident 112 was admitted to the facility on [DATE], with diagnoses which included pneumonia (bacterial lung infection), pulmonary fibrosis (scarring and thickening of lung tissue), and sepsis (life-threatening response to an infection). Resident 112 was transferred to the General Acute Care Hospital (GACH) on December 30, 2025, due to chest pain. A review of Resident 112's Inventory of Personal Effects, dated December 15, 2025, indicated it was not signed by Resident 112 or Resident 112's representative on the discharge portion of the form, upon or after Resident 112's transfer to the hospital on December 30, 2025. In addition, there was no documented evidence Resident 112's personal belongings were turned over to the resident representative upon transfer to GACH on December 30, 2025, or after the resident was eventually discharged from the facility due to prolonged hospital stay beyond seven days. On March 6, 2026, at 3:35 p.m., the Social Services Assistant (SSA) was interviewed. The SSA stated the nurses would usually have the resident or resident representative sign out the personal belongings upon transfer or discharge, but on the weekends when the Social Service Department staff were not in the building, the housekeepers would keep a list of the belongings turned over to the resident representative. The SSA stated the resident representative might have picked up Resident 112's belongings over a weekend. The SSA stated she would follow up with housekeeping to obtain that list. (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On March 6, 2026, at 4 p.m., the Administrator (ADM) stated the staff were still trying to locate the housekeeper's list of Resident 112's belongings, and if they were unable to locate it. The ADM stated Resident 112's Inventory of Personal Effects should have been completed upon the resident's transfer or discharge from the facility. A review of the facility's policy and procedure titled, Personal Effects, Inventory of, dated January 15, 2026, indicated, .It is the policy of the facility to take reasonable steps to protect the personal property of the residents.On Discharge.Upon discharge of a resident from the facility, the resident or responsible party shall date and sign the Discharge section of the form in conjunction with a staff nurse in order to certify that the resident's personal .effects were received.A photocopy of this completed original form shall be given to the resident or responsible party.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed ensure cigarettes and smoking paraphernalia were kept secured in a locked container in the nursing station, according to the plan of care and facility's policy and procedures, for one of two residents reviewed for smoking (Resident 123).This failure had the potential to place Resident 123 and other residents at risk of harm and injuries.Findings:On March 3, 2026, at 8:58 a.m., a concurrent observation and interview with Resident 123 was conducted in his room. Resident 123 stated his cigarettes and lighter were stored in his bag at the bedside. One box of cigarettes and one lighter were observed inside his gray bag on the bed beside him.A review of Resident 123's Face Sheet, indicated the resident was admitted to the facility on [DATE], with diagnosis which included need for assistance with personal care.A review of Resident 123's History and Physical Examination, dated February 26, 2026, indicated Resident 123 had the capacity to understand and make decisions.A review of Resident 123's care plan, dated March 1, 2026, indicated, .Focus.Resident exhibits non-compliance with the facility smoking schedule.Goal.Will have no injuries.will demonstrate understanding of facility smoking policies and consequences.Interventions.Keep all lighters, matches, and cigarettes secured at nursing station.On March 4, 2026, at 9:25 a.m., a concurrent observation and interview with Licensed Vocational Nurse (LVN) 5 was conducted in Resident 123's room. LVN 5 verified Resident 123 had two and a half cigarettes and one lighter in his bag at bedside. LVN 5 stated Resident 123 could have his cigarettes and lighter at the bedside since he was independent.On March 5, 2026, at 5:50 p.m., an interview was conducted with the Director of Nursing (DON). The DON stated all smoking paraphernalia was to be stored in the locked box at the nursing station. The DON stated Resident 123's smoking paraphernalia was confiscated by staff and stored in the locked box at the nursing station. The DON stated Resident 123's smoking paraphernalia should not have been kept at his bedside. The DON stated it was important to keep all smoking paraphernalia at the nursing station to ensure resident safety.A review of the facility's policy and procedure titled, Smoking Policy, dated January 15, 2026, indicated, .to provide those residents who choose to smoke a means to do so that does not jeopardize their safety or the safety of others.No lighting materials (e.g. matches, lighters), tobacco products.will be allowed to be kept in the possession of the residents. They will be kept in a locked drawer/cabinet/box in the nursing station.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure essential items necessary for hydration were in reach, for two of two residents reviewed for hydration (Residents 12 and 17), when the residents' water pitchers were observed out of reach. This failure had the potential to result in compromised hydration, impaired skin integrity, and increased risk for falls.Findings: 1. On March 2, 2026, at 11:28 a.m., Resident 12's room was observed to have a water drop signage outside of the room labeled under the resident's name. Resident 12 was observed sitting in bed with head of the bed elevated, awake and alert. Resident 12 both forearms were observed to be dry. Resident 12's water pitcher was observed on the nightstand beside the upper part of the bed and was out of reach.On March 5, 2026, at 11:39 a.m., an interview was conducted with Certified Nurse Assistant (CNA) 5. CNA 5 stated the water drop signage by a resident's door would indicate either the resident is on fluid restriction or thickened liquids. CNA 5 stated she would ask the licensed nurse if she was not sure what the water drop signage meant. CNA 5 stated signs and symptoms of dehydration or poor hydration would be identified if a resident had dry lips, dry mouth, dry skin or low urine output. CNA 5 stated these signs and symptoms should be reported to the charge nurse immediately. CNA 5 stated that when a resident had poor fluid intake, the CNA was required to encourage hydration at least every two hours. CNA 5 stated all residents' water pitchers should always be in reach.On March 5, 2026, at 1:22 p.m., a concurrent observation and interview was conducted with CNA 6. CNA 6 stated the signage outside of Resident 12's room indicated Resident 12 was on fluid restriction. CNA 6 stated that when a resident is on fluid restriction, the charge nurse would inform the CNA of the specific amount of fluids the resident was allowed within an 8-hour shift. CNA 2 stated the resident's water pitcher would be filled with the specific amount of water. CNA 2 stated the resident's water bottle should always be in reach.On March 6, 2026, Resident 12's medical record was reviewed. Resident 12 was admitted to the facility on [DATE], with diagnoses which included heart failure (a long-lasting health condition where the heart muscle is too weak to pump blood efficiently) and acute pulmonary edema (a life-threatening medical emergency where sudden fluid buildup in the lungs).A review of Resident 12's Minimum Data Set (MDS - a resident assessment tool), dated February 1, 2026, indicated Resident 12 had a BIMS (Brief Interview of Mental Status) score of 06 (severe cognitive impairment).A review of Resident 12's Care Plan, dated December 8, 2025, indicated, .at risk for bowel incontinence.due to some loss of sensory awareness.at risk for skin issues.will remain free from skin breakdown.encourage fluids during the day to promote prompted voiding responses.A review of Resident 12's Care Plan, dated December 8, 2025, indicated, .at risk for falls.r/t (related to) loss of balance, recent hospitalization, needs assistance in adls (activities of daily living), decreased mobility.hx (history of) fall.will minimize risk of injury.anticipate and meet needs.fall/floor mat to reduce injury r/t falls.keep needed items, water, etc, in reach.A review of Resident 12's physician's order, dated February 2, 2026, indicated, Furosemide (diuretic - medication that helps your body get rid of excess water and by increasing the amount of urine-used to treat fluid buildup and heart failure) Oral Tablet 40 MG (milligram -unit of measurement.Give 1 (one) tablet by mouth two times a day for fluid retention.A review of Resident 12's Care Plan, dated March 5, 2026, indicated, .potential fluid deficit r/t diuretic, poor PO (oral) intake.will be free of symptoms of dehydration.good skin turgor.encourage to drink fluids of choice.monitor/document/report to MD (medical doctor) PRN s/sx (signs and symptoms of dehydration: decrease or no urine output, cracked lips, dizziness, thirst.2.On March 2, 2026, at 4:43 p.m., Resident 17 was found asleep with the bed flat and water pitcher out of reach on the bedside table.On March 3, 2026, at 3:42 p.m., Resident 17 was observed in bed with head of bed elevated approximately 30 degrees, alert and awake. Resident 17's water pitcher was out of reach on the bedside table.On March 4, 2026, at 9:26 a.m., Resident 17 was observed alert and awake lying in bed with the bed flat. Resident 17's water pitcher was observed out of reach on the (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	nightstand.On March 4, 2026, at 9:31 a.m., a concurrent observation and interview was conducted with CNA 6. CNA 6 stated the resident's call light, bed control and water pitcher were essential items that are expected to always be in resident's reach. CNA 6 stated Resident 17 required assistance with hydration and all meals. CNA 6 stated Resident 17 likes to drink water when offered. CNA 6 stated Resident 17 water pitcher should always be in reach.On March 5, 2026, Resident 17's medical record was reviewed. Resident 17 was admitted to the facility on [DATE], with diagnoses which included hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side (weakness or paralysis on the left side of body caused by a stroke) and nutritional deficiency (when the body lacks essential vitamins or minerals needed for proper function).A review of Resident 17's Minimum Data Set (MDS - an assessment tool), dated February 4, 2026, indicated Resident 17 had a BIMS (Brief Interview of Mental Status-a cognitive assessment tool) score of 03 (severe cognitive impairment).A review of Resident 17's care plan, revised November 6, 2025, indicated, .has potential/actual impairment to skin integrity r/t fragile skin.will be free from injury.encourage good nutrition and hydration in order to promote healthier skin.A review of Resident 17's care plan, revised November 6, 2025, indicated, .Keep needed items, water.in reach.A review of the facility's policy and procedure titled, Care and Treatment-Hydration, reviewed on January 15, 2026, indicated, .policy that this facility.must provide each resident.with sufficient fluid intake.to maintain proper hydration and health.based on individual needs.to prevent dehydration.each resident is provided a container of fresh, cool, water .which is located on the resident's bedside stand.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to ensure pain medications were administered according to the physician's order, for two of three residents reviewed under pain (Residents 12 and 62).This failure had the potential for Residents 12 and 62's pain not to be managed appropriately.Findings:On March 5, 2026, at 10:32 a.m., during an inspection of Medication Cart A conducted with the Infection Preventionist (IP), the narcotic box contained controlled medications.1.Resident 12 had a bubble pack of Hyrdocodone-Acetaminophen (controlled medication for pain) 5/325 mg (milligram - unit of measurement). Resident 12's record and narcotic count sheet was concurrently reviewed with the IP.A review of Resident 12's Face Sheet, indicated the resident was admitted to the facility on [DATE], with diagnoses which included heart failure.A review of Resident 12's Order Summary Report, included the following physician's order:-HYDROcodone-Acetaminophen.5-325 MG.1 (one) tablet.every 6 (six) hours as needed for mild to moderate pain 1-3/10 (pain rating scale). date ordered from December 31, 2025, to January 16, 2026;-HYDROcodone-Acetaminophen.5-325 MG.1 (one) tablet.every 6 (six) hours as needed for SEVERE PAIN 7-10 (pain rating scale)., date ordered from January 16, 2026, to January 29, 2026.A review of Resident 12's Medication Administration Record, for January 1 to 16, 2026, and Controlled Medication Count Sheet, indicated Hydrocodone was administered to Resident 12 not according to the physician's order for mild to moderate pain on the following dates:-January 9, 2026, at 8:37 a.m.; pain scale of 7 (severe pain); and-January 10, 2026, at 8:11 a.m.; pain scale of 7.A review of Resident 12's Medication Administration Record, for January 16 to 29, 2026, and Controlled Medication Count Sheet, indicated Hydrocodone was administered to Resident 12 not according to the physician's order for severe pain (7 to 10) on the following dates :-January 17, 2026, at 8:47 a.m.; pain scale of 6;-January 23, 2026, at 10;22 a.m.; pain scale of 4.A review of Resident 12's care plan, revised February 19, 2026, indicated, .At risk for discomfort due to pain on Lt (left) leg.Administer analgesia (pain medication) medication as per orders.Follow pain scale to medicate as ordered.In a concurrent interview with the IP, she stated the pain medication should be administered to Resident 12 according to the pain rating scale as ordered by the physician.2. Resident 62 had a bubble pack of Hydrocodone 5/325 mg in the narcotic box. Resident 62' record and narcotic count sheet was concurrently reviewed with the IP.A review of Resident 62's Face Sheet, indicated the resident was admitted to the facility on [DATE], with diagnoses which included polyneuropathy (a condition characterized by damage to multiple peripheral nerves simultaneously, usually causing symptoms like numbness, burning pain, and weakness starting in the feet and hands). A review of Resident 62's Order Summary Report, included a physician's order, dated February 1, 2026, which indicated, HYDROcodone-Acetaminophen.5-325 MG.1 (one) tablet.every 4 (four) hours as needed for SEVERE PAIN 7-10 (pain rating scale).A review of Resident 62's Medication Administration Record, for the month of February 2026, and Controlled Medication Count Sheet, indicated Hydrocodone was administered to Resident 62 not according to the physician's order for severe pain on the following dates:-February 6, 2026, at 1:13 p.m.; pain scale of 6;-February 15, 2026, at 9:56 a.m.; pain scale of 5; and-February 16, 2026, at 7:59 a.m.; pain scale of 3.In a concurrent interview with the IP, she stated the pain medication should be administered to Resident 62 according to the pain rating scale as ordered by the physician.On March 5, 2026, at 3:37 p.m., during a concurrent interview and review of Residents 12 and 62's record conducted with the Director of Nursing (DON), the DON stated the licensed nurse should assess the resident's pain and administer the pain medication according to the physician's order.A review of the facility's policy and procedure titled, Recognition and Management of Pain, dated January 15, 2026, indicated, .It is the policy of the facility to ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences.Medication(s) received.and response to medication will (continued on next page)

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Premier Care Center for Palm Springs	2990 East Ramon Road Palm Springs, CA 92264

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	be documented on the Electronic Medication Administration Record.A review of the facility's policy and procedure titled, Medication Administration, dated January 15, 2026, indicated, .It is the policy of this facility that medications shall be administered as prescribed by the attending physician.Medications must be administered in accordance with the written orders of the attending physician.

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F 0712 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that the resident and his/her doctor meet face-to-face at all required visits. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure required physician visits and ongoing medical oversight was conducted, for one of one resident reviewed (Resident 17), when there was no documented evidence of a physician visit for 2025. This failure had the potential to place the resident at risk for unidentified changes in medical condition, outdated treatment plans and medication-related complications. ce the resident at risk for unidentified changes in medical condition, outdated treatment plans and medication-related complications. Findings:On March 3, 2026, at 3:42 p.m., Resident 17's medical record was reviewed. Resident 17 was admitted to the facility on [DATE], with diagnoses which included hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side (weakness or paralysis on the left side of body) and nutritional deficiency (when the body lacks essential vitamins or minerals needed for proper function).A review of Resident 17's Minimum Data Set (MDS- an assessment tool), dated February 4, 2026, indicated Resident 17 had a Brief Interview of Mental Status (BIMS - a tool to assess cognition) score of 3 (severe cognitive impairment).On March 10, 2026, at 5:42 p.m., a concurrent interview and review of Resident 17's record was conducted with the Director of Nursing (DON). The DON stated long term care residents were to be seen by the physician at least once a month. In a concurrent review of Resident 17's medical record, the DON verified that Resident 17 did not receive ongoing physician visits including total program of care assessments throughout the year of 2025. The DON stated the facility did not follow the physician visit requirements and Resident 17 should have received physician visits at least once a month.A review of the facility's policy and procedure titled, Physician Services-Physician Visits, dated January 15, 2026, indicated, .residents must be seen.by their attending physician.at least every 90 days.resident's attending physician must review.the resident's total program of care.including medications and treatments.at least quarterly.

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F 0773 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain laboratory tests/services when ordered and promptly tell the ordering practitioner of the results. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure abnormal laboratory result was referred to the physician, for one of 23 residents reviewed (Resident 11), when the potassium (an essential mineral and electrolyte crucial for maintaining healthy blood pressure, heart function, nerve signals, and muscle contractions) level was 3.2 (normal range of 3.5 to 5.1).This failure had the potential for delayed care and treatment and could affect Resident 11's overall health condition.Findings:On March 5, 2026, Resident 11's record was reviewed. Resident 11's Face Sheet, indicated the resident was admitted to the facility on [DATE], with diagnoses which included muscle disorder.A review of Resident 11's physician order, dated January 7, 2026, indicated, .BMP (Basic Metabolic Panel (a laboratory test which measures eight different substances in your blood) 1/8/2026 (January 8, 2026).A review of Resident 11's Lab (laboratory) Results Report, dated January 8, 2026, indicated a potassium level of 3.2 mmol/L (millimoles per liter - unit of measurement).Further review of Resident 11's record indicated there was no documented evidence the low potassium level was referred to the physician.On March 6, 2026, at 11 a.m., a concurrent interview and review of Resident 11's record was conducted with the Director of Nursing (DON). The DON stated the physician was to be notified of any abnormal laboratory values at least within the day or depending on the urgency to report to the physician. The DON stated Resident 11's low potassium level of 3.2 was not referred to the physician. The DON stated the low potassium level for Resident 11 should have been referred to the physician to address.A review of the facility's policy and procedures titled, Laboratory Services, dated January 15, 2026, indicated, .it is the policy of this facility to provide for laboratory services under contract with an independent laboratory.Nursing is notified of the results of any lab drawn and will notify the physician of the results and wait for further orders.

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F 0800 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure fortified diet (having had vitamins or other supplements added to increase the nutritional value) was provided as ordered by the physician and according to the facility's diet menu spreadsheet, for one of 14 residents with fortified diet order (Resident 44).This failure had the potential for Resident 44 not to receive the required dietary nutrients and could lead to weight loss and affect overall health condition of the resident. Findings:On March 5, 2026, at 11 a.m., a tray line (food assembly) observation was conducted for the lunch meal service.During the temperature check of food items beginning at 11:45 a.m., some salad bowls were observed to have F marked on the plastic covers, which indicated these were fortified. The facility document titled, Diet Type Order, indicated Resident 44 had a fortified diet order.Resident 44's meal tray was observed to have the following: 1/2 (one-half) cup tossed green salad (covered, with no F marking on the cover), a bowl of mushroom soup, Salisbury steak with 1 oz (ounce- unit of measurement), 1/2 cup beets, 1/2 cup noodles, 1 cup coffee, 4 oz chocolate shake, 4 oz grape juice, and 1 lemon cookie.On March 5, 2026, at 1:08 p.m. Resident 44 was observed in his room with his meal tray. The bowl of tossed green salad was still unopened, and the cover did not bear an F marking, and the Salisbury steak was still minimally consumed, and had approximately 1 oz of gravy.A review of Resident 44's meal ticket indicated, .Regular-Level 7, Fortified. A review of the facility document titled, Spring 2026 Week 1, indicated, .FORTIFIED LUNCH.Salisbury Steak: 1 oz extra gravy.Salad: 2 tsp (teaspoon) oz extra dressing.On March 5, 2026, Resident 44's record was reviewed. Resident 44 was admitted to the facility on [DATE], with diagnoses which included palliative care (specialized medical care focused on relieving symptoms, pain, and stress caused by serious illnesses like cancer), malignant cancer of the lung, and nutritional deficiency.A review of Resident 44's Order Summary Report, dated March 5, 2026, indicated a physician's order for .FORTIFIED diet REGULAR- Level 7 texture, THIN LIQUIDS consistency.On March 6, 2026, at 8:30 a.m., a concurrent interview and record review was conducted with the Registered Dietitian (RD). The RD stated the meal components of the fortified lunch of Salisbury steak having an extra ounce of gravy, and fortified dressing for the salad, should have been provided on Resident 44's tray.A review of the facility's policy and procedure titled, DIET ORDERS, dated 2023, indicated, .Diet orders as prescribed by the Physician will be provided by the Food & Nutrition Services Department.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observation, interview, and record review, the facility failed to provide food at appropriate temperatures when served to the residents according to the facility's policy and procedure, for two of two residents (Residents 32 and 5), when the milk and salad's temperature were above the recommended temperature when served.This failure placed residents at risk to decrease their oral intake and affect the residents' nutritional status.Findings:On March 2, 2026, at 11:25 a.m., Resident 32 in B Wing (Rooms 11-24), was interviewed. Resident 32 stated meals were lukewarm.On March 3, 2026, at 9:11 a.m., Resident 5 in A Wing (Rooms 1-10), was interviewed. Resident 5 stated food was consistently cold.On March 5, 2026, during the lunch meal service, test tray was requested to determine serving temperature of food served to the residents in the facility. The test tray was placed inside the last meal cart at 12:53 p.m., which departed the kitchen at 12:55 p.m., arriving at A Wing at 12:58 p.m.On March 5, 2026, at 1:10 p.m., temperatures of the following meal items were taken and were as follows:- regular beets: 120 ˆF (degrees Fahrenheit)- beets: 120 ˆF- pureed pasta 120 ˆF- milk: 47 ˆF- salad: 46.6 ˆFOn March 6, 2026, at 8:30 a.m., an interview was conducted with the Registered Dietitian. The RD stated food items should be served within the recommended serving temperatures to the residents to prevent food borne illness, and ensure a palatable meal experience for the residents.A review of the facility's policy and procedure titled, MEAL SERVICE, dated 2023, indicated, .Temperature of the food when the resident receives it is based on palatability. The goal is to serve cold food cold and hot food hot. See table below for suggested temperature.Recommended Temp (temperature) at Delivery to Resident.Salads.ˆ (less than or equal to) 45 ˆF .Milk/Cold Beverage.ˆ 45 ˆF .Starch.ˆ (greater than or equal to) 120 ˆF .Vegetables. ˆ 120 ˆF .

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the Infection Preventionist (IP) implemented the antibiotic stewardship program, for one of 93 residents reviewed (Resident 84), when the IP did not review multiple antibiotics that were prescribed for Resident 84. This failure had the potential to place Resident 84 at risk for complications related to prolonged antibiotic use, adverse drug reactions, and development of antibiotic-resistant organisms. Findings:On March 2, 2026, Resident 84's medical record was reviewed. Resident 84 was admitted to the facility on [DATE], with diagnoses which included cellulitis (serious bacterial infection of the deeper layers of skin and underlying tissue, often causing red, hot, swollen, and painful skin), and type 2 diabetes mellitus (a lifelong disease that occurs when your blood sugar is too high, which makes it difficult for your body to heal and easy for infections to start).A review of Resident 84's Minimum Data Set (MDS - a resident assessment tool), dated January 30, 2026, indicated Resident 84 had a BIMS (Brief Interview of Mental Status) score of 13 (cognitively intact).A review of Resident 84's medical records indicated the following physician orders:- August 20, 2025: Cephalexin (antibiotic used to kill bacteria causing skin infections) oral capsule 500 mg (milligram- unit of measurement), give one capsule by mouth four times a day for cellulitis for 7 (seven) days;- December 23, 2025: Cefpodoxime Proxetil (antibiotic used to treat various bacterial infections) tablet 200 mg, give one tablet by mouth every 12 hours for cellulitis wound to the right foot for 7 days;- December 23, 2025: Doxycycline Hyclate (antibiotic used to kill or stop the growth of bacteria causing infections) oral tablet 100 mg, give one tablet by mouth two times a day for cellulitis to the right foot for 7 days;- December 23, 2025: Mupirocin (antibiotic applied to the skin to treat bacterial infections like infected cuts, or small wounds) External Ointment 2% (percent), apply to the right foot between 1st/2nd toe topically (apply directly to a specific spot on skin) every day shift every Monday, Wednesday, and Saturday for open areas, for 14 days;- January 8, 2026: Cefpodoxime Proxetil tablet 200 mg, give one tablet by mouth every 12 hours for open area to wound for 7 days;- January 8, 2026: Doxycycline Hyclate oral tablet 75 mg, give one tablet by mouth two times a day for wound to the right foot for 7 days;- January 16, 2026: Cefpodoxime Proxetil tablet 200 mg, give one tablet by mouth every 12 hours for cellulitis for 5 (five) days; - January 16, 2026: Doxycycline Hyclate oral tablet 100 mg, give one tablet by mouth two times a day for cellulitis for 5 days;- January 21, 2026: Cefepime HCL Solution (a strong intravenous [IV- into the vein] antibiotic used to treat severe bacterial infections), use 1 gram (unit of measurement) intravenously every 8 hours for cellulitis for 7 days via CADD pump (Continuous Ambulatory Delivery Device-a small, portable, battery-operated device used to deliver medication);- January 21, 2026: Vancomycin HCL Solution (an antibiotic used to treat serious bacterial infections), use 1.1 gram intravenously every 12 hours for cellulitis for 7 days; and- January 27, 2026: Vancomycin HCL Solution, use 1.1 gram intravenously one time a day for Osteomyelitis (a serious infection within the bone, causing pain, swelling, and fever, often resulting from bacteria entering through injuries, nearby infected tissue, or the bloodstream) until January 28, 2026.A review of Resident 84's Infection Screening Evaluation, dated January 8, 2026, indicated, .current, active diagnosis of infection.yes.skin/wound characteristics.redness (erythema).tenderness.warmth.new or increasing swelling at affected site.pus.infection analysis.Loeb's Criteria: suspected skin and soft tissue infection.McGeer's Criteria Met: Cellulitis, Soft Tissue or Wound Infection.A review of Resident 84's, Infectious Disease Progress Note/Antimicrobial Stewardship Note, dated January 13, 2026, indicated, .tolerates antimicrobial therapy.continue oral antibiotic.skin.location: right foot right dorsum 1st interdigit wound.impression: right foot infection.antimicrobials.continue. Vantin (brand name for cefpodoxime proxetil) and Doxycycline January 8-January 15.A review of Resident 84's Care Plan, dated December 23, 2025, indicated, .new impairment.open area to right foot.between 1st and 2nd digit.with serous (clear, watery liquid that leaks from a wound) drainage and swelling.skin issue will (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	begin healing process.monitor/document wound measurements.notify MD of abnormalities.s/sx of infection. Need CP specific to antibiotics/abx stewardshipFurther review of Resident 84's record indicated there was no documented evidence monitoring was conducted for cellulitis, signs and symptoms of infection, or Resident 84's tolerance of the oral or intravenous antibiotics he received. In addition, there was no updated interdisciplinary team (IDT - a group of healthcare professionals) meeting to address Resident 84's ongoing use of multiple antibiotics and his infection status.On March 6, 2026, at 5:33 p.m., an interview was conducted with the Infection Preventionist (IP). The IP stated the purpose of antibiotic stewardship was to ensure the resident was receiving the appropriate antibiotic that was required for his infectious diagnosis. The IP stated a review would be conducted weekly, and as needed, for residents with new antibiotic orders. The IP stated an infection screening evaluation would be completed to verify the resident had a true infection. The IP stated the physician would be notified to review antibiotic orders if it was not a true infection.On March 10, 2026, at 7:06 p.m., a concurrent interview and review of Resident 84's record was conducted with the Director of Nursing (DON). The DON stated the Licensed Nurse (LN) was expected to monitor Resident 84 for adverse reactions to oral and IV antibiotics, assess the IV site, and how the treatment was tolerated by the resident. The DON confirmed there was no documented evidence Resident 84 received ongoing assessment and monitoring, while receiving the above multiple antibiotic treatments. On March 10, 2026, at 8:15 p.m., an interview was conducted with the IP. The IP stated she did not follow the facility antibiotic stewardship or infection surveillance policy. The IP stated she did not review Resident 84's antibiotics to confirm the medications were compatible, or without adverse interactions or contradictions. The IP stated the LN would administer the antibiotic and notify the physician if the resident developed any adverse reactions. The IP stated the LN would use the medication black box warning as an alert for serious medication interactions or side effects. In a concurrent review of Resident 84's record, there was no documented evidence Resident 84 received ongoing assessment and monitoring while receiving multiple antibiotic treatments at once. In addition, the IP stated the antibiotic stewardship or infection surveillance for Resident 84 was not followed since the infection and antibiotic treatment was still ongoing.A review of the facility's policy and procedure titled, Infection Control Prevention and Control Program, revised September 2017, indicated, .on-going monitoring for infections among residents.and subsequent documentation of infections that occur.surveillance tools.to recognize the occurrence of infections.record their number and frequency.A review of the facility's policy and procedure titled, Infection Control-Antibiotic Stewardship, dated January 15, 2026, indicated, .infection prevention and control program.will promote appropriate use of antibiotics.while optimizing the treatment of infections.at the same time reducing the possible adverse events.associated with antibiotic use.this policy has the potential.to limit antibiotic resistance.while improving treatment efficacy.and resident safety.the team.Infection Preventionist.will review, monitor and summarize.antibiotic use.antibiotic time-out.a stop order of an antibiotic when a diagnostic test or symptom.does not support the diagnosis of infection.these practices.improving the evaluation.communication of clinical signs and symptoms.when a resident is first suspected of having an infection.optimizing the use of diagnostic testing.and implementing an antibiotic review process.for all antibiotics prescribed in the facility.to reassess the ongoing need for.choice of an antibiotic.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure influenza vaccine (an annual vaccine that protects against influenza [a contagious respiratory illness] by helping the body produce antibodies) was received after obtaining consent on January 26, 2026, according to the facility's policy and procedure, for one of five residents reviewed for immunization (Resident 88).This failure had the potential for Resident 88 to be at risk of acquiring influenza and increase the risk of experiencing complications related to it. Findings:On March 5, 2026, at 10:13 a.m., during an inspection of the medication refrigerator conducted with the Infection Preventionist (IP), one vial of influenza vaccine was found stored and labeled for Resident 88. The label indicated a pharmacy dispensed date of January 27, 2026.A review of Resident 88's record was conducted with the IP, which indicated the following:-Resident 88's Face Sheet, indicated the resident was admitted to the facility on [DATE];-Resident 88's Resident Consent for Influenza. dated January 26, 2026, indicated the resident wish to receive the influenza vaccine on an annual-basis.-Resident 88's physician's order, dated January 27, 2026, indicated, .FLU (Influenza) VACCINE.WHEN AVAILABLE (CONSENTED).-Resident 88's Minimum Data Set (MDS - a resident assessment tool), dated February 6, 2026, indicated a BIMS (Brief Interview for Mental Status) score of 12 (cognitively intact);_Resident 88's History and Physical Examination, dated March 5, 2026, indicated the resident had capacity to understand and make decisions; and-Resident 88's Immunization Report, indicated Resident 88 did not receive the influenza as ordered by the physician on January 27, 2026.In a concurrent interview with the IP, the IP stated the influenza should have been administered to Resident 88.A review of the facility's policy and procedures titled, Immunization, Influenza. dated January 15, 2026, indicated, .it is the policy of this facility to ensure that.Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period.To minimize the risk of residents acquiring, transmitting, or experiencing complications from influenza.by assuring that each resident.Has the opportunity to receive, unless medically contraindicated or refused or already immunized.If the resident and/or resident representative consented to the vaccine, obtain a physician order for the resident.