STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056391	A. Building B. Wing	08/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Golden Empire	121 Dorsey Drive Grass Valley, CA 95945

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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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep residents' personal and medical records private and confidential. Based on observation, interview, and record review the facility failed to ensure the confidentiality of Identifiable information for a census of 137 residents, when residents' meal tickets with personal information were accessible to view by other residents and visitors.These failures decreased the facility's potential to protect residents' identifiable information.Findings:During an observation on 8/19/25 at 10:21 a.m. in the facility main dining room, the residents' breakfast trays being returned to kitchen were found unattended with meal tickets on them. Each meal ticket had resident's name, facility identification number, resident's colored photograph, room number, bed number and dining location in an easy to view status. Two people were observed entering the dining room.During a concurrent observation and interview on 8/19/25 at 10:30 a.m. with the Dietary Assistant 1 (DA 1), DA 1 was observed bringing residents' breakfast trays into kitchen and throwing meal tickets into a regular trash can while scraping the dishes. DA 1 stated that the trash bags were compacted at the compactor and then were throw away in a dumpster outside the kitchen.During an interview on 8/22/25 at 12:38 p.m. with the Registered Dietician (RD), the RD confirmed that the residents' meal tray tickets with residents' personal information were easily accessible to other residents and visitors. RD agreed disposing of the meal tickets to regular trash was not appropriate. RD stated the confidentiality of the residents' identifiable information was not protected.During a review of the facility's policy and procedure titled, HIPPA [Health Insurance Portability and Accountability Act - a federal law to protect the individually identifiable health information], revised on 4/17/2024, indicated, It is the policy of this facility to comply and protect resident information and to follow all HIPPA guidelines.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure one resident (Resident 26) out of a census of 137 was protected from abuse when Resident 26 slapped Resident 52 on the right side of her face.This failure had potential to result in physical injury for Resident 52.During a review of Resident 52's clinical record, the record indicated Resident 52 was admitted in April of 2025, with a diagnosis of Dementia (a decline in mental ability severe enough to interfere with daily life). A review of Resident 52's Medical Data Set (MDS, a federally mandated resident assessment tool), dated 6/4/25 indicated the resident had severe cognitive impairment. During a review of Resident 52's progress noted dated 8/16/25, the note indicated, . a CNA [Certified Nursing Assistant] looked up to see [Resident 26] slap [Resident 52] across the right side.During a review of Resident 26's clinical record, the record indicated Resident 26 was admitted in November of 2024, with a diagnosis of dementia. A review of Resident 26's MDS dated [DATE], the MDS indicated the resident had severe cognitive impairment. During a review of Resident 26's progress note dated 8/15/25, the note indicated, . [Resident 26] was standing in the room close to the outside door to the courtyard. Another resident [Resident 52] . was rattling to open it. A CNA looked up to see [Resident 26] slap [Resident 52] across the right side of her face.During a telephone interview 8/20/25 at 9:28 a.m. with Certified Nursing Assistant 2 (CNA 2), CNA 2 confirmed she was a witness to the altercation between Resident 26 and 52. CNA 2 stated, .At first, I had my back turned. I didn't see (Resident 26) go outside. (Resident 52) was rattling the door to get it open . and I turned around and I saw (Resident 26) slap (Resident 52) in an instant.During a telephone interview on 8/20/25 with Licensed Nurse 1 (LN 1), LN 1 stated . I was called in and [CNA 2] told me [Resident 52] was standing at the door outside . was rattling it and [Resident 26] was close by and when [Resident 52] was rattling the door in her chair [Resident 26] was standing there and he spontaneously slapped [Resident 52] across the face. LN 1 further stated Resident 26 did abuse Resident 52 and abuse was not tolerated in the facility. During an interview on 8/20/25 at 1:09 p.m. with Director of Nursing (DON), the DON confirmed Resident 26 did harm Resident 52 and residents in the facility should not be hitting or slapping each other. During a review of facility Policy and Procedure (P&P) titled Abuse. dated April 2025, the P&P indicated, .Each. resident has the right to be free from abuse. this includes. physical . Residents must not be subjected to abuse by anyone.

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a significant change in status assessment (SCSA- an assessment to reflect a major decline or improvement in the resident's status) was completed for one of 36 sampled residents (Resident 129) when Resident 129 was enrolled in a hospice program (compassionate care for people who are near the end of life provided within a health care facility). This failure increased the potential for plan of care not to be updated to meet the current needs for Resident 129. A review of the admission Record indicated Resident 129 was admitted [DATE] with diagnoses including frontotemporal neurocognitive disorder (group of brain disorder leading to significant changes in behavior, movement, language and personality) and major depressive disorder (persistent feeling of sadness and loss of interest in activities). A review of Resident 129's physician order revised 2/28/25 indicated, Terminal care via [name of hospice program] with prognosis of 6 month [sic] or less related to End Stage Alzheimer's Disease [a disease characterized by a progressive decline in mental abilities]. A review of Resident 129's 'Medical Director Certification of Terminal Illness' document indicated, . [Resident 129] is terminally ill with a life expectancy of six months or less if the terminal illness runs its normal course. The Initial certification period was from 2/22/25 to 5/22/25. A concurrent interview and record review was conducted on 8/21/25 at 10:16 a.m. with the Minimum Data Set Coordinator (MDSC). The MDSC reviewed the physician's order and confirmed Resident 129 was admitted to hospice end of February and a SCSA was not completed. The MDSC stated she should have done a SCSA in March. In an interview on 8/22/25 at 11:32 a.m., the Director of Nursing (DON) stated if a resident was admitted to hospice a SCSA should be completed. A review of the facility's policy and procedure effective 8/1/18 and titled, Significant Change MDS indicated, Residents are assessed, using a comprehensive assessment process, in order to identify care needs .when significant change is identified .Significant Change in Status Assessment (SCSA) - a comprehensive assessment completed within 14 days of the identification of a status change . A SCSA is required when a resident enrolls in a hospice program . and remains in the facility .

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure accurate assessments were completed for four of 36 sampled residents (Resident 9, Resident 98, Resident 129, and Resident 133) when: 1. Resident 9's Minimum Data Set (MDS- a federally mandated resident assessment tool) was incorrectly marked for invasive mechanical ventilator (a breathing machine connected to a tube inserted into the windpipe through the neck);2. Resident 98's MDS did not reflect the resident's terminal prognosis;3. Resident 129's MDS did not indicate resident was on hospice care; and, 4.Resident 133's MDS assessments were not consistent with resident's status. These failures increased the potential for residents not to receive consistent care.Findings: 1.A review of resident 9’s “admission Record,” dated 8/22/25, indicated Resident 9 was admitted to facility in January 2025 with the diagnoses including sleep apnea (a sleep disorder when breathing pauses repeatedly during sleep). Resident 9 had mental capacity to make own decisions. During a review of Resident 9’s “Order Summary Report,” dated 8/22/25, indicated that an order for C-Pap (a device that delivers a constant stream of pressurized air through a mask worn over the nose or mouth during sleep) was placed and initiated on 2/12/25, to be used at bedtime for sleep apnea. During a review of Resident 9’s “Minimum Data Set (a federal assessment tool), dated 6/9/25, indicated that Resident 9 had a special treatment via an invasive mechanical ventilator (a breathing machine connected to a tube inserted into the windpipe through the neck). During a concurrent observation and interview on 8/20/2025 at 4:17 p.m. with Resident 9, Resident 9 was observed sitting in a wheelchair and breathing normally. No invasive ventilator was applied. Resident 9 stated he never had a ventilator and only used a C-pap machine at bedtime for sleep apnea. During an interview on 8/20/25 at 4:20 p.m. with a Certified Nursing Assistant 10 (CNA 10), CNA 10 stated had not seen Resident 9 with an invasive ventilator. During an interview on 8/21/25 at 8:20 a.m. with a Licensed Nurse 7 (LN 7), LN 7 stated Resident 9 never had an invasive ventilator while at the facility. During a concurrent interview and record review on 8/21/25 at 1:20 p.m. with a MDS Coordinator (MDSC), Resident 9’s MDS record, dated 6/9/25 was reviewed. MDSC confirmed the special treatment of invasive mechanical ventilator was marked incorrectly which could have affected the care planned and provided to the Resident 9. During an interview on 8/22/25 at 1:45 p.m. with the Director of Nursing (DON), the DON expected staff to maintain the error-free assessment records. DON confirmed the inaccurate assessments could result in lack of care and impact on the quality of care for Resident 9. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility’s policy and procedure (P&P) titled, “Conducting an Accurate Resident Assessment, revised on 6/5/24, the P&P indicated, “The purpose of this policy is to assure that all residents receive an accurate assessment … The appropriate, qualified health professional will correctly document .” 2. During a review of Resident 98’s admission records, the records indicated Resident 98 was admitted to the facility in February 2025 with diagnoses that included dementia a (progressive state of decline in mental abilities), psychotic disorder (disconnection from reality), and major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest). Resident 98’s MDS indicated Resident 98 had severe cognitive impairment. During a review of Resident 98’s Certification of Terminal Illness (CTI), dated 2/10/25, the CTI indicated Resident 98 was certified to be terminally ill with a life expectancy of six months or less if the terminal illness runs its normal course. During a review of Resident 98’s physician order, dated 2/10/25, the order indicated, “Terminal Care via [name of hospice program] with Prognosis of 6 month [sic] or less related to End Stage Dementia. ” During a review of Resident 98’s MDS “Section J – Health Conditions,” dated 8/6/25, the MDS indicated “No” was coded for the question if Resident 98 had a condition or chronic disease that may result in a life expectancy of less than 6 months. During an interview on 8/21/25 at 11:54 a.m. with the MDSC, the MDSC confirmed Resident 98 was on hospice and stated “I messed up obviously with hospice…I am going to do a correction on her…I miscoded her on the significant change…I didn't do the prognosis…I think they need to have less than 6 months to live if they are in hospice…” The MDSC further stated, “Important so you know what's going on with patients.” During an interview on 8/22/25 at 9:55 a.m. with the DON, the DON stated, “MDS should be accurate because that is how we capture the details of our residents.” 3. A review of the admission Record indicated Resident 129 was admitted [DATE] with diagnoses including frontotemporal neurocognitive disorder (group of brain disorder leading to significant changes in behavior, movement, language and personality) and major depressive disorder (persistent feeling of sadness and loss of interest in activities). A review of Resident 129's physician order revised 2/28/25 indicated, Terminal care via [name of hospice program] with prognosis of 6 month [sic] or less related to End Stage Alzheimer's Disease [a disease characterized by a progressive decline in mental abilities]. A review of Resident 129's 'Medical Director Certification of Terminal Illness' document indicated, . [Resident 129] is terminally ill with a life expectancy of six months or less if the terminal illness runs its normal course. The Initial certification period was from 2/22/25 to 5/22/25. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A concurrent interview and record review was conducted on 8/21/25 at 10:26 a.m. with the MDSC. The MDSC reviewed Resident 129's MDS assessments dated 5/7/25 and 8/6/25. The MDSC confirmed both MDS assessments did not indicate Hospice care was provided to Resident 129 while a resident in the facility. The MDSC further confirmed the MDS dated [DATE] did not indicate Resident 129 had a life expectancy of less than 6 months. In an interview on 8/22/25 at 11:32 a.m. with the DON, the DON stated her expectation was for MDS assessments to be accurate and the assessment need to show the correct representation of the specific care provided to the resident. 4. A review of the admission Record indicated the facility admitted Resident 133 in early 2025 with diagnoses which included dementia, anxiety disorder (fear characterized by behavioral disturbances), and hypertension (high blood pressure). A review of the physician order, dated 1/21/2025, indicated Resident 133 was admitted to the facility under hospice services with prognosis of 6 months or less related to dementia with severe agitation. A review of Resident 133's MDS, Section J1400, dated 1/27/25, 4/16/25, and 7/16/25 indicated that the resident did not have a condition or chronic disease that may result in a life expectancy of less than 6 months. A review of Resident 133’s MDS assessment dated [DATE] and 4/16/25, Section O describing Special Treatments, Procedures and Programs offered to Resident 133, indicated the resident was on hospice care. Resident 133’s MDS assessment dated [DATE], Section O indicated Resident 133 was not on hospice care. During a concurrent interview and record review with the MDSC on 8/21/25 at 10:55 a.m., the MDSC stated that MDS assessments were to reflect an overall picture of the resident and the type of services, special procedures and programs each resident required. The MDSC acknowledged that Resident 133’s MDS assessments dated 1/27/25, 4/16/25, and 7/16/25 were not coded correctly, had conflicting information, and did not accurately reflect the resident’s condition and services the resident received. The MDSC explained that the MDS assessment was an instrument that helped the facility to have a proper plan of care for the resident and if any section were coded incorrectly, then it could affect the care planning process. The MDSC confirmed that because Resident 133’s sections J and O were not coded correctly, it potentially affected care planning and resulted in resident 133 not having a hospice care plan since 1/21/25. A review of the facility's policy and procedure effective 10/1/19 and titled, Conducting an Accurate Resident Assessment indicated, The purpose of this policy is to assure that all residents receive an accurate assessment, reflective of the resident's status at the time of assessment, by staff qualified to assess relevant care areas .Qualified staff who are knowledgeable about the resident will conduct an accurate assessment addressing each resident's status, needs .areas of decline.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. Based on observation, interview and record review, the facility failed to ensure professional standards of care were followed for two of 36 sampled residents (Resident 116 and Resident 47), when:1. The nurse did not document an assessment of Resident 116's mid-upper arm for proper Peripherally Inserted Central Catheter (PICC) line management per physician order; and 2. The facility altered Resident 47's Insulin administration record. These failures had the potential to negatively affect Resident 116's and Resident 47's health and their ability to achieve their highest practical well-being due to not receiving treatment and services in a timely manner and inaccurate medical information. Findings A review of Resident 116’s medical record indicated Resident 116 was admitted to the facility in June of 2025 with diagnoses of Infection and Inflammatory reaction due to Internal Right Knee Prosthesis (a surgical procedure to implant an artificial body part) and Type Two Diabetes (a chronic disease where the body doesn’t produce enough insulin to maintain normal blood sugar levels). Resident 116’s Minimum Data Set (MDS, a federally mandated resident assessment tool) indicated Resident 116 had no cognitive impairment. During an observation and interview on 8/19/25 at 11 a.m. with Resident 116, Resident 116 was observed to have a dressing, on her right upper arm. Resident 116 stated that she had a PICC line in her right arm. A review of Resident 116’s Physicians’ order dated 7/23/25 indicated an order to “…measure and document every evening shift [sic] Thursday…mid-upper arm…document circumference weekly…” During an interview and concurrent record review on 8/22/25 at 11:50 a.m. with Director of Nursing (DON), the DON confirmed that the physician’s order for Resident 116 was to “…measure and document every evening shift [sic] Thursday…mid-upper arm…document circumference weekly…”. The DON confirmed that the MAR/TAR (medication administration record/treatment administration record) for Resident 116 was missing a signature on 8/21/25. The DON verified that the box with a missing entry was where the nurse was to document that the mid-upper arm was measured. The DON stated her expectation of nurses for following physician orders and documentation was, I expect them to complete the task and sign off that they did it. The DON confirmed that missing a measurement of an arm with a PICC line could result in potential harm to the resident. During an interview and concurrent record review on 8/22/25 at 3 p.m. with Licensed Nurse 1 (LN 1), LN 1 confirmed the current physician’s order for Resident 116 was to “…measure and document every evening shift [sic] Thursday…mid-upper arm…document circumference weekly…”. When LN 1 was asked what it meant if the MAR/TAR had a missing box under a date? LN 1 stated, “…If it is not signed, it is not done…”. When LN 1 was asked, what are the potential complications of not measuring a residents PICC line arm? LN 1 stated, “…You could have swelling [sic], which could mean that there is a dislodge of the catheter and leak of fluids into the surrounding tissues…”. LN 1 confirmed that missing a measurement of an arm with a PICC line could result in potential harm to the resident. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility’s Policy and Procedure (P&P) titled, “Peripherally Inserted Central Catheter (PICC) And Midline”, the P&P indicated, “…Upper arm circumference should be measured on admission and weekly to monitor for infiltration…” A review of Resident 47's admission Record indicated the facility admitted Resident 47 to the facility in 2022. Resident 47’s diagnoses included type I diabetes mellitus (DM, a disorder characterized by difficulty in blood sugar control) with ketoacidosis (DKA, a life-threatening complication of DM when resident's blood sugar is high and the body does not have enough insulin and starts burning fat, which creates ketones (acids) leading to acid build up in the blood). A review of Resident 47’s clinical records contained a physician order to administer Tresiba (long-acting insulin used to manage high blood sugar), 16 units, (unit of measurement), subcutaneously (SQ, injection given in the fatty tissue, under the skin) once a day for DM. A review of Resident 47’s care plan dated 3/3/22 indicated the resident had diagnosis of diabetes mellitus. The care plan goal indicated the resident will have no complications related to diabetes. The nursing interventions included to monitor resident’s blood sugar and administer diabetes medications as ordered by physician. A review of the Medication Administration Record (MAR) for July 2025 indicated Resident 47 did not receive Tresiba insulin on July 22 and July 30. During concurrent interview and record review on 8/21/25 at 2:25 p.m., DON confirmed Resident 47 did not receive Insulin on 7/22/25 and 7/30/25 scheduled to be administered at 8 p.m. The DON searched Resident 47’s nursing progress notes and was unable to find any documentation why it was not administered. The DON validated that due to Resident 47’s history of ketoacidosis, the resident was at increased risk of high blood sugar which had the potential to affect the resident’s safety. A copy of Resident 47’s MAR for July was provided for Department on 8/22/25 at 9:37 a.m. The MAR showed that Licensed Nurse (LN 11) documented that Tresiba Insulin was administered to Resident 47 on 7/22/25 and 7/30/25. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a follow up interview with DON and Assistant of Director of Nursing (ADON) on 8/22/25 at 11 a.m., the DON reviewed Resident 47’s MAR for July and acknowledged that the MAR showed that the resident received Tresiba Insulin on 7/22/25 and 7/30/25 contrary to what was documented the day prior. The DON validated that Resident 47’s MAR for July previously indicated that on 7/22/25 and 7/30/25 the resident missed 2 doses of important medication. The DON acknowledged that “someone documented” that the insulin was administered on 7/22/25 and 7/30/25. The DON explained facility’s policy, “Document immediately after medication [was] administered. If documenting later, the progress note should follow up and indicate that medication was administered and not documented. ” The ADON explained that when she was preparing to print Resident 47’s records per Department request, she noticed two blank spaces on 7/22/25 and 7/30/25 which indicated that insulin was not administered. The ADON stated she questioned LN 11 why the Insulin administration was not documented as given. ADON added further, “I pointed to empty spaces [on 7/22/25 and 7/30/25] and she [LN 11] must have documented” later. The DON stated that when the staff needed to revise or add missed documentation at later dates, there should be documentation in nursing progress notes explaining ‘late charting.’ The ADON searched Resident 47’s record and was unable to find late charting notes. The DON acknowledged that the facility did not follow the process of late documentation. During a phone interview with LN 11 on 8/22/25 at 12:50 p.m., LN 11 confirmed that she “corrected 7/22/25 and 7/30/25 Resident 47's Medication Administration Record. LN 11 explained, “I always administer Resident 47’s insulin, but sometimes I forget to document that it was given.” LN 11 added further, “When [ADON’s name] asked why the insulin administration was not documented, I went in and documented.” The LN 11 was asked the facility’s process for late documentation, and LN 11 initially stated, “I don’t know, I never miss charting.” LN 11 then added, “If I have to go in and document late charting, a late entry should be added.” LN 11 acknowledged that there was no late entry added in resident's progress notes on 8/21/25 when she charted that Resident 47’s insulin was administered on 7/22/25 and 7/30/25. A review of the facility’s ‘Documentation in Medical Record’ policy dated 4/28/25 indicated, “Each resident’s medical record shall contain an accurate representation of the actual experiences of the resident and include… complete, accurate, and timely documentation… documentation shall be completed at the time of service but no later than the shift in which… care service occurred… documentation should be timely and in chronological order . When documentation occurs after the fact, outside acceptable time limits, the entry shall be clearly indicated as “late entry. ”

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on interview and record review, the facility failed to ensure one of 36 sampled residents (Resident 47) received treatment and care in accordance with professional standards of practice, when the facility did not follow physician's orders for insulin (a medication that lowers high level of glucose in the blood) and glucose gel (sweet liquid containing sugar used to quickly raise blood sugar), and did not monitor blood sugar as directed by physician on multiple occasions when Resident 47's blood sugar dropped to critically low levels. These failures increased the risks for Resident 47 for possible complications of hypoglycemia (when the blood sugar is lower than normal) and hyperglycemia (high blood sugar), which could affect resident's health and safety. Findings:A review of Resident 47's admission Record indicated the facility admitted Resident 47 to the facility in 2022. Resident 47's diagnoses included type I diabetes mellitus (DM, a disorder characterized by difficulty in blood sugar control) with diabetic ketoacidosis (DKA, a life-threatening complication of DM when the body does not have enough insulin and starts burning fat which creates ketones (acids) leading to acid build up in the blood). A review of Resident 47's clinical records contained the following physician orders:FSBS (finger stick blood sugar) TID (three times a day) for DM;Tresiba (long-acting insulin used to manage high blood sugar), inject 16 units (unit of measurement) subcutaneously (SQ, injection given in the fatty tissue, under the skin) once a day for DM and,If FSBS is below 60, give 15-30 grams (gm, unit of measurement) of Glucose gel orally. Repeat FSBS in 15 minutes. Daily as needed. A review of Resident 47's care plan dated 3/3/22 indicated the resident had diagnosis of diabetes mellitus. The care plan's goal indicated the resident will have no complications related to diabetes. The nursing interventions included to monitor resident's blood sugar, administer diabetes medications as ordered by physician, monitor and document for side effects and effectiveness. A review of the Medication Administration Record (MAR) for July 2025 indicated Resident 47 did not receive Tresiba insulin on July 22 and July 30. A review of Resident 47's MARs indicated the resident experienced blood glucose below 60 on the following dates:On 7/1/25 at 6 a.m., FSBS was 45; the resident received Glucose gel, but the resident's blood sugar was not rechecked 15 minutes later per physician order;On 7/27/25 at 6 a.m., FSBS was 41; the resident received treatment for low blood sugar, but the resident's blood sugar was not rechecked 15 minutes later per physician order;On 8/8/25 at 6 a.m., FSBS was 59 and the resident was not given Glucose gel or other treatments as directed by physician. There was no evidence the residents FSBS was rechecked until 4 p.m.;On 8/12/25 at midnight FSBS was 39; the resident received treatment for low blood sugar, the nurse documented ‘effective,' but the resident's blood sugar was not rechecked 15 minutes later per physician order; On 8/15/25 at 6 a.m., FSBS was 58; the resident refused treatment for low blood sugar. The nurse administered snack and juice. There was no documented evidence that Resident 47's blood sugar was rechecked 15 minutes after the snack or at a later time. - During a concurrent interview and record review, commencing on 8/21/25 at 2:25 p.m., the Director of Nursing (DON) explained the process when the resident experienced low blood sugar. The DON stated the expectation was to administer Glucose gel or Glucagon injection if resident is unable to swallow and recheck blood sugar 15 minutes after the treatment was administered. Upon reviewing Resident 47's MAR, the DON acknowledged that the resident did not receive Tresiba insulin on 7/22/25 at 8 p.m., and 7/30/25 at 8 p.m. The DON searched Resident 47's nursing progress notes and was unable to find any documentation why it was not administered. The DON validated that due to Resident 47's history of ketoacidosis, the resident was at increased risk of high blood sugar which had the potential to affect the resident's safety. During continued interview and records review on 8/21/25 at 2:25 p.m., the DON validated that Resident 47's blood sugar was not rechecked 15 minutes after the resident received treatment for low blood sugar on 7/1, 7/27, and 8/12/25, or when the resident refused treatment on 8/15/25.The DON confirmed that on 8/8/25 at 6 a.m., Resident 47's FSBS was 59, which indicated it was critically low and there was no documented evidence the resident received treatment for low blood sugar or was offered snack or juice. The DON validated there was no follow up monitoring for low blood sugar for 10 hours after the resident experienced critically low blood sugar. The DON stated the resident should have received treatment for BS of 59, snack and her blood sugar rechecked but it was not done. The DON stated the physician order for Resident 47's low blood sugar was not followed. A review of the ‘Insulin administration/Finger Stick Blood Sugars & Glucagon' policy dated 4/17/24 indicated, A Licensed nurse will perform the finger stick blood sugars (FSBS) and administer the appropriate dosage of insulin as ordered by the Physician. All residents who are diabetic will be monitored for signs and symptoms of

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that pain management was provided, consistent with professional standards of practice for one of 36 sampled residents (Resident 122), when the resident received inadequate pain management and, when non-pharmacological (non-medication) interventions were not used in conjunction with pain medication administration to manage pain. This failure placed Resident 122 at risk for unmanaged pain that had the potential to affect resident's sleep and diminish the residents' quality of life.Findings:A review of the admission Record indicated the facility admitted Resident 122 in the spring of 2025 with multiple diagnoses which included chronic pain and depression. A review of the Minimum Data Set (MDS, a standardized assessment and care-screening tool), dated 4/14/25 indicated Resident 122 was cognitively intact and had no hallucinations or delusions. Resident 122's Pain Interview assessment dated [DATE] indicated the resident experienced pain or hurting.almost constantly and rated her pain as 7 out of 10 (a scale from zero (0) to ten (10), when zero represents no pain and ten being the worst pain possible). When the resident was asked during the assessment How much of the time the pain made it hard for you to sleep at night, the resident replied, Almost constantly. A review of the clinical record for Resident 122 revealed:- A physician order dated 4/9/25 for Resident 122 indicated, Pain assessment every shift, Score 1-10 [0= no pain, 1 to 2= least pain, 3 to 4=mild pain, 5 to 6= moderate pain, 7 to 8=severe pain, 9 to 10=horrible, worst ever experienced.- A physician order dated 4/9/25 indicated to administer Tylenol 325 mg (milligram, unit of measurement), 2 tablet every 4 hours as needed for headache and pain. - A physician order dated 7/18/25, indicated to administer Norco 5-325 (a strong narcotic pain medication containing 5 mg of hydrocodone and 325 mg of acetaminophen known as tylenol). The order directed, Give 1 tablet by mouth as needed for chronic pain BID [twice a day] prn [as needed]. A review of the Resident 122's care plan titled The resident is on pain medication, initiated on 6/27/25, indicated that the resident's goal was to be free of any discomfort. One of the care plan approaches indicated to administer pain medications as ordered by physician. A review of physician progress note dated 8/12/25, indicated, Patient was admitted to the hospital.since readmission continues to c/o [complain] of pain in shoulder and knee [sic] is on Norco which will be continued. During an observation on 8/19/25 at 9:59 a.m., Resident 122 was sitting in the wheelchair in her room. Resident 122 explained that she had concerns with her pain management and frequently had to wait for a few hours to receive pain medication. Resident 122 added that by the time the nurses administered her pain medications, the pain was out of control. Resident 122 explained that she had chronic back pain and she was assured by her physician that she can receive pain medications twice a day as needed. Resident 122 continued, Every time I ask for pain medication, they say, You have already had it. No point of arguing with them.They don't give me pain killers every 12 hours. Even I'm in pain, I have to wait.I'm lucky if I get it [pain medication] once in 24 hours. Resident 122 further stated that sometimes she had hard time sleeping because of the pain. Resident 122 stated her pain was 4 at present because she had Norco earlier this morning, but normally the pain was 7 or 8. During an observation and on 8/20/25 at 9:55 a.m., Resident 122 was sitting in the wheelchair in her room. Resident 122 appeared tense. Resident 122 explained that earlier that morning she slipped from her wheelchair when she bent down to pick something from the floor. Resident 112 added, Hurt my ankle, its sore.Nobody asked me if I need pain pill.When I asked last night, they told me 'It's not time. Resident 122 stated the pain was 4 as long as she did not move her leg but worsened on movement. A review of Resident 122's clinical records, including Medication Administration Record (MAR) indicated that there was no pain assessment completed since resident's fall and the last time the resident was medicated for pain was on 8/19/25 at 4:04 a.m., over 24 hours ago. A review of Resident 122's MAR from 8/1/25 through 8/20/25, indicated nursing staff consistently documented every shift that the resident's pain was 0 out of 10, except on 8/17/25 pain was documented as 6 out of 10 and on 8/20/25 pain was 2 out of 10. In addition, Resident 122's record did not contain non-pharmacological pain interventions (any physical or psychological approaches that do not involve medication, such as massage, heat, cold therapy, relaxation) were offered to resident in conjunction with pain medications. During an interview and concurrent record review on 8/20/25 at 10:20 a.m., Licensed Nurse (LN 2) stated Resident 122 was alert and oriented and able to verbalize her needs. LN 2 stated she normally assessed Resident 122's pain once in the morning during medication administration. LN 2 explained that if the resident took pain medication, she was to be reassessed for effectiveness one to two

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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. Based on observation, interview, and record review, the facility failed to implement an efficient process to accurately document and secure emergency medications (E-Kit) for a census of 137.This failure had the potential for emergency medications to be unavailable when needed, and the potential for not meeting the residents' therapeutic needs or worsening of their medical conditions.Findings:During an inspection of the Station 2 Medication Storage Room on 8/20/25 at 4:13 p.m. with Licensed Nurse 10 (LN 10), the E-Kit containing insulin (a hormone that removes excess sugar from the blood, can be produced by the body or given artificially via medication) was observed inside the medication refrigerator with a red tag (indicating the E-Kit had been opened by the facility). The E-Kit logs inside indicated one vial of Humalog (insulin lispro, a fast-acting insulin) 100units/mL (milliliters, a unit of measurement) was removed on 8/7/25, and one vial Lantus (insulin glargine, a long-acting insulin) 100units/ml was removed on 8/14/25. LN 10 confirmed that the E-kit was opened on 8/14/25 and was not replaced. LN 10 confirmed it was 6 days since the E-kit was opened and stated, .it takes longer for refrigerated ones [to get replaced] .During an interview on 8/22/25 at 2:15 p.m. with the Director of Nursing (DON), when pictures of the E-kit were shown, the DON confirmed the E-kit was opened and the last slip was 8/14/25 and stated, .The pharmacy should have sent it faster.Staff should have followed up on it.It should have been replaced timely. The DON stated it was important for the E-kit to get replaced timely because .we just need what need here and especially, it's for emergency.During a review of the facility's policy and procedure (P&P) titled Emergency Pharmacy Service and Emergency Kits, undated, the P&P indicated, .K. If exchanging kits, open kits are replaced with sealed kits within 72 hours of opening.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, and record review, the facility failed to ensure:Medications and medical supplies were not available for residents' use past their expiration dates in three of three medication carts;Crash carts (storage of supplies needed in emergency situations) were checked regularly, and medical supplies were complete and were not past their expiration dates; andA medication was stored in the Resident Food Refrigerator at the memory unit.These failures had the potential for residents to receive medications with unsafe or reduced potency from being used past their expiration dates, and the potential for malfunctioning equipment and delays during emergency situations for a census of 137.Findings: During a concurrent observation and interview on 8/20/25 at 3:02 p.m. with Licensed Nurse 8 (LN 8), an inspection of the facility's Memory Unit Medication Cart identified the following expired medications and medical supplies: One syringe Haloperidol (medication used to treat mental disorders) 1 mg (milligrams, a unit of measurement) – expired 8/18/25 One bottle Isopropyl alcohol (a clear, colorless liquid used to kill germs) 70% (percent, a unit of measurement) – expired 11/2024 One container Microkill One wipes (a disinfectant to kill germs)– expired 6/2023 One pack Maxorb II wound dressing (dressing that provides moist wound environment) – expired 7/2022 LN 8 confirmed the observation and stated, “It’s no good because of the reaction of the medication…there’s reason why there’s expiration date.” During a concurrent observation and interview on 8/21/25 at 10:06 a.m. with LN 5, an inspection of the Station 2 Medication Cart identified the following expired and discontinued medications and medical supplies: One bottle Antiseptic (a substance that kills or inhibits the growth of microorganisms) Skin Cleanser – expired: 6/1/25 One tube Extra Protective Cream – expired 10/2024 One tube Anti-itch cream 2% - expired 7/2025 One bottle Iodoform Packing Strip – expired 1/20/25 One bottle hydrogen peroxide (antiseptic) – expired 8/2022 Nine tablets Phenazopyridine (urinary pain relief medication) – expired 6/2025 (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	LN 5 confirmed the observation and stated, “…important not to keep expired items in the cart so you don’t end up giving expired medication…” During a concurrent observation and interview on 8/21/25 at 10:29 a.m. with LN 7, an inspection of the Hallway 500 Medication Cart identified the following: One bottle hydrogen peroxide 3% - expired 12/2024 One bottle Skintegrity wound cleanser (used to treat and prevent minor skin irritations) – expired 1/11/25 One tube biofreeze menthol-pain relieving gel – expired 05/2025 One 30mL (milliliters, a unit of measurement) syringe – expired 6/2/23 One catheter stabilization device – expired 10/28/24 Two opened Petrolatum Dressing (used to maintain moist wound environment for effective wound healing) One unlabeled pill in medication cup inside narcotic box LN 7 confirmed the observation and stated the unlabeled pill was methadone (a controlled drug used to treat moderate to severe pain and to treat narcotic drug addiction) pulled out from the E-kit (emergency kit) that had to be wasted. LN 7 added petrolatum dressing should not be reused once opened. During an interview on 8/21/25 at 12:04 p.m. with the Infection Preventionist (IP), the IP stated, “…In the med cart, it should be randomly checked, expired meds should not be on the cart…There should be no expired meds and items in the cart…It has to be two nurses to sign the destruction, immediately…Important because narcotic counts are important, we want to avoid drug diversion…” During an interview on 8/22/25 at 9:16 a.m. with the Director of Nursing (DON), the DON stated, “There should not be any expired items in the med cart, possibly affect residents’ health. ” During a review of the facility’s policy and procedure (P&P) titled “Medication Storage in the Facility,” dated 3/2018, the P&P indicated, “…M. Outdated, contaminated, or deteriorated medications…are removed from stock, disposed of according to procedures for medication disposal…” During a review of the facility’s P&P titled “Medication Destruction,” undated, the P&P indicated, “…G. All controlled drugs are placed in an approved waste container properly labeled as medication waste or pharmaceutical waste…” (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. During a concurrent observation and interview on 8/22/25 at 9:27 a.m. with the DON, an inspection of the Station 2 Crash Cart identified that the crash cart log was not checked for multiple days from May to August 2025. The DON stated, “Looks like they [staff] didn’t check it on those days.” The crash cart log indicated, “Crash cart will be checked every 24 hours and after each use. Replace any items that do not meet par.” The crash cart log further indicated that the cart should contain three containers of normal saline (a mixture of salt and water), but one container of normal saline and two containers of sterile water were observed inside the crash cart drawer. The DON stated, “Important to make sure everything is ready if there is an emergency…I think they messed up…” During a concurrent observation and interview on 8/22/25 at 9:40 a.m. with the DON, an inspection of the Station 1 Crash Cart identified that the crash cart log was not checked for multiple days from May to August 2025. The crash cart log further indicated that the cart should contain three containers of normal saline, but two containers of normal saline and one pack of sterile water were observed inside the crash cart drawer. The crash cart also contained a suction connection tubing that expired on 5/2011. The DON confirmed the observation and stated, “It could be damaged, it could be compromised…” During a review of the facility’s P&P titled “Crash Cart/E-carts,” dated 2/20/19, the P&P indicated, “…It is the policy of this facility to organize and maintain the emergency cart (E-cart) to ensure adequate needed equipment for CPR procedures…1. The nursing staff will ensure the equipment are stocked in the E-cart…3. The E-cart will be inventoried and restocked after each use and checked daily and documented by nursing staff or the pharmacy consultant…6. Once a month the E-cart should be opened and checked for outdated supplies. 7. E-cart checks should be documented on the lists maintained on the E-cart…” Findings: 3. During a concurrent observation and interview on 8/22/25 at 9:36 a.m. with a Certified Nursing Assistant 2 (CNA 2) in the memory unit, the residents’ food refrigerator was observed. A medication bottle was stored inside the refrigerator door compartment. CNA 2 confirmed that a bottle containing medication was stored inside the refrigerator meant to be storing only food for residents. During an interview on 8/22/25 at 9:50 a.m. with a Licensed Nurse 8 (LN 8), LN 8 confirmed a bottle of acidophilus probiotic (live microorganisms consumed for health benefits) was stored inside the resident food refrigerator. LN 8 stated medications stored in the same refrigerator with food posed a risk for cross contamination. During an interview on 8/22/25 at 1:45 p.m. with the Director of Nursing (DON), the DON stated staff should not be storing any medication in the food refrigerators. DON stated all medications that needed refrigeration should be stored in a secured medication refrigerator in the unit. During a review of the facility’s policy and procedure titled, “Medication Storage in the Facility, dated March 2018, indicated, “… Refrigerated medications are kept … separate from foods …”

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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. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Based on observation, interview, and record review, the facility failed to store food in a sanitary manner for a census of 137 residents, when: 1. Expired, undated, unlabeled, spoiled, unsealed opened food items, and a dirty food tray were found in the walk-in refrigerator, walk-in freezer, and in the cooking area in the kitchen;2. The floor in the walk-in freezer was dirty;3. Cooking equipment and utensils were not clean;4. Undated and expired food items were stored in the resident food refrigerators in the three nursing units and temperature logs were inconsistent; 5. No written instructions were followed for cooking spinach; and 6. There were no air gaps for the plumbing system under the sinks and dishwashing machine in the kitchen.These failures had the potential to contaminate food in the kitchen and cause foodborne illnesses among residents. Findings:1. During a concurrent observation and interview on 8/19/25 at 8:45 a.m. with the Dietary Supervisor 1 (DS 1), the food items stored in the walk-in refrigerator, walk-in freezer, and cooking area were observed. DS 1 confirmed the following:- Spoiled, mushy, and brownish apples, an undated container of whipped cream stored in the walk-in refrigerator;- Opened and unsealed bags of sausages and bacon stored in the walk-in freezer;- Several food items with inconsistent and incomplete opening dates written on them. Some containers had day and year, others had month and day in the walk-in refrigerator and freezer;- An empty food tray with food fragments and a used fork in it stored with trays containing food in the walk-in refrigerator; and- Expired ground turmeric, basil leaves, and cooking wine stored in the cooking area in the kitchen.DS 1 stated the spoiled, expired, and undated food items were unsafe to be used. DS 1 expected food bags to be completely sealed, opening dates should be written as month/day/year, and dirty utensils were not to be stored in the refrigerator or freezer.2. During a concurrent observation and interview on 8/19/25 at 9:25 a.m. with DS 1, the floor in the walk-in freezer was observed. A layer of dark grime and garbage accumulated near the door. Several food fragments, a pudding cup, and coins were seen on the floor under the food racks. DS 1 confirmed the freezer floor was dirty. 3. During a concurrent observation and interview on 8/19/25 at 10:45 a.m. with DS 1, the cooking equipment and utensils were observed in the cooking area. A food blender had a sticky residue on it. Two non-stick pans had eroded interior surfaces. Two coffee pitchers had dark discoloration and cracks inside them. A wet cutting board and several cooking pans were stored wet on the ready to use racks. DS 1 confirmed the food blender, wet pans and wet cutting board were not sanitary. DS 1 agreed eroded non-stick pans and damaged coffee pitchers were unsafe for use and could cause food contamination. 4. Three refrigerators for residents' food were observed at the station 1, station 2, and memory unit in the facility. - During a concurrent observation and interview on 8/21/25 at 11:57 a.m. with Licensed Nurse 3 (LN 3), a resident food refrigerator at station 1 was observed. LN 3 confirmed two boxes of frozen food were expired on 7/22/25. LN 3 agreed the temperature log was not maintained for 8/21/25.- During a concurrent observation and interview on 8/21/25 at 12.09 p.m. with a Certified Nursing Assistant 9 (CNA 9), a resident food refrigerator at station 2 was observed. CNA 9 confirmed several unlabeled, undated food items were stored in it. CNA 9 agreed the temperature log was maintained a day in advance for 8/22/25. - During a concurrent observation and interview on 8/22/25 at 09:37 a.m. with CNA 2, a resident food refrigerator was observed at the memory unit. CNA 2 confirmed an undated ice cream container and a medication bottle were stored in it. CNA 2 agreed the temperature log was not maintained consistently and several days were missed. 5. During a concurrent observation, interview, and record review on 8/21/25 at 9:45 a.m. with the Head [NAME] (HC), twelve spinach bags were observed cooking in boiling water inside a big metal pot on the stove. HC described the frozen spinach inside the plastic bags boiled for one to one and half hours followed by removing it from the plastic bags and draining it. HC agreed the spinach recipe in the recipe book did not indicate boiling the spinach inside the plastic bags. HC stated there was no instructions on the spinach bags to be boiled inside the plastic bags. 6. During a concurrent observation and interview on 8/21/25 at 4:45 p.m. with the Maintenance Supervisor (MS), the drainage system was observed for the air gap to prevent the sewer back flow. MS confirmed there was no air gap in the kitchen drainage system. MS stated a drainage problem was fixed on 3/21/25 but no air gap was established.During an interview on 8/22/25 at 10;00 a.m. with DS 1, DS 1 expected staff to check the food items daily and remove the spoiled, expired, and undated food items. DS 1 stated all kitchen equipment and surfaces should be kept clean. DS 1 agreed the resident food refrigerators temperature logs had only provision to be maintained once a day. DS 1 confirmed there were no instructions to boil frozen spinach inside the plastic bags. DS 1 stated was not aware of no air gaps in the drainage system in the kitchen During an interview on 8/22/25 at 12:38 p.m. with

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Dispose of garbage and refuse properly. Based on observation, interview, and record review, the facility failed to ensure trash was stored in a sanitary manner for a census of 137 when, trash dumpsters were observed with open lids.This failure had the potential to create breeding ground for insects and rodents.Findings:During a concurrent observation and interview on 8/19/25 at 10:30 a.m. with the Head [NAME] (HC), a facility dumpster outside the kitchen backdoor was observed with the lid open. An additional trash container which had trash including used gloves, hairnet and a cigarette butt was found with no lid. The HC confirmed the lids were open. During an interview on 8/22/25 at 3:17 p.m. the Registered Dietitian (RD), RD agreed that open dumpsters and trash cans near the kitchen were sources to attract flies. RD stated flies could have entered the kitchen when the back door was opened. RD further stated flies could cause food contamination which could lead to food borne illnesses among the residents.During a review of the facility's policy and procedure titled, General Cleaning of Food and Nutritional Services Department, dated 2023, indicated, Garbage and trashcans must be inspected daily that no debris is on the ground or surrounding area, and the lids are closed.

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Golden Empire	121 Dorsey Drive Grass Valley, CA 95945

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on interview and record review, the facility failed to ensure coordination of care between the hospice team (care designed to provide supportive care for physical, psychological, spiritual, and emotional needs to a terminally ill resident) and the facility for one of 36 sampled residents (Resident 133), when the resident's clinical records did not include hospice documents. This failure placed Residents 133 at risk for not receiving services necessary to promote comfort and quality of life. Findings:A review of 'Inpatient Service Agreement' between the [name of the hospice agency] and facility, dated 11/16/2023 indicated the hospice and the facility will communicate with each other and document such communications to ensure that the needs of the patients are addressed and met 24 hours a day. The agreement policy indicated, The Hospice is providing the facility with a copy of the patient's plan of care [POC]. at the time of the patient's admission or as soon.as possible, and.specify the inpatient services to be furnished.The Hospice . patient's clinical record includes a record of all impatient services furnished.The FACILITY shall prepare and maintain medical records for each hospice patient.The medical record shall consist of progress notes and clinical notes describing all inpatient services.A review of the admission Record indicated the facility admitted Resident 133 in early 2025 with diagnoses which included dementia (decline in mental ability severe enough to interfere with daily functioning and life). A review of the physician order, dated 1/21/2025, indicated Resident 133 was admitted to the facility under hospice services with prognosis of 6 months or less related to dementia. A review of Resident 133's records, including paper chart located at the nursing station did not contain documents reflecting the care resident received from hospice agency. During a concurrent interview and record review on 8/19/25 at 12:15 p.m., Licensed Nurse (LN 3, a Nurse Coordinator) confirmed Resident 133 have been receiving hospice services since 1/21/25. LN 3 acknowledged that the special dedicated to hospice binder for Resident 133 had no hospice documents indicating coordination of care, except consent for hospice services. Upon reviewing Resident 133's clinical records, LN 3 confirmed Resident 133's clinical records contained no hospice POC, no visit schedule and no visit notes. LN 3 verified that hospice sheets with sign-in and visit log were blank. LN 3 stated, I don't understand why there are no [hospice] documents.Should be here under 'Hospice' tab, but nothing here. LN 3 added, We don't know their [hospice staff] schedule or when they come, they just show up.When hospice nurses come, we discuss resident's care.Not sure about other staff who visits the resident. LN 3 was not able to explain the process of coordination of care between facility and hospice agency and stated the communication might not be documented. During an interview with LN 4 on 8/19/25 at 12:40 p.m., LN 4 stated she was not sure about visit schedule and what disciplines were assigned to resident receiving hospice services. LN 4 added that nurses usually visited hospice residents twice a week and they were checking with facility nurses when they came to visit. LN 4 reviewed Resident 133's chart and stated, We should have hospice records in paper chart or scanned into electronic chart, but I don't know why there are no hospice documents here.During a concurrent interview with the Director of Nursing (DON) and Assistant of Director of Nursing (ADON) on 8/21/25, commencing at 11:35 a.m., the DON stated there should be collaboration of resident's care between hospice and facility staff. The DON stated when residents received hospice services, the resident records should include a POC, a calendar showing hospice staff who were assigned to the resident, a log sheet for hospice staff to sign in to show the staff came in and visit notes where the staff document a summary of their visits. The DON stated these documents were important to ensure that Resident 133 received the necessary care and services consistent with hospice philosophy. The DON acknowledged that Resident 133's records and hospice binder did not contain Resident 133's Plan of Care and had none of the required documents. DON agreed that without communication notes from the hospice nurse, staff might not know the care needs of Resident 133 if there was improvement or decline. DON stated nursing supervisors were responsible for monitoring the hospice coordination of care and communication between hospice and facility staff regarding residents on hospice care.A review of the facility's 'Hospice Services Facility Agreement' policy dated 5/29/25, indicated, It is the policy of this facility to provide.hospice services in order to protect a resident's right to a dignified existence, self-determination, and communication with.services inside and outside the facility. The policy explained that the facility will have a designated staff to be responsible for working with hospice representatives to coordinate care to the resident provided by facility and hospice staff.

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F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly Based on interview and record review, the facility failed to ensure the facility's Medical Director (MD) attended the Quality Assurance and Performance Improvement (QAPI, a program that helps healthcare facilities consistently evaluate and improve their services and improve the quality of life and quality of care for residents) committee meetings. This failure had the potential for the QAPI meetings to lack medical guidance for medical care concerns, lack quality care improvement activities, lack effective evaluation of the program resulting in negative outcomes and decline in quality of care for a census of 137 residents.During a concurrent interview and record review with the Administrator (ADM) and Director of Nursing (DON) on 8/22/25 at 2:10 p.m., the ADM stated that from January to May 2025 the facility held QAPI meetings monthly when they reviewed quality reports, identified the concerns with residents' care, discussed quality safety concerns, and ensured corrective actions were implemented. The ADM stated that the Medical Director (MD), who have been in the facility since January 2025, was a required member of the committee but he had not attended any of the QAPI meetings. A review of the QAPI Committee attendance sign-in sheet from 1/20/25 through 5/29/25 revealed the Medical Director's name was missing.The DON stated that the facility invited Medical Director to attend QAPI meetings, but every time they invited him, he declined stating he was too busy. The ADM added, We notify him verbally of all the issues encountered, prepare written report, but he never signed those reports acknowledging that he is aware of all the issues. The ADM further explained that the facility did not have the MD's designee to attend QAPI meetings in MD's absence. A review of the facility's Quality Assurance and Performance Improvement (QAPI) , implemented 4/28/2025 indicated, It is the policy of this facility to develop, implement, and maintain an effective.QAPI program.The QAPI program includes the establishment of a Quality Assessment and Assurance (QAA) Committee.The QAA Committee shall be interdisciplinary and shall.consist at a minimum of.The Medical Director or his/her designee.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observation, interview, and record review, the facility failed to maintain effective infection prevention and control measures to prevent the occurrence and spread of infections to residents, when: 1. The enhanced barrier precautions (EBP, infection control measures to prevent spread of infections) signage was not accurately assigned; 2. The nursing staff did not implement EBP for Resident 36;3. The nursing staff did not close the door of rooms on isolation precautions for COVID-19 positive residents;4. Blood Pressure (BP) cuff and BP machine were not disinfected with appropriate disinfectant;5. Resident 66's nebulizer (a machine that turns liquid medicine into a mist that can be easily inhaled) mask was not labeled and stored properly; and,6. Resident 98's humidifier (used to provide additional humidity to oxygen therapy) was left open when not in use and not replaced as ordered. These failures increased the potential to spread infections and cross contamination.1. An observation was conducted on 8/19/25 starting at 12:02 p.m., Resident 35's room had an EBP sign by the door. The Certified Nursing Assistant 3 (CNA 3) entered said room with a transfer device without a personal protective equipment (PPE- clothing and equipment that is worn or used to provide protection against hazardous substances and/or environment). In an interview on 8/19/25 at 12:22 p.m., CNA 3 stated he assisted resident in bed #1 [Resident 35] in the bathroom for an incontinence brief change. The CNA 3 further stated he used gloves when he changed Resident 35's brief. The CNA 3 added the EBP sign by the door was intended for the resident in bed #2 due to resident had a wound. A subsequent observation and interview with CNA 3 was conducted on 8/19/25 at 12:28 p.m. The CNA 3 looked at the EBP sign by the door, and he stated he should have worn a gown when he assisted resident to the toilet. In a concurrent observation and interview on 8/20/25 at 8:58 a.m., the Infection Preventionist (IP) wrote Bed #1 in the EBP sign by Resident 35's room. The IP stated the EBP sign was for Resident 35, resident had a wound that required a dressing. The IP further stated when staff are doing high contact care with the resident, staff should use gown and gloves, anytime staff perform transfer, shower and brief change. A review of Resident 35's clinical record did not indicate presence of wounds. In a follow up interview on 8/22/25 at 11:25 a.m., the IP stated she misplaced the EBP sign for Resident 35, the sign was for resident in bed #2 instead of Resident 35 in bed #1. 2. An observation was conducted on 8/20/25 at 9:45 a.m., CNA 3 and CNA 4 went inside Resident 36's with a transfer device. The door to resident's room had an EBP sign and Bed #2 (Resident 36) was handwritten on the sign. An interview was conducted on 8/20/25 at 9:53 a.m. with CNA 4. The CNA 4 stated CNA 3 and herself performed an incontinence brief change to Resident 36. The CNA 4 further stated CNA 3 and herself did not use a gown while caring for Resident 36. CNA 4 added she was not aware of the EBP sign posted on Resident 36's door. CNA 4 confirmed gown and gloves should be worn when changing Resident 36's brief. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 8/20/25 at 10:27 a.m., the IP stated the EBP sign was intended for Resident 36 due to colonized bacteria (presence of germs in the body without signs and symptoms of illness) and skin tear requiring dressing. A review of Resident 36's care plan initiated 4/1/24 indicated Enhanced barrier precautions in place for Infection Prevention and the intervention indicated, Staff will [NAME] proper PPE when giving high contact care. In an interview on 8/22/25 at 11:25 a.m., the Director of Nursing (DON) stated her expectation was for staff to clarify with the nurse if there was no specific resident indicated on the EBP sign. The DON further stated staff should be more careful when caring for residents on EBP because residents have a higher chance of contacting infection due to presence of wound, indwelling urinary catheter, or some sort of tube in the body. The DON added the staff are expected to use gown and gloves for high contact activity. A review of the facility's policy and procedure effective 7/2025 and titled, Enhanced Barrier Precautions indicated, It is the policy of this facility to implement enhanced barrier precautions for the prevention of transmission of multidrug-resistant organisms (MDROs) .Enhanced Barrier Precautions involve gown and glove use during high-contact resident care activities for residents known to be colonized or infected with a MDRO as well as those at increased risk of MDRO acquisition (e.g., residents with wounds or indwelling medical devices). High-contact resident activities include: .Transferring .Changing briefs or assisting with toileting .Wound care: any skin opening requiring a dressing . 3. During an observation on 8/22/25 at 9:26 a.m. in the 600 hall, the doors of two rooms were open. Both rooms had a sign on the door labeled “Special Droplet/Contact Precautions” that stated, “Keep door closed” During an interview and observation on 8/22/25 at 10:02 a.m. with CNA 5, CNA 5 confirmed that the 600 hall had positive Covid-19 residents in those two rooms. CNA 5 stated that the residents in the rooms were on isolation precautions due to Covid-19 and confirmed the doors of both rooms were left open. During an interview and observation on 8/22/25 at 10:12 a.m. with IP, the IP stated that there were five Covid-19 positive residents in Hall 600. The IP confirmed both rooms had two residents in each room that tested positive for Covid-19. The IP stated that the residents in the rooms were on isolation precautions due to Covid-19 and confirmed the doors of both rooms were left open. Per the IP, “The doors should be closed while on isolation to prevent the spread of Covid…they should have the doors closed since it is in our policy” During an interview and concurrent record review on 8/22/25 at 11:56 a.m. with the DON, the DON confirmed it was the facility’s policy to have doors closed for residents that were positive for Covid-19. The DON confirmed the Policy titled, “Covid-19 Response Plan”, is the policy the DON expects to be followed. The DON stated, “…expectation is that the staff follow the policy to prevent spread of Covid -19…” (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the facility's Policy and Procedure (P&P) titled “Covid-19 Response Plan”, the P&P indicated in “…F…3. Implement airborne, droplet and contact precautions for all residents with suspected or confirmed Covid-19…Isolate the resident in their room, with the door closed…” 4. During a medication administration observation on 8/20/25 at 8:07 a.m. with LN 9, LN 9 was observed disinfecting the BP cuff and machine with hand sanitizer wipes after using it with a resident. LN 9 confirmed the observation and stated she used the hand sanitizer wipes “…because bleach wipes are too harsh for the equipment.” During an interview on 8/20/25 at 12:01 p.m. with LN 2, LN 2 stated, “I use the alcohol prep pad to disinfect the blood pressure cuffs…It is easier for me to use the alcohol prep pad…” LN 2 further stated that she should have used the proper disinfectant wipe. During an interview on 8/21/25 at 12:04 p.m. with the IP, the IP stated BP cuff and equipment should be disinfected after use and stated, “ .clean with alcohol-based cleaner with blue top…” The IP further stated alcohol-based cleaners are okay to use for disinfection and stated, “So they can use the hand sanitizer…I would prefer to use the sanitizer, they can use alcohol wipes as a last resort and not for convenience…” The IP added, “Proper disinfectant is going to clean certain bacteria and virus to reduce transmission of nosocomial infection [infection acquired in a healthcare facility]. ” During an interview on 8/22/25 at 9:55 a.m. with the DON, the DON stated, “They [staff] should be using micro-kill one for bp cuffs and medical equipment…” When asked if staff can use hand sanitizer wipes to disinfect BP cuff and equipment, the DON stated, “I don’t think so” and stated staff cannot use alcohol swabs either “for infection prevention.” During a review of the facility’s P&P titled “Cleaning and Disinfection of Resident-Care Equipment,” revised 4/17/24, the P&P indicated, “Resident-care equipment can be a source of indirect transmission of pathogens. Reusable resident-care equipment will be cleaned and disinfected in accordance with current CDC [Centers for Disease Control and Prevention] recommendations in order to break the chain of infection…g. Use only EPA [Environment Protection Agency]-registered disinfectants with kill claims for the common organisms found in the facility…” 5. During a review of Resident 66’s admission records, the records indicated Resident 66 was admitted in January 2021 and readmitted in October 2023 with diagnosis that included Chronic Obstructive Pulmonary Disease (COPD, a chronic lung disease causing difficulty in breathing). Resident 66’s MDS indicated Resident 66 had severe cognitive impairment. During a review of Resident 66’s care plan, dated 2/6/24, the care plan indicated, “[Resident 66] has COPD…The resident will be free of s/sx [signs and symptoms] of respiratory infections…Give aerosol [tiny solid or liquid particles suspended in the air] or bronchodilators [relaxes the muscles in the airways to open them up] as ordered…” During a review of Resident 66’s physician order, dated 3/6/25, the order indicated, “Change nebulizer equipment every evening shift 1 days on and 2 days off…” (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 66’s physician order, dated 3/13/25, the order indicated, “Ipratropium-Albuterol [inhaled medication to open the airways] Inhalation Solution…3 ml [milliliters, a unit of measurement] inhale orally [by mouth] via nebulizer two times a day for chronic congestion via nebulizer…” During a review of Resident 66’s Medication Administration Record (MAR) for August 2025, the MAR indicated Resident 66 received Ipratropium-Albuterol inhalation on 8/19/25 at 8 a.m. During an observation on 8/19/25 at 9:41 a.m. in Resident 66’s room, Resident 66’s nebulizer mask was observed on the bedside table connected to nebulizer, without label and not in a bag. During a concurrent observation and interview on 8/19/25 at 10:04 a.m. with LN 8 in Resident 66’s room, LN 8 stated Resident 66 received nebulization in the morning of 8/19/25 around 7:30 a.m. LN 8 confirmed Resident 66’s nebulizer mask was not labeled and stated, “…We just put it there on top of neb [nebulizer] machine…We are supposed to label it…So we will know when to change it…” During an interview on 8/21/25 at 12:04 p.m. with the IP, the IP stated, “…staff should store them [nebulizer mask] in a bag, changed weekly and date it .For infection prevention, it can grow bacteria if it falls on the floor…Important to prevent spread of bacteria keep the resident healthy…It can build up bacteria from the droplets overtime, we want to prevent infection…” During an interview on 8/22/25 at 9:55 a.m. with the DON, the DON stated, “…For neb mask, it should be labeled with the date to make sure it’s a new mask…” During a review of the facility’s P&P titled “Medical Gas and Oxygen Policy,” revised 2/20/19, the P&P indicated, “…All oxygen equipment will have the date of change and initials of the nurse…” 6. During a review of Resident 98’s admission records, the records indicated Resident 98 was admitted to the facility in February 2025 with diagnoses that included COPD and anemia (a condition where the body does not have enough healthy red blood cells). Resident 98’s MDS indicated Resident 98 had severe cognitive impairment. During a review of Resident 98’s physician order, dated 2/13/25, the order indicated, “Oxygen @[at]2L/min [liters/minute] via nasal cannula (oxygen tubing) as needed for shortness of breath q [every] shift prn [as needed].” During a review of Resident 98’s physician order, dated 2/17/25, the order indicated, “Change humidifier every night shift every Sat [Saturday].” During a review of Resident 98’s MAR for August 2025 the MAR indicated Resident 98’s humidifier was changed on 8/9/25. During an observation on 8/19/25 at 9:44 a.m. in Resident 98’s room, oxygen concentrator was observed at bedside, not in use, with opened humidifier in place, labeled “8/10.” (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview on 8/20/25 at 10:04 a.m. with LN 8 in Resident 98’s room, LN 8 confirmed the humidifier was opened and labeled on 8/10/25, and stated, “Humidifiers are changed by Noc [night] shift…Nurses sign it when they change it…usually, we change it once a week, we don’t throw it…” LN 8 further stated, “…once it [humidifier] is open and not going to use it, we throw it…resident can't use it because it is past one week…” During an interview on 8/21/25 at 12:04 p.m. with the IP, the IP stated, “Humidifiers should be dated as well and changed weekly and depends on the order…” During an interview on 8/22/25 at 9:55 a.m. with DON, the DON stated, “…for humidifiers, should be labeled and changed as ordered.” During a review of the facility’s P&P titled Medical Gas and Oxygen Policy, dated 2/20/19, the P&P indicated, “8. Humidifiers will be replaced 1x/week and prn…All equipment will have the date of change and initials of the nurse…”

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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 ensure an effective pest control program was implemented for a census of 137 residents, when flies were observed in the kitchen. This failure decreased the facility's potential to maintain a pest-free environment in the kitchen that prevented food contamination.Findings: During a concurrent observation and interview on 8/19/25 at 10:45 a.m. with Dietary Supervisor 1 (DS 1), flies were observed in the kitchen. Flies were observed flying around and landing on kitchen counters, food processors, cooking utensils, dishes, and food. DS 1 confirmed the presence of flies in the kitchen and stated it posed a risk for food contamination.During a concurrent observation and interview on 8/19/25 at 11:55 a.m. with the Maintenance Supervisor (MS), MS confirmed the flies problem in the kitchen. MS stated the last pest control was conducted on 8/8/25 and agreed the issues were not resolved.During an interview on 8/19/25 at 3:40 p.m. with the Registered Dietitian (RD), the RD confirmed an infestation of flies in the kitchen. RD agreed flies could contaminate food and cause illness among residents. RD expected implementation of better pest control measures to eradicate flies from the kitchen.During an interview on 8/22/25 at 1:40 p.m. with the Director of Nursing (DON), the DON acknowledged the flies' issue in the kitchen. The DON stated facility had monthly pest control services and the last one was on 8/8/25. The DON expected the MS to contact the pest control vendor for additional and stronger pest control measures to eliminate flies from the kitchen.A review of the facility's policy and procedure titled, Pest, Rodents & Insect Policy, revised on 4/17/2024, indicated, Maintenance will ensure insects are not present in or around the premises . if found, maintenance will contact our outside vendor for additional treatments and/or solutions.