STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056410	A. Building B. Wing	05/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Whitney Oaks Care Center	3529 Walnut Avenue Carmichael, CA 95608

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 50282 Based on observation, interview, and record review, the facility failed to promote dignity and respect for Resident 61 when Licensed Nurse 3 (LN 3) did not provide privacy to body after leaving Resident 61's room, and did not communicate with Resident 61 while providing care. These failures decreased the facility's ability to provide care in a dignified and respectful manner for Resident 61. Findings: A review of Resident 61's admission record indicated he was originally admitted in November 2020 with diagnoses including dementia (a progressive state of decline in mental abilities), and functional quadriplegia (inability to move legs and arms due to physical weakness). A review of Resident 61's Minimum Data Set (MDS- a federally mandated assessment tool), dated 3/3/25, indicated Resident 61's Brief Interview for Mental Status (BIMS- an assessment tool used by facilities to screen and identify memory, orientation, and judgement status of the resident) score was 0 out of 15 with an inability to express ideas and make decisions. A review of Resident 61's Activity of Daily Living (ADL- routine tasks/activities a person performs daily to care for themselves) care plan, dated 3/13/23 and revised on 3/11/25, indicated an intervention to provide verbal and tactile cues; explain task during ADL care. During an observation on 5/20/25 at 11:15 a.m., Licensed Nurse 3 (LN 3) entered Resident 61's room without knocking on the door, she did not verbally acknowledge his presence, and did not explain the purpose for entering his room. LN 3 prepared for his tube feeding administration, uncovered Resident 61 to expose his stomach's gastrostomy (a surgical opening fitted with a device to allow feedings to be administered directly to the stomach) site, then left the room without covering Resident 61's body with the gown or linen. Approximately five minutes later LN 3 returned to Resident 61's bedside, and continued with tube feeding administration, without talking or explaining the task to him. During an interview on 5/20/25 at 11:30 a.m. with Licensed Nurse 3 (LN 3), LN 3 acknowledged that she did not communicate with Resident 61 while providing care, and that she did not cover him when she left the room. LN 3 stated I know better, and confirmed that Resident 61 had the right for respect, dignity and privacy. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/23/25 at 10 a.m., in the Director of Nursing's (DON) office, with Administrator (ADM) and DON, DON stated that LN 3 is familiar with Resident 61 and has been working with him for a long time. ADM and DON acknowledged the importance of Resident 61 having privacy and being treated with respect. Furthermore, stated that staff should introduce themselves when entering a resident's room, and communicate with residents when they are helping with care. During a review of the facility's policy titled, Dignity, revision date February 2021, the policy stipulated, 1. Residents are treated with dignity and respect at all times . 7. Staff are expected to knock .before entering residents' rooms . 8. Staff speak respectfully to residents at all times, including addressing the resident by his or her name .9. Procedures are explained before they are performed . 11. Staff promote, maintain and protect resident privacy, including bodily privacy during assistance with personal care and during treatment procedures.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46242 Based on observation, interview, and record review, the facility failed to accurately complete the quarterly Minimum Data Set (MDS - a federally mandated resident assessment tool) for one of 24 sampled residents (Resident 64). Failure to accurately assess Resident 64's Multi-Drug Resistant Organism (MDRO, an organism that is resistant to multiple antibiotics) status resulted in an inaccurate record. Findings: A review of Resident 64's Admission Record, dated 5/23/25, indicated, Resident 64 was admitted to the facility in January 2024 with diagnoses that included diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), peripheral vascular disease (PVD - a slow progressive narrowing of the blood flow to the arms and legs), and Resistance to Multiple Antimicrobial Drugs. During a review of Resident 64's MDS, dated [DATE], the MDS indicated the presence of MDRO as an active diagnosis. During a review of Resident 64's Health Care Facility Transfer Form, dated 1/18/24, the Health Care Facility Transfer Form indicated there was no need for isolation or MDRO status for Resident 64. A review of Resident 64's hospitalization record titled History and Physical, dated 7/17/24, did not indicate a need for isolation or MDRO status. A review of Resident 64's Microbiology Cultures, dated 7/17/24, indicated a urinary infection with bacteria that was sensitive to multiple antibiotics (non-MDRO). During an observation on 5/20/25 at 8:36 a.m., entrance to Resident 64's room was observed without signage for contact based precautions, specifically Enhanced Barrier Precautions (EBP- a set of personal protective equipment measures customarily implemented for MDRO control). During an interview on 5/21/25 at 11:21 a.m. with Infection Preventionist (IP), IP confirmed that Resident 64 did not have an MDRO and the MDS needed to be corrected. She further stated that MDRO status was likely marked when bacterial culture laboratory results were pending. During an interview on 5/23/25 at 8:05 a.m. with MDS Coordinator (MDS-C), MDS-C confirmed that Resident 64's MDS was marked for MDRO in July 2024 when culture laboratory results were pending. She agreed that MDRO status should have been corrected when lab results became available within a week. During an interview on 5/23/25 at 9:23 a.m. with IP, IP agreed that there should be better communication with MDS because if Resident 64 had actual MDRO and it wasn't communicated to the IP to implement appropriate precautions, the facility would have been at higher risk of spread of infections. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/23/25 at 10:47 a.m. with the Director of Nursing (DON), the DON stated that Resident 64's MDRO status should have been coded accurately in the MDS, and it should have been verified by the IP. DON also stated that the facility did not have MDS specific policy.

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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. 40867 Based on observation, interview, and record review, the facility failed to administer a medication according to professional standards of quality for one of 34 sampled residents (Resident 23) when his insulin lispro (a fast acting insulin, medication to treat diabetes (a disorder characterized by difficulty in blood sugar control and poor wound healing)) according to the physician's order. This failure had the potential to cause poor glycemic (blood sugar) control which could lead to heart disease, nerve damage, kidney disease, vision loss, and foot problems. Findings: A review of Resident 23's medical record indicated he was admitted to the facility Fall 2022 with diagnosis which included diabetes. A review of Resident 170's clinical record included a physician's order dated 5/20/25, for insulin lispro 100 unit/milliliter (a unit of measurment) inject 8 unit subcutaneously (under skin) before meals for DMII (typle 2 diabetes). During a medication pass observation on 5/20/25 at 7:55 a.m. with Licensed Nurse 1(LN1), LN 1 was observed preparing 10 medications for Resident 23, including insulin lispro to Resident 23. LN 1 confirmed Resident 23 was done eating breakfast and removed his breakfast tray from the room. A review of the facilities dietary service schedule, the schedule indicated breakfast trays for Resident 23's hallway were routinely scheduled for 7:10 a.m. delivery. During an interview on 5/20/25 at 12:07 p.m. with LN 1, LN 1 stated Resident 23 had just finished his breakfast after you got to me. LN 1 confirmed Resident 23's breakfast trays were routinely delivered between 7:10 am. to 7:30 a.m. LN 1 confirmed Resident 23's medication order for insulin lispro was ordered before meals and she had administered after he had eaten his breakfast. During an interview on 5/22/25 at 08:50 a.m. with the DON, the DON stated nursing staff were expected to follow physician orders insulin and blood sugars are to be check prior to meal. DON stated adverse outcome can be uncontrolled blood sugar levels. During a review of the facility's policy titled, Medication Administration-General Guidelines dated 3/2018, the policy indicated, Medications are administered as prescribed in accordance with good nursing principles and practices .Medications are administered within 60 minutes of scheduled time, except before or after meal orders, which are administered based on mealtimes unless otherwise specified by the prescriber . Medications are administered in accordance with written orders of the attending physician.

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. 52129 Based on observation, interview and record review, the facility failed to ensure communication needs were met for one of 34 sampled residents (Resident 51) when communication materials were not available for use by the resident. This failure had the potential to impede Resident 51 from maintaining or reaching the highest practicable well-being. Findings: Resident 51 was admitted to the facility in April 2025 with diagnoses which included right femur fracture, and muscle weakness. Resident 51's Minimum Data Set (MDS, an assessment tool) dated 4/28/25 indicated memory was severely impaired. The MDS also indicated Resident 51's preferred language was other than English. During a review of activities care plan for Resident 51 initiated 4/28/25, indicated Provide activity calendar in room .Provide activity materials like books, magazines, TV, radio, arts and crafts .in accordance with interests. During a review of Resident 51's Comprehensive Skilled Review Note dated 5/15/25, indicated .Language barrier-Russian speaking only. During a concurrent observation and interview on 5/20/25 at 11:20 a.m., Resident 51 was laying in bed, responded to questions in English by waving hand and shaking head with no verbal response. There were no communication devices observed in the room. During an observation on 5/22/25 at 1:31 p.m., in Resident 51's room, observed Resident 51 in bed awake TV on tuned to an English channel. During an interview with Certified Nurse Assistant (CNA 2) on 5/21/25 at 10:15 a.m., CNA 2 stated she was not sure of the language Resident 51 spoke. CNA 2 stated Resident 51 used gestures in an attempt to communicate. CNA 2 confirmed there were no communication devices in the resident's room. CNA 2 further stated he had not used a translation service and had not seen any other staff use it for Resident 51. During an interview on 5/20/25 at 2:05 p.m. with Resident 51's family member (FM), FM stated staff communicated with Resident 51 with gestures which were not very effective. FM stated he was concerned regarding mother's inability to communicate with staff. FM further indicated he requested an interpreter on admission and was told there was no interpreter. FM stated his mother's inability to understand and communicate in an unfamiliar environment can lead to increased confusion. (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with Licensed Nurse 2 (LN 2) on 5/21/25 at 9:15 a.m., LN 2, stated, To assess pain, we use facial expressions, posture, and gestures. LN 2 stated, The resident was not able to verbalize pain or pain level. LN 2 stated there was no communication board in Resident 51's room. During an interview on 5/21/25 at 11:25 a.m. with Resident 51's physician, she stated Resident 51 spoke Russian. Physician stated Resident 51 had cognitive impairment. Physician further stated she assessed and treated Resident 51 when her family member was present to interpret. The physician stated she had discussed with facility staff the possibility of using a translation service for Resident 51. During an interview on 5/22/25 at 9:13 a.m. the Director of Nursing (DON) stated that expectations were that interventions utilized for non-English speaking residents included the usage of the facilities contracted translator service line and communication boards. The DON stated she was not aware of how Resident 51 was communicating her needs with staff. DON verified from the record that Resident 51 had no communication care plan. Review of the facility's policy and procedure titled, Social Services, revised September 2021, indicated .to assure that each resident can attain or maintain his/her highest practicable . wellbeing .assisting with or arranging for a resident's communication needs through resident's preferred method of communication and/or language that the resident understands .

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36624 Based on observation, interview, and record review, the facility failed to ensure two (2) of 34 sampled residents (Resident 27 and Resident 220) received services to maintain nail care, good grooming, and personal hygiene for the use of neck brace device. This failure decreased the facility's ability to promote healthy nail growth and enhanced residents' appearance, overall well-being and to prevent skin irritation and potential infections. Findings: A review of Resident 27's Admission Record (AR) indicated she was admitted on [DATE] with diagnoses which included depression (serious medical illness that can significantly impact how a person feels, thinks, and acts), left sided body weakness and cognitive impairment. A review of Resident 27's Physician's Order (PO) dated 2/19/25, the PO indicated, Resident's Consult - Podiatry As Needed For Mycotic/Hypertrophic Nails And/Or Keratotic Lesions. During a concurrent observation and interview on 5/20/25 at 4:18 p.m., Resident 27's right fingernails were long, jagged and had substances underneath the nail beds. Resident 27's left fingernails, especially the middle finger including the second and little fingers, had long and curled inward nails and fungus-like appearance. Resident 27 stated she wanted her fingernails trimmed and had told the staff about it but it was not done. During a concurrent observation and interview, on 5/22/25 at 12:51 p.m., with Licensed Nurse 7 (LN 7), LN 7 confirmed the findings. LN 7 stated she would get a treatment order from the physician for the fungus-like condition of the left fingernails. LN 7 stated resident's fingernails should be kept short and clean to prevent nail infections becasue dirt and germs could live under fingernails. During an interview on 5/23/25 at 11:01 a.m., with the Director of Nursing (DON), together with the Administrator (ADM), the DON stated her expectation was for the nurses to do the nail care for the residents, especially when fingernails had some sort of fungus, then the physician should be notified for a treatment order. The DON stated keeping residents' nails trimmed and clean is crucial for hygiene, health, overall well-being, helped prevent infections, and promote healthy nail growth. A review of Resident 220's AR indicated he was admitted on [DATE] with diagnoses which included cervical spinal fusion (a surgery that joins two or more vertebrae in the neck to create a stable, solid piece of bone). A review of Resident 220's PO dated 5/15/25, the PO indicated, keep [Brand name] collar neck brace at all times as ordered. During an observation on 5/20/25 at 12:09 p.m., Resident 220's neck collar foampad had brownish to blackish discoloration. On 5/22/25 at 10:47 a.m., Resident 220 was brushing his teeth and toothpaste bubbles cascaded down to his discolored and dirty neck brace foampad. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview on 5/22/25 at 10:47 a.m., Resident 220 stated his neck collar foampad had not been changed or washed since he was admitted . Resident 220 stated if it was dirty and smell, then it should have been washed or changed. During a concurrent observation and interview, on 5/22/25 at 10:47 a.m., LN 8 confirmed the neck brace foampad had brownish to blackish discolorations. LN 8 stated cleaning the neck collar foampad is crucial to prevent skin irritation, bacterial growth, and unpleasant odors. LN 8 added regularly cleaning the foampads and the collar itself helps maintain hygiene and comfort, especially during extended use, but cleaning/washing the neckbrace foampad was not done. During an interview on 5/23/25 at 11:01, with the DON together with the ADM, the DON stated because the foampad had direct contact with the skin, she expected the staff to clean it regularly to prevent possible skin rashes, soreness, and irritation caused by sweat, bacteria, and debris. The DON also added, neck brace foampads when worn for extended period of times while it is dirty could become breeding grounds for bacteria and cleaning it, including hand washing it with soap and water, could help control bacterial growth and reduce the risk of skin infection. A review of the facility's Policy and Procedure (P/P) titled, ACTIVITIES OF DAILY LIVING, SUPPORTING, revised 4/2025, the P/P indicated, Residents who are unable to carry out activities of daily living independently receive the services to maintain good grooming and personal hygiene. A review of the facility's Policy and Procedure (P/P) titled, CLEANING AND DISINFECTION OF RESIDENT-CARE ITEMS AND EQUIPMENT, revised 10/2018, the P/P indicated, Resident care equipment including reusable items and durable medical equipment will be cleaned .

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate foot care. 48140 Based on observation, interview and record review the facility failed to ensure one resident (Resident 31) out of 34 sampled residents was provided nail care. This failure resulted in Resident 31's overgrown toenails and the potential to develop an infection or injury. Findings: A review of Resident 31's admission record indicated Resident 31 was admitted to the facility in July 2024 with diagnoses which included respiratory failure (inadequate gas exchange by the respiratory system) and chronic obstructive pulmonary disease (COPD). During a concurrent observation and interview on 5/20/25 at 8:33 a.m. in Resident 31's room, Resident 31 indicated she had stated her toenails needed to be trimmed. An observation of Resident 31's toenails showed her toenails were long, past the edge of her toes. Resident 31 stated her toenails kept getting caught on her bed linens and was worried about scratching herself. During a concurrent observation and interview on 5/22/25 at 11:06 a.m. with Licensed Nurse (LN) 6, in Resident 31's room, LN 6 observed Resident 31's toenails and acknowledged they needed to be trimmed. LN 6 confirmed it was in the LNs scope of practice to cut or trim residents' toenails. LN 6 acknowledged resident nails should be assessed frequently for length and infection. During an interview on 5/22/25 at 11:47 a.m. with the Director of Nursing (DON), the DON acknowledged nail care should be assessed frequently. The DON confirmed it was within the LNs scope of practice to cut, trim or file the resident's toenails. A review of the facility's policy and procedure (P&P) titled, Care of Fingernails/Toenails, revised February 2018, indicated The purposes of this procedure are to clean the nail bed, to keep the nails trimmed, and to prevent infections .Nail care incudes daily cleaning and regular trimming.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 36624 Based on observation, interview, and record review, the facility failed to ensure one of 34 sampled residents (Resident 102) indwelling catheter (IC, a type of urinary catheter designed to remain in place for an extended period to drain urine from the bladder) tubing was free from accumulated urine sediments. This failure decreased the facility's ability to prevent obstruction of the catheter's lumen, leading to reduced urine flow or complete blockage. Findings: A review of Resident 102's Admission Record (AR) indicated he was admitted on [DATE] with diagnoses which included urine retention and enlarged prostate (gland that produces some of the fluid) with lower urinary tract symptoms. A review of Resident 102's Physician's Order (PO) dated 5/12/25, the PO indicated: Indwelling [Brand Name] Catheter . # 18F [FR: French; catheter size]/10 ml [milliliter, metric unit of measurement] for diagnoses of obstructive and reflux uropathy; monitor every shift; cleanse with warm soap and water, rinse and pat dry; irrigate with 10 ml of normal saline [PRN, as needed] for clogging and notify (MD, Medical Director) as needed. During an observation on 5/20/25 at 8:27 a.m. and on 5/22/25 at 11:11 a.m., Resident 102 had his catheter tubing with accumulated whitish urine-sediment-like substances. During a concurrent observation and interview on 5/22/25 at 11:11 a.m., with Licensed Nurse 8 (LN 8), LN 8 confirmed there was accumulated whitish urine sediments in Resident 102's IC tubing. LN 8 stated it should not be that way, because accumulated urine sediments in the IC could affect the kidney, resident could get infection, kidney problem and urinary tract infection (UTI, an infection in any part of the urinary system). During an interview on 5/23/25 at 11:01, with the Director of Nursing (DON) together with the Administrator (ADM), the DON stated her expectation on catheter care was that nurses should monitor the urine color, the catheter tubing for any accumulation of urine sediments, and flush it to prevent Resident 102 from getting infection. The DON stated infection is a big thing. The DON also stated, urine tubing flush is crucial for maintaining the proper function of urinary catheters and preventing complications like blockages and it helped clear any debris, mucus, or blood clots that may obstruct the flow of urine. A review of the facility's Policy and Procedure (P/P) titled, CATHETER CARE, URINARY, dated 8/2022, the P/P indicated, Maintaining Unobstructed Urine Flow: Residents who form encrustations that can quickly lead to an obstruction need more catheter changes at intervals specific to individual resident. The catheter should be changed before blockage is likely to occur.

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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** 36624 Based on observation, interview, and record review, the facility failed to ensure one of 34 sampled residents (Resident 220) incentive spirometer (IS, a handheld medical device used to help patients practice taking deep breath, encouraging lung expansion to prevent respiratory complications) was available and provided as ordered. This failure decreased the facility's ability to help Resident 220's exercise his lungs to expand, strengthen, inflate, and clear mucus and other secretions after surgery. Findings: A review of Resident 220's Admission Record (AR) indicated he was admitted on [DATE] with diagnoses which included cervical spinal fusion (a surgery that joins two or more vertebrae in the neck to create a stable, solid piece of bone). A review of Resident 220's Physician's Order (PO) dated 5/13/25, the PO indicated, Incentive Spirometer: three times per day for 10 days due to pulmonary dysfunction related to: PNEUMONIA [PNA, a lung infection where the air sacs (alveoli) fill with fluid or pus, making it difficult to breathe and potentially causing fever, cough, and other symptoms] PREVENTION . every shift documented minutes to include the time the respiratory nurse spends with the resident including evaluation/assessment, treatment administration and monitoring, and setup and removal of treatment equipment. During observations on 5/20/23 at 12:09 p.m., and on 5/22/25 at 10:07 a.m , Resident 220's IS device was out of sight and was not observed he had used it. During a concurrent observation and interview on 5/22/25 at 1:43 p.m., Resident 220 stated he had not used the IS. During a concurrent observation, interview, and record review on 5/22/25 at 10:51 a.m., with Licensed Nurse 8 (LN 8), LN 8 confirmed Resident 220 had an order to use the IS, three time per day for 10 days from 5/13/25-5/23/25. LN 8 confirmed the IS was out of sight and she had not provided it. LN 8 stated Resident 220 had not moved that much due to his spine surgery and the IS should be available to Resident 220 to use to prevent lung infection, but no IS was provided. During an interview and record review, on 5/23/25 at 11:01 a.m., with the Director of Nursing (DON), Resident 220's record was reviewed. The DON confirmed Resident 220 had an order to use the IS. The DON stated she expected the nurses to provide Resident 220 the care and treatment he needed like the IS to prevent lung infection. The DON stated by not offering Resident 220 the IS, he could develop pneumonia and other lung complications after surgery. A policy about breathing device to include incentive spirometer was requested but none was available/provided. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's Registered Nurse's (RN's) duties and responsibilities: On Equipment and Supplies indicated: Ensure that an adequate stock level of . medical supplies, equipment is maintained on premises at all times to meet the needs of the residents.

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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. 51483 Based on observation, interview and record review, the facility failed to ensure: 1. Destruction prescription medications according to facility policy and procedure (P&P); and, 2. The narcotic emergency kit (e-kit; a kit/box containing medications and supplies for immediate use during a medical emergency) was replaced according to facility P&P after use. These failures had the potential for abuse or misuse of medications and for emergency medications to be unavailable when needed. Findings: During an observation and interview on 5/20/25 at 8:52 a.m. with Licensed Nurse 2 (LN 2), LN 2 stated there was not a drug buster (a container to safely hold disposed drugs) available on her cart. LN 2 placed amiodarone (medication primarily used to treat heart rhythm problems) and another unidentified loose pill she found in the medication drawer inside a used latex glove and stored it inside the med cart. LN 2 confirmed there was not a drug buster located in her medication cart. LN 2 stated proper disposal of medications should be immediately in a drug buster and not in glove. During an interview on 5/21/25 at 1:59 p.m., with Director of Nursing (DON), DON stated all medication carts were to be equipped with a drug buster. DON stated she expected staff to used the drug buster for medication disposal and not a glove. During a review of the facility's P&P titled, Medication Destruction, dated 3/2018, the P&P indicated, All non-controlled drugs that are eligible for disposal are placed in an approved waste container properly labeled as medication waste, hazardous waste (RCRA) or pharmaceutical waste. The provider pharmacy is contacted if the facility is unsure of proper disposal methods for a medication . During a concurrent interview and inspection on 5/20/25 at 11:20 a.m. of Station 2 medication storage room with Registered Nurse (RN), an e-kit with a red plastic tie (indicating it had been opened) was identified. Inside the e-kit was a log, indicating medication had been removed from the e-kit. RN confirmed the finding and stated e-kits were to be reordered from the pharmacy as soon as they were opened but it had not. RN stated the nurse that pulls medication from e-kit was responsible for reordering it as soon as possible. She stated it should have been followed up on to ensure the replacement was delivered. During an interview on 5/21/25 at 1:59 p.m., with DON, DON stated the expectation was opened e-kits should be replaced as soon as possible according to facility policy. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's P&P titled, Emergency Pharmacy Service and Emergency Kits, dated 3/2018, the P&P indicated, Procedures . E. The emergency supply is maintained at a designated area, along with a list of supply contents as follows . The kit is examined at the time of the shift count. The off-going nurse is responsible for reordering the kit, and reports such to the on-coming nurse if the kit is found to have been opened at the time of the shift count . G. As soon as possible, the nurse records the medication use on the medication order form and notifies the pharmacy for replacement of the kit by transmitting the entire order for the resident and indicating that the first dose was used from the kit . K. If exchanging kits, opened kits are replaced with sealed kits within 72 hours of opening. If replacing used medications, the replacement doses are added to the kit within 72 hours of opening.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. 51483 Based on observation, interview and record review, the facility's consultant pharmacist (CP) failed to identify drug-related issues on one of 34 sampled residents (Resident 170). This failure had the potential for unsafe medication use for all residents in the facility. Findings: A review of Resident 170's admission record indicated she was admitted in Spring 2025 diagnoses including anxiety disorder (a mental health disorder characterized by feelings of worry, anxiety or fear that are strong enough to interfere with one's daily activities) schizoaffective disorder (a mental illness that can affect thoughts, mood, and behavior), depression, diabetes mellitus II (disorder characterized by difficulty in blood sugar control and poor wound healing), and hyperlipidemia (having too much fat, like cholesterol or triglycerides in the blood) A review of Resident 170's clinical record included a physician's order dated 5/20/25, for quetiapine (an antipsychotic) 25 milligram (mg, a unit of measure), 1 tablet by mouth 12 hours as needed for agitation. A review of Resident 170's medical record confirmed no baseline glycated hemoglobin (A1C-measures average blood sugar levels) or lipid panel (blood test that checks different types of fat in the blood) was obtained. During a concurrent interview and record review, on 5/22/25 at 11:58 a.m., with the Director of Nursing (DON), Resident 170's medication regimen reviews (MRR, a comprehensive review of current medications currently in use by a resident) dated January 2025 to current were reviewed. The DON stated, I don't see that [the consultant pharmacist] made any lab recommendations. Side effects are monitored for psychotropic medications through lab work. The DON confirmed there was no lipid panel lab order or hemoglobin A1C recommendations for Resident 170 from 1/1/2025 to current. According to the Food and Drug Administration (FDA)- approved prescribing information for quetiapine revised 10/2013, indicates: .Patients who are diagnosed with diabetes, those with risk factors for diabetes, or those that develop these symptoms during treatment should have their blood glucose monitored at the beginning of and periodically during treatment . Patients should have their lipid profile monitored at the beginning of and periodically during treatment . (https://www.fda.gov/drugsatfda). During a review of the facility's policy and procedure (P&P) titled, Psychoactive/Psychotropic Medication Use, dated 4/25, the policy indicated, Staff will monitor for potential adverse consequences, such as . Metabolic: increase in total cholesterol and triglycerides, unstable or poorly controlled blood sugar . (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's P&P titled, Consultant Pharmacist Reports, version 3 undated, the P&P indicated, The consultant pharmacist identifies irregularities through a variety of sources including: The consultant pharmacist's evaluation includes, but is not limited to reviewing and/or evaluating the following: S) Laboratory results, diagnostic studies, or other medication therapy measurements are obtained by staff/physician and acted upon

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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. 51483 Based on observation, interview, and record review, the facility failed to ensure opened multi-dose medications and biologicals were dated with an open and discard date, expired medications were not available for resident use, and single resident over-the-counter (OTC) products were appropriately labeled . These failures had the potential for residents to receive medications with unsafe and reduced potency from being used past their discard date, incorrect medications from inadequate labeling, and unsafe or ineffective medications or biologicals from inadequate temperature monitoring and storage. Findings: During a concurrent observation and interview on 5/20/25 at 12:29 p.m. alongside Licensed Nurse (LN) 3, an inspection of Medication Cart 100 (Med Cart 1) identified two bottles of nitroglycerine (a medication used to treat chest pain). LN 3 confirmed the two bottles of nitroglycerine were not labeled with a pharmacy label. During a concurrent observation and interview on 5/20/25 at 12:40 p.m. with LN 4, an inspection of Medication Cart 300 (Med Cart 3) identified one medication opened and unlabeled Arnuity Ellipta (inhaled to reduce airway inflammation) 200 micrograms (mcg- a unit of measurement), one Spiriva Respimat (an inhaler to relax lungs and keep them open) 2.5 mcg/puff, one fluticasone (an inhaler to reduce airway inflammation) 250 mcg/50 mcg, one budesonide (an inhaler to reduce airway inflammation) 0.5 mg/2 mL (milligram, a unit of measure; milliliter, a uinit of measure) vials, one geri-tussin DM (medication to treat chest congestion) with spilled dry pink liquid on outside of bottle and med cart 1. One bottle of ear wax removal drops were identified without a resident specific label, one Covid-19 antigen rapid test expired (4/14/25), and one box Prilosec (a medication to treat heartburn) over the counter (OTC) 20 mg tab. LN 4 confirmed the manufacturer's packaging for each medication that indicated to dispose after first use and confirmed they should have been disposed of according to manufacturer's recommendations. LN 4 confirmed Arnity Ellipta inhaler was opened, undated, and expired 6 weeks after first use. LN 4 confirmed Spiriva Respimat was opened, undated, and expired 3 months after first use. LN 4 confirmed fluticasone was opened, undated, and expired 1 month after first use. LN 4 confirmed budesonide was opened, undated, and expired 2 weeks after first use. LN4 confirmed Ear Wax removal was labeled with a room number. LN 4 stated It's not ok for it (Ear Wax Removal) to be labeled that way because it can be used for the wrong patient if their room changes. LN 4 stated she expected medications to be labeled with open dates and using expired medications could be harmful to residents. During an interview on 5/21/25 at 2:07 p.m. with Director of Nursing (DON), DON stated she expected nursing staff to regularly check their carts of expired medication and ensure all medications are labeled with open date. DON stated nursing staff were expected to remove expired and soiled drugs from their medication carts and place them in a destruction bin located inside the medication storage rooms or carts. DON stated that nursing staff were expected to label medications with the date they were opened and to ensure each medication had a resident-specific label or a pharmacy label. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's policy and procedure (P&P) titled, Medication Storage in the Facility, dated March 2018, the P&P indicated, Medications and biologicals are stored safely, securely, and properly, following manufacturer's recommendations or those of the supplier . 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 . Medication storage areas are kept clean . The facility must label drugs and biological ls in accordance with currently accepted professional principles . 12. Drugs shall not be kept in stock after the expiration date on the label and no contaminated or deteriorated drugs shall be available for use . Each prescription medication label includes resident's name, specific directions for use, including route .Nonprescription medications not labeled by the pharmacy are . identified with the resident's name .

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. 40830 Based on observation, interview, and record review, the facility failed to ensure the planned menu was followed for the therapeutic diets during lunch on 5/21/25 when: 1. Six residents (Resident 1, 11, 70, 85, 88, and 108) with small portion diets received three ounces (oz.) of meat instead of two oz.; 2. Six residents (Resident 16, 23, 49, 81, 82, and 112) with fortified diets did not receive planned fortified food; and, 3. 57 out of 113 residents who received lunch meals did not receive garnishes with their lunch meals. These failures had the potential to result in compromising the medical and nutrition status of residents who received meals from the facility kitchen. Findings: During the lunch meal distribution on 5/21/25 beginning at 11:49 a.m., it was noted as follows: 1. During both interviews with [NAME] (CK) 1 and CK 2 on 5/21/25 at 11:55 a.m. and 12:35 p.m., CK 1 and CK 2 confirmed and stated all the regular roast beef they prepared were three oz. per serving (slice). During the meal distribution, it was noted six residents (Resident 1, 11, 70, 85, 88, and 108) with small portion diets received three oz. of roast beef instead of two oz. A concurrent review of facility spreadsheet (a menu excel sheet that indicated what items and portions to be served for each prescribed diet) titled, Spring Cycle Menus, Week 4 Wednesday, indicated small portion diet should receive two oz. of roast beef. 2. During an interview with CK 2 on 5/21/25 at 8:26 a.m. before the meal distribution started, CK 2 stated the fortified food for lunch on 5/21/25 was to give extra one oz. of melted butter or margarine on mashed potatoes. During the meal distribution, it was noted six residents (Resident 16, 23, 49, 81, 82, and 112) with fortified diets did not receive extra one oz. of melted butter/margarine on the mashed potatoes. 3. 57 out of 113 residents who received lunch meals from the facility kitchen did not have parsley garnish. A current review of facility spreadsheet titled, Spring Cycle Menus, Week 4 Wednesday, indicated all diets should have received a parsley garnish. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with Dietary Manager (DM) on 5/21/25 at 1:52 p.m., DM acknowledged issues were found during meal distribution. DM stated her expectation would be the staff should follow the spreadsheet or menu. During an interview with Registered Dietitian (RD) on 5/22/25 at 9:52 a.m., RD stated the small portion for the residents was for the residents' preferences due to some residents might overwhelm with regular or bigger portion. RD further explained the small portion was for residents on a weight loss plan. RD stated for the fortified food was to add extra calories to the residents to meet their caloric needs and for the residents had weight loss issue. RD stated garnish was for the presentation of food and could make the food more appealing to increase appetite for the residents to eat. RD stated overall the kitchen staff needed to follow menu/spreadsheet and the diets as planned. A review of facility document titled, Diet Manual, dated 2020, indicated .fortified diet is designed for residents who cannot consume adequate amounts of calories and/or protein to maintain their weight or nutritional status .adding calories may include .extra margarine or butter to food items . It also indicated small portion diet should follow the menu unless the residents requested specific portions. A review of the facility's policy titled, Menu Planning dated 2023, it indicated, .menus are planned to meet nutritional needs of residents in accordance with established national guidelines .the facility's diet manual and diets are ordered by the physician should mirror the nutritional care provided by the facility .menus are written for regular and therapeutic diets in compliance with the diet manual. A review of facility document titled, Job Description, Cook, dated 2/2024, it indicated [NAME] was to follow prepare menus and portion control guides .prepare special diets accurately . A review of facility document titled, Job Description, Director of Food and Nutrition (Dietary Manager), dated 2/2018, indicated, Essential Job Functions .supervise preparation of food and service of residents' meals and nourishments in accordance with recipes and posted menus for both regular, modified and therapeutic diets . A review of facility documents titled, Job Description, Registered Dietician, dated 2/2024, indicated, . Essential Duties .monitor food control systems such as .portion control, preparation methods, garnishment and presentation of food in order to ensure that food is prepared and presented in an acceptable manner .

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 40830 Based on observation, interview and record review, the facility failed to ensure food was prepared, stored, served, or distributed in accordance with professional standards of food served safety when: 1. Several various sizes metal pans were stacked wet at the clean and ready-to-use areas; 2. Found meats were not thawed in a proper procedure in the walk-in refrigerator; 3. The blade of the can opener was not well maintained; 4. Dietary Aide (DA) 1 was not able to verbalize the proper process of manual dishwashing by the 3-comparment sink; and, 5. Resident's food was not stored at safe temperatures in the resident's food refrigerators and freezers at the nursing stations. These failures had the potential to cause foodborne illness in a highly susceptible population of 113 residents who consumed food from the facility kitchen and food from outside sources. Findings: 1. During an initial kitchen tour on 5/20/25 at 8:21 a.m., there were following food serving items found stacked wet and stored away at the clean and ready-to-use storage area: -four of half sheet metal pans -seven of 1/6 sheet metal pans A concurrent confirmation with Dietary Manager (DM) and DM stated the dishes and pans should be completely air-dried before being stored away. During an interview with Registered Dietitian (RD) on 5/22/25 at 9:52 a.m., RD stated the dishes and pans should be completely dried and free of moisture before stored away to prevent bacteria growth. A review of facility policy and procedure (P&P) titled, Dishwashing, dated 2023, indicated .5. Dishes are to be air dired in racks before stacking and storing . According to 2022 Federal Food and Drug Administration (FDA) Food Code, under section 4-901.11 Equipment and Utensils, Air-Drying Required, it stated, .Items must be allowed to drain and to air-dry before being stacked or stored. Stacking wet items such as pans prevents them from drying and may allow an environment where microorganisms can begin to grow . (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	2. An observation of the walk-in refrigerator in the kitchen and a concurrent interview with DM on 5/20/25 at 8:10 a.m. was conducted. It was noted there were issues found for the thawing meats as followed: a. Five loaves of raw ground turkey in a tub with a label of pulled out date of 5/17/25 and used by date of 5/20/25 placed next to the cooked deli meats at the bottom shelf. b. A box (cardboard box) of raw ground turkey meats with a written pulled out date of 5/19/25 and used by date of 5/21/25 placed next to the cooked deli meats on the second bottom shelf, and there were cooked deli meats on the bottom of that raw ground turkey meats. DM confirmed and stated both raw turkey meats were thawing for later use. She stated the raw turkey meats should need to be rearranged. She further stated the raw meats should placed on the bottom and the cooked meats should be on the top of the raw meat. During an interview with RD on 5/22/25 at 9:52 a.m., RD stated the kitchen staff should follow the correct procedure and arrangement for the cooked and raw foods. She stated the cooked meats should place on the top of the raw meats. She further stated the thaw meats should place in a tub or pan to prevent dripping water or juice during the thawing process. A review of facility P&P titled, Thawing of Meats, dated 2023, indicated thawing meats should .use a drip pan under food being thawed so drippings do not contaminate other food .thaw meats on the bottom shelf below prepared, ready-to-eat foods .thaw similar meat items together . A review of facility P&P titled, Refrigerated Storage and Storage of Frozen Food, dated 2023, indicated . Store cooked or ready-to-eat food above raw meat, poultry, and fish, if these items are stored in the same unit. This will prevent raw-product juices from dripping onto the prepared food and causing food borne illness .Store raw meat, poultry, and fish in the order from top to bottom. This order is based on the required minimum internal cooking temperature of each food .a. Whole fish, b. Whole cuts of beef and pork, c. Ground meat and fish, d. Whole and ground poultry . 3. During an observation and a concurrent interview with DM on 5/20/25 at 8:21 a.m., it was observed the blade of the can opener with the metal surface worn off. DM confirmed and stated the blade worn off and should be replaced. She further stated the blade usually change weekly. During an interview with RD on 5/22/25 at 9:32 a.m., RD stated the blade of the can opener should be clean and no sign of worn off. She stated the blade needed to be replaced if worn off because if may cause physical contamination. A review of facility P&P titled, Can Opener and Base, dated 2023, .Proper sanitation and maintenance of the can opener and base is important to sanitary food preparation. Metal shavings and shredding can result form a dull cutting blade .Replace blade on can opener as needed . (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	4. During an interview with Dietary Aide (DA) 1 on 5/20/25 at 8:41 a.m. regarding the process of manual dishwashing with 3-compartment sink. DA 1 stated he would start the manual dishwashing when the dishwashing machine was not working. He stated the steps involved washing, rinsing, sanitizing and air-dried. He stated the water temperatures for washing and rinsing should be 110 degrees Fahrenheit (F). DA 1 stated for the sanitizing step, the dishes immersion time was 15-30 minutes in the sanitizer and the concentration for the sanitizer (quaternary ammonium, one type of sanitizer agent) should be 200-300 ppm (parts per million, a concentration measurement unit for the sanitizer). A concurrent confirmation with DM and she stated the immersion time of the sanitizer should be 15 seconds. A concurrent review of the posted 3-compartment sink dishwashing instruction and it stated the immersion time should be 60 seconds. During an interview with RD on 5/22/25 at 9:52 a.m., RD stated the dietary aide should know the procedure of 3-compartment sink dishwashing. RD further stated the staff should know where to find the resources if they did not remember the procedure. A review of facility P&P titled, 3-Compartment Procedure for Manual Dishwashing, dated 2023, indicated . The third compartment is for sanitizing .immerse all washed items (dishes or utensils) for one minute (60 seconds) . 5. An observation of the resident's food refrigerator located on nurse station (400-500 halls) and a concurrent interview with Licensed Nurse (LN) 7 on 5/20/25 at 12:35 p.m. was conducted. It was noted there three issues found as followed: a. The instruction on the temperature log for the refrigerator temperature monitor range was 36-46 degrees F. b. The instruction for the freezer temperature monitor range was at or below zero degree F. A review of the temperature log for the month of May 2025, it showed there were three recorded freezer temperatures on the AM (morning) shift were above zero degrees F and nine recorded freezer temperatures on the PM (afternoon/evening) shift were above zero degrees F. On the comments column on the temperature log did not show any action taken for the freezer temperatures were above zero degrees F. c. The temperature log showed the refrigerator and freezer temperatures were prefilled for the PM shift on 5/20/25 at 12:35 p.m. LN 7 confirmed and stated the nurses were responsible for monitor temperature and the food for the resident's food refrigerators. She stated she always followed the instructions on the temperature log and the refrigeration temperature range 36-46 degrees F was correct. During an interview with Assistant Director of Nurses (ADON) on 5/20/25 at 12:40 p.m., ADON stated the nurses included, infection Preventionist (IP), unit managers and charge nurses, were responsible to monitor the temperature and the food of the resident's food refrigerators. ADON stated she followed the temperature range (36 to 46 degrees F) for the refrigerator which was indicated on the temperature log. She stated the instructed temperature ranges were for the food storage and she just followed the instructions and not aware the temperature range was for medication storage. (continued on next page)

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	056410	A. Building B. Wing	05/23/2025

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	An observation of the resident's food refrigerator located on nurse station (100 halls) and a concurrent interview with Licensed Nurse (LN) 6 on 5/20/25 at 12:45 p.m. was conducted. It was noted there four issues found as followed: a. The instruction on the temperature log for the refrigerator temperature monitor range was 36-46 degrees F. b. The instruction for the freezer temperature monitor range was at or below zero degree F. A review of the temperature log for the month of May 2025, it showed there were 20 recorded freezer temperatures on the AM shift were above zero degrees F and 19 recorded freezer temperatures on the PM shift were above zero degrees F. On the comments column on the temperature log did not show any action taken for the freezer temperatures were above zero degrees F. c. Observed the freezer temperature in the freezer was 24 degrees F which was above zero degrees F. d. The temperature log showed the refrigerator and freezer temperatures were prefilled for the PM shift on 5/20/25 at 12:45 p.m. LN 6 confirmed and stated she was not aware the freezer temperature was above zero degrees F because she was not the one who monitored and recorded the temperature. LN 6 was acknowledged about the prefilled temperatures (refrigerator and freezer) for the PM shift on 5/20/25. She stated, I cannot tell you why but should not be filled until PM shift here. She stated PM shift started at 2:30 p.m. and ended at 11 p.m. LN 6 confirmed the recorded freezer temperature mentioned above were above zero degree F, and she stated she would check the thermometer if it was working. She further stated she might turn down the freezer and check later if the temperature was out of range. During an interview with RD on 5/22/25 at 9:52 a.m., RD stated the food storage in refrigerator should be at 40 degrees F or below. RD stated if the freezer temperature was out of range, the staff needed to take a corrective action and notified the maintenance department to correct the issue. She further stated when the refrigerator or freezer temperatures out of range may potentially cause the food went bad and food borne illness. Regarding the prefilled temperature on the temperature log for PM shift on 5/20/25, RD stated the PM shift started around 2-3 p.m. and it should be blank until the PM shift staff started to record the temperatures. A concurrent review of the temperature log, there was no action taken written on the comments section for the freezer temperatures were out of range. LN 6 confirmed and stated the action should report to the Director of Nurses (DON) and/or maintenance department to correct the issues. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	A review of facility P&P titled, Refrigerators and Freezers, dated 2001, indicated, .Refrigerators and/or freezers are maintained in good working condition. Refrigerators keep foods at or below 41 degrees F . Monthly tracking sheets for all refrigerators and freezers are posted to record temperatures .the last column will be completed only if temperatures are not acceptable .check and record refrigerator and freezer temperatures daily with first opening and at closing in the evening .the supervisor takes immediate action if temperatures are out of range. Actions necessary to correct the temperatures are recorded on the tracking sheet (temperature log), including the repair personnel and/or department contacted .

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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. 34328 Based on observation, interview, and record review, the facility failed to maintain an effective infection prevention and control program when: 1. The licensed nurse (LN) did not perform hand hygiene (HH, washing hands with soap and water or use of an alcohol-based sanitizer) in accordance with standards of practice during medication pass for Resident 6 and Resident 23; and, 2. Residents were not offered to clean their hands by staff prior to consuming their lunches in the dining room. These failures had the potential to result in transmission of infection to residents in the facility. Findings: 1. During a medication pass observation on 5/20/25 at 8:40 a.m. with LN 2, LN 2 prepared medications for Resident 6 without wearing gloves or handwashing prior to preparation and administration. When asked if she wore gloves during the medication pass, LN 2 stated she could not remember. During a medication pass observation on 5/20/25 at 12:12 p.m., LN 1 picked up Resident 23's partially eaten meal tray from on top of a trash can without wearing gloves and left the room. LN 1 then returned to Resident 23's room without performing hand hygiene, applied gloves, and prepared Resident 23's medication for administration. LN 1 stated that gloves can be used in place of handwashing. During an interview on 5/20/25 at 1:13 p.m., the Infection Preventionist (IP) stated that staff are expected to wash their hands before entering a room, between different routes, after they are finished, and anytime their hands get soiled. The IP stated that hand hygiene involves washing with soap and water or using an alcohol rub. The IP confirmed that gloves cannot be used in place of handwashing, stating, alcohol rub first, then gloves. During an interview on 5/21/25 at 2:06 p.m., the Director of Nursing (DON) stated that staff are expected to wash their hands when entering and exiting a room, if they touch a patient, and if their hands become soiled. The DON stated that a negative outcome of not washing hands can put residents at risk for infection. During a review of the facility's P&P titled, Handwashing/Hand Hygiene, revised 8/2015, the P&P indicated, Use an alcohol-based hand rub containing at least 62% alcohol; or, alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situations: .b. Before and after direct contact with residents .c. Before preparing or handling medications. 2. During an observation of the main dining room on 05/20/25 at 12 p.m., there were 24 residents present. There were three Certified Nursing Assistants (CNA's) assisting the residents to sit down and get ready for their lunch. Further observation, there was no hand hygiene performed on the residents' hands before receiving their lunches. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an observation on 5/20/25 at approximately 12:05 p.m., the food was brought out from the kitchen and the trays were checked by Registered Nurse 1 (RN 1) prior to being served out to the residents. The CNA's were observed to pass out the trays to the individual residents. During an interview with Resident 30 on 5/20/25 at approximately 12:15 p.m., the resident was seated in his wheelchair and was asked if he had washed his hands before eating. Resident 30 indicated his hands were not washed and he wanted to wash his hands before he begins eating. Concurrently, Resident 106 was seated and was asked if her hands were washed. She stated she did not wash her hands nor did any CNA come by to ensure she had washed her hands. She stated she would want to wipe or wash her hands before eating. During an interview with RN 1 on 5/20/25 at 12:20 p.m., RN1 stated the expectations were the residents hands must be clean before eating. The CNAs generally go around the residents in the main dining room with a wipe for the residents to clean their hands with. RN 1 also stated the resident's food trays did not have a moist towelette for the residents to wipe their hands before eating. During an interview with the facility Registered Nurse Consultant (NC) on 5/20/25 at 12:25 p.m., the NC stated the expectations were the residents hands were to be sanitized by a moist towelette in the residents tray to wipe their hands with. The NC was asked to go around and observed each and every lunch tray that was served if there were any moist towelettes. The NC confirmed there were no moist towelettes on the residents lunch trays. During an interview with the Infection Preventionist (IP) on 5/22/25 at 10:43 a.m., she stated the expectations were all residents must wash their hands before eating. The resident trays must have a moist towelette on them to wipe their hands before eating. Review of a facility policy, Handwashing/Hand Hygiene, revision date 10/23 Indicated: .This facility considers hand hygiene the primary means to prevent the spread of healthcare- associated infections .6. Residents, family members and/ or visitors are encouraged to practice hand hygiene. 51483

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. 48140 Based on observations, interviews and record review the facility failed to ensure resident safety for three residents (Resident 56, 76, and 114) out of 34 sampled residents when the call lights were out of reach. This failure had the potential for the residents to be unable to notify staff if there was an emergency. Findings: A review of Resident 114's admission record indicated he was admitted to the facility in December 2024 with diagnoses which included hemiplegia (muscle weakness to one side of the body) and diabetes mellitus (high blood glucose). During a concurrent observation and interview on 5/20/25 at 7:48 a.m. in Resident 114's room, Resident 114 could not locate his call light. Resident 114's call light was observed hanging over the right-side bed rail and laying under the bed, out of reach. Resident 114 confirmed he would not be able to notify staff if there was an emergency. A review of Resident 56's admission record indicated he was admitted to the facility in February 2025 with diagnoses which included quadriplegia (partial or complete loss of function in all four limbs) and fusion of the spine (surgical joining of two or more vertebrae in the spine). During a concurrent observation and interview on 5/20/25 at 7:58 a.m. in Resident 56's room, Resident 56's call light was wrapped around the left-side bed rail out of reach. Resident 56 confirmed he could not reach the call light. A review of Resident 76's admission record indicated he was admitted to the facility in February 2022 with diagnoses which included hemiplegia and muscle atrophy (partial or complete wasting away of a part of the body). During a concurrent observation and interview on 5/20/25 8:03 a.m. in Resident 76's room, Resident 76's call light was wrapped around the left-side bed rail out of reach. Resident 76 confirmed he could not reach the call light. During a concurrent observation and interview on 5/20/25 at 11:50 a.m. with Certified Nursing Assistant (CNA) 3, in Resident 114, 56 and 76's shared room, CNA 3 confirmed Resident 114's, 56's and 76's call lights were out of reach. CNA 3 stated, Call lights should be placed by the resident's hand, it's a safety hazard when they're out of reach. During an interview on 5/22/25 at 11:47 a.m. with the Director of Nursing (DON) the DON confirmed the call lights should always be within the residents' reach in case the resident needs to call for assistance or if there's an emergency. (continued on next page)

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F 0919 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, Answering the Call Light, revised September 2022, the P&P indicated, Ensure that the call light is accessible to the resident when in bed .