STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056333	A. Building B. Wing	03/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mountain View Conv Hosp	13333 Fenton Avenue Sylmar, CA 91342

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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 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Dispose of garbage and refuse properly. Based on observation, interview, and record review, the facility failed to dispose garbage and refuse properly when: a. Two (2) dumpsters (a movable waste container designed to be brought and taken away by special collection vehicle, or to a bin that a specially designed garbage truck lifts) were not completely closed and was propped open by a piece of wood when not actively in use. b. There were gloves, trash, and liquid drippings in the dumpster surroundings. c. The trash can did not have a cover in the dishwashing area. These failures had potential to attract birds, flies, insects, pests and possibly spread infection to 77 of 77 facility residents. Findings: a&b. During a concurrent observation and interview on 3/24/2026 at 2:32 p.m., of the dumpster area, observed 2 dumpsters were not fully closed, propped open by a piece of wood and the floor surroundings had gloves, trash and liquid drippings. The Dietary Supervisor (DS) stated the garbage needed to be always closed but because the dumpster was in a closed area, it's okay. The DS stated there are gaps and spaces where insects and flies could enter in the closed space where the dumpster is located and it's not acceptable to have the dumpster open because flies could get into it. The DS stated flies could spread infection to residents as a potential outcome. During an interview on 3/25/2026 at 9:20 a.m. with the Maintenance Supervisor (MS), the MS stated he cleans the dumpster area once a week or as needed to make sure there was no trash in the surroundings. The MS stated they needed to make sure that the dumpster lid is always closed so it would not attract flies to minimize the use of pesticide in the facility. The MS stated residents could get sick of stomachache when flies transfer bacteria from one place to another. The MS stated staff placed some wood to hold the lid of the dumpster because the trash is heavy and they forget to close it. During a review of the facility's policies and procedures (P&P) titled, Sanitation, dated 9/10/2025, the P&P indicated, 14. Garbage and refuse containers are in good condition, without leaks, and waste is properly contained in dumpsters/compactors with lids (or otherwise covered). 15. Areas used for garbage disposal free from odors and waste fats and maintained to prevent pests. During a review of Food Code 2022, dated 1/18/2023, the Food Code 2022 indicated, 5-501.116 Cleaning Receptacles. Proper storage and disposal of garbage and refused are necessary to minimize the development of odors, prevent such waste from becoming an attractant and harborage of breeding places for insects and rodents, and prevent the soiling of food preparation and food service areas. Improperly handled garbage creates nuisance conditions, makes housekeeping difficult, and may be possible source of contamination of food, equipment, and utensils. Outside receptacles must be constructed with tight-fitting lids or covers to prevent the scattering of the garbage or refuse by birds, the breeding of flies, or the entry of rodents. Proper equipment and supplies must be made available to accomplish thorough and proper cleaning of garbage storage areas and receptacles so that unsanitary conditions can be eliminated. c. During a concurrent observation and interview of the trash can by the handwashing sink with the DS in the dishroom area, observed a trash can without a cover while not actively being used. The DS stated the trash can is used for soiled paper towels. The DS stated all trash cans should be covered to keep flies away from the area. The DS stated flies could contaminate clean dishes and residents could get sick as a potential outcome. During a review of the facility's P&P titled Sanitation, dated 9/10/2025, the P&P indicated, 13. Kitchen wastes that are not disposed of by mechanical means are kept in clean, leakproof, (continued on next page)

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

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	nonabsorbent, tightly closed containers and disposed of daily. During a review of Food Code 2022, dated 1/18/2023, the Food Code 2022 indicated, 5-501.113 Covering Receptacles and waste handling units for refuse, recyclables, and returnable shall be kept covered: (A) Inside food establishment if the receptacles and units: (1) Contain food residue and are not in continuous use; or (2) After they are filled; and 174 (B) With tight-fitting lids or doors if kept outside the food establishment.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide reasonable accommodation of resident needs and preferences by failing to ensure the pad call light (a specialty alerting device that have ultra-sensitive touch surface for residents with limited mobility for nurses or other nursing personnel to assist a resident when in need) or call light (an alerting device for nurses or other nursing personnel to assist a patient when in need) was within reach for five of seven sampled residents (Residents 66, 40, 90, 31, and 37) reviewed under the environment task. This deficient practice had the potential to result in a delay of care and services and possible injury when Residents 66, 40, 90, 31, and 37 were unable to call for staff assistance. Findings: 1. During a review of Resident 66's admission Record (AR - front page of the chart that contains a summary of basic information about the resident), the AR indicated the facility admitted the resident onˆ6/2/2023ˆwith diagnoses includingˆacute respiratory failure with hypoxia (aˆcondition that happens when theˆbodyˆdidˆnot have enough oxygen in the bloodˆleading to low oxygen levels),ˆtracheostomy (an opening a surgeon makes through the neck and into the trachea [also known as windpipe] to help a patient breathe), andˆcardiac arrest (a condition when the heart suddenly stops beatingˆand ca no longer pump blood to the brain and other vital organsˆand can be fatal).ˆ During a review of Resident 66's History and Physical (H&P), datedˆ6/2/2025, the H&PˆindicatedˆResident 66ˆdid not haveˆthe capacity to understand and make decisions.ˆ During a review of Resident 66's Minimum Data Set (MDS - a resident assessment tool), datedˆ2/27/2026, the MDS indicated Resident 66ˆhadˆseverely impairedˆcognition (mental action or process ofˆacquiringˆknowledge and understanding) andˆwasˆnotˆable toˆunderstand and make herˆneeds known. The MDS furtherˆindicatedˆResident 66ˆhad impairment of both upper and lower extremities andˆrequiredˆtotalˆassistanceˆfrom staffˆwith all activities of daily living (ADLs - activities such as bathing, dressing and toileting a person performs daily).ˆˆ During a review of Resident 66's Order Summary Report, dated as of 3/26/2026, the Order Summary Report indicated an order on 9/5/2023 for insulin regular, inject subcutaneously (under the skin) per sliding scale (dosage of medication is determined by the resident's blood sugar) before meals and at bedtime.ˆ During a review of Resident 66's care plan (CP) onˆrisk forˆfalls,ˆinitiatedˆonˆ6/3/2023ˆand last revised onˆ9/8/2025, the CPˆindicatedˆto place call light within reach as one of the interventions to keep the resident free from falls.ˆ During an observation on 3/23/2026 at 10:04 a.m.ˆinside Resident 66's room, observed Resident 66ˆ was unable to talk, turned towards the left side facing the doorwayˆand the pad call light was placed onˆResident 66'sˆbed on theˆuppermost rightˆcorner and not touching any part of the resident's head.ˆ During a concurrent observation and interview onˆ3/23/2026 at 12:19 p.m. inside Resident 66's room withˆLicensed Vocational Nurse (LVN) 3, Resident 66ˆwasˆobservedˆlying in bed, unable to talk, and was turned towards the left side.ˆLVN 3ˆstated Resident 66ˆwas unable to move both of her upper extremitiesˆand that the padˆcall light wasˆplacedˆon theˆuppermost rightˆcornerˆof the bedˆandˆwas away fromˆany part of the resident's head.ˆLVN 3ˆstated that the staff should ensure that theˆpadˆcall light was within the residents' reach prior to leaving the room, especially residents (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	who were unable to move bothˆarms and legs,ˆso they can call forˆassistance.ˆLVN 3ˆstated that Resident 66's pad call light should have been within reach at least next to theˆheadˆso the residentˆcan touch itˆforˆassistanceˆby moving her head.ˆLVN 3ˆstated if the call lightˆwasˆnot within Residentˆ66's reach, itˆwould placeˆthe resident at risk for a delay in providing the care and services the resident needed.ˆ Duringˆaˆconcurrentˆinterviewˆand record reviewˆonˆ3/25/2026 at 1:40 p.m. with theˆSubacute Coordinator (SAC), Residentˆ66's fall risk assessments and CP were reviewed. The SACˆstatedˆthat the fall risk assessmentsˆindicatedˆthat Residentˆ66ˆwas atˆa risk for fallsˆand that the CP onˆriskˆfor fallsˆindicatedˆto place the call light within reach as one of the interventions to keep Residentˆ66ˆfree from falls.ˆThe SACˆstatedˆthat staff are supposed to ensure that theˆpadˆcall lights are placed within the residents' reach after providing care and prior to leaving the room.ˆThe SACˆstated Residentˆ66's ˆpadˆcall light should have been placed withinˆthe resident'sˆreach and notˆon theˆuppermost rightˆcorner of the bedˆas the resident was unable to move bothˆupper andˆlower extremities and it placed Residentˆ66ˆat risk for a delay in receiving the careˆshe needed.ˆTheˆSACˆstatedˆthat ifˆResidentˆ66's ˆpadˆcall light was placedˆcloser to the head,ˆtheˆresident wouldˆbe able toˆtouchˆthe pad call light andˆcall forˆassistanceˆwhen needed.ˆˆ 2.ˆDuring a review of Residentˆ40's AR, the AR indicated the facility admitted the resident onˆ10/12/2023 with diagnoses including acute respiratory failure, tracheostomy, and cardiac arrest.ˆ During a review of Residentˆ40's H&P, datedˆ10/12/2025, the H&PˆindicatedˆResidentˆ40ˆdid not have the capacity to understand and make decisions.ˆ During a review of Resident 66's MDS,ˆdatedˆ1/9/2026, the MDS indicated Residentˆ40ˆhad severely impaired cognition. The MDS furtherˆindicatedˆResidentˆ40ˆhad impairment of both upper and lower extremities andˆrequiredˆtotalˆassistanceˆfrom staff withˆall ADLs.ˆ During a review of Residentˆ40's fall risk assessments, datedˆ7/14/2025,ˆ10/9/2025, andˆ1/9/2026, the fall risk assessmentsˆindicatedˆResidentˆ40ˆwas at a risk for falls.ˆ During a review of Residentˆ40's CPˆonˆrisk forˆfalls,ˆinitiatedˆonˆ1/4/2024ˆand last revised onˆ10/13/2025, the CPˆindicatedˆtoˆensure theˆresident'sˆcall lightˆisˆwithin reach as one of the interventions to keep the resident free from falls.ˆ During an observation on 3/23/2026 at 10:27ˆa.m., inside Residentˆ40's room, observed Residentˆ40ˆwasˆlying in bed in supine position,ˆunable to talk,ˆand the pad call light was placed on Residentˆ40's bed on the uppermost right corner and not touching any part of the resident's head.ˆ During a concurrent observation and interview on 3/23/2026 at 12:21ˆp.m., inside Residentˆ40's room, with LVNˆ3, Residentˆ40ˆwas observed lying in bedˆin supine position, unable to talk,ˆand the pad call light was placed onˆthe uppermost right cornerˆof the bedˆand away from any part of the resident's head. LVN 3 stated Residentˆ40ˆwas unable to move both of her upper extremities. LVN 3 stated that the staff should ensure that the pad call light was within the residents' reach prior to leaving the room, especially residents who were unable to move both arms and legs, so they can call forˆassistance. LVN 3 stated that Residentˆ40's pad call light should have been within reach at leastˆcloserˆto the head so the resident can touch itˆforˆassistanceˆby moving her head. LVN 3 stated if the call lightˆwasˆnot within Residentˆ40's reach, it would place the resident at risk for a (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	delay in providing the care and services the resident needed.ˆ During a concurrent interview and record review on 3/25/2026 at 1:40 p.m. with the SAC, Residentˆ40's fall risk assessments, and CP were reviewed.ˆThe SACˆstatedˆthat the fall risk assessmentsˆindicatedˆthat Residentˆ40ˆwas at a risk for falls and that the CP on risk for fallsˆindicatedˆto place call light within reach as one of the interventions to keep Residentˆ40ˆfree from falls. The SACˆstatedˆthat staff are supposed to ensure that the pad call lights are placed within the residents' reach after providing care and prior to leaving the room. The SAC stated Residentˆ40's pad call light should have been placed within the resident's reach and not on the uppermost right corner of the bed as the resident was unable to move both upper and lower extremities and it placed Residentˆ40ˆat risk for a delay in receiving the care she needed. The SACˆstatedˆthat if Residentˆ40's pad call light was placed closer to the head, the resident would be able to touch the pad call light and call forˆassistanceˆwhen needed.ˆˆ 3. During a review of Resident 90's AR, the ARˆindicatedˆthe facility admitted the resident on 2/27/2026, with diagnoses including dementiaˆ(a progressive state of decline in mental abilities), muscle weakness, and reduced mobility.ˆ During a review of Resident 90's H&P, dated 3/2/2026, the H&PˆindicatedˆthE resident had the capacity to understand and make decisions.ˆ During a review of Resident 90's MDS, dated [DATE], the MDS indicated the resident had the ability to make self-understood and understand others and hadˆmoderate cognitive impairment. The MDS indicated the resident was dependent to needing supervisionˆassistanceˆon mobility and ADLs.ˆˆ During a review of Resident 90's Admission/readmission Data Tool (ADT), dated 2/27/2026, the ADTˆindicatedˆthe resident was at risk for falls.ˆ During a review of Resident 90's CP Report titled, The resident is at risk for falls with injury related to limited mobility, cardiac medication use, confusion, incontinence, psychoactive drugˆ(is any chemical substance that crosses into the brain and changes how a person feels, thinks, behaves, or perceives the world)ˆuse, initiated on 2/27/2026, the CP indicated an intervention of to be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed.ˆ During a concurrent observation and interview on 3/23/2026 at 10:10 a.m. withˆDialysis Technicianˆ(DT)ˆ1, inside Resident 90's room,ˆobservedˆResident 90's call light was on the floor at the left side of the bed. DT 1ˆstatedˆthe call light should always be within the reach of the resident so they can make their needs known or to call for help when needed. DT 1ˆstatedˆthe resident can also fall while reaching for the call light on the floor.ˆ During an interview and record review on 3/25/2026, at 1:01 p.m., with theˆAssistant Director of Nursing (ADON), Resident 90's ADT and CP were reviewed. The ADONˆstated the call light shouldˆalwaysˆbe within the reach ofˆResidentˆ90.ˆThe ADON stated all staffˆwasˆresponsibleˆinˆensuring the call light is within reachˆof all residentsˆso they can call for help when needed.ˆThe ADON stated during the observation period,ˆthe staffˆfailed toˆkeep the call light within reach. The ADON statedˆthe failure of the staff to keep the call light within reachˆcan lead toˆaˆdelay in careˆand the residentˆcan fall while reaching for itˆon the floor.ˆ TheˆDONˆstatedˆtheˆresidentˆwasˆat risk for falls dated 6/12/2025 onˆthe ADTˆand alsoˆon theˆQuarter Risk Data Collection tool dated 3/10/2026, still at riskˆfor falls. TheˆADON stated (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	theˆcare planˆfor falls was not followedˆand theˆpolicy and procedureˆ(P&P)ˆtitled Answering the Call Light, wasˆnot followed.ˆ 4. During a review of Resident 31's AR, the AR indicated the facility admitted the resident on 6/12/2025, with diagnoses including dementia, muscle weakness, and hemiplegiaˆ(total paralysis of the arm, leg, and trunk on the same side of the body)ˆand hemiparesisˆ(weakness on one side of the body)ˆfollowing cerebral infarctionˆ(a type of stroke that occurs when an artery supplying blood to the brain becomes blocked).ˆ During a review of Resident 31's H&P, dated 6/13/2025, the H&PˆindicatedˆthE resident had the capacity to understand and make decisions.ˆ During a review of Resident 31's MDS, dated [DATE], the MDS indicated the resident had the ability to make self-understood and understand others and had moderate cognitive impairment. The MDS indicated the resident was dependent to needing supervisionˆassistanceˆon mobility and ADLs.ˆˆ During a review of Resident 31's Quarterly Risk Data Collection Tool (QRDCT), dated 3/10/2026, the QRDCT indicated the resident was at risk for falls.ˆ During a review of Resident 31's CP Report titled, The resident is at risk for falls with injury related to limited mobility, stroke, dementia, fracturesˆ(break in bone), psychoactive drug use, and weakness, last revised on 6/13/2025, the CP indicated an intervention to be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed.ˆ During a concurrent observation and interview on 3/23/2026, at 11:04 a.m., withˆCertified Nursing Assistant (CNA)ˆ1, inside Resident 31's room,ˆobservedˆResident 31's call light was on the floor at the left side of the bed. CNA 1ˆstatedˆthe call light should always be within the reach of the resident so they can make their needs known or to call for help when needed. CNA 1ˆstatedˆthe resident can also fall while reaching for the call light on the floor.ˆ During a concurrent interview and record review on 3/25/2026 at 1:01 p.m., with the ADON, Resident 31's QRDCT and CP were reviewed. The ADON stated the call light should always be within the reach of Resident 31. The ADON stated all staff were responsible in ensuring the call light is within reach of all residents do they can call for help when needed. The ADON stated during the observation period, the staffˆfailed toˆkeep the call light within reach. The ADON stated the failure of the staff to keep the call light within reach can lead to a delay in care and the resident can fall while reaching for it on the floor.ˆ The DONˆstatedˆResident 31 was at risk for falls on the QRDCT dated 3/10/2026. The ADON stated the care plan for falls was not followed and the P&P titled Answering the Call Light, was not followed.ˆ 5. During a review of Resident 37's AR, the AR indicated the facility admitted the resident on 8/23/2021, and readmitted on [DATE], with diagnoses including parkinsonism, unspecified (a condition where a person moves slowly, feels stiff, may shake, and has balance problems, but the exact reason is not identified), chronic respiratory failure with hypoxia, and type 2 diabetes mellitus without complications (a disorder characterized by difficulty in blood sugar control and poor wound healing). During a review of Resident 37's H&P, dated 8/1/2025, the H&PˆindicatedˆthE resident can make needs known but cannot make medical decisions. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 37's MDS, dated [DATE], the MDS indicated the resident had the ability to sometimes make self-understood and sometimes understand others and had severe cognitive impairmentˆ(very limited memory, thinking, decision-making and needs help with daily activities).The MDS indicated Resident 37 was independent to need maximalˆassistanceˆon mobility and ADLs.ˆ During an observation on 3/23/2026, at 12:25 p.m., in Resident 37's room, the resident was observed lying in bed watching television. The call light was noted to be on the left side of the bed, resting on the floor. During a concurrent observation and interview on 3/23/2026, at 12:33 p.m., with CNA 4 stated the call light is on the floor and it is not supposed to be there. CNA 4 stated the call light is supposed to be next to resident so the resident can call for anything that may be needed or in case of emergency. CNA 4 stated the resident would not have been able to call for assistance and it is not appropriate for the call light to be on the floor. During an interview on 3/25/2026, at 1:01 p.m., with the Assistant Director of Nursing (ADON), the ADON stated the call light should be within the reach of the resident. All staff are responsible for ensuring the call light is within reach. The ADON stated call lights not within reach can lead to delays in care and the resident can fall while reaching for call light. ADON stated that the Policy & Procedure (P&P) titled, Answering the Call Light was not followed. During a review of the facility's P&P titled, Call Lights, last reviewed onˆ9/10/2025, the P&Pˆindicatedˆaˆpurpose to ensureˆtimelyˆresponses to the resident's requests and needs. The P&P furtherˆindicatedˆto ensure that the call light is accessible to the resident when in bed, from the toilet, from the shower, or bathing facility and from the floor.ˆ During a review of the facility's recent P&P titled, Answering the Call Light, last reviewed on 9/10/2026, the P&Pˆindicatedˆthepurpose of this procedure is to ensureˆtimelyˆresponse to the resident's requests and needs.ˆ General Guidelinesˆ 5. Ensure that the call light is accessible to the resident when in bed, from the toilet, from the shower or bathing facility and from the floor.ˆ During a review of the facility's recent P&P titled, Safety and Supervision of Residents, last reviewed on 9/10/2025, the P&Pˆindicatedˆourˆfacility strives to make the environment as free from accident hazards as possible. Resident safety and supervision andˆassistanceˆto prevent accidents are facility-wide priorities.ˆ Policy Interpretation and Implementationˆ Resident Risks and Environmental Hazardsˆ 1. Due to their complexity and scope, certain resident risk factors and environmental hazards are addressed in dedicated policies and procedures. These risk factors and environmental hazards include the following:ˆ c. Fallsˆ

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to inform and provide a written information to all adult residents concerning the right to accept and refuse medical surgical treatment and, at the resident's option, formulate an advance directiveˆ(a legal document indicating resident preference on end-of-life treatment decisions)ˆto three of nine sampled residents (Residents 9, 17, and 3)ˆ by the Social Services Director (SSD) failing to provide written information to residents on advanced directive formulationˆreviewed for Advanced Directives.ˆ These deficient practices violated the resident's rights and/or representative's right to be fully informed of theˆoptionˆto formulate their advanced directives.ˆˆ Findings:ˆ ˆ 1. During a review of Resident 9's admission Record (AR), the AR indicated the facility admitted the resident on 10/8/2024, and readmitted ˆthe residentˆon 9/4/2025, with diagnoses including encephalopathyˆ(a broad term for any disease, damage, or malfunction that alters brain function), dysarthriaˆ(a motor speech disorder caused by weakness, paralysis, or lack of coordination in the muscles used for speaking), and hemiplegiaˆ(total paralysis of the arm, leg, and trunk on the same side of the body)ˆand hemiparesisˆ(weakness on one entire side of the bodyˆ(left or right))ˆfollowing cerebral infarctionˆ(a type of stroke that occurs when an artery supplying blood to the brain becomes blocked).ˆ During a review of Resident 9's History and Physical (H&P), dated 9/5/2025, the H&PˆindicatedˆthePresident does not have the capacity to understand and make decisions.ˆ During a review of Resident 9's Minimum Data Set (MDS - a resident assessment tool), dated 1/8/2026, the MDS indicated the resident rarely to never had the ability to make self-understood and understand others and had severe cognitiveˆimpairmentˆ(a profound loss of mental capacity where a person cannot live independently or care for themselves).ˆThe MDS indicated the resident had a family and significant other that was activelyˆparticipatingˆin assessment and goal setting on theˆresident'sˆhealth.ˆˆ During a review of Resident 9's Social Service Review (SSR), dated 12/9/2025, the SSR indicated the resident/representative was not provided with advance directive information.ˆ During a review of Resident 9's Care Plan (CP) Report titled, Advanced directives, resident has directives as follows perˆPhysician Orders for Life-Sustaining Treatmentˆ(POLST -ˆa form that contains written medical orders for healthcare professionals regarding specific medical treatments that can or cannot be done at the end-of life), last revised on 10/15/2025, the CP indicated an intervention to respect resident and family wishes.ˆ During a concurrent interview and record review on 3/25/2026 at 9:36 a.m. withˆRegistered Nurse (RN)ˆ1, Resident 9's electronic health record was reviewed for scanned advanced directive acknowledgement form. RN 1ˆstatedˆthey got rid of the physical medical records for residents, everything was scanned and uploaded toˆpoint click care (PCC - an electronic healthcare record). RN 1ˆstatedˆshe did not find any advanced directive acknowledgement form uploaded in PCC for Resident 9.ˆ During a concurrent interview and record review on 3/25/2026 atˆ9:39 a.m. with the SSD, Resident 9'sˆSSR, CP, and Miscellaneous documents in PCC were reviewed. The SSDˆstatedˆthere was no scanned advanced healthcare directive acknowledgment form on the Miscellaneous tab in PCC and (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	her documentation in SSR indicated she did not provide a written advanced healthcare directive formulation information to the resident or representative. The SSDˆstatedˆshe misunderstood the question in the SSR and thought the question was asking if the family provided the advance directive information to her. The SSDˆstatedˆshe had not documented if she has given the information to the resident or representative. The SSDˆstatedˆher failure to provide a written information on the formulation of advance directive to the resident or representative had violated the rights of the resident to formulate an advanced healthcare directive.ˆˆˆ 2. During a review of Resident 17's AR, the AR indicated the facility admitted the resident on 1/30/2025, with diagnoses of hepatic encephalopathy (the liver is damaged, it cannot remove toxins from the blood, causing toxins to build up and affect the brain, leading to changes in thinking and behavior); chronic obstructive pulmonary disease, unspecified (COPD - a chronic lung disease causing difficulty in breathing); heart failure, unspecified. During a review of Resident 17's H&P, dated 1/30/2026, the H&P indicatedˆthe resident was awake, alert, oriented, cooperative, able to follow commands. The H&P indicated the resident has the capacity to understand and make decisions. During a review of Resident 17's MDS, dated [DATE], the MDS indicated Resident 17 was able to make self-understood and able to understand others. The MDS further indicated that Resident 17 had normal cognitive function (can understand, think clearly, and remember things). The MDS indicated the resident is independent with bed mobility, transfer, dressing, toilet use, eating, and personal hygiene. During a review of Resident 17's SSR, dated 2/1/2026, the SSR indicated the resident/representative was not provided with advance directive information.ˆ During a concurrent interview and record review on 3/25/2026 at 9:36 a.m. withˆRNˆ1,ˆResident 17's electronic health record was reviewed and scanned advanced directive acknowledgement form. RN 1 statedˆthey do not have physical medical records for residents, everything was scanned and uploaded toˆPCC. RN 1ˆstatedˆshe did not find any advanced directive acknowledgement form uploaded into PCC for Resident 17.ˆ During a concurrent interview and record review on 3/25/2026 at 9:39 a.m., with the SSD Resident 17's SSR and Miscellaneous documents in PCC were reviewed. The SSD stated there was no scanned advanced healthcare directive acknowledgment form on the Miscellaneous tab in PCC and her documentation in the SSR indicated she did not provide written advanced healthcare directive formulation information to the resident or representative. The SSDˆstatedˆshe misunderstood the question in the SSR. The SSDˆstatedˆshe had not documented if she had given the information to the resident or representative. The SSD stated that by not providing written information about formulating an Advanced Directive there was a potential risk for not honoring resident wishes. 3. During a review of Resident 3's AR, the AR indicated that the facility originally admitted the resident on 4/28/2025 and readmitted on [DATE] with diagnoses including post-traumatic stress disorder (PTSD – a disorder in which a person has difficulty recovering after experiencing, or witnessing a traumatic event), unspecified psychosis (a severe mental condition in which thought, and emotions are so affected that contact is lost with reality) not due to a substance or known physiological condition, other psychoactive (affecting the mind) substance abuse, dysphagia (difficulty swallowing), acute kidney failure (a sudden, temporary loss of kidney function), and history (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	of colon cancer (disease caused when normal body cells stop following instructions, grow uncontrollably, and spread into surrounding tissues). During a review of Resident 3's H&P, dated 8/30/2025, the H&P indicated the resident has the capacity to understand and make decisions. During a review of Resident 3's MDS, dated [DATE], the MDS indicated Resident 3 was able to make needs known and understand others. The MDS further indicated that Resident 3's the resident had moderate cognitive impairment. The MDS indicated the resident requires assistance with mobility, transfer, and dressing, toilet use, and personal hygiene. During a concurrent interview and record review on 3/25/2026 at 9:36 a.m. with RN 1, Resident 3's electronic health record was reviewed for scanned advance directive acknowledgement form. RN 1 stated they got rid of the physical medical records for residents, everything was scanned and uploaded to PCC. RN 1 stated she did not find any advance directive acknowledgment form uploaded in PCC for Resident 3. During a concurrent interview and record review on 3/25/2026 at 9:39 a.m. with the SSD, Resident 3's SSR, CP, and miscellaneous documents in PCC were reviewed. The SSD stated there was no scanned advance directive healthcare directive formulation information for the resident. The SSD stated she misunderstood the question in the SSR and thought the question was asking if the family provided the advance directive information to her. The SSD stated she had not documented if she has given the information to the resident or representative. The SSD stated her failure to provide a written information on the formulation of advance directive to the resident or representative had violated the rights of the resident to formulate an advanced healthcare directive. During an interview onˆ3/25/2026 atˆ1:11ˆp.m. with theˆAssistant Director of Nursing (ADON), the ADON stated the Social Workerˆwasˆresponsible forˆoffering advance healthcare directive formulation information to residents.ˆThe ADON stated the SSD should have provided and documentedˆyesˆon the question in the SSR, on 1b letter g, AdvanceˆDirective: Resident/representative provided written advanced directive information.ˆThe ADON stated an Advanced Directive is intended to honor residents' wishes regarding medical care and living wills. The ADON stated the SSD failed to provide residents information about the formulation of an Advanced Directive and failed to properly document whether the information had been offered. The ADON stated the SSDˆfailed toˆprovide the advanced healthcare directive information to the resident or representative that led to violation of the resident or representative's right to formulate an advance healthcare directive.ˆThe ADON stated there is a potential risk that the resident's wishes may not be followed.ˆ During a review of the facility's recent policy and procedureˆ(P&P)ˆtitled, Advanced Directives, last reviewed on 9/10/2025, the P&Pˆindicatedˆthe resident has the right to formulate an advance directive, including the right to accept or refuse medical or surgical treatment. Advance directives are honoredˆin accordance withˆstate law and facility policy.ˆ Policy Interpretation and Implementationˆ The facility defines the followingˆin accordance withˆcurrent OBRA definitions and guidelines:ˆ Advance Directive- a written instruction, such as a living will or durable power of attorney for health (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	care, recognized by state law (whether statutory or as recognized by the courts of the state), relating to the provisions of health care when an individual is incapacitated (per 489.100)ˆ DeterminingˆExistence of Advance Directiveˆ 1. The resident or representative is providedˆwith written information concerning the right to refuse or accept medical or surgical treatment and to formulate an advancedˆdirective if he or she chooses to do so.ˆˆ 2. The resident or representative is providedˆwith written information concerning the right to refuse or accept medical or surgical treatment and to formulate an advancedˆdirective if he or she chooses to do so.ˆ 3. Written information about the right to accept or refuse medical or surgical treatment, and the right to formulate an advancedˆdirective is provided in a manner that is easily understood by the resident or representative.ˆ 4. Written information includes a description of the facility's policies to implement advancedˆdirectives as applicable state law.ˆ

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed the facility failed to ensure residents are screened using the Preadmission Screening and Resident Review (PASRR - a federal requirement to help ensure that individuals are not appropriately placed in nursing homes for long-term care) for a mental disorder (MD - a person's mind makes it hard to think, feel, or act normally in daily living) or intellectual disability (ID - a person has trouble learning, understanding, or solving problems like most people their age) prior to admission and that individuals identified with serious mental illness (SMI) and/or ID/developmental disability (DD)/related conditions (RC) receive the care and services in maintaining his/her highest practicable level in the most appropriate setting for three (3) of 3 sampled residents (Resident 4, 10, and 74), by failing to submit a new Level I PASRR for Resident 4 and Resident 10, who had discrepancy in the previous PASRR Level I Screening and failing to submit a new Level I PASRR screening for Resident 3, who was readmitted to the facility with a diagnosis of a serious mental illness/disorder. These deficient practices had the potential to result in inappropriate placement and unidentified specialized services for the residents. Findings: 1. During a review of Resident 4's admission Record (AR - front page of the chart that contains a summary of basic information about the resident), the admission Record indicated the facility admitted the resident on 2/3/2025 with diagnoses including respiratory failure (a condition that occurs when the lungs cannot remove all of the carbon dioxide [a colorless, odorless gas that the body breathes out] the body produces), tracheostomy (a surgical opening in the neck into the windpipe when a person is unable to breathe thru the nose or mouth), and bipolar disorder (sometimes called manic-depressive disorder; mood swings that range from the lows of depression [a serious, persistent mood disorder characterized by a constant feeling of hopelessness, loss of interest in activities, and low energy] to elevated periods of emotional highs). During a review of Resident 4's History and Physical (H&P), dated 2/3/2026, the H&P indicated Resident 4 did not have the capacity to understand and make decisions. During a review of Resident 4's Minimum Data Set (MDS - a resident assessment tool), dated 2/5/2026, the MDS indicated Resident 4 the resident diagnosis including bipolar disorder and the resident was not taking any antipsychotic (drug used to manage abnormal condition of the mind described as involved a loss of contact with reality) medications. During a review of Resident 4's PASRR Level I Screening, dated 2/3/2025, the PASRR Level I Screening indicated that the resident did not have a serious diagnosed mental disorder, no suspected mental illness, and has not been prescribed psychotropic (medications capable of affecting the mind, emotions, and behavior) medications. During a concurrent interview and record review on 3/25/2026 at 1:17 p.m. with the Subacute Coordinator (SAC), Resident 4's admission Record, MDS, and PASRR Level I Screening, dated 2/3/2025, were reviewed. The SAC stated that the admission Record indicated that Resident 4 had a diagnosis of bipolar disorder during admission on [DATE] and that Resident 4's PASRR Level I Screening indicated the resident did not have a SMI/ID/DD/RC and did not require a Level II Screening. The SAC stated prior to a resident's admission to the facility, the acute hospital was responsible in ensuring the Level I Screening was completed, then the facility's admitting nurse will verify the accuracy of the screening. The SAC further stated if there was a discrepancy, the facility would then resubmit a new Level I Screening reflecting the resident's current diagnosis. The SAC stated that Resident 4's Level I Screening should have been resubmitted by the admitting nurse to (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	understand and make decisions. During a review of Resident 3's MDS, dated [DATE], indicated Resident 3 was able to make needs known and understand others. The MDS further indicated that Resident 3's the resident had moderate cognitive impairment (a profound loss of mental capacity where a person cannot live independently or care for themselves). The MDS indicated the resident requires assistance with mobility, transfer, and dressing, toilet use, and personal hygiene. During a review of Resident 3's Medication Administration Record (MAR - document used by healthcare professionals to track all medications given to a resident), dated 3/26/2026, the MAR indicated an order for Zoloft (also known as sertraline - a medication commonly used to treat depression, anxiety, PTSD) oral tablet 37.5 milligrams (mg – a unit of measure for mass) one time a day for depression and Seroquel (also known as quetiapine, an atypical antipsychotic medication used to treat bipolar disorder, schizophrenia, and major depressive disorder) oral tablet 25 mg give at bedtime for psychosis. During a review of Resident 3's PASRR Level I Screening, dated 4/25/2025, the PASRR Level I Screening indicated that the resident did not have a serious diagnosed mental disorder, no suspected mental illness, and has not been prescribed psychotropic (medications capable of affecting mind, emotions, and behavior) medications. During a concurrent interview and record review on 3/25/2026 at 1:17 p.m. with the SAC, Resident 3's AR, MDS, MAR, and PASRR Level I Screening, dated 2/3/2025, were reviewed. The SAC stated that the AR indicated that Resident 3 had a diagnosis of PTSD, unspecified psychosis not due to a substance or known physiological condition, and other psychoactive substance abuse during readmission on [DATE]. The SAC stated Resident 3 was prescribed Zoloft and Seroquel and Resident 3's PASRR Level I Screening indicated Resident 3 did not have a SMI/ID/DD/RC and did not require a Level II Screening. The SAC stated prior to a resident's admission to the facility, the acute hospital was responsible in obtaining a completion of Level I Screening, followed by the facility's admitting nurse verification of accuracy of the screening. The SAC further stated that if there was a discrepancy, the facility would resubmit a new Level I Screening showing the current diagnosis of the resident. SAC further stated Resident 3's Level I Screening should have been resubmitted by the admitting nurse to reflect that the resident has SMI. SAC stated that if there was no Level I Screening submitted, the resident would not receive appropriate treatment and referral as needed. SAC stated it could result in a delay of care and services needed for Resident 3. During a review of the facility's policy and procedure (P&P) titled, admission Criteria, last reviewed on 9/10/2025, the P&P indicated that the facility admits only residents who's medical and nursing care needs can be met. The P&P further indicated that one of the objectives of the admission criteria is to admit residents who can be cared for adequately by the facility. The P&P further indicated: - Prior to admission, the resident or representative is informed of any service limitations or special characteristics of the facility. - All new admissions and readmissions are screened for MD, ID, or RD per the PASRR process. a. The facility conducts a Level 1 PASRR screen for all potential admissions, regardless of payor source, to determine if the individual meets the criteria for a MD, ID, or RD. (continued on next page)

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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 observation, interview, and record review, the facility failed to develop and implement a comprehensive person-centered care plan (a tool that ensures residents receive personalized, comprehensive, and goal-oriented care in a nursing home setting) for three (3) of three sampled residents (Residents 11, 4) by failing to ensure: 1. Resident 11 had a care plan addressing the schizophrenia (a mental illness that is characterized by disturbances in thought) upon admission from another long-term care facility. 2. Resident 4 had a care plan addressing the bipolar disorder (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs). These deficient practices had the potential for a delay in the delivery of the necessary care and services the residents need. Findings: a. During a review of Resident 11's admission Record (front page of the chart that contains a summary of basic information about the resident), the admission Record indicated the facility admitted the resident on 8/10/2023, with diagnoses including chronic respiratory failure (a condition that occurs when the lungs cannot get enough oxygen into the blood or remove enough carbon dioxide [a colorless, odorless gas that the body breathes out] from the body), tracheostomy (a surgical opening in the neck into the windpipe when a person is unable to breathe thru the nose or mouth), and paranoid schizophrenia. During a review of Resident 11's History and Physical (H&P) dated 8/10/2025, the H&P indicated Resident 11 had the capacity to understand and make decisions. The H&P further indicated that Resident 11 had a diagnosis of schizophrenia. During a review of Resident 11's Minimum Data Set (MDS, a resident assessment tool), dated 2/5/2026, the MDS indicated Resident 11 had diagnosis of schizophrenia and that the resident was not taking any antipsychotic (drug used to manage abnormal condition of the mind described as involved a loss of contact with reality) medications. During a review of Resident 11's care plans (CP), there was no care plan developed and implemented addressing the resident's schizophrenia. During a concurrent interview and review on 3/25/2026 at 4 p.m., with the MDS Coordinator (MDSC), Resident 11's admission Record, H&P, and CP were reviewed. The MDSC stated Resident 11 was admitted from another long-term care facility with a diagnosis of schizophrenia, and the H&P indicated the resident had schizophrenia. The MDSC further stated there was no CP developed and implemented addressing Resident 11's schizophrenia. The MDSC stated baseline CP is initiated within 48 hours of admission and the comprehensive CP are developed and implemented seven (7) after completion of admission MDS assessment or 21 days after admission in the facility. The MDSC stated that the MDS assistant is responsible in making sure that the care plans are developed and implemented and reviewed during the MDS quarterly assessment. The MDSC stated that the importance of CP is that it is the basis for the facility staff involved in the residents' care of how to properly care for them and meet their needs. The MDSC stated that Resident 11's care plan for schizophrenia should have been developed and implemented timely so the staff involved in his care would be aware of his current condition and properly care for Resident 11 to prevent a delay in the care and services the resident needs. During a concurrent interview and record review on 3/25/2026 at 4:15 p.m., with the Subacute Coordinator (SAC), Resident 11's admission Record, H&P, and CP were reviewed. The SAC stated Resident 11 was admitted from another long-term care facility. The SAC stated that Resident 11 was admitted with a diagnosis of schizophrenia, and the H&P indicated the resident has schizophrenia. The SAC stated there was no CP developed and implemented addressing Resident 11's schizophrenia. The SAC stated that the comprehensive CP are developed and implemented 7 after completion of admission MDS assessment or 21 days after admission in the facility. The SAC stated that the MDSC or her assistant are responsible in making sure that the care plans are developed and implemented and reviewed during the MDS quarterly assessment. The SAC stated that the licensed nurses are also responsible in developing and implementing a care plan to (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	address each resident's needs. The SAC stated that the importance of CP is that it is the basis for the facility staff involved in the residents' care of how to properly care for them and meet their needs. The SAC stated that Resident 11's care plan for schizophrenia should have been developed and implemented timely so the staff involved in his care would be aware of his current condition and properly care for Resident 11 to prevent a delay in the care and services the resident needs. b. During a review of Resident 4's admission Record, the admission Record indicated the facility admitted the resident on 2/3/2025, with diagnoses including respiratory failure (a condition that occurs when the lungs cannot remove all of the carbon dioxide [a colorless, odorless gas that the body breathes out] the body produces), tracheostomy (a surgical opening in the neck into the windpipe when a person is unable to breathe thru the nose or mouth), and bipolar disorder (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs). During a review of Resident 4's History and Physical (H&P) dated 2/3/2026, the H&P indicated Resident 4 did not have the capacity to understand and make decisions and had a diagnosis of bipolar disorder. During a review of Resident 4's MDS dated [DATE], the MDS indicated Resident 4 had the diagnosis of bipolar disorder, and the resident was not taking any antipsychotic medications. During a review of Resident 4's care plans (CP), there was no care plan developed and implemented addressing the resident's bipolar disorder. During a concurrent interview and review on 3/26/2026 at 2:30 p.m., with the MDSC, Resident 4's admission Record, H&P, and CP were reviewed. The MDSC stated Resident 4 was admitted from an acute hospital with a diagnosis of bipolar disorder, and the H&P indicated the resident has bipolar disorder. The MDSC further stated there was no CP developed and implemented addressing Resident 4's bipolar disorder. The MDSC stated baseline CP is initiated within 48 hours of admission and the comprehensive CP are developed and implemented 7 after completion of admission MDS assessment or 21 days after admission in the facility. The MDSC stated that the MDS assistant is responsible in making sure that the care plans are developed and implemented and reviewed during the MDS quarterly assessment. The MDSC stated that the importance of CP is that it is the basis for the facility staff involved in the residents' care of how to properly care for them and meet their needs. The MDSC stated that Resident 4's care plan for bipolar disorder should have been developed and implemented timely so the staff involved in his care would be aware of his current condition and properly care for Resident 4 to prevent a delay in the care and services the resident needs. During a concurrent interview and record review on 3/26/2026 at 2:45 p.m., with the SAC, Resident 4's admission Record, H&P, and CP were reviewed. The SAC stated that Resident 4 was admitted with a diagnosis of bipolar disorder, and the H&P indicated the resident has bipolar disorder. The SAC stated there was no CP developed and implemented addressing Resident 4's bipolar disorder. The SAC stated that the comprehensive CP are developed and implemented 7 after completion of admission MDS assessment or 21 days after admission in the facility. The SAC stated that the MDSC or her assistant are responsible in making sure that the care plans are developed and implemented and reviewed during the MDS quarterly assessment. The SAC stated that the licensed nurses are also responsible in developing and implementing a care plan to address each resident's needs. The SAC stated that the importance of CP is that it is the basis for the facility staff involved in the residents' care of how to properly care for them and meet their needs. The SAC stated that Resident 4's care plan for bipolar disorder should have been developed and implemented timely so the staff involved in his care would be aware of his current condition and properly care for Resident 4 to prevent a delay in the care and services the resident needs. During a review of the facility's policy and procedure (P&P) titled, Care Plans - Comprehensive Person-Centered, last reviewed on 9/10/2026, the P&P indicated a comprehensive, person-centered care plan that includes measurable objective and timetables to meet the resident's physical, psychosocial, and functional needs is developed and implemented for each resident. The P&P further indicated: - The interdisciplinary team (IDT - a group of health care professionals with various areas of expertise who work together toward the goals of the patients) in conjunction with the resident and his/her family or (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	legal representative, develops and implements a comprehensive person-centered care plan for each resident. - The comprehensive person-centered care plan is developed within 7 days of completion of the required MDS assessment (Admission, Annual, or Significant Change in Status), and no more than 21 days after admission. - The care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment. - The comprehensive person-centered care plan: a. Includes measurable objective and timeframes b. Describes the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, including: (1) Services that would otherwise be provided for the above, but are not provided due to the resident exercising his/her rights, including the right to refuse treatment; (2) Any specialized services to be provided (3) Which professional services are responsible for each element of care. - When possible, interventions address the underlying source(s) of the problem area(s), not just symptoms or triggers. - Assessment of residents are ongoing, and care plans are revised as information about the residents and the resident's conditions change.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility's licensed nursing staff failed to provide care in accordance with professional standards of care for two of two sampled residents (Residents 7 and 90) reviewed for insulin (a hormone that removes excess sugar from the blood, can be produced by the body or given artificially via medication) use by failing to rotate (a method to ensure repeated injections are not administered in the same area) subcutaneous (sq, beneath the skin) insulin administration sites. The deficient practice had the potential for adverse effect (unwanted, unintended result) of the same site subcutaneous administration of insulin such as excessive bruising, lipodystrophy (abnormal distribution of fat) and cutaneous amyloidosis (is a condition in which clumps of abnormal proteins called amyloids build up in the skin). Cross reference F760. Findings: 1. During a review of Resident 7's admission Record (AR), the AR indicated the facility admitted the resident on 7/1/2025, and readmitted the resident on 12/31/2025, with diagnoses including type two (2) diabetes mellitus (DM 2, a disorder characterized by difficulty in blood sugar control and poor wound healing) with foot ulcer (an open sore, wound, or crater on the skin of the foot or toe that takes a long time to heal or keeps returning), long term use of insulin, and alcoholic cirrhosis of liver (a severe, late-stage liver disease caused by long-term, heavy alcohol consumption). During a review of Resident 7's History and Physical (H&P), dated 1/2/2026, the H&P indicated the resident did not have the capacity to understand and make decisions. During a review of Resident 7's Minimum Data Set (MDS, a resident assessment tool), dated 3/20/2026, the MDS indicated the resident had the ability to make self-understood and understand others and had intact cognition (having a clear, sharp, and functioning mind that allows a person to think, learn, remember, and make decisions effectively). The MDS indicated the resident was on a high-risk drug class hypoglycemic medication (a type of medicine taken by mouth toˆlower high blood sugar levelsˆin people with type two (2) diabetes). During a review of Resident 7's Order Summary Report (OSR), the OSR indicated an order for: 12/31/2025 Novolog (a type of insulin) FlexPen (a pre-filled, disposable insulin injection pen) Subcutaneous Solution 100 unit per milliliter (unit/ml, in insulinˆmeasures theˆconcentrationˆor strength of the medication-essentially, how much active medicine is packed into a specific volume of liquid) (Insulin Aspart). Inject as per sliding scale (a simple, pre-set chart used to determine a rapid-acting insulin dose based on blood sugar levels): if 151 - 200 = 2 units (Give OJ 8 ounces (oz, a unit of weight equal to one sixteenth of a pound or 16 drams or 28.349 grams) If BS is equal or less than 70, and notify MD); 201 - 250 = 3 units; 251 - 300 = 4 units; 301 - 350 = 5 units; 351 - 400 = 6 units, subcutaneously before meals and at bedtime for DM 2 (Notify MD if blood sugar (BS) is equal or greater than 400), subcutaneously before meals and at bedtime for DM (Administer insulin coverage per sliding scale promptly before or after meals, or with food) (Rotate injection sites). 3/12/2026 Insulin Glargine (a type of insulin) Subcutaneous Solution 100 unit/ml (Insulin Glargine). Inject 28 unit subcutaneously one time a day for DM 2 (Hold if BS is less than 100) (Rotate injection sites). During a review of Resident 7's Care Plan (CP) Report titled, The resident is at risk for hyper (high)/hypoglycemia (low blood sugar) related to diabetes mellitus, initiated on 7/10/2025, the CP indicated an intervention to administer insulin per MD order and to rotate site for insulin injections. During a review of Resident 7's Location of Administration Report (LAR) on the use of Insulin from 1/2026 to 3/2026, the LAR indicated insulin: Glargine Subcutaneous Solution 100 unit/ml was given subcutaneously on, 2/23/2026 at 8:24 a.m. on the Abdomen - Left Lower Quadrant (LLQ) 2/24/2026 at 9:07 a.m. on the Abdomen - LLQ 3/4/2026 at 9:44 a.m. on the Abdomen - LLQ 3/5/2026 at 10:16 a.m. on the Abdomen - LLQ Novolog FlexPen Subcutaneous Solution 100 unit/ml was given subcutaneously on, 2/8/2026 at 11:04 a.m. on the Abdomen - Right Upper Quadrant (RUQ) 2/8/2026 at 4:44 p.m. on the Abdomen - RUQ 2/12/2026 at 9:35 p.m. on the Abdomen - LLQ 2/12/2026 at 9:35 p.m. on the Abdomen - LLQ During a concurrent interview and record review on 3/25/2026, at 1:19 p.m., with the Assistant (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Director of Nursing (ADON), Resident 7's OSR, CP, and LAR were reviewed. The ADON stated not rotating insulin administration sites of administration is a medication error. The ADON stated the staff failed to rotate sites of injection as seen on the LAR. The ADON stated they rotate insulin administration site to prevent skin damage to residents. The ADON stated the frequented sites of administration can develop lipodystrophy and if administered on that site will cause malabsorption of insulin. The ADON stated the residents can suffer from hypo/hyperglycemia. During a review of the facility's recent policy and procedure (P&P) titled, Insulin Administration, last reviewed on 9/10/2025, the P&P indicated to provide guidelines for the safe administration of insulin to residents with diabetes. Steps in the Procedure (Insulin Injections via Syringe) 16. Select an injection. a. Insulin may be injected into the subcutaneous tissue of the upper arm, and the anterior or lateral areas of the thighs and abdomen. Avoid the area approximately 2 inches around the navel. b. Injection sites should be rotated, preferably within the same general area (abdomen, thigh, upper arm). During a review of the facility-provided information on the use of glargine-ygfn subcutaneously, copyright 2023, the information indicated to administer Insulin Glargine-ygfn subcutaneously into the abdominal area, thigh, or deltoid, and rotate injection sites within the same region from one injection to the next to reduce risk of lipodystrophy and localized cutaneous amyloidosis. Do not inject into areas of lipodystrophy or localized cutaneous amyloidosis {see Warnings and Precautions (5.2) and Adverse Reactions (6)]. During a review of the facility-provided Highlights of Prescribing Information (HPI) on the use of Humulin N (insulin isophane human) injectable suspension, for subcutaneous use, with initial U.S. approval in 1982, the HPI indicated to rotated injection sites to reduce the risk of lipodystrophy and localized cutaneous amyloidosis. 2. During a review of Resident 90's AR, the AR indicated the facility admitted the resident on 2/27/2026, with diagnoses including type two (2) diabetes mellitus with proliferative diabetic retinopathy (the most advanced stage of diabetic eye disease, where damaged, blocked blood vessels in the retina trigger the growth of new, fragile vessels), and end stage renal disease (ESRD, irreversible kidney failure). During a review of Resident 90's H&P, dated 3/2/2026, the H&P indicated the resident had the capacity to understand and make decisions. During a review of Resident 90's MDS, dated [DATE], the H&P indicated the resident had the ability to make self-understood and understand others and had moderate cognitive impairment (a stage of brain decline between mild forgetfulness and dementia, where memory or thinking problems noticeably interfere with daily life). The MDS indicated the resident was on a high-risk drug class hypoglycemic medication. During a review of Resident 90's OSR, the OSR indicated an order for: 3/2/2026 Insulin Lispro Injection Solution 100 unit/ml (Insulin Lispro). Inject as per sliding scale: if 150 - 200 = 2 units (Give OJ 8 oz. If BS is less than or equal to 70, and notify MD); 201 - 250 = 3 units; 251 - 300 = 4 units; 301 - 350 = 6 units; 351 - 400 = 8 units (Notify MD if BS is equal or greater than 400), subcutaneously before meals and at bedtime for DM2 administer insulin coverage per sliding scale promptly right before or after meals, and with foods) (Rotate injection sites). 3/3/2026 Insulin Glargine-yfgn Subcutaneous Solution 100 unit/ml (Insulin Glargine-yfgn). Inject 15 unit subcutaneously at bedtime for DM2 (Hold if BS is less than 100) (Rotate injection sites). During a review of Resident 90's Care Plan (CP) Report titled, The resident is at risk for hyper/hypoglycemia related to diabetes mellitus, initiated on 3/2/2026, the CP indicated an intervention to administer insulin per order and to rotate site for insulin injections. During a review of Resident 90's Location of Administration Report (LAR) on the use of Insulin from 3/1/2026 to 3/31/2026, the LAR indicated insulin: Lispro Injection Solution 100 unit/ml was administered subcutaneously on, 3/3/2026 at 4:50 p.m. on the Abdomen - LLQ 3/5/2026 at 4:09 p.m. on the Abdomen - LLQ 3/7/2026 at 9:36 p.m. on the Arm - left 3/8/2026 at 11:23 a.m. on the Arm - left During a concurrent interview and record review on 3/25/2026, at 1:19 p.m., with the ADON, Resident 90's OSR, CP, and LAR were reviewed. The ADON stated not rotating insulin administration sites of administration is a medication error. The ADON stated the staff failed to rotate sites of injection as seen on the LAR. The ADON stated they rotate insulin administration site to prevent skin damage to residents. The ADON stated the frequented sites (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	of administration can develop lipodystrophy and if administered on that site will cause malabsorption of insulin. The ADON stated the residents can suffer from hypo/hyperglycemia. During a review of the facility's recent P&P titled, Insulin Administration, last reviewed on 9/10/2025, the P&P indicated to provide guidelines for the safe administration of insulin to residents with diabetes. Steps in the Procedure (Insulin Injections via Syringe) 16. Select an injection. a. Insulin may be injected into the subcutaneous tissue of the upper arm, and the anterior or lateral areas of the thighs and abdomen. Avoid the area approximately 2 inches around the navel. b. Injection sites should be rotated, preferably within the same general area (abdomen, thigh, upper arm). During a review of the facility-provided information on the use of glargine-ygfn subcutaneously, copyright 2023, the information indicated to administer Insulin Glargine-ygfn subcutaneously into the abdominal area, thigh, or deltoid, and rotate injection sites within the same region from one injection to the next to reduce risk of lipodystrophy and localized cutaneous amyloidosis. Do not inject into areas of lipodystrophy or localized cutaneous amyloidosis {see Warnings and Precautions (5.2) and Adverse Reactions (6)]. During a review of the facility-provided Instructions for use on Insulin Lispro, Kwikpen injection, for subcutaneous use 3 ml single-patient use pen (100 units per ml), last revised 7/2023, the Information indicated to change (rotate) your injection sites within the area you choose for each dose to reduce your risk of getting lipodystrophy (pits in skin or thickened skin) and localized cutaneous amyloidosis (skin with lumps) at the injection sites.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to: 1. Provide appropriate treatment and services for care of one (1) of three (3) sampled residents (Residents 111) reviewed for urinary tract infection (UTI, a common infection that occurs when bacteria enters and multiplies in the urinary system, which includes the kidneys, bladder, and urethra) by failing to ensure Resident 111's suprapubic catheters (a thin, flexible tube used to drain urine (pee) from the bladder when a person cannot urinate normally) did not have loops on the catheter tubing. The deficient practice had the potential for the resident to develop urinary tract infection. 2. Provide appropriate treatment and services for care of one (1) of three (3) sampled residents (Residents 113) reviewed for UTI by failing to ensure that Resident 113`s urinary catheter (a hollow tube inserted into the bladder to drain or collect urine) tubing did not have a dependent loop while hanging on the side of the bed. The deficient practice had the potential for the urine not to flow freely, which may lead to the development of UTI. 3. Ensure the urinal bottleˆ(a handheld container designed for collecting urine)ˆfor one (1) of three (3) sampled residents (Resident 17), was labeled withˆthe name, room number, and the date the bottle was provided. The deficient practice had the potential to place Resident 17 at risk for an infection Findings: a. During a review of Resident 111's admission Record (AR), the AR indicated the facility admitted the resident on 7/16/2025, and readmitted the resident on 3/6/2026, with diagnoses including urinary tract infection (UTI), enterocolitis due to clostridium difficile (a serious infection of the intestines, specifically affecting the lining of the large intestine (colon) and sometimes the small intestine), and methicillin resistant staphylococcus aureus infection (a type of staph bacteria that causes infections resistant to many common antibiotics, making them harder to treat). During a review of Resident 111's History and Physical (H&P), dated 3/8/2026, the H&P indicated the resident did not have the capacity to understand and make decisions. During a review of Resident 111's Minimum Data Set (MDS, a resident assessment tool), dated 3/12/2026, the MDS indicated the resident had the ability to make self-understood and understand others and had intact cognition (having a clear, sharp, and functioning mind that allows a person to think, learn, remember, and make decisions effectively). The MDS indicated that the resident had a catheter and urinary ostomyˆ(commonly called aˆurostomy). During a review of Resident 111's Order Summary Report (OSR), the OSR indicated an order for: 3/8/2026 Suprapubic catheter French size (FR, is a universal measurement system used to determine the outer diameter (thickness) of a catheter tube) #18/10 cubic centimeter (cc, a small unit of volume used to measure how much space a solid, liquid, or gas takes up) to bladder sphincter dyssynergia (BSD, is a breakdown in coordination between the bladder and the urinary sphincter (the muscle that opens/closes to let urine out)) due to diagnosis (DX). Neurogenic Bladder (a loss of bladder control caused by damage to the nerves, spinal cord, or brain) due to history of cerebrovascular accident (CVA, stroke, loss of blood flow to a part of the brain). 3/8/2026 Change suprapubic Catheter FR#18/10 cc and bag if needed (PRN) if leaking, plugged or pulled out, obstruction, excessive sedimentation (the buildup of mineral salts, and crystalline deposits within the catheter tubing) or when the closed system is compromised. 3/7/2026 Suprapubic Care (flush if with sediments, use of leg strap, position urinary bag below (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	bladder level, with dignity bag, drainage bag not touching the floor). Every day shift and as needed. During a review of Resident 111's Care Plan (CP) Report titled, The resident is at risk for infection due to the resident had a suprapubic catheter for obstructive uropathy (a blockage in the urinary tract that prevents urine from flowing freely, causing it to back up and potentially damage one or both kidneys), last revised on 7/29/2025, the CP indicated an intervention to position the catheter bag and tubing below the level of the bladder, check for kinks each shift, and to provide suprapubic care. During a concurrent observation and interview on 3/23/2026 at 10:06 a.m., with Restorative Nursing Assistant (RNA) 1, inside Resident 111's room, observed Resident 111's suprapubic catheter's tubing looped at the side of the bed with urine trapped on them not draining in the collection bag. RNA 1 stated the suprapubic catheter tubing should not have loops to prevent backflow of the urine into the bladder or growth of bacteria on the tubing where the urine settles, to prevent UTI. During a concurrent interview and record review on 3/25/2026, at 1:44 p.m., with the Assistant Director of Nursing (ADON), Resident 111's OSR and CP were reviewed. The ADON stated the licensed nurses should provide catheter care to the resident and ensured the drainage bag was below the waist, with no loops and kink on tubing. The ADON stated the licensed staff failed to ensure that the urinary catheter tubing was free of loops, which could potentially lead to a backflow of urine into the bladder increasing the risk of UTI. The ADON stated the policy and procedure (P&P) titled, Cather Care, Urinary, was not followed. During a review of the facility's recent P&P titled, Cather Care, Urinary, last reviewed on 9/10/2025, the P&P indicated the purpose of this procedure is to prevent urinary catheter-associated complications, including urinary tract infections. Maintaining Unobstructed Urine Flow 1. Check the resident frequently to be sure he or she is not lying on the catheter and to keep the catheter and tubing free of kinks. 3. Position the drainage bag lower than the bladder at all times to prevent urine from flowing back into the urinary bladder. Steps in the Procedure Routine Perineal Hygiene 17. Check drainage tubing and bag to ensure that the catheter is draining properly. b. During a review of Resident 113's admission Record, the admission Record indicated the facility admitted the resident on 2/27/2026, with diagnoses including acute and chronic respiratory failure (a condition that occurs when the lungs cannot remove all of the carbon dioxide [a colorless, odorless gas that the body breathes out] the body produces), tracheostomy (a surgical opening in the neck into the windpipe when a person is unable to breathe thru the nose or mouth), and neuromuscular dysfunction of bladder (lack of bladder control due to a brain, spinal cord or nerve problem). During a review of Resident 113's H&P dated 2/28/2026, the H&P indicated Resident 113 did not have the capacity to understand and make decisions. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 113's MDS dated [DATE], the MDS indicated Resident 113 had severely impaired cognition (mental action or process of acquiring knowledge and understanding) and was unable to understand others and make his needs known. The MDS further indicated Resident 113 required total assistance from staff with all activities of daily living (ADLs - basic tasks that must be accomplished every day for an individual to thrive). The MDS indicated Resident 113 had an indwelling urinary catheter. During a review of Resident 113's Order Summary Report, the Order Summary Report indicated the following physician's order: - 2/27/2026: Foley catheter (FC – also known as urinary catheter) French (Fr – a unit of measurement) 16 per ten (10) milliliters (ml – a unit of measurement) attached to bedside drainage bag due to neurogenic bladder. - 2/27/2026: Change FC Fr 16 per10 ml and bag if leaking, plugged or pulled out, for obstruction, excessive sedimentation or when the closed system is compromised. as needed. - 2/27/2026: FC: may irrigate with 100 ml of normal saline (NS - a saltwater solution) as needed for clogged catheter tube. - 2/27/2026: FC care every shift During an observation on 3/23/2025 at 11:14 a.m., inside Resident 113's room, observed Resident 113 lying in bed. Observed Resident 113's bedside drainage bag hanging on the right side of the bed frame in the middle and the FC tubing had a dependent loop. During a concurrent observation and interview on 3/23/2026 at 12 p.m. inside Resident 113's room with Licensed Vocational Nurse (LVN) 6, LVN 6 stated Resident 113's urinary tubing had a loop preventing the urine from flowing freely into the bag. LVN 6 stated the urinary catheter tubing had urine in the loop with some white sediments. LVN 6 stated staff responsibility when it comes to care of urinary catheter is to ensure the bag is below the bladder, the bag had privacy cover, and there must be no kink or loop in the tubing. LVN 6 stated if there is a kink or loop the urine cannot flow freely and cause development of urine infection. LVN 6 stated Resident 113's urinary catheter tubing should not have a loop so the urine can flow freely and prevent backing up to the bladder which can cause development of UTI. During an interview on 3/25/2926 at 1:40 p.m., with the Subacute Coordinator (SAC), the SAC stated that for urinary catheter care, the staff are supposed to ensure the drainage bag is not touching floor to keep the bag clean, monitor for signs and symptoms of UTI, application of a leg strap to anchor the tubing and prevent accidental pulling, and the urine should be free flowing. The SAC stated the tubing should not be coiled or have a dependent loop because it prevents the urine to flow freely and can back flow. The DON stated Resident 113's urinary catheter tubing should not have been coiled or kinked as it had the potential for the urine not to flow freely and flow back into the bladder which could lead to development or UTI. During a review of the facility's policy and procedure (P&P) titled, Catheter Care, Urinary, last reviewed on 9/10/2025, the P&P indicated that the purpose of the procedure is to prevent urinary catheter-associated complications, including urinary tract infections. The P&P further indicated that to maintain unobstructed urine flow, check the resident frequently to be sure he or she is not lying on (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the catheter and to keep the catheter and tubing free of kinks and to position the drainage bag lower than the bladder at all times to prevent urine from flowing back into the urinary bladder. c. During a review of Resident 17's admission Record (AR), the AR indicated the facility admitted the resident on 1/30/2025, with diagnoses of hepatic encephalopathy (the liver is damaged, it cannot remove toxins from the blood, causing them to build up and affect the brain, leading to changes in thinking and behavior); chronic obstructive pulmonary disease, unspecified (COPD- a chronic lung disease causing difficulty in breathing); heart failure, unspecified (when the heart is weak and cannot pump blood around the body properly). During a review of Resident 17's H&P, dated 1/30/26, the H&P indicatedˆthe resident was awake, alert, oriented, cooperative, able to follow commands. The H&P indicated the resident had the capacity to understand and make decisions. During a review of Resident 17's MDS, dated [DATE], the MDS indicated Resident 17 was able to make self- understood and able to understand others. The MDS further indicated that Resident 17 had normal cognitive function (can understand, think clearly, and remember things). The MDS indicated the resident was independent to staff with bed mobility, transfer, dressing, toilet use, eating, and personal hygiene. During a concurrent observation and interview on 3/23/2026, at 12:35 p.m., with Certified Nurse Assistant (CNA) 4, CNA 4 stated the urinal for Resident 17 did not have room number or the resident's name, initials, and date. CNA 4 stated that by the urinal not having a name, it can be confused with other resident's urinal, and the residents can also get an infection. CNA 4 stated that he (CNA 4) will change the urinal and write room number, initials, and date when it was changed. During an interview on 3/25/2026, at 1:35 p.m., with the Assistant Director of Nursing (ADON), ADON stated urinals should be labeled with the residents' initial and date it was provided to the residents for infection prevention purposes. The ADON stated the Admitting the Resident: Role of the Nursing Assistant, policy was not followed. During a review of the facility's recent policy and procedureˆ(P&P)ˆtitled, Admitting the Resident: Role of the Nursing Assistant revised on 9/2013, the P&Pˆindicated write resident's name on appropriate articles (i.e., water pitcher, cup, urinal, denture cup, etc.).

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to ensure residents were free of any significant medication errors (means the observed or identified preparation or administration of medications or biologicals which are not in accordance with the prescriber's order, manufacturer's specifications, and accepted professional standards) for two of three sampled residents (Residents 7 and 90) reviewed for insulin (a hormone that removes excess sugar from the blood, can be produced by the body or given artificially via medication) use by failing to rotate (a method to ensure repeated injections are not administered in the same area) subcutaneous (sq, beneath the skin) insulin administration sites. The deficient practices had the potential for adverse effect (unwanted, unintended result) of the same site subcutaneous administration of insulin such as excessive bruising, lipodystrophy (abnormal distribution of fat) and cutaneous amyloidosis (is a condition in which clumps of abnormal proteins called amyloids build up in the skin). Cross reference F658. Findings: 1. During a review of Resident 7's admission Record (AR), the AR indicated the facility admitted the resident on 7/1/2025, and readmitted the resident on 12/31/2025, with diagnoses including type two (2) diabetes mellitus (DM 2, a disorder characterized by difficulty in blood sugar control and poor wound healing) with foot ulcer (an open, slow-healing sore or crater-like wound on the skin of the foot), long term use of insulin, and alcoholic cirrhosis of liver (the final, severe stage of long-term liver damage caused by excessive alcohol consumption). During a review of Resident 7's History and Physical (H&P), dated 1/2/2026, the H&P indicated the resident did not have the capacity to understand and make decisions. During a review of Resident 7's Minimum Data Set (MDS, a resident assessment tool), dated 3/20/2026, the MDS indicated the resident had the ability to make self-understood and understand others and had intact cognition (having a clear, sharp, and functioning mind that allows a person to think, learn, remember, and make decisions effectively). The MDS indicated the resident was on a high-risk drug class hypoglycemic medication (a type of medicine used toˆlower high blood sugar levelsˆin people with diabetes, specifically two (2) diabetes). During a review of Resident 7's Order Summary Report (OSR), the OSR indicated an order for: 12/31/2025 Novolog (a type of insulin) FlexPen (a pre-filled, disposable insulin injection pen) Subcutaneous Solution 100 unit per milliliters (unit/ml, a measure of concentration, defining how many units of insulin medication are dissolved in one milliliter (mL) of liquid) (Insulin Aspart). Inject as per sliding scale (a simple, pre-set chart used to determine a rapid-acting insulin dose based on blood sugar levels): if 151 - 200 = 2 units (Give OJ 8 ounces (oz., a unit of weight equal to one sixteenth of a pound or 16 drams or 28.349 grams) If blood sugar (BS) is equal or less than 70, and notify MD); 201 - 250 = 3 units; 251 - 300 = 4 units; 301 - 350 = 5 units; 351 - 400 = 6 units, subcutaneously before meals and at bedtime for DM 2 (Notify MD if BS is equal or greater than 400), subcutaneously before meals and at bedtime for DM (Administer insulin coverage per sliding scale promptly before or after meals, or with food) (Rotate injection sites). 3/12/2026 Insulin Glargine (a type of insulin) Subcutaneous Solution 100 unit/ml (Insulin Glargine). Inject 28 unit subcutaneously one time a day for DM 2 (Hold if BS is less than 100) (Rotate injection sites). During a review of Resident 7's Care Plan (CP) Report titled, The resident is at risk for hyper (high)/hypoglycemia (low blood sugar) related to diabetes mellitus, initiated on 7/10/2025, the CP indicated an intervention to administer insulin per order and to rotate site for insulin injections. During a review of Resident 7's Location of Administration Report (LAR) on the use of Insulin from 1/2026 to 3/2026, the LAR indicated insulin: Glargine Subcutaneous Solution 100 unit/ml was given subcutaneously on, 2/23/2026 at 8:24 a.m. on the Abdomen - Left Lower Quadrant (LLQ) 2/24/2026 at 9:07 a.m. on the Abdomen - LLQ 3/4/2026 at 9:44 a.m. on the Abdomen - LLQ 3/5/2026 at 10:16 a.m. on the Abdomen - LLQ NovoLog FlexPen Subcutaneous Solution 100 unit/ml was given subcutaneously on, 2/8/2026 at 11:04 a.m. on the Abdomen - Right Upper Quadrant (RUQ) 2/8/2026 at 4:44 p.m. on the Abdomen - RUQ 2/12/2026 at (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	9:35 p.m. on the Abdomen - LLQ 2/12/2026 at 9:35 p.m. on the Abdomen - LLQ During a concurrent interview and record review on 3/25/2026, at 1:19 p.m., with the Assistant Director of Nursing (ADON), Resident 7's OSR, CP, and LAR were reviewed. The ADON stated not rotating insulin administration sites of administration is a medication error. The ADON stated the staff failed to rotate sites of injection as seen on the LAR. The ADON stated they rotate insulin administration site to prevent skin damage to residents. The ADON stated the frequented sites of administration can develop lipodystrophy and if administered on that site will cause malabsorption of insulin. The ADON stated the residents can suffer from hypo/hyperglycemia. During a review of the facility's recent policy and procedure (P&P) titled, Adverse Consequences and Medication Errors, last reviewed on 9/10/2025, the P&P indicated the interdisciplinary team monitors medication usage in order to prevent and detect medication-related problems such as adverse drug reactions (ADRs) and side effects. Policy Interpretation and Implementation Medication Errors 1. A medication error is defined as the preparation or administration of drugs or biological which is not in accordance with physician's orders, manufacturer specifications, or accepted professional standards and principles of the professional(s) providing services. During a review of the facility's recent P&P titled, Insulin Administration, last reviewed on 9/10/2025, the P&P indicated to provide guidelines for the safe administration of insulin to residents with diabetes. Steps in the Procedure (Insulin Injections via Syringe) 16. Select an injection. a. Insulin may be injected into the subcutaneous tissue of the upper arm, and the anterior or lateral areas of the thighs and abdomen. Avoid the area approximately 2 inches around the navel. b. Injection sites should be rotated, preferably within the same general area (abdomen, thigh, upper arm). During a review of the facility-provided information on the use of glargine-ygfn subcutaneously, copyright 2023, the information indicated to administer Insulin Glargine-ygfn subcutaneously into the abdominal area, thigh, or deltoid, and rotate injection sites within the same region from one injection to the next to reduce risk of lipodystrophy and localized cutaneous amyloidosis. Do not inject into areas of lipodystrophy or localized cutaneous amyloidosis [see Warnings and Precautions (5.2) and Adverse Reactions (6)]. During a review of the facility-provided Highlights of Prescribing Information (HPI) on the use of Humulin N (insulin isophane human) injectable suspension, for subcutaneous use, with initial U.S. approval in 1982, the HPI indicated to rotate injection sites to reduce the risk of lipodystrophy and localized cutaneous amyloidosis. 2. During a review of Resident 90's AR, the AR indicated the facility admitted the resident on 2/27/2026, with diagnoses including type two (2) diabetes mellitus with proliferative diabetic retinopathy (the most advanced stage of diabetic eye disease, where high blood sugar causes damage so severe that the eye grows new, fragile blood vessels), and end stage renal disease (ESRD, irreversible kidney failure). During a review of Resident 90's H&P, dated 3/2/2026, the H&P indicated the resident had the capacity to understand and make decisions. During a review of Resident 90's MDS, dated [DATE], the H&P indicated the resident had the ability to make self-understood and understand others and had moderate cognitive impairment (a stage of mental decline, often between mild impairment and dementia, where memory, thinking, and reasoning problems are noticeable to others and interfere with daily tasks). The MDS indicated the resident was on a high-risk drug class hypoglycemic medication. During a review of Resident 90's OSR, the OSR indicated an order for: 3/2/2026 Insulin Lispro Injection Solution 100 unit/ml (Insulin Lispro). Inject as per sliding scale: if 150 - 200 = 2 units (Give OJ 8 oz. If BS is less than or equal to 70, and notify); 201 - 250 = 3 units; 251 - 300 = 4 units; 301 - 350 = 6 units; 351 - 400 = 8 units (Notify MD if BS is equal or greater than 400), subcutaneously before meals and at bedtime for DM2 administer insulin coverage per sliding scale promptly right before or after meals, and with foods) (Rotate injection sites). 3/3/2026 Insulin Glargine-yfgn Subcutaneous Solution 100 unit/ml (Insulin Glargine-yfgn). Inject 15 unit subcutaneously at bedtime for DM 2 (Hold if BS is less than 100) (Rotate injection sites). During a review of Resident 90's Care Plan (CP) Report titled, The resident is at risk for hyper/hypoglycemia related to diabetes mellitus, initiated on 3/2/2026, the CP indicated an intervention to administer (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	insulin per order and to rotate site for insulin injections. During a review of Resident 90's Location of Administration Report (LAR) on the use of Insulin from 3/1/2026 to 3/31/2026, the LAR indicated insulin: Lispro Injection Solution 100 unit/ml was administered subcutaneously on, 3/3/2026 at 4:50 p.m. on the Abdomen - LLQ 3/5/2026 at 4:09 p.m. on the Abdomen - LLQ 3/7/2026 at 9:36 p.m. on the Arm - left 3/8/2026 at 11:23 a.m. on the Arm - left During a concurrent interview and record review on 3/25/2026, at 1:19 p.m., with the ADON, Resident 90's OSR, CP, and LAR were reviewed. The ADON stated not rotating insulin administration sites of administration is a medication error. The ADON stated the staff failed to rotate sites of injection as seen on the LAR. The ADON stated they rotate insulin administration site to prevent skin damage to residents. The ADON stated the frequented sites of administration can develop lipodystrophy and if administered on that site will cause malabsorption of insulin. The ADON stated the residents can suffer from hypo/hyperglycemia. During a review of the facility's recent P&P titled, Adverse Consequences and Medication Errors, last reviewed on 9/10/2025, the P&P indicated the interdisciplinary team monitors medication usage in order to prevent and detect medication-related problems such as adverse drug reactions (ADRs) and side effects. Policy Interpretation and Implementation Medication Errors 1. A medication error is defined as the preparation or administration of drugs or biological which is not in accordance with physician's orders, manufacturer specifications, or accepted professional standards and principles of the professional(s) providing services. During a review of the facility's recent P&P titled, Insulin Administration, last reviewed on 9/10/2025, the P&P indicated to provide guidelines for the safe administration of insulin to residents with diabetes. Steps in the Procedure (Insulin Injections via Syringe) 16. Select an injection. a. Insulin may be injected into the subcutaneous tissue of the upper arm, and the anterior or lateral areas of the thighs and abdomen. Avoid the area approximately 2 inches around the navel. b. Injection sites should be rotated, preferably within the same general area (abdomen, thigh, upper arm). During a review of the facility-provided information on the use of glargine-ygfn subcutaneously, copyright 2023, the information indicated to administer Insulin Glargine-ygfn subcutaneously into the abdominal area, thigh, or deltoid, and rotate injection sites within the same region from one injection to the next to reduce risk of lipodystrophy and localized cutaneous amyloidosis. Do not inject into areas of lipodystrophy or localized cutaneous amyloidosis [see Warnings and Precautions (5.2) and Adverse Reactions (6)]. During a review of the facility-provided Instructions for use on Insulin Lispro, Kwikpen injection, for subcutaneous use 3 ml single-patient use pen (100 units per ml), last revised 7/2023, the Information indicated to change (rotate) your injection sites within the area you choose for each dose to reduce your risk of getting lipodystrophy (pits in skin or thickened skin) and localized cutaneous amyloidosis (skin with lumps) at the injection sites.

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. Based on observation, interview, and record review, the facility failed to ensure kitchen staff were routinely trained and evaluated for competency skills when:1.Cook 1 was unable to verbalize final minimum internal temperature of foods when cooking and did not check if the blender was completely dry before preparing puree foods. 2. Dietary Aide 1 (DA 1) did not submerge the blender appropriately in the sanitizer. 3. Dietary Aide 2 (DA 2) was unable to use the right test strips when checking for chlorine concentration. These failures had potential to result in harmful bacterial growth and cross-contamination (transfer of harmful bacteria from one place to another) that could lead to foodborne illness (a disease caused by consuming food and drinks that are contaminated with germs or chemicals) in 71 of 77 medically compromised residents who received food from the kitchen. Findings: 1. During an observation on 3/23/2026 at 11:13 a.m., of [NAME] 1 cooking seas green peas, observed [NAME] 1 did not take the temperature of the seas green peas. Observed [NAME] 1 took portions of the vegetables and placed them in the blender. During an interview on 3/24/2026 at 9:03 a.m., with [NAME] 1 with the use of a Spanish interpreter and the Dietary Supervisor (DS), [NAME] 1 stated that she checks the food temperature two times, one during cooking and another one before starting trayline (an area where foods were assembled form the steamtable [kitchen appliance that keeps food warm at a safe temperature for serving] to resident's plates). [NAME] 1 stated she knows when food already cooks when the food temperature reaches 165 degrees Fahrenheit (F, a scale of temperature). [NAME] 1 stated she checked the temperature of the vegetables while she was cooking it, and it was 75 F as minimum temperature of cooking vegetables. [NAME] 1 stated the next time she checked the vegetables temperature was before the start of the trayline. The DS stated they do not record cooking temperature of foods. During an interview on 3/24/2026 at 10:01 a.m., with [NAME] 1 and [NAME] 2 (Cook 2 as an interpreter), [NAME] 1 stated she misspoke earlier about the temperature of the vegetables, and it was supposed to be 165 F instead of 75 F. [NAME] 1 stated she started cooking the vegetables at 11 a.m. then she checked it to see with her eyes if it was cooked and okay. [NAME] 1 stated she knew that the vegetables were cooked by looking at it, and she did not use a thermometer. [NAME] 1 stated she did not check the temperature of the vegetables, and they checked the temperature of it before the start of trayline. During an interview on 3/25/2026 at 9:52 a.m., with Registered Dietitian 1 (RD 1), RD 1 stated they record the food temperatures before trayline starts but not after cooking but the practice was for the cooks to take the temperature of the food during cooking. RD 1 stated the food needed to reach minimum temperatures to kill any bacteria in the food and it was not appropriate to eyeball it without taking the temperature of the food. RD 1 stated residents could have food borne illness as a potential outcome when food did not reach its minimal internal temperatures. During a review of the facility's P&P titled, Food Service Temperature Control, dated 9/10/2025, the P&P indicated, The preparation of food will be done following the food safety practices outlines in the most current FDA Food Code. Minimum temperature for fruit, vegetables that will be hot-held for service is 135 F for 15 seconds. During a review of Food Code 2022, dated 1/18/2023, the Food Code 2022 indicated, 3-401.13 Plant Food Cooking for Hot Holding. Plant foods that are cooked for hot holding shall be cooked to a temperature of 135 F) During an observation on 3/23/2026 at 11:20 a.m., of DA 1's dishwashing process using the two-compartment sink, observed DA 1 washed the blender and did not completely dry it. Observed [NAME] 1 used the blender to puree meat sauce and there was still liquid dripping from the blender. During an observation on 3/23/2026 at 11:22 a.m., of the food preparation by [NAME] 1, observed [NAME] 1 took the meat sauce from the regular meat sauce in the oven and started pureeing the food using the blender. During an interview on 3/23/2026 at 12:40 p.m., with the DS, the DS stated it was important to air dry kitchen utensils to make sure there is no sanitizer left to prevent chemical contamination. The DS stated chemical contamination could poison the residents. During an interview on 3/23/2026 at 12:54 (continued on next page)

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	p.m., with Registered Dietitian 2 (RD 2), RD 2 stated air drying is the cleanest way to dry the dishes, and they could not use towels because particles from the towel could get in the equipment. During an interview on 3/23/2026 at 12:56 p.m. with RD 1 stated staff needed to allow kitchen equipment to air dry completely to allow the sanitizer to dry to prevent chemical contamination. RD 1 stated residents could get gastrointestinal upset depending on the transfer of chemicals to food. RD 1 stated chemical contamination could spoil the food and get residents' sick. During a concurrent interview and record review on 3/23/2026 at 1:59 p.m. with the DS, the facility Safety Data Sheet titled, Sani-10%, dated 9/30/2015, the document indicated, Maybe harmful when swallowed. The DS stated quaternary ammonium compound (QUAT, a chemical used to kill bacteria, germ and viruses) sanitizer is harmful when swallowed and may cause gastrointestinal irritation with nausea, vomiting and diarrhea according to the safety data sheet (SDS,) for QUAT sanitizer. During an interview on 3/24/2026 at 9:39 a.m. with [NAME] 1, [NAME] 1 stated she prepared the puree foods yesterday and used the blender. [NAME] 1 stated they only have one blender, and the dishwasher washed it in between use. [NAME] 1 stated she used the blender three times yesterday for the vegetables, meat and pasta and did not cook anything in between preparing these food items. [NAME] 1 stated the second compartment sink has sanitizer in it and after sanitizing the blender, it had to be air dried on the countertop. [NAME] 1 stated that the blender is dry when there is no water dripping and if there is still visible water dripping, it could contaminate the food, and residents could get sick of upset stomach and stomach pain. [NAME] 1 stated she did not check if the blender was dry before using it yesterday. During a review of the facility's P&P titled, Sanitization, dated 9/10/2025, the P&P indicated, (7) Food preparation equipment and utensils that are manually washed are allowed to air dry whenever practical. Drying food preparation equipment and utensils with a towel or cloth may increase risk for cross-contamination. During a review of the facility's P&P titled, Two Compartment Sink Method, dated 9/10/2025, the P&P indicated, Place sanitized dishes on drain board to air dry. During a review of the facility's posted instructions on the wall titled, Compartment Sink Cleaning Procedures, dated 9/10/2025, the P&P indicated, 5. Place on clean surface, allow to air dry. During a review of Food Code 2022, dated 1/18/2023, the Food Code 2022 indicated, 4-901.11 Equipment and Utensils, air-drying required. After cleaning and sanitizing equipment and utensils: (A) Shall be air-dried or used after adequate draining as specified in the first paragraph of 40 CFR 180.940 tolerance exemptions for active and inert ingredients for use in antimicrobial formulations (food-contact surface sanitizing solutions), before contact with food and; (B) May not be cloth dried except that utensils that have been air-dried may be polished with cloths that are maintained clean and dry. During a review of the facility's job description (JD) titled Cook, signed and dated 7/30/2025 by [NAME] 1, the JD indicated, Essential Duties and Responsibilities included: adhering to sanitation and food safety guidelines during meal preparation and clean up. During a review of the facility's competency checklist titled, Food and Nutrition: Competency Checklist-Food Service Worker, dated 8/15/2025, the checklist indicated [NAME] 1 is competent when demonstrating correct sanitation and equipment and utensils and monitor and log time/temperature of food. The checklist did not indicate [NAME] 1 was competent with internal minimum temperature of food when cooking. 2. During an observation on 3/23/2026 at 11:27 a.m., observed [NAME] 1 placed the soiled blender in the two-compartment sink and DA 1 washed it. Observed DA 1 used the soap in the green bucket and then placed it in the second compartment for 26 seconds. DA 1 removed the blender from the second compartment then placed it in the small drying area next to the second compartment sink. During an observation on 3/23/2026 at 11:29 a.m., observed DA 1 took the blender from the drying area and gave it to [NAME] 1. Observed [NAME] 1 put the spaghetti noodles in the blender and there was still liquid dripping from the blender. During an interview on 3/23/2026 at 11:31 a.m., with DA 1, DA 1 stated the second compartment has sanitizer and it is used to sanitize the dishes. During an observation on 3/23/2026 at 11:34 a.m., of the puree food preparation, observed [NAME] 1 finished preparing puree spaghetti and placed the blender in the two-compartment sink. During an interview on (continued on next page)

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3/23/2026 at 12:34 p.m., with the DS, the DS stated they have one blender and one food processor and the process of washing in the two-compartment sink was to wash and rinse in the first compartment then sanitize on the second compartment. The DS stated the blender must stay in the sanitizer completely submerging for one minute and air dry. The DS stated if there were water dripping from the blender then it's not completely air dried. The DS stated it was important to submerge the blender for one minute so that the sanitizer 100 percent work and kill bacteria. The DS stated if the blender was not submerged for one minute, it would not kill bacteria. During an interview on 3/23/2026 at 12:46 p.m., with RD 2, RD 2 stated the process of dishwashing in the two-compartment sink is to wash, rinse, sanitize and air-dry. RD 2 stated the second compartment has QUAT sanitizer and water and the sanitizer disinfects the dishes. RD 2 stated the dishes or kitchen equipment had to be submerged in the sanitizer for 1 minute to prevent bacterial growth and residents could get sick of foodborne illness due to contamination. During an interview on 3/23/2026 at 2:24 p.m., with the DS, the DS stated she asked DA 1 about dishwashing and DA 1 thought he submerged the blender for one minute and he usually air-dried it before using however, [NAME] 1 needed to use the blender so DA 1 rushed it. During a review of the facility's P&P titled, Two Compartment Sink, dated 9/10/2025, the P&P indicated, 6. Submerse the clean dishes in the sanitizing solution of the compartment #3 according to chemical vendor's time requirements. During a review of the facility's posted instructions on the wall titled, Compartment Sink Cleaning Procedures, dated 9/10/2025, the P&P indicated, 3. Place items in sanitizing solution for 1 minute. During a review of Food Code 2022, dated 1/18/2023, the Food Code 2022 indicated, 4-501.114 Manual and Mechanical Warewashing Equipment, Chemical Sanitation- Temperature, pH, Concentration, and Hardness. A chemical sanitizer used in a sanitizing solution for a manual or mechanical operation at contact times specified under 4-703.11 (C) shall meet criteria specified under 7-204.11 Sanitizers, criteria shall be used in accordance with the EPA-registered label use instructions, and shall be used as follows: (C) A quaternary ammonium compound solution shall (1) Have a minimum temperature of 24 C (75 F), (2) Have a concentration as specified under 7-204.11 and as indicated by the manufacturer's use directions included in the labeling. During an observation on 3/23/2026 at 11:37 a.m. of DA 1 washing the dishes in the two-compartment sink, observed DA 1 washed the blender in the first compartment then used the soap from the green bucket then place the blender to the second compartment sink without submerging it completely in the sanitizing solution. During an observation on 3/23/2026 at 11:42 a.m., of DA 1 washing kitchen utensils in the two-compartment sink, observed DA 1 removed the blender from the second compartment with sanitizer. Observed DA 1 handed the blender to [NAME] 1 and there was still water dripping from it. During an interview on 3/23/2026 at 12:40 p.m. with the DS, the DS stated the blender had to be completely submerge in the sanitizing solution to ensure it goes inside the blender to kill bacteria. The DS stated residents could get sick of foodborne illness if it was not sanitized correctly. During a concurrent interview and record review on 3/23/2026 at 2:08 p.m. with the DS, the facility P&P titled Two Compartment Sink, dated 9/10/2025 was reviewed. The P&P indicated, Submerse the clean dishes in the sanitizing solution. The DS stated, the clean dishes and kitchen utensils are submersed in the sanitizing solution of compartment number 3 according to the chemical vendor's time requirements then place the sanitize dishes on the drain board to air dry. During a review of the facility's JD, titled, Dietary Aide, dated 7/24/2013, the JD indicated, Duties and responsibilities included, perform dishwashing/cleaning procedures. Assure that utensils, etc., are readily available for next meal. Prepare food, etc., in accordance with sanitary regulations as well as without established policies and procedures. During a review of the facility's competency checklist titled, Food and Nutrition: Competency Checklist-Food Service Worker, signed and dated on 7/31/2025 by DA 1, the checklist indicated, DA 1 was competent in utilizing 2 or 3 compartments sink correctly but did not indicate he was competent in air drying of utensils. 3. During a concurrent observation and interview on 3/24/2026 at 2:02 p.m., of the dishwashing process demonstration with DA 2, DA 2 stated he wash, rinse, sanitize and air-dry dishes. DA 2 stated he (continued on next page)

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	checks the temperature of the dish machine, and it should be at 140 F and above and if it's below it, he reports it to the supervisor. DA 2 stated he did not know what type of dish machine they use and stated he used a test strip to check the sanitizer concentration. Observed DA 2 got the test strip for QUAT sanitizer and stated the test strip turned yellow when dipped into the chlorine and it was not an acceptable concentration for the chlorine. Observed DA 2 dipped the test strip for QUAT sanitizer and agitated it. DA 2 stated the test strips were not reading an acceptable chlorine concentration, and he uses this test strip when checking the chlorine concentration. The DS stated DA 2 was using the wrong test strips and handed the correct test strips to DA 2. The DS stated it was important to use the correct test strips to ensure that they get the correct concentration of the sanitizer. The DS stated the chlorine needed to be at the right concentration to sanitize and kill bacteria from the dishes. The DS stated residents could get sick of cross contamination as a potential outcome. During a review of the facility's P&P titled Chemical Sanitation, dated 9/10/2025, the P&P indicated, The appropriate temperature, pH concentration and water hardness will be used when chemical sanitation requires techniques are used as in storing wet wiping cloths, cleaning food preparation surfaces and manual and mechanical (chemical machine) ware washing. Sanitizers shall be used in accordance with the EPA-approved manufacturer's label use instructions. During a review of the facility's manufacturer's guidelines, Chlorine Test Paper, the guidelines indicated, The chlorine test paper measures total available chlorine from 0-200 parts per million (ppm, a unit of measurement expressing dilute concentrarion) and give results just seconds. During a review of Food Code 2022, the Food Code 2022 indicated, 4-501.116 Warewashing Equipment, Determining Chemical Sanitizer Concentration. Concentration of the sanitizing solution shall be accurately determined by using a test kit or other device. During a review of the facility's JD titled, Dietary Aide, signed and dated by DA 2 on 7/27/2021, the JD indicated, essential duties and responsibilities of DA 2 included adhering to sanitation and food safety guidelines during meal preparation and clean up and dishwashing and cleaning of utensils. During a review of the facility's competency checklist titled, Food and Nutrition: Competency Checklist-Food Service Worker, dated 7/31/2025, the checklist indicated DA 2 was competent in stating proper sanitizer solution range and correctly prepares sanitizer solution and test concentration. The checklist did not indicate DA 2 was competent in using the correct test strip in testing chlorine concentration.

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure meals and snacks are served at times in accordance with resident?s needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times. Based on observation, interview, and record review, the facility failed to provide residents' meals at regular times scheduled in accordance with resident needs, preferences, and requests when lunch was served late on 3/23/2026. This deficient practice had the potential to result in hunger and frustration for 71 of 77 residents getting food from the kitchen. Findings: During an observation on 3/23/2026 at 8:19 a.m. of the meal schedule posted in the hallway, observed a sign posted in the hallway indicating meals are scheduled as follows: - Breakfast 7:00 a.m. - Lunch 12:00 p.m. - Dinner 5:00 p.m. During a concurrent observation and interview on 3/23/2026 at 11:48 a.m. of the trayline (an area where foods were assembled from the steamtable [kitchen appliance that keeps food warm at a safe temperature for serving] to residents' plates) service with the Dietary Aide (DA) 3, observed DA 3 holding the stem of the thermometer when taking the temperature of the food. Registered Dietitian (RD) 1 corrected DA 3 to hold the indicator head instead of the stem to get accurate food temperatures. DA 3 stated the puree green seas peas had a temperature of 130 degrees Fahrenheit (F - a scale of temperature). During an interview on 3/23/2026 at 11:51 a.m. with RD 1, RD 1 stated they needed to reheat the food because their standard for food temperature is 165 F. RD 1 instructed [NAME] 1 to place the puree green seas peas back in the oven. During an observation on 3/23/2026 at 11:52 a.m. of DA 3 taking puree meat sauce temperature, observed puree meat sauce was at 126 F. [NAME] 1 placed the puree meat sauce back in the oven. During a concurrent observation and interview on 3/23/2026 at 12:22 p.m. of the lunch trayline service with the Dietary Supervisor (DS), observed trayline service started. The DS stated the trayline service was late because the food temperatures could not be met. During an observation on 3/23/2026 at 12:30 p.m. of the trayline service, observed the first cart come out from the kitchen. During an interview on 3/23/2026 at 2:28 p.m. with the DS, the DS stated the lunch time schedule is at 12 noon. The DS stated the lunch meals were late today (3/23/3036). The DS stated it was important to have the meals served on time for the residents to not get too hungry and have the same time between each meal. The DS stated residents could be agitated as a potential outcome when they are hungry. During a review of the facility's policies and procedures (P&P) titled, Meal Service Time, dated 9/10/2025, the P&P indicated, Each resident will receive at least three meals daily and offered a bedtime snack with no more than 14 hours between dinner and breakfast the next day. If a nourishing snack is offered at bedtime, then 16 hours may lapse between dinner and breakfast the next day. This meal span must be approved by residents. Procedure: 1. Meal hours will be established by management with input from the Resident's Council, who must agree to the 16 hours between the substantial evening meal and breakfast het next day provided that a nourishing snack is offered. 2. The following mealtimes have been established. Breakfast: 7 a.m. Lunch: 12 p.m. Dinner: 5 p.m. Snacks: 10 a.m., 2 p.m., 8 p.m. 3. A schedule of mealtimes shall be posted in resident areas and dining rooms. 4. The order of service shall be established and maintained.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure safe and sanitary food storage and food preparation practices in the kitchen when: 1. Thawed ground beef was placed back in the freezer and was at 31 degrees Fahrenheit (F, a scale of temperature). 2. Walk-in refrigerator's gasket (a rubber placed between two solid and flat surfaces to create a tight leak-proof seal) was torn, it had dust and dirt buildup. 3. Two (2) dented (a hallow, dip, or depression on a surface, caused by blow, impact or pressure) cans were stored with non-dented cans. 4. [NAME] 1 did not take the temperature of the vegetables during cooking using a food thermometer. (Cross Reference Ftag 802) 5. Dietary Aide 1 (DA 1) did not wash kitchen equipment correctly in the three-compartment sink when: a. DA 1 did not completely air dry the blender before [NAME] 1 used the blender in preparing puree foods. (Cross-Reference Ftag 802) b. DA 1 did not submerge the blender in the quaternary (QUAT, a common chemical cleaner used to kill germs, bacteria and viruses) sanitizer for one (1) minute per sanitizer manufacturer's guidelines. (Cross-reference Ftag 802) c. DA 1 did not submerge the blender completely in the sanitizer. 6. Kitchen staff did not perform handwashing, going to dirty and then the clean area when: a. DA 1 did not wash his hands when washing dishes in the two-compartment sink then putting away clean dishes. b. Dietary Aide 2 (DA 2) washed his hands for five (5) seconds and used a blue towel when drying his hands. DA 2 turned off the faucet using his hands after handwashing. 7. [NAME] 1 directly toasted the tortilla on the stove without sanitizing it prior to use. 8. Kitchen equipment and utensils were not free from dirt, dust and food debris. a. Wall air conditioning in the preparation area had dust and dirt buildup. b. Residents' refrigerator in Station 1 had dirt debris. 9. Sugar-free watermelon drink had a best buy date of 3/23/2026 and was not discarded on 3/24/2026. 10. DA 2 used the wrong test strips when checking chlorine concentration of the dish machine. 11. Residents' refrigerator had visible dirt in Station 1 and nursing staff did not address the out-of-range temperatures of the residents' refrigerator. 12. There was no thermometer in the residents' freezer in Station 3 where egg waffles were stored. 13. An unlabeled bottle of Powerade (is a sports drink that is designed to help the body rehydrate and replenish essential minerals lost through sweat during exercise) was stored in the residents' refrigerator inside the Medication Storage Room in Station 1. Powerade bottle had no name, room number, and the date it was received. These failures had the potential to result in harmful bacterial growth and cross contamination (transfer of harmful bacteria from one place to another) that could lead to foodborne illness (a disease caused by consuming food or drinks that are contaminated by germs or chemicals) in 71 of 77 medically compromised residents who received food from the kitchen. Findings: 1. During an observation on 3/23/2026 at 8:33 a.m. of the meat freezer, observed ground beef was soft to touch. During a concurrent observation and interview on 3/23/2026 at 8:40 a.m., of the meat freezer with the Dietary Supervisor (DS), observed the DS touched the ground meat. The DS stated the ground meat was not frozen because it was soft to touch. The DS stated the ground beef was received last Sunday and it was thawed but it should not be returned to the freezer as the bacteria could start growing during the thawing process and it should not be refrozen to prevent foodborne illnesses. The DS stated [NAME] 1 prepared the ground beef this morning and cut the ground beef and got what she needed. The DS stated [NAME] 1 needed to place the thawed ground beef in the refrigerator and not in the freezer. During a review of the facility's P&P titled, Thawing, dated 9/10/2025, the P&P indicated, Once thawed raw food will not be re-frozen, unless it is thoroughly cooked. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Food Code 2022, dated 1/18/2023, the Food Code 2022 indicated, 3-501.11 Frozen Food. Stored Frozen Food shall be maintained frozen. Freezing prevents microbial growth in foods but usually does not destroy all microorganisms. Improper thawing provides an opportunity for surviving bacteria to grow to harmful numbers and/or produce toxins. If the food is then refrozen, significant numbers of bacteria and/or all preformed toxins are preserved. 2. During an observation on 3/23/2026 at 8:52 a.m. of the walk-in refrigerator observed the refrigerator gasket was torn on the bottom portion and there was dust and dirt accumulation. During an interview on 3/23/2026 at 8:54 a.m. with the DS, the DS stated the walk-in refrigerator is cleaned once a week but there was no assigned day to clean it. The DS stated the last time the walk-in refrigerator was cleaned was last weekend, but the gasket has dirt accumulation, and it should be because the dirt could go to the food causing bacterial growth and cross contamination of food. The DS stated residents could have foodborne illnesses as a potential outcome. During an interview on 3/23/2026 at 8:56 a.m. with the DS, the DS stated the walk-in refrigerator gasket was torn and it should not be torn to prevent hot air from coming in because if the air comes in the walk-in refrigerator, it could spoil the food. The DS stated spoiled food could get the residents sick of foodborne illness. The DS stated she told the maintenance staff to replace it long time ago but forgot to follow-up. During a review of the facility's P&P titled, Sanitization dated 9/10/2025, the P&P indicated, The food service is maintained in a clean and sanitary manner. (1) All kitchens, kitchen areas and dining areas are kept clean, free from garbage and debris, and protected from rodents and insects. (2) All utensils, counters, shelves and equipment are kept clean, maintained in good repair and are free from breaks, corrosion, open seams, cracks and chipped areas that may affect their use or proper cleaning. Seals, hinges and fasteners are kept in good repair. During a review of the facility's P&P titled, Refrigerator and Freezers, dated 9/10/2025, the P&P indicated, 10. Supervisors inspect refrigerators and freezer monthly for gasket condition, fan condition, presence of rust, excess condensation, and any other damage or maintenance needs. Necessary repairs are initiated immediately. Maintenance schedules per manufacturer guidelines are scheduled and followed. During a review of Food Code 2022, dated 1/18/2023, the Food Code 2022 indicated,4-602.13 Nonfood-Contact Surfaces. Nonfood-contact surfaces of equipment shall be cleaned at a frequency necessary to preclude accumulation of soil residues. 3. During a concurrent observation and interview on 3/23/2026 at 9:11 a.m. of the dry storage area with the DS, found 2 dented cans were stored with non-dented cans. The DS stated dented cans needed to be separated from non-dented cans to prevent using them because there could be air going in the dented cans in which bacteria could grow. The DS stated residents could get foodborne illness when they consume food from dented cans. During a review of the facility's P&P titled, Recommended Food Storage Practices-Dry dated 9/10/2025, the P&P indicated Leaking, dented, or rusty cans should be disposed of promptly to prevent contamination. During a review of Food Code 2022, dated 1/18/2023, the Food Code 2022 indicated, 3-101.11 Safe Unadulterated, and Honestly Presented. Food shall be safe, unadulterated, and, as specified under (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3-601.12, honestly presented. 3-201.11 Compliance with Food Law. A primary line of defense ensuring that food meets the requirements of 3-101.11 is to obtain food from approved sources, the implications of which are discussed below. However, it is also critical to monitor food products to ensure that, after harvesting, processing, they do not fail victim to conditions that endanger their safety, make them adulterated, or compromise their honest presentation. The regulatory community, industry, and consumers should exercise vigilance in controlling the conditions to which foods are subjected and be alert to signs of abuse. FDA considers food in hermetically sealed containers that are swelled or leaking to be adulterated and actionable under the Federal Food, Drug, and Cosmetic Act. Depending on the circumstances, rusted, and pitted or dented cans may also present a serious potential hazard. 4. During an observation on 3/23/2026 at 11:13 a.m., of [NAME] 1 cooking seas green peas, observed [NAME] 1 did not take the temperature of the seas green peas. Observed [NAME] 1 took portions of the vegetables and placed them in the blender. During an interview on 3/24/2026 at 9:03 a.m., with [NAME] 1 and the DS, [NAME] 1 stated that she checks the food temperature two times, one during cooking and another one before starting trayline (an area where foods were assembled form the steamtable [kitchen appliance that keeps food warm at a safe temperature for serving] to resident's plates). [NAME] 1 stated food is already cooked when the food temperature reaches 165 degrees F. [NAME] 1 stated she checked the temperature of the vegetables while she was cooking it, and it was 75 degrees F. [NAME] 1 stated the next time she checked the vegetables temperature was before the start of the trayline. The DS stated they do not record cooking temperature of foods. During an interview on 3/24/2026 at 9:20 a.m. with the DS, the DS stated that it was not in their policy to record temperatures of foods during cooking. During an interview on 3/24/2026 at 10:01 a.m., with [NAME] 1 and [NAME] 2 (Cook 2 as an interpreter), [NAME] 1 stated she misspoke earlier about the temperature of the vegetables, and it was supposed to be 165 degrees F instead of 75 degrees F. [NAME] 1 stated she started cooking the vegetables at 11 a.m. then she checked it to see with her eyes if it was cooked and okay. [NAME] 1 stated she knew that the vegetables were cooked by looking at it, and she did not use a thermometer. [NAME] 1 stated she did not check the temperature of the vegetables, and they checked the temperature of it before the start of trayline. During an interview on 3/25/2026 at 9:52 a.m., with Registered Dietitian 1 (RD 1), RD 1 stated they record the food temperatures before trayline starts but not after cooking but the practice was for the cooks to take the temperature of the food during cooking. RD 1 stated the food needed to reach minimum temperatures to kill any bacteria in the food and it was not appropriate to eyeball it without taking the temperature of the food. The RD stated residents could have food borne illness as a potential outcome when food did not reach its minimal internal temperatures. During a review of the facility's P&P titled, Food Service Temperature Control, dated 9/10/2025, the P&P indicated, The preparation of food will be done following the food safety practices outlines in the most current FDA Food Code. Minimum temperature for fruit, vegetables that will be hot-held for service is 135 degrees F for 15 seconds. During a review of Food Code 2022, dated 1/18/2023, the Food Code 2022 indicated, 3-401.13 Plant Food Cooking for Hot Holding. Plant foods that are cooked for hot holding shall be cooked to a (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	temperature of 135 degrees F. 5. a. During an observation on 3/23/2026 at 11:20 a.m., of DA 1's dishwashing process using the two-compartment sink, observed DA 1 washed the blender and did not completely dry it. Observed [NAME] 1 used the blender to puree meat sauce and there was still liquid dripping from the blender. During an observation on 3/23/2026 at 11:22 a.m., of the food preparation by [NAME] 1, observed [NAME] 1 took the meat sauce from the regular meat sauce in the oven and started pureeing the food using the blender. During an interview on 3/23/2026 at 12:40 p.m., with the DS, the DS stated it was important to air dry kitchen utensils to make sure there is no sanitizer left to prevent chemical contamination. The DS stated chemical contamination could poison the residents. During an interview on 3/23/2026 at 12:54 p.m., with Registered Dietitian 2 (RD 2), RD 2 stated air drying is the cleanest way to dry the dishes, and they could not use towels because particles from the towel could get in the equipment. During an interview on 3/23/2026 at 12:56 p.m. with Registered Dietitian 1 (RD), RD 1 stated staff needed to allow kitchen equipment to air dry completely to allow the sanitizer to dry to prevent chemical contamination. RD 1 stated residents could get gastrointestinal upset depending on the transfer of chemicals to food. RD 1 stated chemical contamination could spoil the food and get residents sick. During a concurrent interview and record review on 3/23/2026 at 1:59 p.m. with the DS, the facility Safety Data Sheet titled, Sani-10%, dated 9/30/2015, the document indicated, Maybe harmful when swallowed. The DS stated QUAT sanitizer is harmful when swallowed and may cause gastrointestinal irritation with nausea, vomiting and diarrhea according to the safety data sheet (SDS) for QUAT sanitizer. During an interview on 3/24/2026 at 9:39 a.m. with [NAME] 1, [NAME] 1 stated she prepared the puree foods yesterday and used the blender. [NAME] 1 stated they only have one blender, and the dishwasher washed it in between use. [NAME] 1 stated she used the blender three times yesterday for the vegetables, meat and pasta and did not cook anything in between preparing these food items. [NAME] 1 stated the second compartment sink has sanitizer on it and after sanitizing the blender, it had to be air dried on the countertop. [NAME] 1 stated that the blender is dry when there is no water dripping and if there is still visible water dripping, it could contaminate the food, and residents could get sick of upset stomach and stomach pain. [NAME] 1 stated she did not check if the blender was dry before using it yesterday. During a review of the facility's P&P titled, Sanitization, dated 9/10/2025, the P&P indicated, (7) Food preparation equipment and utensils that are manually washed are allowed to air dry whenever practical. Drying food preparation equipment and utensils with a towel or cloth may increase risk for cross-contamination. During a review of the facility's P&P titled, Two Compartment Sink Method, dated 9/10/2025, the P&P indicated, Place sanitized dishes on drain board to air dry. During a review of the facility's posted instructions on the wall titled, Compartment Sink Cleaning (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procedures, dated 9/10/2025, the P&P indicated, 5. Place on clean surface, allow to air dry. During a review of Food Code 2022, dated 1/18/2023, the Food Code 2022 indicated, 4-901.11 Equipment and Utensils, air-drying required. After cleaning and sanitizing equipment and utensils: (A) Shall be air-dried or used after adequate draining as specified in the first paragraph of 40 CFR 180.940 tolerance exemptions for active and inert ingredients for use in antimicrobial formulations (food-contact surface sanitizing solutions), before contact with food and; (B) May not be cloth dried except that utensils that have been air-dried may be polished with cloths that are maintained clean and dry. b. During an observation on 3/23/2026 at 11:27 a.m., observed [NAME] 1 placed the soiled blender in the two-compartment sink and DA 1 washed it. Observed DA 1 used the soap in the green bucket and then placed it in the second compartment for 26 seconds. DA 1 removed the blender from the second compartment then placed it in the small drying area next to the second compartment sink. During an observation on 3/23/2026 at 11:29 a.m., observed DA 1 took the blender from the drying area and gave it to [NAME] 1. Observed [NAME] 1 put the spaghetti noodles in the blender and there was still liquid dripping from the blender. During an interview on 3/23/2026 at 11:31 a.m., with DA 1, DA 1 stated the second compartment has sanitizer and it is used to sanitize the dishes. During an observation on 3/23/2026 at 11:34 a.m., of the puree food preparation, observed [NAME] 1 finished preparing puree spaghetti and placed the blender in the two-compartment sink. During an interview on 3/23/2026 at 12:34 p.m., with the DS, the DS stated they have one blender and one food processor and the process of washing in the two-compartment sink was to wash and rinse in the first compartment then sanitize on the second compartment. The DS stated the blender must stay in the sanitizer completely submerging for one minute and air dry. The DS stated if there were water dripping from the blender then it's not completely air dried. The DS stated it was important to submerge the blender for one minute so that the sanitizer will 100 percent work and kill the bacteria. The DS stated if the blender was not submerged for one minute, it would not kill bacteria. During an interview on 3/23/2026 at 12:46 p.m., with RD 2, RD 2 stated the process of dishwashing in the two-compartment sink is to wash, rinse, sanitize and air-dry. RD 2 stated the second compartment has QUAT sanitizer and water and the sanitizer disinfects the dishes. RD 2 stated the dishes or kitchen equipment had to be submerged in the sanitizer for 1 minute to prevent bacterial growth and residents could get sick of foodborne illness due to contamination. During an interview on 3/23/2026 at 2:24 p.m., with the DS, the DS stated she asked DA 1 about dishwashing and DA 1 thought he submerged the blender for one minute and he usually air-dried it before using, however, [NAME] 1 needed to use the blender so DA 1 rushed it. During a review of the facility's P&P titled, Two Compartment Sink, dated 9/10/2025, the P&P indicated, 6. Submerse the clean dishes in the sanitizing solution of the compartment #3 according to chemical vendor's time requirements. During a review of the facility's posted instructions on the wall titled, Compartment Sink Cleaning Procedures, dated 9/10/2025, the P&P indicated, 3. Place items in sanitizing solution for 1 minute. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Food Code 2022, dated 1/18/2023, the Food Code 2022 indicated, 4-501.114 Manual and Mechanical Warewashing Equipment, Chemical Sanitation- Temperature, pH, Concentration, and Hardness. A chemical sanitizer used in a sanitizing solution for a manual or mechanical operation at contact times specified under 4-703.11 (C) shall meet criteria specified under 7-204.11 Sanitizers, criteria shall be used in accordance with the EPA-registered label use instructions, and shall be used as follows: (C) A quaternary ammonium compound solution shall (1) Have a minimum temperature of 24 degrees C (75 degrees F), (2) Have a concentration as specified under 7-204.11 and as indicated by the manufacturer's use directions included in the labeling. c. During an observation on 3/23/2026 at 11:37 a.m. of DA 1 washing the dishes in the two-compartment sink, observed DA 1 washed the blender in the first compartment then used the soap from the green bucket then place the blender to the second compartment sink without submerging it completely in the sanitizing solution. During an observation on 3/23/2026 at 11:42 a.m., of DA 1 washing kitchen utensils in the two-compartment sink, observed DA 1 removed the blender from the second compartment with sanitizer. Observed DA 1 handed the blender to [NAME] 1 and there was still water dripping from it. During an interview on 3/23/2026 at 12:40 p.m. with the DS, the DS stated the blender had to be completely submerge in the sanitizing solution to ensure it goes inside the blender to kill bacteria. The DS stated residents could get sick of foodborne illness if it was not sanitized correctly. During a concurrent interview and record review on 3/23/2026 at 2:08 p.m. with the DS, the facility P&P titled Two Compartment Sink, dated 9/10/2025 was reviewed. The P&P indicated, Submerse the clean dishes in the sanitizing solution. The DS stated, the clean dishes and kitchen utensils are submersed in the sanitizing solution of compartment number 3 according to the chemical vendor's time requirements then place the sanitize dishes on the drain board to air dry. 6. a. During an observation on 3/23/2026 at 11:46 a.m., of DA 1 washing kitchen utensils and equipment in the two-compartment sink, observed DA 1 washed the kitchen equipment then put away the clean dishes without washing his hands. During an observation on 3/23/2026 at 11:55 a.m., of DA 1 washing kitchen utensils and equipment in the two-compartment sink, observed DA 1 did not wash his hands after washing kitchen utensils and before putting away clean dishes. During an interview on 3/23/2026 at 1 p.m., with the DS, the DS stated the dishwasher should wash their hands after washing kitchen equipment and before putting the sanitized kitchen equipment away as it could be dirty again and bacteria could grow causing the residents to get sick of foodborne illness. During a review of the facility's P&P titled Handwashing, dated 9/10/2025, the P&P indicated, Employee will wash his or hands frequently to eliminate visible dirt and reduce bacterial load. Procedure when to wash hands: (i)After working with or cleaning dirty equipment or utensils (k) Anytime hands are soiled. (l) Between gloves changes (q) Between any dirty to clean task. During a review of the facility's P&P titled, Preventing Foodborne Illness-Employee Hygiene and Sanitary Practices, dated 9/10/2025, the P&P indicated, Handwashing/hand hygiene (g) During food preparation, as often as necessary to remove soil and contamination and to prevent (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	cross-contamination when changing task and or (h) After engaging in other activities that contaminate the hands. b. During an observation on 3/24/2026 at 1:43 p.m., of the dishwashing process, observed DA 2 performed handwashing by wetting his hand with water and soap then touched the faucet knob then wiped his hands with a blue towel. Observed DA 2 threw the blue towel on top of the tile by the window after wiping his hands. During an observation on 3/24/2026 at 1:47 p.m., of the dishwashing process, observed DA 2 wash his hands and use the soap for five (5) seconds then wiped his hands with a blue towel. During an interview on 3/24/2026 at 2:02 p.m., with the DS, the DS stated DA 2 was using a blue towel to dry his hands and did a quick handwashing. The DS stated handwashing should be 20 to 30 seconds or not less than 20 seconds to make sure they are washing their hands thoroughly. The DS stated handwashing is important to protect the residents from getting bacteria and prevent cross-contamination of their food. The DS stated kitchen staff should not be using a blue towel and should be using disposable towel because it was not sanitary. During an interview on 3/24/2026 at 2:18 p.m., with DA 2, DA 2 stated he washes his hands for 10 to 15 seconds and thought he washed his hands for 10 seconds by counting 1, 2, 3, 4, 5. DA 2 stated it was important to wash hands in a specific time to prevent cross-contamination. DA 2 stated he also used the blue towel because it was inconvenient for him to go around and get the disposable towel. DA 2 stated it was important to use the disposable towel to prevent cross-contamination. DA 2 stated he used the blue towel to dry his hands and stated he threw the other blue towel near the window. During a review of the facility's P&P titled Handwashing, dated 9/10/2025, the P&P indicated, How to wash: a. Place hands under warm, running water, wetting wrists and forearms. b. Apply soap to hands and rub them together vigorously for at least 10-15 seconds. c. Scrub wrists, forearms, and both sides of the hands. d. Clean fingers, fingertips, and under nails by rubbing one hand against the other. Be sure to clean under the fingernails with a nail brush e. Rinse the washed areas thoroughly with warm, running water f. Dry hands with paper towel. g. Use paper towel to turn off the faucet. Do not sure bare hands. h. Discard paper towel. i. Total handwashing time should be no less than 20 seconds. During a review of Food Code 2022, dated 1/18/2023, the Food Code 2022 indicated 2-301.14 When to Wash. FOOD EMPLOYEES shall clean their hands and exposed portions of their arms as specified (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	under 2-301.12 immediately before engaging in FOOD preparation including working with exposed FOOD, clean EQUIPMENT and UTENSILS, and unwrapped SINGLE-SERVICE and SINGLE-USE ARTICLESP and: (A) After touching bare human body parts other than clean hands and clean, exposed portions of arms; P (B) After using the toilet room; P (C) After caring for or handling SERVICE ANIMALS or aquatic animals as specified in ¶ 2-403.11(B); P (D) Except as specified in ¶ 2-401.11(B), after coughing, sneezing, using a handkerchief or disposable tissue, using TOBACCO PRODUCTS, eating, or drinking; P (E) After handling soiled EQUIPMENT or UTENSILS; P (F) During FOOD preparation, as often as necessary to remove soil and contamination and to prevent cross contamination when changing tasks; P (G) When switching between working with raw FOOD and working with READY-TO-EAT FOOD; P (H) Before donning gloves to initiate a task that involves working with FOOD; P and (I) After engaging in other activities that contaminate the hands. 7. During an observation on 3/23/2026 at 12:05 p.m., of [NAME] 1 toasting the tortilla, observed [NAME] 1 toasted the tortillas directly on the stove. During an interview on 3/23/2026 at 9:30 a.m., with [NAME] 1 and the DS, [NAME] 1 stated she placed the tortilla directly on the stove because the resident wants it crunchy. The DS stated they sanitize the stove after every shift. The DS stated it was acceptable for [NAME] 1 to cook the tortilla directly to the stove because heat kills bacteria however they clean the stove to prevent dirt buildup and burning. The DS stated spill could happen in between cooking and bacteria could grow causing cross contamination to food. The DS stated toasting the tortilla directly on the stove would not be acceptable because the stove is not clean and the tortilla could be contaminated. The DS stated [NAME] 1 has been doing it for a month for a resident and she did not talk to the resident about it. During a review of the facility's P&P titled, Food Preparation and Service, dated 9/10/2025, the P&P indicated, Food and nutrition service employees prepare and serve food in a manner that complies with safe food handling practices. During a review of Food Code 2022, dated 1/18/2023, the Food Code 2022 indicated, 3-307.11 Miscellaneous Sources of Contamination. Food shall be protected from contamination that may result from a factor or source not specified under subparts 3-391 – 3-306. 8. a. During an observation on 3/24/2026 at 11:36 a.m., of the wall air conditioning (AC) unit by the preparation area, observed dust buildup on the vent. During an interview on 3/24/2026 at 12:02 a.m., with the DS stated the AC filter has sticky dust buildup and it needed to be clean as it could blow dust in the food during preparation of food causing cross contamination. The DS stated kitchen staff should clean the filter every single shift. During a review of the facility's P&P titled Sanitization, dated 9/10/2025, the P&P indicated, The Food service area is maintained in a clean and sanitary manner. b. During a concurrent observation and interview on 3/25/2026 at 8:33 a.m. of the residents' refrigerator with Registered Nurse 1 (RN 1) in Station 1, observed dirt debris in the refrigerator. RN 1 stated nursing staff maintains the resident's refrigerator and cleans it when there is visible dirt. RN 1 stated there is visible dirt in the resident's refrigerator and the staff should have cleaned it. RN 1 stated she was not sure about the facility's policy regarding food from outside source, but it was important to ensure cleanliness of the resident's refrigerator for infection control for contamination of food that belongs to the residents. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's P&P titled, Refrigerator and Freezer, dated 9/10/2025, the P&P indicated, Refrigerator and Freezers are kept clean, free of debris, and disinfected with sanitizing solution on a scheduled basis and more often than necessary. During a review of Food Code 2022, the Food Code 2022 indicated, 4-601.11 (E) Except when dry cleaning methods are used as specified under 4-603.11, surfaces of utensils and equipment contacting food that is not time/temperature control for safety food shall be cleaned: (1) At anytime when contamination may have occurred; (2) At least every 24 hours for iced tea dispensers and consumer self-service utensils such as tongs, scoops, or ladles; (3) Before restocking consumer self-service equipment and utensils such as condiment dispensers and display containers; and (4) In equipment such as ice bins and beverage dispensing nozzles and enclosed components of equipment such as ice makers, cooking oil storage tanks and distribution lines, beverage and syrup dispensing lines or tubes, coffee bean grinders, and water vending equipment: (a) At a frequency specified by the manufacturer, or (b) Absent manufacturer specification, at a frequency necessary to preclude accumulation of soil or mold. 9. During an observation on 3/24/2026 at 11:37 a.m., of the juice containers, observed sugar free watermelon with a best buy date of 3/23/2026 and were not discarded. During an interview on 3/24/2026 at 12:05 p.m., with the DS, the DS stated they date food items with open date and use by date, and they needed to consume the food item by the use by date or throw it away because they do not want the food to be bad and get spoiled. The DS stated residents could get sick upon consuming spoiled food. The DS stated the sugar free watermelon has a best buy date of 3/23/2026 and it should have been thrown away yesterday because it was no longer good. During a review of the facility's P&P titled, Recommended Food Storage Practices, dated 9/10/2025, the P&P indicated, Check expiration date of milk, prepared salads and other dated foods. Discard outdated product daily. During a review of Food Code 2022, the Food Code 2022 indicated, 3-501.17 Commercially processed food, open and hold cold, (B) except specified in (E) – (G) of this section, refrigerated, ready-to-eat time/temperature control for food safety food prepared and packed by a food processing plant shall be clearly [NAME]

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F 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Inform resident or representatives choice to enter into binding arbitration agreement and right to refuse. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the binding arbitration agreement (a resident waives the right to pursue legal action against the nursing home in court, and instead agrees to have any future disputes handled by a private arbitrator [an independent person or body officially appointed to settle a dispute]) indicated the resident or anyone else (e.g., resident's representative) were allowed to communicate with federal, state, or local officials such as federal and state surveyors, other federal or state health department employees and representative of the Office of the State Long Term Care Ombudsman (a resident advocate) for three of three sampled residents (Residents 33, 75, and 93) reviewed for Arbitration Facility Task. The deficient practice had the potential for residents to be unaware of their rights pertaining to Arbitration Agreement. Findings: 1. During a review of Resident 33's admission Record (AR), the AR indicated the facility admitted the resident on 3/18/2025, with diagnoses including major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest) and anxiety disorder (a mental health condition characterized by excessive, persistent, and uncontrollable fear or worry that interferes with daily life). During a review of Resident 33's History and Physical (H&P), dated 3/19/2025, the H&P indicated the resident could make needs known but cannot make medical decisions. During a review of Resident 33's Minimum Data Set (MDS - a resident assessment tool), dated 3/17/2026, the MDS indicated the resident had the ability to make self-understood and understand others and had impaired cognition (aˆdecline in mental abilitiesˆwhere a person has trouble with thinking, memory, concentration, judgment, or learning new things). The MDS indicated the resident had a family member who participated in the assessment and goal setting of resident's healthcare management. During a review of Resident 33's Resident-Facility Arbitration Agreement (AA), electronically signed by Resident 33 on 4/1/2025, the AA did not indicate the resident were allowed to communicate with federal, state, or local officials such as federal and state surveyors, other federal or state health department employees and representative of the Office of the State Long Term Care Ombudsman. During a concurrent interview and record review on 3/26/2026 at 9:46 a.m. with the Admissions Coordinator (AC), Resident 33's AA was reviewed. he AC stated nothing on the AA mentions about allowing the resident or anyone else (e.g., resident's representative) to communicate with federal, state, or local officials such as federal and state surveyors, other federal or state health department employees and representative of the Office of the State Long Term Care Ombudsman. The AC stated she will call their legal department and ask if the AA Form they have was the latest. During a concurrent interview and record review on 3/26/2026 at 11 a.m. with the AC and the Administrator (ADM), Resident 33's AA was reviewed. Both the AC and ADM stated the verbiage of allowing residents or anyone else from communicating with federal, state, or local officials, including but not limited to, federal and state surveyors, other federal or state health department employees, and representative of the Office of the State Long-Term Care Ombudsman was not on their Arbitration Agreement and they agreed it should be included in the agreement so the residents know they can or are allowed toˆcommunicate to the entities mentioned. 2. During a review of Resident 75's AR, the AR indicated the facility admitted the resident on 3/31/2025, and readmitted the resident on 10/13/2025, with diagnoses including depression (a serious, common mood disorder causing persistent sadness, loss of interest, and exhaustion, lasting at least two weeks) and systolic heart failure (a chronic condition where the heart's main pumping chamber (left ventricle) becomes weak, enlarged, or damaged). During a review of Resident 75's H&P, dated 10/15/2025, the H&P indicated the resident had the capacity to understand and make decisions. During a review of Resident 75's MDS, dated [DATE], the MDS indicated the resident had intact cognition (having a clear, sharp, and functioning mind that allows a person to think, learn, remember, and make decisions effectively). During a review of Resident 75's (continued on next page)

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F 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	AA, electronically signed by Resident 75 on 4/1/2025, the AA did not indicate the resident were allowed to communicate with federal, state, or local officials such as federal and state surveyors, other federal or state health department employees and representative of the Office of the State Long Term Care Ombudsman. During a concurrent interview and record review on 3/26/2026, at 9:46 a.m., with the AC, Resident 75's AA was reviewed. The AC stated nothing on the AA mention about allowing the resident or anyone else (e.g., resident's representative) to communicate with federal, state, or local officials such as federal and state surveyors, other federal or state health department employees and representative of the Office of the State Long Term Care Ombudsman. The AC stated she will call their legal department and ask if the AA Form they have was the latest. During a concurrent interview and record review on 3/26/2026 at 11 a.m. with the AC and the ADM, Resident 75's AA was reviewed. Both the AC and ADM stated the verbiage of allowing residents or anyone else from communicating with federal, state, or local officials, including but not limited to, federal and state surveyors, other federal or state health department employees, and representative of the Office of the State Long-Term Care Ombudsman was not on their Arbitration Agreement and they agreed it should be included in the agreement so the residents know they can or are allowed toˆcommunicate to the entities mentioned. 3. During a review of Resident 93's AR, the AR indicated the facility admitted the resident on 6/10/2024, and readmitted the resident on 2/27/2026, with diagnoses including acute embolism ('plug' or 'stopper' or a clot that blocks blood flow) and thrombosis (the formation of aˆblood clot (called a thrombus) inside a blood vesselˆ(a vein or an artery) that restricts or completely blocks the normal flow of blood) of deep veins in the lower extremity, bilateral and diverticulitis (a digestive condition that occurs when small, bulging pouches (diverticula) in the lining of the large intestine (colon) become inflamed or infected) of intestine. During a review of Resident 93's H&P, dated 10/18/2025, the H&P indicated the resident had the capacity to understand and make decisions. During a review of Resident 93's AA, electronically signed by Resident 93 on 3/10/2026, the AA did not indicate the resident were allowed to communicate with federal, state, or local officials such as federal and state surveyors, other federal or state health department employees and representative of the Office of the State Long Term Care Ombudsman. During a concurrent interview and record review on 3/26/2026 at 9:46 a.m. with the AC, Resident 93's AA was reviewed. The AC stated nothing on the AA mention about allowing the resident or anyone else (e.g., resident's representative) to communicate with federal, state, or local officials such as federal and state surveyors, other federal or state health department employees and representative of the Office of the State Long Term Care Ombudsman. The AC stated she will call their legal department and ask if the AA Form they have was the latest. During a concurrent interview and record review on 3/26/2026 at 11 a.m. with the AC and the ADM, Resident 93's AA was reviewed. Both the AC and ADM stated the verbiage of allowing residents or anyone else from communicating with federal, state, or local officials, including but not limited to, federal and state surveyors, other federal or state health department employees, and representative of the Office of the State Long-Term Care Ombudsman was not on their Arbitration Agreement and they agreed it should be included in the agreement so the residents know they can or are allowed toˆcommunicate to the entities mentioned. During a review of the facility's recent policy and procedure (P&P) titled, Arbitration, last revised on 9/10/2025, the P&P indicated under Policy Interpretation and Implementation, the agreement may not contain language that prohibits or discourages communications with federal, state, or local officials, including federal, state, or local officials, including federal and state surveyors, otherˆ federal or state health department employees, and representatives of the Office of the State Long Term Care Ombudsperson.

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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 interview and record review the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections by failing to ensure: 1. Certified Nurse Assistant (CNA) 3 washed hands after removing gloves from changing Resident 26's diaper and proceeded to leave the room, observed during infection control tasks. 2. Linen carts for resident's personal clothing were not covered with a loosely woven/permeable (having pores or openings that permit liquids or gases to pass through) material to protect the linens inside the cart, observed during infection control tasks. 3. The water in the facility was above 108 degrees Fahrenheit (F - a unit of measurement for temperature) based on the Centers for Disease Control Prevention (CDC - federal government agency that works to protect public health) Toolkit: Developing a Legionella (a bacteria found naturally in water and soil) Water Management Program that the facility is observing during infection control tasks. 4. Licensed Vocational Nurse (LVN) 4 properly disinfected (cleanse of bacteria that may cause disease) the glucometer (blood glucose meter - device that measures the amount of glucose [sugar] in the blood of someone with diabetes mellitus (DM II - a disorder characterized by difficulty in blood sugar control and poor wound healing) prior to placing the used glucometer in Medication Cart 4 (MC 4) for one (1) of three (3) sampled residents (Resident 66) observed during the medication administration task. These deficient practices had a potential to spread infections and illnesses among residents. Findings: 1. During a review of Resident 26's admission Record (front page of the chart that contains a summary of basic information about the resident), the admission Record indicated the facility admitted the resident on 3/11/2026 with diagnoses including fracture of head and neck of right femur (broken thigh bone), DM, hypothyroidism (thyroid gland not making enough thyroid hormones to meet body needs), anxiety (a mental health disorder characterized by feelings of worry or fear that interfere one's daily activities), hypertension (high blood pressure) and history of falling. During a review of Resident 26's History and Physical (H&P), dated 3/13/2026, the H&P indicated the resident did not have the capacity to understand and make decisions. During a review of Resident 26's Minimum Data Set (MDS - a resident assessment tool), dated 3/16/2026, the MDS indicated that Resident 26's cognitive skills for daily decision making is moderately impaired (decisions poor; cues/supervision required). The MDS indicated Resident 26 required supervision or touching assistance (helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completed activity) with oral, toileting and personal hygiene. The MDS also indicated that Resident 26 is dependent on staff (helper does all of the effort) in putting on/taking off shoes. During a concurrent observation and interview on 3/23/2026 at 9:57 a.m., with CNA 3, inside Room A, with Resident 26 and Resident 53, CNA 3 changed Resident 26 adult brief and removed her gown and gloves without performing proper hand hygiene after removal. CNA 3 stated she should have used a hand sanitizer or washed her hands after removing her gloves after providing care to Resident 26. CNA 3 stated that without performing hand hygiene after giving care to a resident, cross-contamination (the process by which bacteria or other microorganisms are unintentionally transferred from one substance or object to another, with harmful effect) can occur especially when there are two residents in one room. During an interview on 3/25/2026 at 2:10 p.m. with Registered Nurse (RN) 1, RN 1 stated that (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	handwashing is important especially between resident care as it is a safe practice to prevent cross-contamination and spread infection. During an interview on 3/25/2026 at 2:24 PM with the Assistant Director of Nursing (ADON), the ADON stated that the appropriate length of time for handwashing should be at least 20 seconds. The ADON stated after giving care to each resident, proper hand hygiene must be observed. The ADON stated if hands are not visibly soiled, alcohol-based hand sanitizer can be used. The ADON stated if hands are visibly soiled, hand washing with soap and water must be performed to prevent cross-contamination. 2. During a concurrent observation and interview on 3/24/2026 at 1:19 p.m. with Laundry Personnel (LP) 1, in the laundry area, observed linen carts with different covering materials. LP 1 stated that he is responsible for doing the laundry linens. LP 1 stated that the linen carts are covered with green non-woven covers while the residents' personal clothing are covered with blue-colored woven/permeable cover to protect the clothing inside the cart and stated that it has always been that way. During an interview on 3/25/2026 at 9:45 a.m. with the Maintenance Supervisor (MS), the MS stated that the cart for the residents' personal clothing has always used blue-colored permeable cover. The MS stated that with the mesh covering, cross-contamination can occur. During a concurrent observation and interview on 3/25/2026 2:35 p.m. with the ADON, inside the laundry area, the ADON stated the maintenance department is responsible for maintaining clean linen carts. The ADON stated that the covers for residents' personal clothing were not totally protected from environmental contamination because air and water can seep through the covers. The ADON further stated that a non-permeable cover should be used to minimize transmission and cross-contamination. 3. During a review of the facility provided Daily Water Temperature Log for the months of January 2026 through March 2026, indicated the following: - On 1/13/2026, in rooms [ROOM NUMBERS], the water temperature was 107 degrees F. - On 1/14/2026, in rooms [ROOM NUMBERS], the water temperature was 108 degrees F. - On 1/22/2026, in rooms [ROOM NUMBERS], the water temperature was 107 degrees F. - On 2/11/2026, in rooms [ROOM NUMBERS], the water temperature was 108 degrees F. - On 2/19/2026, in rooms [ROOM NUMBERS], the water temperature was 107 degrees F. - On 3/5/2026, in rooms [ROOM NUMBERS], the water temperature was 106 degrees F. - On 3/12/2026, in rooms [ROOM NUMBERS], the water temperature was 108 degrees F. - On 3/16/2026, in rooms [ROOM NUMBERS], the water temperature was 108 degrees F. During a concurrent interview and record review on 3/26/2026 at 11:16 a.m. With the MS and the Infection Preventionist (IP), the IP stated that the MS is responsible for the water management (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	program with the involvement of the IP, Administrator, Director of Nursing (DON), and Medical Director. The IP stated that the facility is following the CDC Toolkit: Developing a Legionella Water Management Program. The MS stated that they are doing water temperature control to prevent the growth of water-borne bacteria and should not be less than 106 degrees F and not more than 120 degrees F. The MS and the IP stated that per CDC Toolkit guidelines, the water temperature fluctuations: provide conditions where Legionella grows best (77 degrees F – 108 degrees F); Legionella can still grow outside this range. The MS stated that bacteria can grow if water temperature goes within those ranges. The MS further stated that they do water check temperatures on different locations within the facility and that the facility only uses temperature control, not chemical treatments. During an interview on 3/26/2026 at 1 p.m. with the DON, the DON stated that when water temperature falls within the range where bacteria grow best, there is a risk for bacteria going into the facility's water system that could potentially cause illness among residents. 4. During a review of Resident 66's admission Record, the admission Record indicated the facility admitted the resident on 6/2/2023 with diagnoses including acute respiratory failure with hypoxia (a condition that happens when the body did not have enough oxygen in the blood leading to low oxygen levels), tracheostomy (an opening a surgeon makes through the neck and into the trachea [also known as windpipe] to help a patient breathe), and cardiac arrest (a condition when the heart suddenly stops beating and ca no longer pump blood to the brain and other vital organs and can be fatal). During a review of Resident 66's H&P, dated 6/2/2025, the H&P indicated Resident 66 did not have the capacity to understand and make decisions. During a review of Resident 66's MDS, dated [DATE], the MDS indicated Resident 66 had severely impaired cognition (mental action or process of acquiring knowledge and understanding) and was not able to understand and make her needs known. The MDS further indicated Resident 66 had impairment of both upper and lower extremities and required total assistance from staff with all activities of daily living (ADLs- activities such as bathing, dressing and toileting a person performs daily). During a review of Resident 66's Order Summary Report, dated 3/26/2026, the Order Summary Report indicated a physician's order for insulin lispro, inject subcutaneously (under the skin) per sliding scale (dosage of medication is determined by the resident's blood sugar) every six (6) hours for DM II, dated 9/30/2024. During a medication pass observation on 3/25/2025 at 12 p.m. with LVN 4, at MC 4, LVN 4 stated she would check Resident 66's blood sugar. Observed an enhanced barrier precaution (EBP - an infection control intervention designed to reduce transmission of multidrug-resistant organisms [MDRO - microorganisms, mainly bacteria, that are resistant to one or more classes of antibiotics] that uses targeted gown and glove use during high contact resident care activities) was posted at Resident 66's door. Observed LVN 4 remove a glucometer from MC 4 and disinfected with alcohol swab from the front to the back in 1 sweeping motion, disinfected the bedside table with Disinfectant Wipe (DW) 1, gathered all the equipment and placed the glucometer on the resident's bedside table, used a disposable lancet (sharp needle that's used to prick the skin to draw a small amount of blood) on the resident's finger, placed a test strip in the glucometer, and angled the glucometer at the resident's finger to test the blood. After the test was completed LVN 4 then removed and disposed of the used test strip, walked back to MC 4 after administration of the insulin. Observed LVN 4 used an alcohol (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	pad to clean the glucometer with one sweeping motion on the middle part from front to back. LVN 4 stated they were told to clean the glucometers using alcohol pad in 1 sweeping motion in the middle from front to back. LVN 4 stated each medication cart has DW 1 and is used for disinfecting any resident care equipment before and after use. LVN 4 disinfecting the glucometer in 1 sweeping motion in the middle from front to back did not disinfect the glucometer properly as Resident 66 as well as other residents in the unit is on EBP due to indwelling devices such as tracheostomy and is at risk for developing MDROs. LVN 4 stated not disinfecting the glucometer can cause cross contamination and placed Resident 66 and other residents at risk for acquiring infection due to not disinfecting the glucometer properly During an interview on 3/25/2026 at 12:40 p.m. with the Subacute Coordinator (SAC), the SAC stated each medication cart has a canister of DW 1 and the licensed nurses are supposed to use the DW 1 when disinfecting any resident care equipment such as the glucometer and should be wiped all over paying close attention to where the test strip was inserted not just on one 1 area of the glucometer. The SAC stated all residents in the subacute unit all have tracheostomy and were all at risk for acquiring infection if any shared resident care equipment was not disinfected properly. The SAC stated that LVN 4 should have properly disinfected the glucometer after use on Resident 66 by wiping the unit with DW 1 all over the sides, front, and back as it placed Resident 66 and other residents for acquiring infection. During a review of the facility's Policy and Procedure (P&P) titled, Handwashing/Hand Hygiene last revised in October 2023, the P&P indicated the facility considers hand hygiene the primary means to prevent the spread of healthcare-associated infections. Hand hygiene is indicated: - Immediately before touching a resident; - After contact with blood, body fluids, or contaminated surfaces; - After touching a resident; - After touching the resident's environment; - Before moving from work on a soiled body site to a clean body site on the same resident; and - Immediately after glove removal. Use an alcohol-based hand rub containing at least 60% alcohol for most clinical situations. Wash hands with soap and water: - When hands are visibly soiled; and Single-use disposable gloves must be used: - Before aseptic procedures. - When anticipating contact with blood or body fluids; and - When in contact with a resident, or the equipment or environment of a resident, who is on contact (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	precautions. The use of gloves does not replace hand washing/hand hygiene. During a review of the facility's P&P titled, Department (Environment Services) Laundry and Linen, last revised on December 2025, the P&P indicated that the purpose of this procedure is to provide a process for safe and aseptic handling, washing, and storage of linen. - Clean linen will remain hygienically clean (free of pathogens [tiny organisms that cause disease] in sufficient numbers to cause human illness) through measures designed to protect it from environmental contamination, such as covering clean linen carts. During a review of the facility's P&P titled, Legionella Surveillance and Detection, last revised December 2022, the P&P indicated, Our facility is committed to the prevention, detection and control of water-borne contaminants, including Legionella. Legionnaire's disease is included as part of our infection surveillance activities. Policy Interpretation and Implementation - Legionella can grow in parts of building water systems that are continually wet (e.g., pipes, faucets, water storage tanks, decorative fountains), and certain devices can spread contaminated water droplets via aerosolization. During a review of the facility P&P titled, Policies and Practices - Infection Control, last reviewed 9/10/2025, the P&P indicated the facility's infection control policies and practices are intended to facilitate maintaining a safe, sanitary and comfortable environment and to help prevent and manage transmission of diseases and infections. The P&P further indicate that the objectives the infection control policies and practices are to prevent, detect, investigate, and control infections in the facility, and provide guidelines for the safe cleaning and reprocessing or reusable resident-care equipment. During a review of the facility P&P titled, Obtaining a Fingerstick Glucose Level, last reviewed on 9/10/2025, the P&P indicated always ensure that blood glucose meters intended for reuse are cleaned and disinfected between resident uses. The P&P further indicated to clean and disinfect reusable equipment between uses according to the manufacturer's instructions and current infection control standards of practice.

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. Based on observation, interview, and record review, the facility failed to maintain sanitary conditions in the food services department when there were five (5) flies (a type of insect) observed in the dishroom. This failure had the potential to result in 71 of 77 residents, who received food from the kitchen, to acquire food borne illnesses (illness caused by consuming contaminated foods or beverages) by consuming potentially contaminated food. Findings: During a concurrent observation and interview on 3/24/2026 at 1:41 p.m., of the dishwashing area with the Dietary Supervisor (DS), observed 5 flies flying and landing from dirty dishes, to trash, then to the clean dishes. The DS stated there were flies flying around the dishwashing area, but she did not know why as the pest control company just came in this morning. During an interview on 3/24/2026 at 1:53 p.m. with the DS, the DS stated flies were landing on the clean dishes and the area needed to be fly free to keep the clean dishes away from the flies. The DS stated flies could spread diseases and bacteria to the residents as a potential outcome. During a review of facility's policies and procedures (P&P) titled, Pest Control, dated 9/10/2025, the P&P indicated, Our facility shall maintain an effective pest control program. (1) This facility maintains an on-going pest control program to ensure that the building.

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. Based on interview and record review, the facility failed to honor the resident's right to be informed in advance by the physician or other practitioner or professional, of the risks and benefits of proposed care, treatment, and treatment alternative or option for one of one sampled resident (Resident 73) reviewed for informed consents (voluntary agreement to accept treatment and/or procedures after receiving education regarding the risks, benefits, and alternatives offered) by failing to complete Resident 73's informed consent on the use of bolsters and matched the physician's order. This deficient practice violated the resident's/resident representative's right to make an informed decision regarding the use of the bolsters. Findings: During a review of Resident 73's admission Record (front page of the chart that contains a summary of basic information about the resident), the admission Record indicated the facility originally admitted the resident on 9/14/2018 and readmitted in the facility on 9/15/2025 with diagnoses including chronic respiratory failure (a long-term condition that happens when your lungs cannot get enough oxygen into the blood), tracheostomy (an opening a surgeon makes through the neck and into the trachea [also known as windpipe] to help a resident breathe), and quadriplegia (paralysis from the neck down, including legs, and arms, usually due to a spinal cord injury). During a review of Resident 73's History and Physical (H&P), dated 9/23/2025, the H&P indicated Resident 73 did not have the capacity to understand and make decisions. During a review of Resident 73's Minimum Data Set (MDS - a resident assessment tool), dated 2/18/2026, the MDS indicated Resident 73 had severely impaired cognition (mental action or process of acquiring knowledge and understanding) and was not able to understand and make his needs known. The MDS further indicated Resident 73 had impairment of both upper and lower extremities and required total assistance from staff with all activities of daily living (ADLs - basic tasks that must be accomplished every day for an individual to thrive). During a review of Resident 73's Order Summary Report, dated as of 3/26/2026, the Order Summary Report indicated a physician's order for bilateral bolster on bed for comfort, positioning and safety dated 9/23/2025. During a review of Resident 73's informed consent form, dated 9/23/2025, the informed consent indicated that a phone consent was obtained by the physician from the party responsible. The informed consent indicated that the facility verified an informed consent was obtained for the use of bolsters but did not indicate the reason for the use of the device. During a review of Resident 73's fall risk assessments dated 8/20/2025, 11/28/2025, and 2/18/2026, the fall risk assessments indicated Resident 73 was at a risk for falls. During a review of Resident 77's care plan (CP) on risk for falls, initiated on 9/15/2018 and last revised on 3/6/2026, the CP indicated the use of bilateral bolster in bed for comfort, positioning, and safety as one of the interventions to minimize falls or injury. During an observation on 3/23/2026 at 11:33 a.m. inside Resident 73's room, observed Resident 73 lying in bed with triangular shaped bolsters on both sides of the bed and strapped around the bed frame. During a concurrent observation and interview on 3/25/2026 at 9:30 a.m. inside Resident 73's room with the Subacute Coordinator (SAC), the SAC stated that the bilateral bolsters were strapped on the bedframe and are used for resident safety and positioning. During a concurrent interview and record review on 3/25/2026 at 1:54 p.m. the SAC, Resident 73's physician's order, informed consent, fall risk assessments, and CP were reviewed. The SAC stated Resident 73 had a physician's order for bilateral bolsters in bed for comfort, positioning, and safety. The SAC stated the fall risk assessments indicated Resident 73 was at a risk for falls, and the CP indicated the use of bolsters as one of the interventions to minimize resident falls/injury. The SAC stated that the informed consent did not indicate the reason for the use of bilateral bolsters in bed. The SAC stated when obtaining informed consent from the resident and/or responsible party, the informed consent should be complete to indicate the device/restraint to be used and the reason for the use of the device/restraint. The SAC stated that Resident 73's informed consent should have been complete to indicate the reason for the use of the bilateral bolsters to give the resident and/resident representative the opportunity to accept or decline the use of the device for Resident (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	73's safety and minimize falls or injury. The SAC stated that the policy on Use of Restraints to include the specific reason for the restraint was not followed. During a review of the facility's policy and procedure (P&P) titled, Use of Restraints, last reviewed on 9/10/2025, the P&P indicated that restraints shall only bed used upon the written order of the a physician and after obtaining a consent from the resident and/or representative and should include the specific reason for the restraint as it relates to the resident's medical symptom, how the restraint will be used to benefit the resident's medical symptom, and the type of restraint, and period of time for the use of the restraint.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observation, interview, and record review, the facility failed to honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and support for daily living safely for one of seven sampled residents (Resident 84) reviewed under environment facility task by failing to ensure Resident 84 did not have a dilapidated (in very bad condition because of age or lack of care) bedside drawer on the resident's room.^ The deficient practice had violated the resident's right to a safe, clean, comfortable, and homelike environment that can potentially lead to the resident`s depression and not feeling welcomed. Findings: During a review of Resident 84's admission Record (AR), the AR indicated the facility admitted the resident on 11/25/2025, with diagnoses including major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), anxiety disorder (a mental health condition characterized by excessive, persistent, and uncontrollable fear or worry that interferes with daily life), and age-related physical debility (the gradual loss of strength, energy, and physical function that happens with older age, making a person more vulnerable to health issues and less able to handle daily activities). During a review of Resident 84's History and Physical (H&P), dated 11/26/2025, the H&P indicated the resident had impaired mental status, and did not follow commands. The H&P indicated the resident did not have the capacity to understand and make decisions. During a concurrent observation and interview on 3/23/2026, at 10:26 a.m., with the Director of Nursing (DON), inside Resident 84's room, observed Resident 84's bedside drawer dilapidated, with multiple tapes on to keep the furniture intact. Resident 84's drawer was not properly maintained, when pulled out, could fall apart into pieces. The DON stated the drawer had multiple tapes to keep the drawer intact and when you pull the drawer it could fall off and hurt the resident. The DON stated the dilapidated drawer was not promoting a homelike environment to the resident. During an interview on 3/25/2026, at 1:48 p.m., with the Assistant Director of Nursing (ADON), the ADON stated it was not appropriate to have broken furniture on Resident 84's environment because it does not promote a homelike environment. The ADON stated the policy and procedure (P&P) titled Homelike Environment, was not followed. The ADON also stated the broken furniture can make the resident feel unwelcomed and depressed. During a review of the facility's recent P&P titled, Homelike Environment, last reviewed on 9/10/2025, the P&P indicated residents are provided with a safe, clean, comfortable environment and encouraged to use their personal belongings to the extent possible. Policy Interpretation and Implementation 1. Staff provides person-centered care that emphasizes the resident's comfort, independence and personal needs and preferences. 2. The facility staff and management maximize, to the extent possible, the characteristics of the facility reflect a personalized, homelike setting. These characteristics include: a. clean, sanitary, and orderly environment. d. personalized furniture and room arrangements.

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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. Based on interview and record review, the facility failed to follow its policy and procedure (P&P) regarding transfers and discharge by failing to ensure that necessary medical information was communicated to the receiving long term care facility for one (1) of three (3) sampled residents (Resident 118) during a review of closed records. This deficient practice placed Resident 118 at risk for a delay in the continuity of care and receiving the services and treatment the resident needed. Findings: During a review of Resident 118's admission Record, the admission Record indicated the facility admitted the resident on 1/8/2026 with diagnoses including dementia (a progressive state of decline in mental abilities), difficulty in walking, and heart failure (a heart disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling). During a review of Resident 118's History and Physical (H&P), dated 1/9/2026, the H&P indicated the Resident 118 had the capacity to understand and make decisions. During a review of Resident 118's Minimum Data Set (MDS - a resident assessment tool), dated 1/13/2026, the MDS indicated Resident 118 had moderately impaired cognition (mental action or process of acquiring knowledge and understanding) and was able to understand others and make his needs known. The MDS further indicated Resident 118 required setup or clean-up assistance with eating; supervision or touching assistance with oral hygiene; partial/moderate assistance with upper body dressing and personal hygiene; substantial/maximal assistance from staff with all other activities of daily living (ADLs - basic tasks that must be accomplished every day for an individual to thrive). During a review of Resident 118's Order Summary Report, dated as of 3/26/2026, the Order Summary Report indicated a physician's order dated 1/13/2026 to discharge Resident 118 to Skille Nursing Facility (SNF) 1. During a review of Resident 118's Social Services Notes, dated 1/12/2026, the Social Services Notes indicated that the Social Services Director (SSD) received a message from the resident representative with a request to transfer Resident 118 to SNF 1 where the resident used to reside. During a review of Resident 118's Discharge Summary Note, dated 1/14/2026, the Discharge Summary Note indicated the resident was discharged to SNF 1 per family request. The Discharge Summary Note further indicated the physician was notified of the discharge. The Discharge Summary Note did not indicate a verbal report was provided to the SNF 1 prior to Resident 118's transfer. During a review of Resident 118's Discharge Instruction Form/Recapitulation of Stay, dated 1/14/2026, the Discharge Instruction Form/Recapitulation of Stay did not indicate the name of the next provider, the provider type, and that e verbal report was provided to SNF 1. During a concurrent interview and record review on 3/25/2026 at 1:03 p.m. with Registered Nurse (RN) 2, Resident 118's physician's order, Social Services Notes, Discharge Summary Notes, and Discharge Instruction Form/Recapitulation of Stay were reviewed. RN 2 stated that Resident 118 had a physician's order to discharge the resident to SNF 1, dated 1/13/2026, and that the Discharge Summary Notes, and Discharge Instruction Form/Recapitulation of Stay did not indicate that a verbal report was provided to SNF 1 and did not indicate the name of the next provider and provider type. RN 2 stated that the process for discharging residents to another long-term care facility is the licensed nurse will complete the Discharge Instruction Form/Recapitulation of Stay to include the name of the next provider and provider type and document that a report was provided to the receiving facility. RN 2 stated that upon discharge, the Discharge Instruction Form/Recapitulation of Stay and a list of the medications the resident will be discharged with will be sent with the resident. RN 2 stated that the discharging nurse has to call the receiving facility for a report for continuity of care and for the receiving facility to be aware of the resident's current status and document in the resident's medical record. RN 2 stated that she was the one who discharged Resident 118 and she did not document that she called SNF 1 for a report on the resident. RN 2 stated that she should have documented that she called SNF 1 for a report prior to Resident 118 discharge to ensure that SNF 1 was aware of the resident current functional status and current plan (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	of care. RN 2 stated if the report was not documented, it placed Resident 118 for a delay in receiving the care and services he needed. During an interview on 3/26/2026 1 p.m. with the Assistant Director of Nursing (ADON), the ADON stated that when discharging residents, the discharging nurse has to call the receiving facility or hospital for a report to ensure the receiving facility was aware of the resident's current status including level of functioning, any isolation status, and the medications and document in the resident's medical record. The ADON stated that the Discharge Instruction Form/Recapitulation of Stay will be completed by the discharging nurse to include the next provider and provider type. The ADON stated that RN 2 should have documented that she called SNF 1 for a report to ensure SNF 1 was aware of the resident's current tatus for continuity of care and prevent delay in the delivery of care and services Resident 118 needed. During a review of the facility's P&P titled, Discharging the Resident, last reviewed on 9/10/2025, the P&P indicated that if the resident is being discharged to a hospital or another facility, ensure that a transfer summary is completed and telephone report is call to the receiving facility. The P&P further indicated that the date and time the discharge was made should be recorded in the resident's medical record.

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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. Based on observation, interview, and record review, the facility failed to ensure a resident`s environment was free of accident hazards for one of three sampled residents (Resident 90) reviewed for accidents by failing to ensure Resident 90 did not have medications or biologicals (medicines derived from living organisms-such as humans, animals, or microorganisms-rather than being created from chemicals) left at the bedside. These deficient practices increase the risk of accidents such as ingestion poisoning on residents. Findings: During a review of Resident 90's admission Record (AR), the AR indicated the facility admitted the resident on 2/27/2026, with diagnoses including dependence on renal dialysis (a person requires regular, ongoing artificial blood filtration to remove waste and excess fluids, usually due to permanent kidney failure (ESRD) or severe acute injury), end stage renal disease (ESRD, irreversible kidney failure), and peritoneal abscess (aˆlocalized pocket of pus (infected fluid) that forms inside the belly (abdomen)). During a review of Resident 90's History and Physical (H&P), dated 3/2/2026, the H&P indicated the resident had the capacity to understand and make decisions. During a review of Resident 90's Minimum Data Set (MDS, a resident assessment tool), dated 3/4/2026, the MDS indicated the resident had the ability to make self-understood and understand others and had moderate cognitive impairment (a stage of brain decline between normal aging and dementia, where memory or thinking issues are noticeable to family and friends but don't severely disrupt daily life). The MDS indicated the resident was dependent to needing supervision on mobility and activities of daily living (ADLs, activities such as bathing, dressing and toileting a person performs daily). During a review of Resident 90's Order Summary Report (OSR) dated 3/23/2026, the OSR indicated an order for Refresh Tears Ophthalmic Solution (Carboxymethylcellulose Sodium (Ophth)). Instill one drop in both eyes every four hours as needed for Dry eyes. During a concurrent observation and interview on 3/23/2026, at 10:13 a.m., with the Hemodialysis Supervisor (HDS), inside Resident 90's room, observed a bottle of Refresh eye drop was left on top of the resident's side table. The HDS stated there should be no medications left at the bedside of the resident for the resident`s safety. During a concurrent interview and record review on 3/25/2026, at 1:31 p.m., with the Assistant Director of Nursing (ADON), Resident 90's OSR was reviewed. The ADON stated the resident does not have any assessment for self-administration of medication and it was not appropriate to leave medication at the bedside. The ADON stated if the residents are capable of self-administering medications, licensed nurses still keep the medications inside the medication cart and provided once needed. The ADON stated the staff failed to keep medication away from Resident 90 by leaving a bottle of eye drop at the bedside (Refresh). The ADON stated the staff should have removed the medication right away for patient safety and there was a potential for confused residents to accidentally ingest the medication that can cause adverse effects (aˆharmful, unintended, and undesired resultˆstemming from a medical treatment, such as taking a prescription drug, over-the-counter medication, or undergoing a procedure). The ADON stated the policy and procedure (P&P) titled Storage of Medications, and Safety and Supervision of Residents, were not followed. During a review of the facility's recent P&P titled, Storage of Medications, last reviewed on 9/10/2026, the P&P indicated medications and biologicals are stored safely, securely, and properly, following manufacturer's recommendations or those of the supplier. The medication supply is accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized. Procedures B. Only licensed nurses, pharmacy personnel, and those lawfully authorized are allowed access to medications. Medication rooms, carts, and medication supplies are locked or attended by persons with authorized access. H. Potentially harmful substances such as urine test reagent tablets, household poisons, cleaning supplies; disinfectants are clearly identified and stored in a locked area separately from medications. During a review of the facility's recent P&P, Safety and Supervision of Residents, last reviewed on 9/10/2025, the P&P indicated our facility strives to make (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the environment as free from accident hazards as possible. Resident safety and supervision and assistance to prevent accidents are facility-wide priorities. Policy Interpretation and Implementation Resident Risks and Environmental Hazards 1. Due to their complexity and scope, certain resident risk factors and environmental hazards are addressed in dedicated policies and procedures. These risk factors and environmental hazards include the following: c. Falls f. Poison Control During a review of the facility's recent P&P titled, Self-Administration of Medications, last reviewed on 9/10/2025, the P&P indicated residents have the right to self-administer medications if the interdisciplinary team has determined that it is clinically appropriate and safe for the resident to do so. Policy Interpretation and Implementation 3. If it is deemed safe and appropriate for a resident to self-administer medications, this is documented in the medical record and the care plan. The decision that a resident can safely self-administer medications is reassessed periodically based on changes in the resident's medical and/or decision-making status. 4. If the team determines that a resident cannot safely self-administer medications, the nursing staff administer the resident's medications. The IDT evaluated options which allow residents to safely participate in the medication administration process if they wish to do so. 8. Self-administered medications are stored in a safe and secure place, which is not accessible by other residents. If storage is not possible in the resident's room, the medications of the residents permitted to self-administer are stored on a central medication cart or in the medication room. A licensed nurse transfers the unopened medication to the resident when the resident requests them. 9. Any medications found at the bedside that are not authorized for self-administration are turned over to the nurse in charge for return to the family or responsible party. During a review of the facility's recent P&P titled, Medication Labeling and Storage, last reviewed on 9/10/2025, the P&P indicated the facility stores all medications and biologicals in locked compartments under proper temperature, humidity, and light controls. Only authorized personnel have access to keys. Policy Interpretation and Implementation Medication Storage 4. Compartments (including, but not limited to, drawers, cabinets, refrigerators, carts, and boxes) containing medications and biologicals are locked when not in use, and trays or carts used to transport such times are not left unattended if open or otherwise potentially available to others.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure residents receiving enteral feeding (EF-also known as tube feeding, a method of supplying nutrients directly into the stomach) received appropriate care and services to prevent complications of enteral feeding for two (2) of two sampled residents (Residents 119 and 43) reviewed for tube feeding when the water flush bag was not changed according to the manufacturer's recommendations. This deficient practice had the potential to result in altered nutritional status such as dehydration (when the body uses or loses more fluid than it takes in), malnutrition (a serious condition that happens when your diet does not contain the right amount of nutrients), and complications associated with enteral feeding such as gastrointestinal (GI-relating to stomach and intestines) problems such as abdominal pain and diarrhea (loose stool). Findings:a. During a review of Resident 119's admission Record (front page of the chart that contains a summary of basic information about the resident), the admission Record indicated the facility admitted the resident on 3/19/2026, with diagnoses including acute respiratory failure with hypoxia (a condition that happens when the body did not have enough oxygen in the blood leading to low oxygen levels), tracheostomy (an opening a surgeon makes through the neck and into the trachea [also known as windpipe] to help a patient breathe), and gastrostomy (GT - a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems). During a review of Resident 119's History and Physical (H&P) dated 3/20/2026, the H&P indicated Resident 119 was able to make her needs known but cannot make medical decisions. During a review of Resident 119's Minimum Data Set (MDS, a resident assessment tool), dated 3/25/2026, the MDS indicated Resident 119 had severely impaired cognition (mental action or process of acquiring knowledge and understanding) and was usually able to understand and make her needs known. The MDS further indicated Resident required substantial/maximal assistance oral hygiene and totally dependent from staff with all other activities of daily living (ADLs - basic tasks that must be accomplished every day for an individual to thrive). The MDS further indicated Resident 119 received GT feeding. During a review of Resident 119's Order Summary Report dated 3/26/2026, the Order Summary Report indicated the following physician's orders: 3/19/2026: Tube Feeding (TF) 1 at 35 ml milliliters (ml - a unit of measurement) per hour for 20 hours via GT feeding for a total of 700 ml per 1200 kilocalories (kcal - a unit of measurement for energy or calories) for 20 hours or until dose is met. 3/20/2026: Free water flushing at 50 ml per hour for 20 hours via enteral feeding (also known as tube feeding, a method of delivering liquid nutrition directly into the stomach or small intestine using a soft, flexible tube) pump to provide 1000 ml per day. During a review of Resident 119's care plan (CP) on tube feeding initiated on 3/20/2026 and last revised 3/23/2026, the CP indicated to administer free water flush and TF 1 as ordered as a few of the interventions for the resident to be free from aspiration (a medical term for accidentally inhaling food or liquid through the vocal cords into the airway) . During an observation on 2/23/2026 at 10:04 a.m. inside Resident 119's room, observed Resident 119 ?s GT feeding and the water flush bag indicated a date of 3/22/2026 6:10 a.m. During a concurrent observation and interview on 3/23/2026 at 12:19 p.m., inside Resident 119's room with Licensed Vocational Nurse (LVN) 3, LVN 3 stated the water flush bag and TF 1 bag indicated a date of 3/22/2026 6:10 a.m. LVN 3 stated the date and time indicated on TF 1 bag and water flush bag was the date the bags were hung. LVN 3 stated that the facility process when changing water flush bags and feeding bags is that whenever the feeding bag finishes, they change the water flush bag as well. LVN 3 stated she was not aware that the water flush cannot be used for more than 24 hours. During a concurrent interview and record review on 3/25/2026 at 1:55 p.m., with the Subacute Coordinator (SAC), Resident 119's physician's order and the facility provided manufacturer's guideline for the Water Flush Bag (WFB) 1 were reviewed. The SAC stated that (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident 119 had a physician's order for free water flushing at 50 ml per hour for 20 hours. The SAC stated that water flush bags and enteral feeding bags are changed together when the formula in the bag is finished. The SAC stated the manufacturer's guideline or package insert for WFB 1, indicated that the feeding set cannot be used for more than 24 hours. The SAC stated the facility did not follow the manufacturer's recommendation. The SAC stated that they should have followed the manufacturer's recommendation not to use the feeding set for more than 24 hours as it placed Resident 119 at risk for acquiring bacterial infection leading to intolerance of feeding, nausea and vomiting and diarrhea. During a review of the facility's policy and procedure (P&P) titled, Enteral Tube Reefing via Continuous Pump, last reviewed on 9/10/2026, the P&P indicated that the procedure is for the use of a pump for enteral feedings. The P&P further indicated to refer to facility procedures for hang times and administration set changes. During a review of the facility provided manufacturer's guideline or package insert for WFB 1, dated 2024, it indicated that due to the risk of bacterial contamination and overall system accuracy, do not use feeding sets for greater than 24 hours. b. During a review of Resident 43's admission Record, the admission Record indicated the facility admitted the resident on 1/6/2026, with diagnoses including acute and chronic respiratory failure with hypoxia (a sudden worsening of breathing in a patient with a known, long-term lung condition leading to low oxygen levels), tracheostomy, and gastrostomy. During a review of Resident 43's History and Physical (H&P) dated 1/8/2026, the H&P indicated Resident 43 had the capacity to understand and make decisions. During a review of Resident 43's MDS dated [DATE], the MDS indicated Resident 43 had severely impaired cognition (mental action or process of acquiring knowledge and understanding) and was usually able to understand and make her needs known. The MDS further indicated Resident 43 required substantial/maximal assistance with oral hygiene, rolling left and right, lying to sitting on side of bed and totally dependent from staff with all other activities of daily living (ADLs - basic tasks that must be accomplished every day for an individual to thrive). The MDS further indicated Resident 43 received GT feeding. During a review of Resident 43's Order Summary Report dated 3/26/2026, the Order Summary Report indicated the following physician's orders: 1/6/2026: TF 2 via GT for a total of 100 ml per 1500 kcal at 50 ml per hours for 20 hours or until the dose is met. 2/25/2026; Free water flushing at 45 ml per hour for 20 hours to provide 900 ml of free water. During a review of Resident 43's CP on tube feeding initiated on 1/7/2026 and last revised 3/23/2026, the CP indicated to administer the free water flush and TF 2 as ordered as a few of the interventions for the resident to be free from complications related to tube feeding. During an observation on 2/23/2026 at 10:51 a.m. inside Resident 43's room, observed Resident 43 ?s GT feeding and the water flush bag indicated a date of 3/22/2026 6:10 a.m. During a concurrent observation and interview on 3/23/2026 at 12:23 p.m., inside Resident 43's room with LVN 3, LVN 3 stated that the water flush bag and TF 2 bag indicated a date of 3/22/2026 6:10 a.m. LVN 3 stated the date and time indicated on TF 2 bag and water flush bag was the date the bags were hung. LVN 3 stated that the facility process when changing water flush bags and feeding bags is that whenever the feeding bag finishes, they change the water flush bag as well. LVN 3 stated she was not aware that the water flush cannot be used for more than 24 hours. During a concurrent interview and record review on 3/25/2026 at 1:55 p.m., with the SAC, Resident 43's physician's order and the facility provided manufacturer's guideline for WFB 1 were reviewed. The SAC stated that Resident 43 had a physician's order for free water flushing at 45 ml per hour for 20 hours. The SAC stated that water flush bags and enteral feeding bags are changed together when the formula in the bag is finished. The SAC stated the manufacturer's guideline or package insert for WFB 1, indicated that the feeding set cannot be used for more than 24 hours. The SAC stated the facility did not follow the manufacturer's recommendation. The SAC stated that they should have followed the manufacturer's recommendation not to use the feeding set for more than 24 hours as it placed Resident 43 at risk for acquiring bacterial infection leading to intolerance of feeding, nausea and vomiting and diarrhea. During a review of the facility's policy and procedure (P&P) titled, Enteral Tube Reefing via Continuous Pump, (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	last reviewed on 9/10/2026, the P&P indicated that the procedure is for the use of a pump for enteral feedings. The P&P further indicated to refer to facility procedures for hang times and administration set changes. During a review of the facility provided manufacturer's guideline or package insert for WFB 1, dated 2024, it indicated that due to the risk of bacterial contamination and overall system accuracy, do not use feeding sets for greater than 24 hours.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 respiratory care provided to residents was consistent with professional standards of practice for two of three sampled residents (Residents 111 and 90) reviewed for respiratory care by failing to ensure: 1. Resident 111's oxygen via nasal cannula (a lightweight, flexible plastic tube used to deliver supplemental oxygen directly into a person's nostrils), dated 3/12/2026,ˆwasˆdiscarded and replaced with a new setup.ˆ 2. Resident 90's bottle of sterile water for inhalation 1000 milliliters (ml - a unit of volume) with a date opened on 3/1/2026 was discarded. These deficient practices had the potential for residents to develop complications such as shortness of breath and desaturation (low levels of oxygen in the blood) and respiratory infections. Findings: 1. During a review of Resident 111's admission Record (AR), the AR indicated the facility admitted the resident on 7/16/2025, and readmitted the resident on 3/6/2026, with diagnoses including acute respiratory failure (a serious condition where the lungs cannot get enough oxygen into the blood or fail to remove carbon dioxide from the blood, leading to oxygen starvation or toxic gas buildup) with hypoxia (a dangerous condition where your body tissues and organs do not receive enough oxygen to function properly), and abnormalities of breathing. During a review of Resident 111's History and Physical (H&P), dated 3/8/2026, the H&P indicated the resident did not have the capacity to understand and make decisions. During a review of Resident 111's Minimum Data Set (MDS - a resident assessment tool), dated 3/12/2026, the MDS indicated the resident had the ability to make self-understood and understand others and had intact cognition (having a clear, sharp, and functioning mind that allows a person to think, learn, remember, and make decisions effectively). During a review of Resident 111's Order Summary Report (OSR), dated 3/23/2026, the OSR indicated an order for oxygen at 2-3 liters per minute (L/min, isˆthe measure of how much oxygen is delivered by the device every minute) via nasal cannula if needed (prn) for diagnosis shortness of breath (SOB)/Asthma (a long-term (chronic) lung condition where the airways become swollen, narrow, and inflamed, making it hard to breathe). During a concurrent observation and interview on 3/23/2026, at 10:06 a.m., with Restorative Nursing Assistant (RNA) 1, inside Resident 111's room, observed Resident 111's oxygen tubing via nasal cannula placed inside a plastic bag, dated 3/12/2026. RNA 1 stated the nasal cannula tubing should have been changed last Wednesday (3/18/2026) to prevent buildup of bacteria on the tubing that can cause a resident to get sick. During a concurrent interview and record review on 3/25/2026, at 1:40 p.m., with the Assistant Director of Nursing (ADON) Resident 111's OSR and CP were reviewed. The ADON stated the oxygen via nasal cannula setup should have been discarded and replaced with a new setup to prevent respiratory infection to Resident 111. The ADON stated the oxygen tubing should be changed weekly. The ADON stated there was an order for O2 2-3L/min on 3/23/2026, with a care plan on Oxygen therapy. The ADON stated the policy and procedure (P&P) titled, Departmental (Respiratory Therapy) - Prevention of Infection, was not followed. 2. During a review of Resident 90's AR, the AR indicated the facility admitted the resident on 2/27/2026, with diagnoses including chronic obstructive pulmonary disease (COPD - a chronic lung disease causing difficulty in breathing), obstructive sleep apnea (a common sleep disorder where breathing repeatedly stops and starts because throat muscles relax too much, blocking the airway during sleep), and chronic diastolic heart failure (a long-term condition where the heart's main pumping chamber becomes stiff and cannot relax properly between beats). During a review of Resident 90's H&P, dated 3/2/2026, the H&P indicated the resident had the capacity to understand and make decisions. During a review of Resident 90's MDS, dated [DATE], the MDS indicated the resident had the ability to make self-understood and understand others and had moderate cognitive impairment (a stage of brain-related decline between mild impairment, characterized by noticeable difficulties with memory, thinking, or language that interfere with daily tasks). The MDS indicated the resident had a non-invasive mechanical ventilator (a machine that (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	helps a patient breathe by providing air under pressure through a tight-fitting mask (nasal or face) rather than an endotracheal tube). During a concurrent observation and interview on 3/23/2026, at 10:13 a.m., with the Hemodialysis Supervisor (HDS), inside Resident 90's room, observed Resident 90 had a bottle of sterile water for inhalation 1000 ml with an opened date of 3/1/2026. The HDS stated he does not know when to discard the bottled after opening them, he will ask the RN supervisor and will get back to the surveyor. During a concurrent observation and interview on 3/23/2026, at 10:20 a.m., with Licensed Vocational Nurse (LVN) 1, inside Resident 90's room, observed Resident 90 had a bottle of sterile water for inhalation 1000 ml with an open date of 3/1/2026. LVN 1 stated it had an expiration date of 6/2029, however when opened it should be discarded within 24 hours and it is a single patient use. LVN 1 stated the failure of the staff to discard the bottle of sterile water for inhalation with an open date of 3/1/2026 had the potential for Resident 90 to develop respiratory infection due to outdated bottle of sterile water. During an interview on 3/25/2026, at 1:37 p.m., with the ADON, the ADON stated the 1000 ml bottle of sterile water for inhalation is for one-time use and should be discarded. The ADON stated the P&P titled, Departmental (Respiratory Therapy) - Prevention of Infection, was not followed and can potentially cause respiratory infection to Resident 90.ˆ During a review of the facility's recent P&P titled, Departmental (Respiratory Therapy) - Prevention of Infection, last reviewed on 9/10/2025, the P&P indicated the purpose of this procedure is to guide prevention of infection associated with respiratory therapy tasks and equipment, including ventilators, among residents and staff. General Guidelines 1. Distilled water used in respiratory therapy must be dated and initialed when opened, and discarded after twenty-four (24) hours. Steps in the Procedureˆ 3. [NAME] bottle with date and initials upon opening and discard after twenty-four (24) hours. 7. Change the oxygen cannula and tubing every seven (7) days, or as needed. Infection Control Considerations Related to Medication Nebulizers/Continuous Aerosol: 9. Discard administration set-up every seven (7) days.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed timely identification and removal (from current medication supply) of medications for disposition for: 1. One (1) of three (3) Medication Storage Room (Medication Storage for Station 1) observed during Medication Storage and Labeling facility task by failing to ensure there were no expired medications in the Medication Storage for Station 1. On 3/25/2026 found an expired Major Co q-10 soft gels (a vitamin-like nutrient naturally produced by the body and found in every cell) withˆexpirationˆdate of 1/2026.ˆ 2. 1 of six (6) Medication Carts (Station 1, Cart 1) observed during Medication Storage and Labeling facility task by failing to discardˆan insulin (a hormone that removes excess sugar from the blood, can be produced by the body or given artificially via medication) lispro Kwik pen (a disposable, pre-filled pen used to injectˆinsulin lispro, a fast-acting, man-made insulin designed to manage blood sugar levels) with an open date of 2/6/2026ˆin Station 1, Cart 1. These deficient practices had the potential for administering expired/outdated medications that can cause potential adverse effects (an unexpected, harmful, or undesirable medical outcome resulting from a medication, treatment, or procedure) on residents. 3. 1 of five (5) sampled residents (Resident 66) during Medication Administration observation by failing to ensure Licensed Vocational Nurse (LVN) 4 checked the electronic medication administration records (eMAR - a daily documentation record used by a licensed nurse to document medications and treatments given to a resident) prior to setting the dose of insulin to be administered to the resident. This deficient practice placed the resident at risk not to receive the appropriate amount of insulin which may lead to abnormal blood sugar level. Findings: 1. During a concurrent observation and interview on 3/25/2026 at 7:59 a.m. with Registered Nurse (RN) 1, inside Medication Storage Room in Station 1, observed a bottle of Major Co q-10 50 milligrams (mg - a unit of weight) soft gels house supply with an expiration date of 1/2026. RN 1 stated the bottle of Major Co q-10 50 mg soft gels house supply was expired. RN 1 stated she does not know how frequently the licensed nurses were checking for expired medications in the Medication Storage Room. RN 1 stated she knew that the Central Supply checks them weekly. RN 1 stated there was no potential for administering expired medications to residents as her licensed nurses are always checking the expiration dates when administering medications. During a concurrent observation and interview on 3/25/2025 at 12 p.m. with Licensed Vocational Nurse (LVN) 4, in front of Resident 66's room, observed LVN 4 remove Insulin Lispro from the 1st drawer on the left side of the med cart. LVN 4 stated the insulin pen was dispensed 2/24/2026 and was not opened until 3/19/2026. LVN 4 compared the insulin pen label with the electronic Medication Administration Record (eMAR) for the resident name and room number. LVN 4 did not read or check the expiration date of the insulin pen. LVN 4 stated the expiration date is 5/16/2028 and stated she forgot to check the expiration date because she was anxious. LVN 4 stated she should have checked the expiration date so she would be sure that the resident will not receive expired medications. During an interview on 3/26/2026 at 8:10 a.m. with the Assistant Director of Nursing (ADON), the ADON stated the licensed staff should have discarded the bottle of Major Co q-10 50 mg soft gels house supply with an expiration date of 1/2026. The ADON stated the RN Supervisors and Licensed Nurses were supposed to check the stocks of medications in the Medication Storage Room daily and every time they access medications in the Medication Storage Room. The ADON stated there could be a potential for administering expired medications to the resident that can cause adverse effects. 2. During a review of Resident 32's admission Record (AR), the AR indicated the facility admitted the (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident on 8/27/2019, and readmitted the resident on 2/25/2025, with diagnoses including type 2 diabetes mellitus (DM - a disorder characterized by difficulty in blood sugar control and poor wound healing), end stage renal disease (ESRD - irreversible kidney failure), and dependence on renal dialysis (a person requires regular, ongoing artificial blood filtration to remove waste and excess fluids, usually due to permanent kidney failure (ESRD) or severe acute injury). During a review of Resident 32's History and Physical (H&P), dated 12/5/2025, the H&P indicated the resident had the capacity to understand and make decisions. During a review of Resident 32's Minimum Data Set (MDS - a resident assessment tool), dated 2/10/2026, the MDS indicated the resident had the ability to make self-understood and understand others and had intact cognition (mental action or process of acquiring knowledge and understanding). The MDS indicated the resident was on a high-risk drug class hypoglycemic (drugs used to lower blood glucose [sugar] levels, primarily to manage DM). During a review of Resident 32's Order Summary Report (OSR), dated 12/3/2025, the OSR indicated an order for Insulin Lispro Injection Solution 100 unit per milliliters (unit/mL - insulin measures theˆconcentrationˆof the medicine—specifically, how many units of insulin are packed into every 1 mL of liquid) (Insulin Lispro) Inject as per sliding scale (a personalized chart or formula that tells a person with diabetes how much fast-acting insulin to inject based on their blood sugar level immediately before a meal or at bedtime): if 150 - 200 = 1 unit (Give orange juice (OJ) eight (8) ounces (oz - a unit of measurement). If blood sugar (BS) is equal or less than 70, and notify MD); 201 - 250 = 2 units; 251 - 300 = 3 units; 301 - 350 = 4 units; 351 - 400 = 5 units (Notify MD if blood sugar (BS) is equal or greater than 400), subcutaneously before meals and at bedtime for DM2 (Administer insulin coverage promptly before or after meals, or with food) (Rotate injection sites). During a concurrent observation and interview on 3/25/2026 at 11 a.m. with LVN 2, during Medication Storage and Labeling facility task, observed Resident 32's insulin lispro Kwik pen with a date opened on 2/6/2026, inside Station 1, Cart 1 Medication Cart. LVN 2 stated the insulin lispro Kwik pen with a date open of 2/6/2026 should have been discarded because it is only good for 28 days once opened. LVN 2 stated the expired insulin lispro Kwik pen with a date opened on 2/6/2026 is expired and it cannot do the possible purpose of the medication. During an interview on 3/26/2026 at 8:10 a.m. with the ADON, the ADON stated the insulin Kwik pen with an opened date of 2/6/2026, should have been discarded because it is only good for 28 days once opened. The ADON stated the failure of the staff to discard the expired insulin pen had the potential to cause hypo (low)/hyperglycemia (high blood sugar) to residents. 3. During a review of Resident 66's AR, the AR indicated the facility admitted the resident on 6/2/2023 with diagnoses including acute respiratory failure with hypoxia (a condition that happens when the body did not have enough oxygen in the blood leading to low oxygen levels), tracheostomy (an opening a surgeon makes through the neck and into the trachea [also known as windpipe] to help a patient breathe), and DM 2. During a review of Resident 66's H&P dated 6/2/2025, the H&P indicated Resident 66 did not have the capacity to understand and make decisions. During a review of Resident 66's MDS, dated [DATE], the MDS indicated Resident 66 had severely impaired cognition and was not able to understand and make her needs known. The MDS further (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	indicated Resident 66 had impairment of both upper and lower extremities and required total assistance from staff with all activities of daily living (ADLs - activities such as bathing, dressing and toileting a person performs daily). The MDS indicated that Resident 66 had a diagnosis of DM 2 and received insulin. During a review of Resident 66's OSR dated 3/26/2026, the OSR indicated a physician's order, dated 9/30/2024, for: - insulin lispro injection solution 100 unit/ml inject as per sliding scale; for blood glucose (BG) less than 70 give glucagon (a hormone that the pancreas make to help regulate the blood glucose sugar levels) 1 mg intramuscular (IM -injecting medication directly into a muscle); if 150-200 give two (2) units, 201-250 give four (4) units, 251-300 give six (6) units, 301-350 eight (8) units; if BG above 351 give ten (10) units and call the physician subcutaneously (under the skin) every 6 hours for DM 2 rotate injection site. During a review of Resident 66's care plan (CP) on DM 2, initiated on 10/1/2024, the CP indicated to administer diabetes medications ordered as one of the interventions to ensure the resident will be free from any signs and symptoms of hypoglycemia (low blood sugar) or hyperglycemia (high blood sugar). During a medication administration observation on 3/25/2026 at 12 p.m. for Resident 66 with LVN 4, LVN 4 gathered all the supplies she needed such as the glucometer (blood glucose meter - device that measures the amount of glucose in the blood of someone with DM 2), disposable lancet (sharp needle that's used to prick the skin to draw a small amount of blood), alcohol swabs, insulin lispro pen injector, and quick injection safety needle, placed in a medication tray. LVN 4 proceeded to check Resident 66's blood sugar and the result was 205 milligram per deciliter (mg/dl – a unit of measurement). LVN 3 then attached the quick injection safety needle into the insulin pen injector and stated that Resident 66 will receive 4 units of insulin according to the sliding scale. LVN 4 stated she did not check the eMAR to verify the amount of insulin to be administered but she remembers the sliding scale. LVN 4 then proceeded to check the eMAR prior to attempting to set the insulin dosage in the pen. LVN 4 stated that prior to administration preparing the dose of a medication such as insulin, the eMAR should be checked first before setting the insulin dose to ensure the resident will receive the correct amount of insulin. LVN 4 stated that she should have checked Resident 66's eMAR first prior to attempting to set the dose on the insulin pen and not go by her memory to be sure that Resident 66 will receive the correct amount of insulin based on the resident's blood sugar level. LVN 4 stated that if she did not check the eMAR first, it placed Resident 66 at risk for receiving less insulin than what she needed which could result to hyperglycemia or more insulin than what she needed which could result to hypoglycemia. During a concurrent interview and record review on 3/25/2026 at 2:05 p.m. with the Subacute Coordinator (SAC), Resident 66's physician's order and CP were reviewed. The SAC stated the eMAR should be checked prior to setting the dose on the resident's insulin pen to ensure that the resident receives the correct amount of insulin based on the result of blood sugar check not by going with the licensed nurses' memory as the resident may not get the correct amount of insulin. The SAC stated that LVN 4 should have checked Resident 66's eMAR prior to setting the dose on the insulin pen as it placed Resident 66 at risk for hypoglycemia and/or hyperglycemia due to receiving more than or less than the prescribed dose by the physician. During a review of the facility's recent policy and procedure (P&P) titled, Storage of Medications, last (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	reviewed on 9/10/2026, the P&P indicated medications and biologicals are stored safely, securely, and properly, following manufacturer's recommendations or those of the supplier. The medication supply is accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized. Procedures M. Outdated, contaminated, or deteriorated medications and those in containers that are cracked, soiled, or without secure closures are immediately removed from stock, disposed of according to procedures for medication disposal, and reordered from the pharmacy if a current order exists. During a review of the facility's P&P titled, Insulin Administration, last reviewed on 9/10/2025, the P&P indicated a purpose to provide guidelines for the safe administration of insulin to residents with diabetes. The P&P further indicated that the type of insulin, dosage requirements, strength, and method of administration must be verified before administration, to assure that it corresponds with the order on the medication sheet and the physician's order.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** During an observation, interview, and record review, the facility failed to ensure drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable for two of six Medication Carts (Station 1 Medication Cart 1 and Station 1 Medication Cart 2), by failing to: 1. Place the name of the resident, a readable room number, and an open date on a bottle of eyeˆdrop (Refreshe, over-the-counterˆartificial tearsˆused to instantly moisturize, lubricate, and soothe dry, gritty, burning, or irritated eyes)ˆin Medication Cart 1 in Station 1.ˆ 2. Plan an open date on Resident 87's bottle of Potassium Citrate-Citric Acid (also known as Potassium CIT-CITRIC ACID, medication that reduces acid in urine in Medication Cart 2 in Station 1. These deficient practices had the potential to administer expired/outdated medications to residents that can cause adverse reactions (anˆunwanted, unpleasant, or harmful effectˆcaused by a medicine or medical treatment). Findings: 1. During a concurrent observation and interview on [DATE] at 11 a.m. with Licensed Vocational Nurse (LVN) 2, during Medication Storage and Labeling facility task, in Station 1, Cart 1, observed a bottled of Refreshe eye drops with an unreadable room number, no resident name, and had no open date. LVN 2 stated the Refreshe eye drop bottle should have the resident's name, room number and the open date to ensure the medication is given to the right resident and the medication was not expired. LVN 2 stated once the bottle of eye drops was open it is only good for 28 days and needed to be discarded to prevent the adverse effects of the medication. During an interview on [DATE] at 8:10 a.m. with the Assistant Director of Nursing (ADON), the ADON stated the staff should have discarded the Refreshe eye drop bottle with no name, unreadable room number, and had no open date as it could cause medication error and there is a potential to administer an expired medication since it did not have an opened date. The ADON stated once a bottle of eye drop is opened, it will be only good for 28 days and should be discarded regardless of the expiration date on the bottle. 2. During a review of Resident 87's admission Record (AR), the AR indicated the facility originally admitted the resident on [DATE] and re-admitted on [DATE], with diagnoses including Aphasia following cerebral infarction (has trouble speaking, understanding, reading or writing after a stroke [when blood flow to part of the brain is cut off, depriving brain cells of oxygen and causing them to die within minutes]); dysphagia following cerebral infarction (difficulty swallowing after a stroke); calculus of kidney (hard stone formed in the kidney). During a review of Resident 87's History and Physical (H&P), dated [DATE], the H&Pˆindicatedˆthe resident has ability to understand and make decisions. During a review of Resident 87's Minimum Data Set (MDS - a resident assessment tool), dated [DATE], the MDS indicated Resident 87 usually makes self-understood and sometimes understands others. The MDS further indicated that Resident 87 had severe cognitive impairment (serious trouble thinking, remembering, or understanding things). The MDS indicated the resident required extensive assistance with bed mobility, transfer, dressing, toilet use, and personal hygiene. During a concurrent observation and interview on [DATE] at 11:43 a.m. withˆLVN 7, during Medication Storage and Labeling facility task, in Station 1, Cart 2,ˆobservedˆa bottled of Potassium (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	CIT-CITRIC ACID for Resident 87 which did not have an open date and was less than half empty. LVN 7 stated there was no open date on bottle and medication should have had an open date. LVN 7 stated that without an open date, staff cannot tell if the medication is expired, which may make it less effective. During an interview on [DATE] at 2:20 p.m. with the ADON, the ADON stated multidose medication bottles should have an open date because without it, staff may not know if the medication is expired, which can lead to medication errors. During a review of the facility's recent policy and procedure (P&P) titled, Medication Labeling and Storage, last reviewed on [DATE], the P&P indicated the facility stores all medications and biologicals in locked compartments under proper temperature, humidity and light controls. Only authorized personnel have access to keys. Policy Interpretation and Implementation Medication Labeling 1. Labeling of medications and biologicals dispensed by the pharmacy is consistent with applicable federal and state requirements and currently accepted pharmaceutical practices. 2. Medication label includes, at a minimum: a. Medication name (generic and/or brand); b. Prescribed dose; c. Strength; d. Expiration date, when applicable; e. Resident's name; f. Route of administration; and g. Appropriate instructions and precautions. 5. Multi-dose vials that have been opened or accessed (e.g., needle punctured) are dated and discarded within 28 days unless the manufacturer specifies a shorter or longer date for the open vial.

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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. Based on interview and record review, the facility failed to implement its policy for antibiotic (medication used to treat infection) stewardship (efforts in long-term care facilities to ensure that antibiotics are used only when necessary and appropriate [means prescribing the right drug at the right dose at the right time for the right duration]) program and infection prevention and control program for one (1) of 1 sampled resident (Resident 119) by failing to clarify with the physician the appropriate indication for the continued use of antibiotic from the hospital. This deficient practice had the potential to increase antibiotic resistance (when bacteria develop the ability to withstand the effects of antibiotics, making it difficult or impossible to treat infections) from unnecessary or inappropriate antibiotic use. Findings: During a review of Resident 119's admission Record (front page of the chart that contains a summary of basic information about the resident), the admission Record indicated the facility admitted the resident on 3/19/2026 with diagnoses including acute respiratory failure with hypoxia (a condition that happens when the body did not have enough oxygen in the blood leading to low oxygen levels), tracheostomy (an opening a surgeon makes through the neck and into the trachea [also known as windpipe] to help a patient breathe), and acute serious otitis media (a middle ear infection or inflammation, commonly caused by bacteria or viruses trapping fluid behind the eardrum). During a review of Resident 119's History and Physical (H&P), dated 3/20/2026, the H&P indicated Resident 119 was able to make her needs known but cannot make medical decisions. During a review of Resident 119's Minimum Data Set (MDS - a resident assessment tool), dated 3/25/2026, the MDS indicated Resident 119 had severely impaired cognition (mental action or process of acquiring knowledge and understanding) and was usually able to understand and make her needs known. The MDS further indicated Resident 119 required substantial/maximal assistance oral hygiene and totally dependent from staff with all other activities of daily living (ADLs - basic tasks that must be accomplished every day for an individual to thrive). The MDS further indicated Resident 119 received antibiotics. During a review of Resident 119's physician's orders, dated 3/19/2026, the physician's order indicated a physician's order for amoxicillin-pot clavulanate (a type of medication that is used to treat different types of infection) oral tablet 875-125 milligrams (mg - a unit of measurement) 1 tab via gastrostomy (GT - a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems) two (2) times a day give 1 tablet for otitis media for (6) days. During a review of Resident 119's care plan (CP) on otitis media, initiated on 3/20/2026, the CP indicated to administer antibiotic as ordered, as one of the interventions so Resident 119 will be free from complications related to infection. During a review of Resident 119's Antibiotic Time Out form, dated 3/23/2026, the Antibiotic Time Out form indicated that Resident 119 did not have a fever, no trending up or down for respirations, pulse rate, and blood pressure, and did not have any signs and symptoms of infection. The Antibiotic Time Out form further indicated that the physician was notified of the current antibiotic order and the physician stated to continue with the antibiotic therapy. During a concurrent interview and record review on 3/26/2026 at 8:22 a.m. with the Infection Preventionist (IP), Resident 119's physician's order, CP, and Antibiotic Time Out form were reviewed. The IP stated that Resident 119 had a physician's order for amoxicillin-pot clavulanate for otitis media upon admission. The IP stated the Antibiotic Time Out form indicated that Resident 119 did not have a fever, no trending up or down for respirations, pulse rate, and blood pressure, and did not have any signs and symptoms of infection. The IP further stated that based on the Antibiotic Time Out form, Resident 119 did not meet the criteria for continuation of the use of antibiotic and the physician recommended to continue. The IP stated if a resident does not meet the criteria for the antibiotic, she notifies the physician and documents what the physician recommended. The IP stated if the physician stated to continue with the antibiotic order, she has to ask the physician for the appropriate indication for the continued use of antibiotic from the hospital. The IP stated she discussed with the physician that Resident 119 did not meet the criteria for the (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	continued use of amoxicillin-pot clavulanate, but she did not ask the physician for the appropriate indication for continued use. The IP stated she should have asked the physician for the appropriate indication for continued use of the amoxicillin-pot clavulanate for Resident 119. The IP stated that continued use of the antibiotic if Resident 119 did not meet the criteria placed Resident 119 at risk for resistance to multiple types of antibiotics, which makes it difficult to treat other infections. During a concurrent interview and record review on 3/26/2026 at 11 a.m. with the Subacute Coordinator (SAC), Resident 119's physician's order, CP, and Antibiotic Time Out form were reviewed. The SAC stated Resident 119 had a physician's order for amoxicillin-pot clavulanate for otitis media upon admission. The SAC stated the Antibiotic Time Out form indicated that Resident 119 did not have a fever, no trending up or down for respirations, pulse rate, and blood pressure, and did not have any signs and symptoms of infection. The SAC stated that based on the Antibiotic Time Out form, Resident 119 did not meet the criteria for continuation of the use of antibiotic and the physician recommended to continue with the antibiotic, The SAC stated the Antibiotic Time Out form did not indicate the appropriate indication for continued use. The SAC stated the IP should have asked the physician for the appropriate indication for the continued use of amoxicillin-pot clavulanate. The SAC stated that continued use of the antibiotic if Resident 119 did not meet the criteria, placed Resident 119 at risk for resistance to multiple types of antibiotics which makes future infections difficult to treat. During a review of the facility's policy and procedure (P&P) titled, Antibiotic Stewardship, last reviewed on 9/10/2026, the P&P indicated that antibiotics will be prescribed and administered to residents under the guidance of the facility's antibiotic stewardship program. The P&P further indicated: - The purpose of the antibiotic stewardship program is to monitor the use of antibiotics in the residents. - Orientation, training and education of staff will emphasize the importance of antibiotic stewardship and will include how inappropriate use of antibiotics affects individual residents and the overall community.

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For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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 implement its Pneumonia Immunization (vaccine for an infection/inflammation in the lungs) policy and procedure (P&P) for one of three sampled residents (Resident 3) investigated under infection control facility task by failing to administer pneumonia vaccine to Resident 3. This deficient practice had the potential to place Resident 3 at risk for respiratory infection including pneumonia (a lung infection). Findings: During a review of Resident 3's admission Record (AR), the AR indicated that the facility originally admitted the resident 4/28/2025, and readmitted on [DATE], with diagnosis including post-traumatic stress disorder (PTSD - a disorder in which a person has difficulty recovering after experiencing, or witnessing a traumatic event), unspecified psychosis (a severe mental condition in which thought, and emotions are so affected that contact is lost with reality) not due to a substance or known physiological condition, other psychoactive substance abuse, dysphagia (difficulty swallowing), acute kidney failure (a sudden, temporary loss of kidney function), and history of colon cancer. During a review of Resident 3's History and Physical (H&P), dated 8/30/2025, the H&P indicated Resident 3 had a past medical history of acute respiratory failure status post (s/p) tracheostomy (a surgically created hole in front of the neck to allow a person to breath directly into their lungs), and had the capacity to understand and make decisions. During a review of Resident 3's Minimum Date Set (MDS-a resident assessment tool) dated 8/30/2025, the MDS indicated Resident 3 was able to make needs known and understand others. The MDS indicated Resident 3 was dependent (helper does all of the effort) with oral hygiene, toileting hygiene, personal hygiene, showers and upper and lower body dressings. During an interview and record review on 3/26/2026 at 9:37 a.m. with Infection Preventionist (IP) Nurse, Resident 3's Immunization Report was reviewed. The IP Nurse stated that the Immunization Report indicated that Resident 3 had Pneumovax Dose 1 with Historical status with administered info dated 5/14/2018, and Pneumovax Dose 2 with Historical status with administered info dated 6/24/2019. IP Nurse stated pneumococcal vaccine should have been given after five (5) years. IP Nurse further stated that she (IP Nurse) uses Pneumorecs VaxAdvisor App as a guide to immunization and that based on the app, Resident 3 should have been offered or given the Pneumonia vaccine. IP Nurse stated there were no documentation that Resident 3 refused pneumococcal vaccine. IP Nurse stated administering pneumonia vaccine can prevent residents from getting sick and lessen the severity of symptoms should they contract pneumonia. During an interview on 3/26/2026 at 1:40 PM with Director of Nursing (DON), the DON stated that upon admission, pneumonia vaccine is being offered. The DON further stated that based on the guidelines, pneumonia vaccine is being given every five years or depending on the type of pneumonia vaccine. DON stated that residents who have not received a pneumonia vaccine may be at risk for respiratory problems, most especially among high-risk group such as the older population. During a review of facility's policy and procedure (P&P) titled, Pneumococcal Vaccine, last revised on October 2023, the P&P indicated that All residents are offered pneumococcal vaccines to aid in preventing pneumonia/pneumococcal infections. The P&P further indicated: Prior to or upon admission, residents are assessed for eligibility to receive the pneumococcal vaccine series, and when indicated, are offered the vaccine series within thirty days of admission to the facility unless medically contraindicated or the resident has completed the current recommended vaccine series.Pneumococcal vaccines are administered to residents (unless medically contraindicated, already given, or refused) per our facility's physician-approved pneumococcal vaccination protocol. Resident/representatives have the right to refuse vaccination. If refused, appropriate information is documented in the resident's medical record indicating the date of the refusal of the pneumococcal vaccination. Administration of the pneumococcal vaccines are made in accordance with current Centers for Disease Control and Prevention (CDC) recommendations at the time of the vaccination.