STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056425	A. Building B. Wing	02/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Studebaker Healthcare Center	13226 Studebaker Rd Norwalk, CA 90650

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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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the nursing staff had appropriate competencies and skill set to provide 94 out of 94 residents with care and services when:94 out of 94 licensed nursing staff were not in-serviced, and competency was not validated in the provision of Cardiopulmonary Resuscitation ([CPR] emergency lifesaving procedure when the heart stops beating) and emergency services for residents who are unresponsive.One of four nursing staff (Licensed Vocational Nurse (LVN) 4) did not have a performance evaluation (process organizations follow to assess an employee's work quality and skills over a specific period) in 2025.Three out of three Restorative Nursing Aides (RNA, trained nursing staff who help residents gain an improved quality of life by increasing their level of strength and mobility) were not in-service and competency was not validated at least annually on skill set needed to function as RNAs.The facility failed to ensure Restorative Nursing Aide 1 (RNA 1) was competent to perform passive range of motion (PROM, movement at a given joint with full assistance from another person) exercises to Resident 42's both arms.The facility failed to ensure CNAs were competent to apply and remove Resident 42's splints to both wrists. These failures had the potential to result in the provision of inadequate care and services for residents' to attain their highest practicable physical, mental, and psychosocial well-being. These failures had the potential to cause Resident 42 pain, harm, injury, pressure ulcer (a localized area of skin damage that develops when prolonged pressure is applied to a specific area of the body) development, and functional decline.Findings: 1. During a concurrent interview and record review on [DATE] at 8:30 a.m., with the Director of Staff Development (DSD), RNA 1's personnel files were reviewed and there was no documented evidence of an RNA performance evaluation/ skills competency since date of hire. The DSD stated there were 3 RNAs and the facility did not Inservice or check RNA competency to ensure they were providing RNA services competently. 2. During a concurrent interview and record review on [DATE] at 8:30 a.m., with the DSD, LVN 4's personnel files were reviewed and there was no documented evidence of a performance evaluation/ skills competency checklist for 2025. The DSD stated annual performance/ skills competency check was important to ensure staff competencies. 3. During a concurrent interview and record review on [DATE] at 9:50 a.m., with the DSD, Licensed staff competency validation skills check form was reviewed. The DSD confirmed and stated CPR and emergency services provided for residents who were unresponsive were not part of the competency skills check. During an interview on [DATE] at 5:10 p.m., the Director of Nursing (DON) stated Validating CPR competency was important to reassess staff knowledge in emergency response with unresponsive (continued on next page)

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

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	residents. During a review of the facility's policy and procedures (P&P) titled, Competency Evaluation, released 7/2019, the P&P indicated the facility will evaluate all employees performance competencies annually. The P&P indicated the review will include the most common procedures performed in the facility. During a review of the Facility Assessment Tool, reviewed [DATE], the tool indicated staff training and education will be provided at least monthly and on as needed basis. Competency and performance evaluations were completed at least annually. Topics include emergency preparedness. 4. During a review of Resident 42's admission Record, the admission Record indicated the facility initially admitted Resident 42 on [DATE] with diagnoses including quadriplegia (weakness or paralysis of all four extremities), polyneuropathy (damage of the nerves that can cause weakness, numbness, and burning pain), and muscle spasm (involuntary tightening or contraction of one or more muscles). During a review of Resident 42's Minimum Data Set (MDS, a resident assessment tool), dated [DATE], the MDS indicated Resident 42 was cognitively (mental action or process of acquiring knowledge and understanding) intact. The MDS indicated Resident 42 was dependent (helper does all the effort) in eating, hygiene, toileting, bathing, dressing, rolling to both sides, and transfers. The MDS indicated Resident 42 had functional limitations in range of motion (limited ability to move a joint that interferes with daily functioning, including activities of daily living, or places the resident at risk of injury) in both arms and legs. During an observation and interview on [DATE] at 3:37 pm with Resident 42 in Resident 42's room, Resident 42 was sitting in a motorized wheelchair wearing splints to both wrists and resting both arms on the wheelchair armrests. Resident 42 stated he was unable to move both wrists and both hands due to his injury, had no sensation from the neck down, and could not feel when RNA assisted with ROM exercises. During an observation of a Restorative Nursing Aide (RNA, nursing aide program that helps residents maintain any progress made after therapy intervention to maintain their function) session on [DATE] at 8:48 am in Resident 42's room, Resident 42 was lying in bed while RNA 1 assisted with PROM exercises to Resident 42's both arms. While providing PROM exercises to Resident 42's both arms, RNA 1 bent all of Resident 42's fingers of both hands backwards at the knuckle joints, hyperextending (the extension of a body part beyond its normal limits) the fingers approximately 45 degrees past neutral, and then forcefully pushed the fingers down at the end of the movement, 20 times each side. During an interview on [DATE] at 9:18 am with RNA 1, RNA 1 stated PROM meant RNA provided total assistance with ROM to the resident. RNA 1 stated she provided PROM exercises to residents by bending and straightening all the joints of the body as far as possible and pushing down at the end range of motion to obtain increased stretch. RNA 1 stated she hyperextended Resident 42's fingers and forcefully pushed down at the end range of hyperextension because Resident 42 stated he liked it since it was the only way he could feel the exercises. During an interview on [DATE] at 11:35 am with Occupational Therapist 2 (OT 2), OT 2 stated RNA should never hyperextend a resident's joint when assisting with ROM exercises because it could cause fractures (broken bones), pain, damage to the joints (where two bones meet) and other (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	structures of the hand, and injury. OT 2 stated forcefully pushing down on hyperextended joints could lead to further injury and was never indicated when performing ROM exercises. During a concurrent record review and interview on [DATE] at 2:02 pm with the Director of Staff Development (DSD), the DSD stated the RNAs in the facility were CNAs with specialized training in RNA services. The DSD stated RNA tasks included assisting residents with ROM exercises, walking exercises, and splinting. The DSD stated she was responsible for completing CNA competencies yearly but never completed any competencies for the RNAs. The DSD stated the CNA competency checklist did not assess staff's competency of RNA tasks such as ROM exercises and splinting. The DSD stated the facility did not have a way to ensure the RNA staff were competent in their job duties since they did not conduct RNA competencies. The DSD stated the facility must ensure RNAs demonstrated competence when delivering RNA services to provide safe and appropriate care for residents and to prevent injury and decline. During an interview on [DATE] at 4:36 pm with the Director of Nursing (DON), the DON stated conducting staff competencies were important to ensure staff were up to date and competent in performing their job duties. The DON stated the RNAs assisted residents with activities such as ROM exercises, walking exercises, sit to stand exercises and feeding to ensure the residents in the facility maintained their current level of function and did not experience a functional decline. The DON stated it was important for the RNAs to be competent in the services they provided to ensure they provided safe and appropriate care to the residents. The DON stated the facility did not have a way to ensure the RNA staff were competent in their job duties since they did not conduct RNA competencies. The DON stated if RNA competencies were not completed routinely, the facility would not know if the RNA staff were up to date and competent in their job duties which could potentially lead to injury of staff and/or residents, ineffective provision of exercises, and failure to detect changes in a resident's condition. 5. During a review of Resident 42's admission Record, the admission Record indicated the facility initially admitted Resident 42 on [DATE] with diagnoses including quadriplegia, polyneuropathy, and muscle spasm. During a review of Resident 42's MDS, dated [DATE], the MDS indicated Resident 42 was cognitively intact. The MDS indicated Resident 42 was dependent in eating, hygiene, toileting, bathing, dressing, rolling to both sides, and transfers. The MDS indicated Resident 42 had functional limitations in range of motion in both arms and legs. During an observation and interview on [DATE] at 3:37 pm with Resident 42 in Resident 42's room, Resident 42 was sitting in a motorized wheelchair wearing splints to both wrists and resting both arms on the wheelchair armrests. Resident 42 stated he was unable to move both wrists and both hands due to his injury and wore splints on both wrists all day because both wrists bent downwards without them. Resident 42 stated he had no sensation from the neck down and could not feel the splints on his arms. During an interview on [DATE] at 5:00 pm with the DOR, the DOR stated Rehab assessed for and issued splints, determined how long a resident could safely wear the splints, and eventually transitioned the splint application and care to RNA once discharged from therapy services. The DOR stated Rehab and RNA were the only services responsible for splint application and removal in the facility because they required proper training and close monitoring to prevent injuries and/or skin breakdown. The DOR stated CNAs were not qualified to apply and remove resident's splints and (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	should not be providing splinting services. During an observation and interview on [DATE] at 9:50 am with Resident 42 in the hallway, Resident 42 was sitting in a motorized wheelchair wearing splints to both wrists. Resident 42 stated the DOR ordered both wrist splints online and issued them to Resident 42 a long time ago but did not remember when. Resident 42 stated the CNAs, not RNAs, applied both splints to Resident 42's wrists in the morning when he got into the wheelchair and removed the splints before he went to bed. Resident 42 stated he wore both wrist splints all day and staff did not remove and/or check his skin throughout the day. During an interview on [DATE] at 2:39 pm with Certified Nursing Assistant 9 (CNA 9), CNA 9 stated the CNAs assisted Resident 42 with applying and removing splints to Resident 42's both wrists. CNA 9 stated Resident 42 always had both wrist splints on when her shift began because the CNAs in the morning shift applied the splints during the day. CNA 9 stated she did not check Resident 42's skin during her shift and only looked at the skin to check for redness when she removed them at 11 pm. During an interview and record review on [DATE] at 2:42 pm with Licensed Vocational Nurse 7 (LVN 7), LVN 7 stated she did not know Resident 42 had splints to both wrists. LVN 7 stated that either the Rehabilitation Department (Rehab) and/or RNA applied and removed the splints once issued because splinting required a physician's order for application and required close monitoring to prevent skin breakdown (tissue damage caused by friction, shear, moisture, or pressure). LVN 7 stated she was unaware the CNAs were applying and removing Resident 42's both wrist splints. LVN 7 stated CNAs were not qualified to apply and/or remove splints and should not be providing splinting services to the residents in the facility. During a concurrent record review and interview on [DATE] at 2:50 pm with the DSD, the DSD stated Rehab and/or RNA were responsible for applying and removing splints for residents in the facility. The DSD stated CNAs were not competent to apply and remove splints as the annual CNA competency checklist did not include splinting application and monitoring. The DSD stated if CNAs applied and removed splints, it could potentially lead to resident harm, injury, incorrect splint placement, and skin breakdown because CNAs were not qualified to provide splinting services. During an interview on [DATE] at 4:36 pm with the DON, the DON stated Rehab and RNA were responsible for applying and removing splints for residents in the facility. The DON stated CNAs were not trained in splint application and monitoring and were not qualified to apply and remove residents' splints. The DON stated if CNAs applied and removed residents' splints, it could lead to resident injury and harm since CNAs were not qualified to perform splinting tasks. During a review of the facility's Policy and Procedures (P/P), titled, Competency Evaluation, dated 7/2019, the P/P indicated it was the facility's policy to perform competency evaluations for all employees. The P/P indicated a skills checklist would be competed for each nursing staff to ensure that related services provided in the facility was maintained. The P/P indicated each employee's competency would be reviewed during performance evaluation reviews annually.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure medical records for 5 of 14 sampled residents (Residents 3, 15, 37, 4, and 101) records were accurate, complete and readily accessible by failing to: 1. Ensure Licensed Vocational Nurse (LVN) 1 did not document Resident 15's bismuth subsalicylate (a medication used to treat diarrhea, nausea, heartburn, indigestion and gas) oral suspension as administered on Medication Administration Record (MAR - a daily documentation record used by a licensed nurse to document medications and treatments given to a resident) when bismuth subsalicylate was not available in stock and was not administered on 2/18/2026.2. Document Resident 3's intravenous ([IV] into the vein) administration of cefepime (an antibiotic administered intravenously or intramuscularly to treat severe bacterial infections) as administered on MAR.3. Maintain accurate and timely documentation of 10 of Resident 37's administered medications on MAR.4. Ensure Resident 4's Joint Mobility Assessment (JMA, a brief assessment of a resident's range of motion [ROM, full movement potential of a joint] in both arms and both legs), dated 1/9/2026, was accurately completed to indicate changes in Resident 4's ROM of both legs.5. Document weekly weights accurately in Resident 101's medical record.6. Document Nutrition notes in Resident 101's medical record when resident 101 was experiencing weight loss.These deficient practices resulted in inaccurate and unclear medical documentation, misunderstanding among facility's licensed nursing staff and had the potential to cause inaccurate care planning, medication errors, and placed Residents 3, 15, and 37 at an increased risk for untreated infection, sepsis and hospitalization. For Resident 4, this deficient practice had the potential to delay and negatively affect the delivery of necessary care and services and result in missed opportunities to detect declines in ROM leading to contracture (loss of motion of a joint associated with stiffness and joint deformity) development and functional decline. For Resident 101, these deficient practices resulted in incomplete and unclear weight and nutrition documentation and had the potential to delay delivery of care and interventions to prevent additional weight loss. Findings: 1. During a review of Resident 15's admission Record dated 2/18/2026, the admission record indicated Resident 15 was admitted to the facility on [DATE] with diagnoses including but not limited to Type 2 Diabetes Mellitus (DM - a disorder characterized by difficulty in blood sugar control and poor wound healing) with hyperglycemia and gastro-esophageal reflux disease ([GERD] a chronic condition where stomach acid frequently flows back into the esophagus, causing persistent heartburn, chest pain, and regurgitation] without esophagitis (inflammation or swelling of the esophagus [a muscular tube that transports food and liquids from the pharynx to the stomach) lining. During a review of Resident 15's History & Physical (H&P) dated 4/30/2025, the H&P indicated Resident 15 had capacity to make decisions. During a review of Resident 15's Minimum Data Set (MDS – resident assessment tool), dated 11/7/2025, the MDS indicated Resident 15's cognition (mental action or process of acquiring knowledge and understanding through thought and the senses) was intact. The MDS indicated Resident 15 was dependent on facility staff for performing activities of daily living (ADLs – routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves) such as toileting hygiene, lower body dressing and putting on/taking off footwear, needed partial assistance for showering, supervision or touching assistance for oral hygiene, upper body dressing and personal hygiene, and was independent for eating. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an observation on 2/18/2026 at 9:11 a.m. outside of Resident 15's room, licensed vocational nurse (LVN) 1 prepared and administered the following eight medications and/or products to Resident 15, which did not include bismuth subsalicylate oral suspension. a. One capsule of vitamin D2 ([ergocalciferol] a formulation of vitamin D used to treat low levels of vitamin D, support bone health, immune function and calcium absorption) 1.25 mg b. One tablet of famotidine (a medication used to reduce stomach acid production) 20 mg c. One capsule of pregabalin (a medication used to treat nerve pain) 150 mg d. One tablet of multivitamins with minerals e. One table of simethicone (a medication used to relieve symptoms of bloating and gas) 80 mg f. One tablet of vitamin B1 (a vitamin used to treat low levels of vitamin B1 to support nerve and muscle function) 100 mg g. 15 mL of Biotene (a mouth rinse used to relieve dry mouth) oral rinse h. An unmeasured amount of diclofenac gel 1 percent ([%] a unit of measurement to show strength or potency) During a medication reconciliation on 2/18/2026, Resident 15's Order Summary Report (a document containing a summary of all active physician orders), dated 2/18/2026 was reviewed. The order summary report indicated the above listed medications as well as the following physician order to be administered at 9:00 a.m.: Bismuth Subsalicylate oral suspension 525 milligrams ([mg] metric unit of measurement, used for medication dosage and/or amount) / 15 milliliters ([mL] a unit of measurement for volume), give 15 mL by mouth four times a day for + (positive) H Pylori (a stomach infection caused by a bacterium called Helicobacter pylori), order date 1/28/2026, start date 1/29/2026. During a review of Resident 15's MAR, dated 2/1/2026 to 2/18/2026, the MAR indicated, LVN 1 documented bismuth subsalicylate oral suspension 525 mg/15 mL, as administered on 2/18/2026 at 9:00 a.m. During a concurrent interview and record review on 2/18/2026 at 1:36 p.m. with LVN 1, the administration details for Resident 15's bismuth subsalicylate, dated 2/18/2026 were reviewed. The administration details indicated, effective date as 2/18/2026 9:14 a.m., amount administered 15 mL administered by LVN 1, documented 2/18/2026 9:26 a.m. LVN 1 stated bismuth subsalicylate was not in stock and was not administered to Resident 15. LVN 1 stated bismuth subsalicylate was important for Resident 15's stomach to kill the bacteria and help recover from the H. Pylori infection and she did not receive the full regimen. LVN 1 stated she (LVN 1) was not supposed to document bismuth subsalicylate oral suspension as administered when she (LVN 1) did not administer the bismuth subsalicylate to Resident 15. LVN 1 stated this could be misleading for other nurses, and it was a risk for Resident 15 because she was not receiving the treatment as prescribed by her physician. LVN 1 stated she needed to correct the documentation by striking it out and indicated it was an incorrect documentation. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a review of Resident 15's Medication Admin Audit Report, dated 2/18/2026, the medication admin audit report for bismuth subsalicylate 525 mg/15 mL indicated the following: a. Schedule date: 2/18/2026 9:00 a.m., administration time: 2/18/2026 2:30 p.m., documented time: 2/18/2026 2:30 p.m. by LVN 1. b. Schedule date: 2/18/2026 1:00 p.m., administration time: 2/18/2026 2:30 p.m., documented time: 2/18/2026 2:30 p.m. by LVN 1. During an interview on 2/20/2026 at 4:04 p.m. with the Director of Nursing (DON), the DON stated the documentation about the bismuth subsalicylate being administered when it was not in stock and not administered was inaccurate. The DON stated there would be a delay in infection treatment and healing and risk for abdominal discomfort for Resident 15 if she (Resident 15) did not receive the bismuth subsalicylate as per physician's orders. 2. During a review of Resident 3's admission Record, dated 2/20/2026, the admission record indicated Resident 3 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included but not limited to sepsis from unspecified organism and bell's palsy (temporary, sudden-onset paralysis or weakness of muscles on one side of the face caused by inflammation of the 7th cranial nerve, likely due to viral infection). During a review of Resident 3's H&P, dated 2/17/2026, the H&P indicated Resident 3 had capacity to understand and make decisions. During a review of Resident 3's MDS, dated [DATE], the MDS indicated Resident 3's cognition was intact. The MDS indicated Resident 3 needed supervision or touching assistance from the facility staff for performing ADLs such as eating, maximal assistance for oral hygiene, upper and lower body dressing, putting on/taking off footwear and personal hygiene, and was dependent on facility staff for toileting hygiene and showering. During a review of Resident 3's Order Summary Report, dated 2/17/2026 and 2/20/2026, the order summary reports included the following physician order: Cefepime hydrochloride (HCl) intravenous solution 1 gram ([gm] a unit of measurement for mass) / 50 mL, use 1 gram intravenously every 12 hours for sepsis (a life threatening infection) for 5 days, order date 2/16/2026, start date 2/17/2026, end date 2/22/2026. During a review of Resident 3's MAR, dated 2/1/2026 to 2/19/2026, the MAR indicated Cefepime HCl intravenous solution 1 gm/50 mL was not administered to Resident 3 on 2/18/2026 at 9:00 a.m. and 2/19/2026 at 9:00 a.m. During a concurrent interview and record review on 2/20/2026 at 11:00 a.m. with Registered Nurse Supervisor (RNS) 1, the administration details for Resident 3's cefepime IV for 2/18/2026 and 2/19/2026 were reviewed. RNS 1 stated she (RNS 1) administered cefepime doses to Resident 3 but did not document that she (RNS 1) administered them. RNS 1 stated it was important to sign and document the cefepime was administered right after its administration. RNS 1 stated it would be difficult for other nursing staff to determine if the cefepime was administered without checking with her (RNS 1) because the administration records were not accurate. RNS 1 stated Resident 3 was prescribed cefepime to treat sepsis, which is a serious infection and if not treated, it could lead to (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	hospitalization and death. During an interview on 2/20/2026 at 4:04 p.m. with the DON, the DON stated RNS 1 should have documented on MAR right after the IV antibiotic (cefepime) was administered to Resident 3. The DON stated there was a risk for medication errors, misleading other nursing staff and an increased the risk of hospitalization and death. 3. During a review of Resident 37's admission Record, dated 2/18/2026, the admission record indicated, Resident 37 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included but not limited to amyotrophic lateral sclerosis (ALS – a progressive, fatal neurodegenerative disease that destroys motor neurons in the brain and spinal cord, leading to muscle weakness, atrophy, and eventually respiratory failure), spinal stenosis (narrowing of the spinal canal, which compresses nerve roots or the spinal cord, leading to pain, numbness, or weakness in the neck, back, arms, or legs) of cervical region, Type 2 Diabetes Mellitus without complications, mild recurrent major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), GERD without esophagitis, essential hypertension (HTN – high blood pressure) and other abnormalities of gait and mobility. During a review of Resident 37's H&P dated 9/19/2025, the H&P indicated Resident 37 had the capacity to understand and make medical decisions. During a review of Resident 37's MDS, dated [DATE], the MDS indicated Resident 37's cognition was intact. The MDS indicated Resident 3 needed setup or clean-up assistance from the facility staff for performing ADLs such as eating, needed maximal assistance for oral hygiene and personal hygiene, and was dependent on the facility for performing ADLs such as toileting hygiene, showering, upper and lower body dressing and putting on/taking off footwear. During an observation on 2/18/2026 at 9:31 a.m. outside of Resident 37's room, LVN 1 only prepared and administered the following two medications to Resident 37. a. One tablet of Eliquis ([generic name – apixaban] a medication used to prevent blood clots and deep venous thrombosis [DVT – a serious condition where a blood clot forms in a deep vein, usually in the legs, causing symptoms like swelling, pain, warmth, and redness]) 2.5 mg b. One tablet of baclofen (a medication used to treat muscle spasms) 20 mg During a medication reconciliation review, Resident 37's MAR, dated 2/18/2026 and Medication Admin Audit Report, dated 2/18/2026, were reviewed. The MAR and Medication Audit Report indicated that the documented administration times for 10 medications did not align with the scheduled administration times on 2/18/2026: a. Clonidine (a medication used to treat HTN) transdermal patch weekly 0.1 mg/24 hour, apply 1 patch transdermally one time a day every Wednesday for HTN, hold if systolic blood pressure ([SBP] maximum pressure in arteries when heart muscle contracts to pump blood) less than 110 and remove per schedule; scheduled time of 9:00 a.m., administration time of 10:03 a.m. and documentation time of 10:07 a.m. This was not administered while surveyors were observing medication pass observation around 9:31 a.m. b. Baclofen 20 mg, give 1 tablet by mouth three times a day for muscle spasm to be given at 9:00 a.m., (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	5:00 p.m., 1:00 a.m. per patient request: scheduled time of 9:00 a.m., administration time of 10:05 a.m. and documentation time of 10:07 a.m. c. Eliquis 2.5 mg, give 1 tablet by mouth two times a day for DVT prophylaxis (prevention), give at 10:00 a.m. and 5:00 p.m. per resident preference; scheduled time of 9:00 a.m., administration time of 10:07 a.m. and documentation time of 10:07 a.m. d. Furosemide (a medication used to treat HTN and swelling in extremities) 20 mg, give 1 tablet by mouth one time a day for generalized edema, give at 10 am per resident preference at 10:00 a.m.: scheduled time of 10:00 a.m., administration time of 11:10 a.m. and documentation time of 11:13 a.m. e. Hydrochlorothiazide (a medication used to treat HTN) 25 mg, give 1 tablet by mouth in the morning for HTN, hold for SBP <110 or Pulse <60. Give at 10 am per resident preference at 10:00 a.m.; scheduled time of 10:00 a.m., administration time of 11:10 a.m. and documentation time of 11:13 a.m. d. Senna Plus ([generic name – sennosides-docusate sodium] a medication used to relieve constipation) 8.6-50 mg, give 1 tablet by mouth one time a day for bowel management hold for loose stools: scheduled time of 9:00 a.m., administration time of 10:07 a.m. and documentation time of 10:07 a.m. e. Riluzole (a medication used to treat ALS) 50 mg, give 1 tablet by mouth two times a day for ALS at 10 a.m. and 10 p.m. per resident's request: scheduled time of 10:00 a.m., administration time of 11:10 a.m. and documentation time of 11:13 a.m. f. Famotidine (a medication used to reduce stomach acid production) 20 mg, give 20 mg by mouth two times a day for gastrointestinal (GI) prevention, give at 10 a.m. and 5 p.m. per resident preference; scheduled time of 10:00 a.m.; administration time of 11:10 a.m. and documentation time of 11:13 a.m. g. Klor-Con M10 (potassium chloride – a medication used to treat low level of potassium) 10 milliequivalent ([mEq] a unit of measurement for mass), give 1 tablet by mouth one time a day for supplement with furosemide give at 10 a.m. per resident preference: scheduled time of 10:00 a.m., administration time of 11:10 a.m. and documented time of 11:13 a.m. h. Docusate sodium (a medication used to relieve constipation)100 mg, give 1 capsule by mouth two times a day for bowel management hold if loose bowel movement, give at 10 a.m. and 6 p.m. per resident preference: scheduled time of 10:00 a.m., administration time of 11:10 a.m. and documentation time of 11:13 a.m. During a concurrent interview and record review on 2/18/2026 at 1:19 p.m. with LVN 1, the administration details for Resident 37's medications were reviewed. The administration times did not align with the prescribed and scheduled administration times. LVN 1 stated she (LVN 1) administered Resident 37's clonidine, furosemide, hydrochlorothiazide, famotidine, potassium chloride, riluzole, senna plus and docusate at 10:00 a.m. LVN 1 stated she should have documented medications as administered at the same time when they were administered to prevent confusion for other facility's nurses. During an interview on 2/20/2026 at 4:04 p.m. with the DON, the DON stated the facility's licensed nurse should document medications in the medical record right after they were administered because if they (nurses) waited to document the administered medications, they might not remember if they (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	gave those medications, which would increase the potential for medication errors and indicate inaccurate records. During a review of the facility's policy and procedure (P&P) titled, Medication – Administration, dated 10/1/2023, the P&P indicated, Medication will be administered by a Licensed Nurse per the order of an Attending Physician or licensed independent practitioner. The P&P indicated, The Licensed Nurse will chart the drug, time administered and initial his/her name with each medication administration and sign full name and title on each page of the MAR. The P&P indicated, Documentation: A. The time and dose of the drug or treatment administered to the resident will be recorded in the resident's individual medication record by the person who administers the drug or treatment. B. Recording will include the date, the time and the dosage of the medication or type of treatment. C. Initials.record. 4. During a review of Resident 4's admission Record, the admission Record indicated Resident 4 was initially admitted to the facility on [DATE] and re-admitted to the facility on [DATE] with diagnoses including osteoarthritis (loss of protective cartilage that cushions the ends of your bones) and quadriplegia (weakness or paralysis to all four extremities). During a review of Resident 4's Physical Therapy (PT, profession aimed in the restoration, maintenance, and promotion of optimal physical function) Evaluation and Plan of Treatment (PT Eval), dated 12/11/2024, the PT Eval indicated Resident 4's right leg ROM was impaired with loss of motion of [the] right knee. The PT Eval indicated Resident 4's left leg ROM was impaired with loss of motion of [the] left knee. The PT Eval did not indicate an assessment of Resident 4's both hips and both ankles. During a review of Resident 4's JMA, dated 1/9/2026, the JMA indicated Resident 4 had severe (zero to 25 percent of ROM intact) ROM limitations in both hips, moderate (50 percent to 75 percent of ROM intact) ROM limitations in both knees, and no ROM limitations in both ankles. The JMA indicated Resident 4 had no change in ROM since the last assessment. The JMA indicated, under Additional Comments, to continue the Restorative Nursing Aide (RNA, nursing aide program that helps residents maintain any progress made after therapy intervention to maintain their function) program for application of the right and left knee extension splints (rigid material or apparatus used to support and immobilize a broken bone or impaired joint) and ROM exercises to both arms and both legs. During a review of Resident 4's Minimum Data Set (MDS, a resident assessment tool), dated 6/21/2026, the MDS indicated Resident 4 had severely impaired cognition (mental action or process of acquiring knowledge and understanding). The MDS indicated Resident 4 required substantial/maximal assistance (helper does more than half the effort) for eating and oral hygiene and was dependent (helper does all the effort) in toilet hygiene, bathing, dressing, personal hygiene, rolling to both sides, and transfers. The MDS indicated Resident 4 had functional limitations in ROM (limited ability to move a joint that interferes with daily functioning, including activities of daily living, or places the resident at risk of injury) in both arms and both legs. During an observation of Resident 4's RNA session on 2/18/2026 at 10:30 am, Resident 4 was lying in bed. Restorative Nursing Aide 1 (RNA 1) and Restorative Nursing Aide 3 (RNA 3) assisted Resident 4 with ROM exercises to both arms and both legs. Resident 4 groaned throughout session but was agreeable to continue ROM exercises with rest breaks in between sets. Resident 4's both hips and knees were bent and rotated to the left side of the body. RNA 1 assisted Resident 4 with right leg passive ROM (PROM, movement at a given joint with full assistance from another person) exercises (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a record review of Resident 101's physician orders, Resident 101's physician orders indicated an order to obtain (measure) weight upon admission and weekly for four weeks starting 11/18/2025. During a concurrent interview and record review on 2/18/2026 at 1:21 p.m. with the Restorative Nursing Assistant (RNA) 3, the Weekly and Monthly Weights for November 2025 to December 2025 were reviewed. RNA 3 stated the RNAs complete the weekly and monthly weights for new admissions and readmissions, and any resident with an order for weekly weights on paper and place them in the Weekly and Monthly Weights Binder. The Weekly and Monthly Weights for November 2025 and December 2025 indicated the following weights for Resident 101: 11/19/2025 – 111 pounds (lbs – a unit of measurement) 11/26/2025 – 101 lbs 12/3/2025 – 96 lbs 12/10/2025 – 95 lbs The RNA stated a copy of the weekly weights was given to the DON, the Registered Nurse Supervisor, the Dietary Supervisor, Medical records, and the MDS Nurse. RNA 3 stated they are unsure who enters the weights into the resident's medical record. During a concurrent interview and record review on 2/18/2026 at 2:57 p.m. with the Registered Dietician (RD), the Weekly and Monthly Weights for November 2025 and December 2025, and Resident 101's weights and nutrition assessments and notes were reviewed. The RD stated Resident 101 had two weights documented in the medical record dated 11/20/2025 and 12/3/2025. The RD stated weekly weights are completed by the RNAs by the first Wednesday of each month then entered into the medical record by the RD on the first Thursday of the month. The RD stated Resident 101's weights on 11/26/2025 of 101 lbs and 12/10/2025 of 95 lbs were not reflected in Resident 101's medical record. The RD stated Resident 101 lost 10 lbs in one week from 11/20/2025 (111 lbs) to 11/26/2025 (101 lbs) and lost 15 lbs in two weeks from 11/20/2025 (111 lbs) to 12/3/2025 (96lbs). The RD stated when a Resident's weight change is identified, they review the medical record to determine if it is a beneficial or planned weight loss by reviewing the resident's diagnosis, meal intakes, medications, labs, and progress notes. The RD stated they (RD) do not always document that they completed a chart review of the resident, but will give recommendations to the DON or nursing staff verbally. The RD stated documenting they completed a chart review every time would be too time consuming. During an interview on 2/20/2026 at 2:20 p.m. with the DON, the DON documentation should be accurate so that it depicts an accurate clinical situation of the patient. The DON stated it is important for weekly weight s to be entered in the medical record so that everyone is aware of any weight changes. The DON stated the paper Weekly and Monthly Weights are not part of the resident's medical record. During a review of the facility's policy and procedure (P&P), titled Medical Record Content, dated (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	10/1/2023, the P&P indicated the medical record will be accurate, timely and complete. During a review of the facility's policy and procedure (P&P), titled Assessment and Management of Resident Weights, dated 10/1/2023, the P&P indicated weights will be entered into the clinical record on that shift. The P&P indicated the registered dietician will document the nutritional assessment and weight management recommendations in the medical record.

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a plan that describes the process for conducting QAPI and QAA activities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility's Quality Assessment and Assurance (QAA) Committee, affecting 94 out of 94 residents, failed to identify and implement corrective action to the systemic problems identified: Ninety-four (94) out of 94 licensed nursing staff were not in-serviced, and competency was not validated in the provision of Cardiopulmonary Resuscitation ([CPR] emergency lifesaving procedure when the heart stops beating) and emergency services for residents who are unresponsive.Three out of three Restorative Nursing Aides (RNA, trained nursing staff who help residents gain an improved quality of life by increasing their level of strength and mobility) were not in-service and competency was not validated at least annually on skill set needed to function as RNAs.Five out of nineteen Residents' (Resident 3, 4, 15, 37, 101) medical records were not accurate and complete due to inaccurate and incomplete documentation by facility staff. The deficient practices placed the residents at risk for not receiving the quality treatment necessary to adequately meet their highest practicable well-being.Findings: During an interview on [DATE] at 2:19 p.m., with the Administrator (Admin), the Admin stated the following existing systemic issues were not identified by the QAA committee:Ninety-four (94) out of 94 licensed nursing staff were not in-serviced, and competency was not validated in the provision of Cardiopulmonary Resuscitation ([CPR] emergency lifesaving procedure when the heart stops beating) and emergency services for residents who are unresponsive.Three out of three Restorative Nursing Aides (RNA, trained nursing staff who help residents gain an improved quality of life by increasing their level of strength and mobility) were not in-service and competency was not validated at least annually on skill set needed to function as RNAs.Five out of nineteen Residents' (Resident 3, 4, 15, 37, 101) medical records were not accurate and complete due to inaccurate and incomplete documentation by facility staff. During a record review of the facility's policy and procedure (P&P) titled, Quality Assurance Performance Improvement Program, revised [DATE], the P&P indicated the QAA committee will continually identify and address specific quality of care issues and implement actions plan to resolve these issues. Cross Reference F726 and F842

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure two of three sampled resident's or their legal representatives' (Resident 78 and 106) informed consent (voluntary agreement to accept treatment and/or procedures after receiving education regarding the risks, benefits, and alternatives offered) for psychotropics (drug or other substance that affects how the brain works and causes changes in mood, awareness, thoughts, feelings, or behavior) was obtained prior to administration of medications and before Resident 106's restraint (measure aimed at controlling a residents' physical movement that cannot be easily removed by the resident him/herself) were used. use. This deficient practice violated the residents' (Resident 78 and 106) right to receive information regarding the risks and benefits of proposed care, treatment, and alternative treatments available before administration of psychotropics for Resident 78 and Resident 106, and application of restraints for Resident 106.Findings: a. During a review of Resident 78's admission Record, the admission Record indicated Resident 78 was readmitted to the facility on [DATE] with diagnoses including dementia (a progressive state of decline in mental abilities), major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), and unspecified psychosis (a severe mental condition in which thought, and emotions are so affected that contact is lost with reality) not due to a substance or known physiological condition. During a review of Resident 78's Minimum Data set ([MDS] a resident assessment tool), dated 12/4/2025, the MDS indicated Resident 78's cognitive (functions your brain uses to think, pay attention, process information, and remember things) skills for daily decision-making was severely impaired. During a review of Resident 78's Order Summary Report the report indicated the following: Starting on 11/27/2025, Mirtazapine (medication for depression) 15 milligrams ([mg] metric unit of measurement, used for medication dosage and/or amount) by mouth, at bedtime. Starting on 12/16/2025, Quetiapine (medication for psychosis) 75 mg, by mouth, at bedtime. During a review of Resident 78's Consent for Psychotropic Medications, effective 1/22/2026, for Mirtazapine, the consent was dated months after the Mirtazapine was ordered on 11/27/2025. The consent also indicated the physicians' signature on the document attested the physician obtained informed consent from the Resident's Representative. The consent was not signed by the physician. During a review of Resident 78's Consent for Psychotropic Medications, effective 1/22/2026, for Quetiapine, the consent was dated months after the Quetiapine was ordered on 12/16/2025. The consent also indicated the physicians' signature on the document will attest that the physician obtained informed consent from the Resident's Representative. The consent was not signed by the physician. During a concurrent interview and record review on 2/19/2026 at 10:37 a.m., with Registered Nurse Supervisor (RNS)1, Resident 78 's psychotropic orders and consents were reviewed. RNS 1 confirmed the consents were not obtained prior to administration of medications. RNS 1 confirmed the consents were not signed by the physician. (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 2/19/2026 at 3:39 p.m., with the Director of Nursing (DON) the DON stated that informed consent should be obtained prior to the administration of psychotropic medications. During a review of the facility's policy and procedure (P&P) titled, Psychotropic Drug Management Policy, 5/19/2025, the P&P indicated the physician / licensed healthcare professional (LHP) was responsible for obtaining residents informed consent for treatment before initiating or changing the dose of a psychotropics. During a review of the facility's P&P titled, Informed Consents, 4/1/2024, the P&P indicated the informed consents must be signed by the physician/ LHP who provided the material information. b. During a review of Resident 106's admission Record, the admission Record indicated Resident 106 was admitted to the facility on [DATE] with diagnoses including down syndrome (a condition present upon birth characterized by a distinctive pattern of physical characteristics including a flattened skull, pronounced folds of skin in the inner corners of the eyes, large tongue, and short stature, and by some degree of limitation of intellectual ability and social and practical skills), depression (mood disorder that causes persistent feeling of sadness and loss of interest), and unspecified psychosis (a severe mental condition in which thought, and emotions are so affected that contact is lost with reality). During a review of Resident 106's Order Summary Report, the order summary report indicated the following: Start date 2/13/2026: Mirtazapine (antidepressant) oral tablet 30 mg 1 tablet via gastrostomy tube (g-tube: a tube placed directly into the stomach for long-term feeding) at bedtime for depression manifested by (m/b) disturbed sleep pattern, Start date 2/14/2026: Seroquel oral tablet 25 mg (Quetiapine Fumarate: (medication for psychosis) 1 tablet via g-tube one time a day for psychosis m/b mood swings. During a review of Resident 106's history and physical (H&P) dated 2/15/2026, the H&P indicated Resident 106 did not have the capacity to understand and make decisions. During a review of Resident 106's Minimum Data Set (MDS, a resident assessment tool), dated 2/20/2026, the MDS indicated Resident 106 had severe cognitive impairment. The MDS indicated Resident 106 was dependent on all aspects of activities of daily living (ADL, basic activities such as eating, dressing, toileting, shower transfer, chair/bed-to-chair transfer), and required substantial assistance (helper does more than half the effort) to roll left and right, sit to lying, and lying to sitting on side of bed. The MDS indicated Resident 106 had impairments on both sides of the lower extremity (hips/legs) During a review of Resident 106's Medication Administration Record (MAR: document used to track administration of medication) dated 2/1/2026 – 2/28/2026, the MAR indicated the following: Mirtazapine oral tablet 30 mg was administered on 2/14/2026. Seroquel oral tablet 25 mg was administered on 2/14/2026. During a review of Resident 106's Consent for Psychotropic Medications, Mirtazapine and Seroquel, (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the consent had the effective date of 2/17/2026 (three calendar days after first administration), indicating the informed consent obtained by resident/resident's representative was 2/17/2026. During a concurrent observation and interview on 2/17/2026 at 11:29 a.m., with Licensed Vocational Nurse 6 (LVN 6), LVN 6 stated Resident 106 had an abdominal binder (a stretchy belt that wraps around the stomach area) on to keep Resident 106 from pulling out his feeding tube. LVN 6 stated based on observation, Resident 106 has tried to pull out her g-tube, however indicated Resident 106 has not had any episodes of trying to remove her g-tube and did not need an abdominal binder. During a concurrent interview and record review on 2/18/2026 at 10:46 a.m. with LVN 4, LVN 4 stated informed consents are usually obtained by the doctor and indicated the informed consents for Mirtazapine and Seroquel were created on 2/17/2026. The LVN 4 stated medications should not be administered prior to obtaining a consent form as the risk and benefits should be explained to the responsible party if the resident is not coherent. The LVN 4 stated she believes abdominal binders are not considered a restraint and does not require consent forms. During a concurrent interview and record review on 2/19/2026 at 3:32 p.m., with the DON, the DON stated a restraint is a device that limits the freedom of movement and indicated an abdominal binder that is used to prevent a resident from pulling on the g-tube would restrict the movement of the upper extremities and would require an informed consent. The DON stated an informed consent for the abdominal binder should be obtained from Resident 106's legal representative by the doctor to verify that they are aware of the use, reasons, risks and benefits of the abdominal binder. The DON stated that a medication cannot be administered without having an informed consent as they want to ensure the informed consent was obtained by the residents' representative to ensure they are aware of the risks and benefits. The DON stated on the order indicating the informed consent was verified and obtained by the doctor from resident representative for the use of Mirtazapine and Seroquel does not serve as a consent. The DON stated the MAR dated 2/1/2026 – 2/28/2026 indicated the Mirtazapine and Seroquel were both administered to Resident 106 on 2/14/2026. The DON stated the consents for psychotropic medications indicated both Mirtazapine and Seroquel both had an effective date of 2/17/20206 and indicated the consent forms were obtained late. The DON stated if medications were administered without getting a consent, the medication could cause adverse effects, and the family/resident will not be aware. The DON stated writing in the order that the informed consent was obtained indicates there should be an informed consent on file. During a review of the facility's P&P titled, Restraints/Seclusions, date revised 7/24/2025, the P&P indicated informed consent will be obtained from the resident or responsible party if a restraint will be used during a treatment or diagnostic procedures. Before any type of restraint is used, the Licensed Nurse will verify that informed consent has been obtained from the resident/responsible party and that the resident/responsible party was educated regarding the risks and benefits of restraint use. During a review of the facility's P&P titled, Informed Consents, dated 4/1/2024, the P&P indicated the Attending Physician/LHP will then obtain an informed consent from the resident or authorized representative before administration of a therapy of procedure that requires an informed consent. The use of an informed consent will be done for but not limited to the following: Psychotherapeutic drugs Physical Restraints (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Physical Restraint means any physical or mechanical device or material attached or adjacent to a resident's body that the resident cannot remove easily, which has the effect of restricting the resident's freedom of movement. Psychotherapeutic Drug means a medication to control a resident's behavior or to treat thought disorder processes. An informed consent is required but not limited to, the administration of psychotherapeutic drugs, physical restraints. The informed consent must be signed by the resident or the resident's representative and the physician/LHP who provided the material information. The Facility verifies that informed consent was obtained prior to the administration of a medical intervention or change in medical intervention that requires informed consent. During a review of the facility's P&P titled, Psychotropic Drug Management, dated 5/19/2025, the P&P indicated the Licensed Nurse will not administer the psychotherapeutic medication until an informed consent form has been obtained and documented by the Attending Physician/LHP from the resident and/or surrogate decision maker.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to: 1. Ensure three of three sampled residents (Resident 52, Resident 67, and Resident 89) had their call lights (device that residents press to request staff assistance when needed) within reach. 2. Ensure the mobility needs of one of seven residents (Resident 84) were accommodated by not providing an appropriately sized wheelchair since the resident's admission in October 2025. This failure resulted in Resident 84's mobility needs not being met and placed the resident at risk for discomfort, loss of independence, and had the potential to place the residents at risk by limiting their ability to request assistance in a timely manner, delayed response to needs, and increased risk for falls or injuries. Findings: a. During a review of Resident 52's admission Record (Face Sheet), the admission Record indicated the facility admitted the resident on 4/28/2023 with diagnoses including asthma (lung disease that makes breathing difficult), chronic obstructive pulmonary disease (COPD- group of lung diseases making breathing harder over time), dysphagia (difficulty swallowing) following cerebral infarction (emergency when part of the brain dies from not getting enough blood, oxygen, and nutrients). During a review of Resident 52's Minimum Data Set (MDS- a resident assessment tool) dated 2/3/2026, the MDS indicated the resident used a wheelchair for mobility. The MDS indicated the resident needed substantial/maximal assistance (helper does more than half the effort) from staff for toileting, showering, upper and lower body dressing, putting on and taking off footwear, personal hygiene, and transferring from bed to chair. During a review of Resident 52's Care Plan Report, initiated on 4/28/2023, the care plan report indicated the resident had Activities of Daily Living (ADL – activities such as bathing, dressing, and toileting a person performs daily) self-care performance difficulties and was at risk for falls and/or injuries. The care plan report indicated interventions included attaching the call light within reach and encouraging the resident to use call light when assistance was needed. During a concurrent observation and interview on 2/17/2026 at 10:56 a.m. with Resident 52 in Resident 52's room, Resident 52 was verbally calling out for nurse. Resident 52 was observed looking for call light and stated he did not know where his call light was. During a concurrent observation and interview on 2/17/2026 at 10:59 a.m. with Licensed Vocational Nurse (LVN) 1 in Resident 52's room, Resident 52's call light was dangling on the left side of the bed outside of Resident 52's reach. LVN 1 stated the call light should be where the resident can reach it to call for assistance. b. During a review of Resident 67's admission Record, the admission Record indicated the facility admitted the resident on 7/2/2015 and was re-admitted on [DATE] with diagnoses including Parkinson's disease (brain disorder that affects how a person moves, balances, and coordinates their body), muscle weakness, and acquired absence of right and left legs below the knee (surgical or traumatic removal of the limb). During a review of Resident 67's MDS dated [DATE], the MDS indicated the resident needed substantial/maximal assistance from staff to transfer from bed to chair or wheelchair. The MDS indicated the resident was dependent (helper does all the effort) on staff for transferring to toilet and for showering. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of Resident 67's Care Plan Report, revised 7/16/2023, the care plan report indicated the resident was at risk for falls and/or injuries related to his leg amputations. The care plan indicated to attach the call light within reach and encourage the resident to use it for assistance as needed. During a concurrent observation and interview on 2/17/2026 at 11:42 a.m. in Resident 67's room, the call light was observed hanging behind Resident 67's bed. Resident 67 stated he could not reach his call light. During a concurrent observation and interview on 2/17/2026 at 11:56 a.m. with LVN 1 in Resident 67's room, Resident 67's call light was hanging behind Resident 67's bed. LVN 1 stated Certified Nurse Assistants (CNA) usually places the call light within Resident 67's reach after providing morning incontinent care. LVN 1 stated the call light should always be within reach because the resident could fall if he was unable to reach the call light for assistance. c. During a review of Resident 89's admission Record, the admission Record indicated the facility admitted the resident on 7/25/2025 with diagnoses including Parkinson's disease and dementia (loss of thinking, remembering, and reasoning skills). During a review of Resident 89's MDS dated [DATE], the MDS indicated resident 89 used a walker for mobility. During a review of Resident 89's Care Plan Report, initiated on 7/26/2025, the care plan report indicated the resident was at risk for falls related to gait/balance problems, Parkinson's disease, and dementia. The care plan interventions indicated to ensure the resident's call light was within reach and to encourage the resident to use the call light for assistance as needed. The care plan indicated the resident needed prompt response to all requests for assistance. During a concurrent observation and interview on 2/19/2026 at 7:35 a.m. with CNA 3 in Resident 89's room, Resident 89 was lying in bed with eyes closed and Resident 89's call light was observed under Resident 89's bed. CNA 3 stated if the call light was not within reach, the resident could fall while attempting to complete tasks independently without proper assistance, such as when needing to use the restroom. During an interview on 2/20/2026 at 2:15 p.m. with Director of Nursing (DON), the DON stated the call lights should be within residents' reach, meaning close to their upper extremities and/or hands, so residents were able to call for help. The DON stated that call lights outside of residents' reach could result in delay of care and inability to call for help when needed, which may lead to injury and/or death if complications arise. During a review of the facility's policy and procedure (P&P) titled, Answering Call Lights, dated August 2017, the P&P indicated, .Steps are taken to ensure that a resident's need and request is consider when request are made and when call lights are used to respond to needs at the time of use.Ensure the call light is plugged at all times. When resident is in bed and confined to a chair, the call light will be placed within easy reach of the resident. d. During a review of Resident 84's admission Record dated 10/14/2025, the admission Record indicated Resident 84 was admitted on [DATE] with diagnoses including other idiopathic (unknown cause) peripheral autonomic neuropathy (nerve damage), cellulitis (bacterial skin infection of right (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	and left lower limbs, chronic venous hypertension (high blood pressure) (idiopathic) with ulcer of bilateral lower extremity, other abnormalities of gait and mobility, and muscle weakness. During a review of Resident 84's Care Conference Interdepartmental (IDT) Meeting Minutes dated 1/07/2026, the IDT Meeting Minutes did not indicate under Rehab Services that Resident was evaluated for a wheelchair appropriate for her size, nor provided with such. During a review of Resident 84's Physical Therapy (PT) Evaluation and Plan of Treatment, the PT-Evaluation indicated, wheelchair management training 5 times a week for 60 days daily during the certification period 10/15/2025-12/13/2025. The PT Evaluation indicated, Patient Resident 84 has a manual w/c for community mobility and did not indicate what w/c size is appropriate for Resident 84. During the Resident Council Meeting on 2/18/26 at 2:15 p.m., Resident 84 stated, her need for an appropriate wheelchair for her size had not been addressed. I should not wait a long time. I cannot go out on my own outside. I want to be independent. I want to be able to maneuver my wheelchair on my own. During an interview on 2/18/26 at 4:05 p.m. with the Director of Rehabilitation/Physical Therapist (DOR), the DOR stated, PT evaluation and screening was done upon admission. DOR stated that she was not aware of the wheelchair too big, but DOR should have noticed during the therapy days. During an interview on 2/20/2026 at 2:45 p.m. with Resident 84, Resident 84 stated that she doesn't walk because of arthritis on both knees the facility provided a 26 inches wheelchair, but it was too big for my size. Resident 84 stated that she cannot fit the van or the entrance door when she has clinic appointments. Resident 84 stated Rehabilitation department are aware of the wheelchair not appropriate for her size. During an interview on 2/20/26 at 2:45 p.m. with Resident 84, Resident 84 stated she continued using the w/c given to her, but it made her legs slanted, and she has done side to side to help her up. Resident 84 stated during her first doctor's appointment she cannot go inside the van (like Access) because the wheelchair is too big. Staff in the facility struggled to get me into the van. Resident 84 stated she struggled to fit into the doctor's room or the bathroom. Wheelchair scraped the doorway each time. Resident 84 stated she felt embarrassed. During an interview on 2/19/2026 at 8:45 a.m. with the DOR, the DOR stated, she informed Resident 84 that a wheelchair appropriate for her size will be available upon discharge. The DOR stated she should have assessed it properly and it can be embarrassing to have a wheelchair not fitted properly. During a review of facility's policy and procedure (P&P) titled Accommodations of Needs dated 10/1/2023, the P& P indicated in order to accommodate resident's individual needs and preferences, Facility staff will assist residents in maintaining independence, dignity and well-being to the extent possible according to resident's wishes.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to:1.Develop and implement a comprehensive care plan to address Resident 101's risk for dehydration (low level of fluids in the body).2.Develop and implement a comprehensive care plan for Resident 101's diuretic (medication used to remove excess salt and water from the body) use and monitoring.3. Develop and implement a comprehensive care plan to address refusals to participate in Physical Therapy (PT, profession aimed in the restoration, maintenance, and promotion of optimal physical function) and Restorative Nursing Aide (nursing aide program that help residents maintain any progress made after therapy intervention to maintain their function) programs for Resident 34 who was identified as having range of motion (ROM, full movement potential of a joint) and mobility (ability to move) concerns.4. Develop and implement a comprehensive care plan for Resident 42's both wrist splints (rigid material or apparatus used to support and immobilize a broken bone or impaired joint).These deficient practices had the potential to negatively affect the delivery of necessary care and services and lead to dehydration for Resident 101 and contracture (loss of motion of a joint associated with stiffness and joint deformity) development, pressure injuries (a localized area of skin damage that develops when prolonged pressure is applied to a specific area of the body), and a decline in overall physical functioning and activities of daily living (ADL, basic activities such as eating, dressing, toileting) for Residents 34 and 42.Findings: 1.During a review of Resident 101's admission Record, the admission Record indicated Resident 101 was admitted to the facility on [DATE] with diagnoses including atrial fibrillation (an irregular, rapid heart rate that may cause symptoms like heart palpitations), severe protein-calorie malnutrition (lack of energy and muscle building nutrients), and dysphagia (difficulty swallowing). During a review of Resident 101's Minimum Data Set (MDS – a resident assessment tool), dated 11/1/2025, the MDS indicated Resident 101 had severe cognitive (ability to learn, reason, remember, understand, and make decisions) impairment, required supervision when eating, required moderate assistance (helper does less than half the effort) for oral hygiene, and was dependent for toileting hygiene, bathing, and lower body dressing. During an interview on 2/19/2026 at 2:05 p.m., with Registered Nurse Supervisor (RNS) 1, RNS 1 stated care plans were important to ensure there were interventions to meet the goals for the resident. RNS 1 stated diuretic medication side effects needed to be monitored because the increased urination placed the resident at risk for excessive diuresis (urinating abnormally large volumes of urine), risk for weight loss, and risk for dehydration. 2.During a concurrent interview and record review on 2/19/2026 at 4:24 p.m., with the Minimum Data Set Nurse (MDSN) 1, Resident 101's physician orders and care plans were reviewed. MDSN 1 stated Resident 101's physician orders indicated an order for furosemide (a diuretic) oral tablet 20 milligrams (MG- a unit of measurement) to be given one time a day for hypertension (high blood pressure). MDSN 1 stated Resident 101 did not have a care plan to address risk for dehydration or to monitor use or side effects of furosemide. MDSN 1 stated Resident 101 was at risk for dehydration because a side effect of furosemide is fluid loss or dehydration. During an interview on 2/20/2026 at 2:20 p.m., with the Director of Nursing (DON), the DON stated Resident 101 was at risk for dehydration and should have had a care plan to address the risk for dehydration and diuretic use and monitoring. The DON stated the care plan interventions should have (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	included monitoring for low urine output, altered mental status, and/or low blood pressure. During a review of the facility's policy and procedure (P&P), titled Care Planning, dated 10/1/2023, the P&P indicated the facility will develop a person-centered comprehensive care plan to include measurable objectives and timetables to meet a resident's medical, nursing, mental, and psychosocial needs. 3. During a review of Resident 34's admission Record, the admission Record indicated the facility admitted Resident 34 on 8/4/2025 with diagnoses including paraplegia (paralysis or weakness of the legs and lower body, typically caused by spinal injury or disease) and reduced mobility. During a review of Resident 34's MDS dated [DATE], the MDS indicated Resident 34 was cognitively (mental action or process of acquiring knowledge and understanding) intact. The MDS indicated Resident 34 required supervision or touching assistance (helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity) for eating and oral hygiene, substantial/maximal assistance (helper does more than half the effort) for toilet hygiene, dressing, rolling, and transfers, and was dependent (helper does all the effort) for bathing. The MDS indicated Resident 34 had functional limitations in ROM (limited ability to move a joint that interferes with daily functioning, including activities of daily living, or places the resident at risk of injury) in both legs. During a review of Resident 34's PT Evaluation and Plan of Treatment (PT Eval), dated 8/6/2025, the PT Eval indicated Resident 34 required maximal assistance (requires 51-75% physical assistance to perform tasks) to total dependence (more than 75% physical assistance) for all mobility and had ROM loss in both ankles and both knees. The PT Eval indicated PT services were not indicated as Resident 34 declined PT services and an RNA program despite explanation and education on importance and benefits of both programs. During a concurrent interview and record review on 2/18/2026 at 5:00 pm with the Director of Rehabilitation (DOR), the DOR stated the Rehabilitation Department (Rehab) was responsible for developing, updating, and discontinuing the therapy and RNA care plans. The DOR reviewed Resident 34's PT Eval, dated 8/6/2025, and confirmed Resident 34 had decreased ROM in both ankles and both knees and required maximal to total dependence with mobility. The DOR confirmed Resident 34 refused PT and RNA services. The DOR reviewed Resident 34's care plan and confirmed therapy did not develop a care plan for Resident 34's PT and RNA program refusals but should have. The DOR stated staff must care plan refusals of recommended services to ensure facility staff were aware of a resident's limitations and refusals and to ensure goals and interventions were in place to address the identified areas of concerns. The DOR stated if resident refusals were not care planned, it could potentially result in a functional decline and contracture development. During an interview on 2/20/2026 at 4:36 pm with the Director of Nursing (DON), the DON stated the purpose of comprehensive care plans was to identify potential or actual areas of concern and develop goals and interventions to manage and address those problems. The DON stated therapy and RNA care plans were developed and managed by Rehab. The DON stated resident refusals must be care planned to ensure a resident's preferences and risk factors were identified and interventions were in place to address those areas of concern. The DON stated if resident refusals for recommended PT and RNA services were not care planned, it could potentially result in a functional decline in mobility and ROM. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. During a review of Resident 42's admission Record, the admission Record indicated the facility initially admitted Resident 42 on 6/26/2023 with diagnoses including quadriplegia (weakness or paralysis of all four extremities), polyneuropathy (damage of the nerves that can cause weakness, numbness, and burning pain), and muscle spasm (involuntary tightening or contraction of one or more muscles). During a review of Resident 42's MDS, dated [DATE], the MDS indicated Resident 42 was cognitively intact. The MDS indicated Resident 42 was dependent in eating, hygiene, toileting, bathing, dressing, rolling to both sides, and transfers. The MDS indicated Resident 42 had functional limitations in ROM in both arms and legs. During an observation and interview on 2/17/2026 at 3:37 pm with Resident 42 in Resident 42's room, Resident 42 was sitting in a motorized wheelchair wearing splints to both wrists and resting both arms on the wheelchair armrests. Resident 42 stated he was unable to move both wrists and both hands due to his injury and wore splints on both wrists all day because both wrists bent downwards without them. Resident 42 stated he had no sensation from the neck down and could not feel the splints on his arms. During an observation and interview on 2/19/2026 at 9:50 am with Resident 42 in the hallway, Resident 42 was sitting in a motorized wheelchair wearing splints to both wrists. Resident 42 stated the Director of Rehabilitation (DOR) ordered both wrist splints online and issued them to Resident 42 a long time ago but did not remember when. Resident 42 stated the Certified Nursing Assistants (CNA), not RNA, applied both splints to Resident 42's wrists in the morning when he got into the wheelchair and removed the splints before he went to bed. Resident 42 stated he wore both wrist splints all day and staff did not remove and/or check his skin throughout the day. During an interview on 2/20/2026 at 2:39 pm with Certified Nursing Assistant 9 (CNA 9), CNA 9 stated Resident 42 always had both wrist splints on when her shift began because the CNAs in the morning shift applied the splints during the day. CNA 9 stated she did not check Resident 42's skin during her shift and only looked at the skin to check for redness when she removed them at 11 pm. During an interview and record review on 2/20/2026 at 2:42 pm with Licensed Vocational Nurse 7 (LVN 7), LVN 7 stated she did not know Resident 42 had splints to both wrists. LVN 7 reviewed Resident 42's care plan and confirmed Resident 42 did not have a care plan for splints to both wrists. LVN 7 stated the Rehabilitation Department (Rehab) issued splints and determined how long a resident could safely wear them. LVN 7 stated staff must care plan all splints to ensure staff were aware the resident was issued splints, the types of splints the resident should be wearing, and for how long the splints should be worn each day. LVN 7 stated it was important for staff to be aware a resident was issued splints to ensure routine skin checks were done to prevent any pressure sores and irritation. LVN 7 stated lack of care planning for splints could result in skin breakdown (tissue damage caused by friction, shear, moisture, or pressure) and discomfort. During a concurrent interview and record review on 2/18/2026 at 5:00 pm with the DOR, the DOR stated Rehab assessed for and issued splints, determined how long a resident could safely wear the splints, and developed, updated, and discontinued the therapy and RNA care plans. The DOR stated she issued Resident 42's both wrist splints a long time ago but did not remember when. The DOR reviewed Resident 42's care plan and confirmed she did not develop a care plan for Resident 34's splints but should have. The DOR stated she did not know who assisted Resident 42 with splint application, removal, and daily splint checks because she never endorsed the splints to RNA and did (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	not develop a care plan for them. The DOR stated Rehab must care plan splints to ensure facility staff were aware the resident was issued splints, the type of splints the resident should wear, how long the resident should wear the splints for during the day, and when to do routine skin checks to prevent skin breakdown. The DOR stated lack of care planning for splints could result in resident harm and pressure injuries. During an interview on 2/20/2026 at 4:36 pm with the DON, the DON stated the purpose of comprehensive care plans was to identify potential or actual areas of concern and develop goals and interventions to manage and address those problems. The DON stated therapy and RNA care plans, which included splinting, were developed and managed by Rehab. The DON stated staff must develop a care plan for splints to ensure staff was aware when a resident received splints, how long the resident should wear them, and what monitoring was necessary to ensure the resident tolerated the splints. The DON stated lack of care planning for splinting needs could lead to pressure injuries and resident harm or injury. During a review of the facility's Policy and Procedures (P/P) titled, Care Planning, dated 10/1/2023, the P/P indicated it was the facility's policy to ensure a comprehensive person-centered care plan was developed for each resident based on the individual assessed needs. The P/P indicated each comprehensive care plan would describe any services that would be required, but were not provided due to the resident's exercises of right which included the right to refuse treatment. During a review of the facility's P/P titled, Contracture – Prevention, dated 10/1/2023, the P/P indicated the Interdisciplinary (IDT) would develop a care plan to prevent and/or minimize contracture. The P/P indicated the care plan would include splints and support devices as appropriate. During a review of the facility's P/P titled, Splinting, dated 10/1/2023, the P/P indicated a care plan must be completed initially by the Occupational Therapist (OT) with specific splinting schedule, application and/or positioning instructions and precautions for RNA and Nursing Staff.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide treatment and care in accordance with professional standards of practice for 3 of 10 sampled residents (Residents 3, 42, 101) by failing to:1.Follow up with an orthopedic (specialty area in medicine referring to the management of the muscles, bones, and their connective structures) consultation appointment for Resident 3's left humerus (upper arm bone) fracture (broken bone) per consulting physician's recommendations.2.Ensure the Director of Rehabilitation (DOR) obtained a physician's order and performed an assessment to determine the appropriateness, fit, and splint (rigid material or apparatus used to support and immobilize a broken bone or impaired joint) wear time tolerance (length of time and frequency a person can tolerate wearing the splint for safety, comfort, and maximal benefits) for Resident 42's both wrist splints.3.Monitor Resident 101's change of condition (COC) on [DATE] and [DATE] during the 11 p.m.- 7 a.m. shift.4.Follow the facility policy and procedure titled Emergency Care-General, dated [DATE], to activate the emergency medical response and call 911 when resident 101 was not responsive to verbal stimuli, had shallow breathing, a weak pulse, and an undetectable blood pressure.These deficient practices resulted in a delay of Resident 3's care and had the potential for worsening of the fracture, delayed healing, and a decline in mobility (ability to move), range of motion (ROM, full movement potential of a joint), physical comfort and psychosocial well-being and had the potential to cause Resident 42 to have skin break down (tissue damage caused by friction, shear, moisture, or pressure), pain, discomfort, decreased ROM, joint dislocation (an injury where the joint is forced out of the normal position), deformity (malformation), and/or bone fractures. For Resident 101, based on the reasonable person concept and expectation (used to determine how an average, rational individual's expectations, actions or response in a given situation) these deficient practices had the potential to miss a worsening or declining change of condition and possible delay of emergency medical assistance.Findings: 1. During a review of Resident 3's admission Record, the admission Record indicated Resident 3 was initially admitted to the facility on [DATE] and re-admitted on [DATE] with diagnoses including a left humeral shaft fracture (break in the long bone of the upper arm), osteoarthritis (loss of protective cartilage that cushions the ends of your bones) of the left shoulder and left elbow, and cerebral palsy (group of neurological disorders that affect a person's ability to move and maintain balance and posture). During a review of Resident 3's Orthopedic Consultation note (Ortho Note), dated [DATE], the Ortho Note indicated Resident 3 was seen by orthopedics for a left humerus fracture. The Ortho Note indicated Resident 3 sustained a fall at the facility in [DATE] where x-rays (image of the internal body, produced by X-rays being passed through it and being absorbed to different degrees by different materials) at the time indicated Resident 3 did not have a fracture. The Ortho Note indicated Resident 3 complained of continued pain in the left shoulder where repeat x-rays were done and indicated Resident 3 had a left humerus fracture. The Ortho Note indicated Resident 3 had a subacute (condition that falls between sudden and long term) left humerus fracture, did not recommend surgery, and recommended a repeat x-ray in 6 weeks to assess fracture healing. The Ortho Note indicated Resident 3's left arm had a five (5) pound weightbearing restriction (guidance from a physician limiting the amount of weight a person can put through a specific arm or leg after a fracture or surgery) for six (6) weeks. The Ortho Note indicated Resident 3 could participate in active range of motion (AROM, performance of ROM of a joint without any assistance or effort of another person) exercises as tolerated to the left elbow and left shoulder, begin passive ROM (PROM, movement at a given joint with full assistance from another person) exercises in 6 weeks, and recommended follow up with (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide services to improve or maintain range of motion (ROM, full movement potential of a joint) for three of seven sampled residents (Residents 3, 4, and 42) with ROM concerns by failing to: 1.Assess Resident 3's left shoulder and left-hand range of motion (ROM, full movement potential of a joint) during the Occupational Therapy (OT, profession that provides services to increase and/or maintain a person's capability to participate in everyday life activities) Evaluation, dated 11/13/2025, and the Joint Mobility Assessment (JMA, a brief assessment of a resident's ROM in both arms and both legs), dated 1/10/2026. 2.Assess Resident 4's both hip and both ankle ROM and objectively (unbiased, based on facts) measure Resident 4's both knee ROM limitations during the Physical Therapy (PT, profession aimed in the restoration, maintenance, and promotion of optimal physical function) Evaluation, dated 12/11/2024. 3.Monitor Resident 42's ROM of both arms and both legs on a quarterly basis in accordance with the facility Policy and Procedure (P/P) titled, Contracture - Prevention. These deficient practices had the potential for Residents 3, 4, and 42 to experience a further decline in ROM resulting in contracture (loss of motion of a joint associated with stiffness and joint deformity) development and have a decline in physical functioning, mobility (ability to move), and activities of daily living (ADL, basic activities such as eating, dressing, toileting). Findings: 1. During a review of Resident 3's admission Record, the admission Record indicated Resident 3 was initially admitted to the facility on [DATE] and re-admitted on [DATE] with diagnoses including a left humeral shaft fracture (break in the long bone of the upper arm), osteoarthritis (loss of protective cartilage that cushions the ends of your bones) of the left shoulder and left elbow, and cerebral palsy (group of neurological disorders that affect a person's ability to move and maintain balance and posture). During a review of Resident 3's Orthopedic Consultation note (Ortho Note), dated 11/11/2025, the Ortho Note indicated Resident 3 was seen by orthopedics for a left humerus fracture. The Ortho Note indicated Resident 3 sustained a fall at the facility in September 2025 where x-rays (image of the internal body, produced by X-rays being passed through it and being absorbed to different degrees by different materials) at the time indicated Resident 3 did not have a fracture. The Ortho Note indicated Resident 3 complained of continued pain in the left shoulder where repeat x-rays were done and indicated Resident 3 had a left humerus fracture. The Ortho Note indicated Resident 3 had a subacute (condition that falls between sudden and long term) left humerus fracture, did not recommend surgery, and recommended a repeat x-ray in 6 weeks to assess fracture healing. The Ortho Note indicated Resident 3's left arm had a five (5) pound weightbearing restriction (guidance from a physician limiting the amount of weight a person can put through a specific arm or leg after a fracture or surgery) for six (6) weeks. The Ortho Note indicated Resident 3 could participate in active range of motion (AROM, performance of ROM of a joint without any assistance or effort of another person) exercises as tolerated to the left elbow and left shoulder, begin passive ROM (PROM, movement at a given joint with full assistance from another person) exercises in 6 weeks, and recommended follow up with orthopedics in 6 weeks with an x-ray of the left humerus. During a review of Resident 3's Occupational Therapy (OT, profession that provides services to increase and/or maintain a person's capability to participate in everyday life activities) Evaluation and Plan of Treatment (OT Eval), dated 11/13/2025, the OT Eval indicated Resident 3 was recently found to have a left humeral shaft fracture and was referred to OT due to a decline in activities of daily living (ADL, basic activities such as eating, dressing, toileting), impaired ROM of the left arm, and left shoulder pain. The OT Eval indicated Resident 3 had the following medical precautions: 5-pound weight bearing restrictions to the left arm for 6 weeks, active ROM exercises to Resident 3's left shoulder and left elbow as tolerated for 6 weeks, and to begin PROM exercises to Resident 3's left arm in 6 weeks. The (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	resting both arms on the wheelchair armrests. Resident 42 stated he was unable to move both wrists and both hands due to his injury and wore splints on both wrists all day because both wrists bent downwards without them. Resident 42 stated he could not move both his legs and arms on his own because he was paralyzed. During a concurrent interview and record review on 2/20/2026 at 3:18 pm with the DOR, the DOR stated the purpose of the JMAs was to monitor changes in a resident's joint ROM and was conducted quarterly and upon admission by Rehab. The DOR reviewed Resident 42's clinical record and confirmed Resident 42 was missing quarterly JMAs for March 2025, June 2025, September 2025, and December 2025. The DOR stated Rehab did not conduct Resident 42's quarterly JMAs per facility policy. The DOR stated missed JMAs could result in missed opportunities to detect ROM declines resulting in functional decline and contracture development. During an interview on 2/20/2026 at 4:36 pm with the Director of Nursing (DON), the DON stated the facility monitored for changes in a resident's ROM by JMAs done quarterly and upon admission by Rehab and by staff report. The DON stated it was important that staff objectively measured ROM of all arm and leg joints during ROM evaluations and JMAs were completed quarterly to ensure the facility had an accurate assessment of a resident's joints since it affected their ability to effectively monitor for changes and provide the appropriate services to address any declines. The DON stated missed JMAs and lack of objective ROM assessment of joint limitations could potentially result in delayed or missed opportunities to detect declines which could lead to a functional decline and contracture development. During a review of the facility's Policy and Procedure (P/P) titled, Contracture - Prevention, dated 10/1/2023, the P/P indicated the facility implemented interventions to prevent the onset of contractures and to prevent worsening of contractures for residents admitted with contractures. The P/P indicated residents would be reviewed for contractures and ROM upon admission and at least quarterly. The P/P indicated ROM would be documented in the resident's medical record. The P/P indicated if a resident had a contracture or is at risk for a contracture, a therapy screening may be requested for measurement and treatment planning.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to:Notify the physician when Resident 101 had less than 50 percent (%) oral intake Notify the physician when Resident 101 experienced a 10lb weight loss in 1 week on 11/26/2025.Follow the facility policy to conduct interdisciplinary team (IDT) on Weight Variance for Resident 101 These deficient practices resulted in incomplete and unclear weight and nutrition status and had the potential to delay delivery of care and timely interventions to prevent further weight loss. Findings: During a review of Resident 101's admission Record, the admission Record indicated Resident 101 was admitted to the facility on [DATE] with diagnoses including atrial fibrillation (an irregular, rapid heart rate that may cause symptoms like heart palpitations), severe protein-calorie malnutrition (low level of energy and muscle building nutrients), and dysphagia (difficulty swallowing). During a review of Resident 101's Minimum Data Set (MDS - a resident assessment tool), dated 11/1/2025, the MDS indicated Resident 101 had severe cognitive (ability to learn, reason, remember, understand, and make decisions) impairment, required supervision when eating, required moderate assistance (helper does less than half the effort) for oral hygiene, and was dependent for toileting hygiene, bathing, and lower body dressing. During a record review of Resident 101's physician orders, Resident 101's physician orders indicated an order to obtain weight upon admission and weekly for four weeks starting 11/18/2025. 1. During a concurrent interview and record review on 2/18/2026 at 11:42 a.m. with Licensed Vocational Nurse (LVN) 4, Resident 101's Nutrition Amount Eaten for November 2025 and December 2025 and Nursing Notes were reviewed. Certified Nurse Assistant (CNA) will notify the LVN if a resident has poor oral intake. LVN 4 stated poor oral intake is when the resident eats less than 50% of their meal. LVN 4 stated if a resident has poor oral intake two meals in a row, the physician should be notified. LVN 4 stated the December 2025 Nutrition Amount Eaten indicated on 12/11/2025 Resident 101 consumed 26%-50% of their breakfast and 26%-50% of their lunch. LVN 4 stated there is no documentation indicating the physician was notified of the poor oral intake on 12/11/2025. During a concurrent interview and record review on 2/18/2026 at 2:57 p.m. with the Registered Dietician (RD), Resident 101's Nutrition Amount Eaten for November 2025 and December 2025 were reviewed. The Nutrition Amount Eaten for December 2025 indicated the following meals with less than 50% consummed: 12/1/2025: Lunch (26-50%)12/5/2025: Lunch (26-50%)12/8/2025: Dinner (26-50%)12/9/2025: Lunch (26-50%)12/10/2025: Breakfast (26-50%)12/11/2025: Breakfast (26-50%), Lunch (26-50%)12/12/2025: Breakfast (26-50%), Lunch (0-25%), Dinner (26-50%)12/13/2025: Breakfast (26-50%), Lunch (0-25%), Dinner (26-50%)12/14/2025: Breakfast (0-25%), Lunch (0-25%)12/15/2025: Breakfast (26-50%), Lunch (26-50%), Dinner (26-50%)12/16/2025: Breakfast (0-25%), Lunch (0-25%)12/17/2025: Breakfast (0-25%), Lunch (0-25%), Dinner (0-25%)12/18/2025: Breakfast (0-25%), Lunch (0-25%)The RD stated there is no documentation indicating interventions or notifications until 12/18/2025. 2. During a concurrent interview and record review on 2/18/2026 at 1:21 p.m. with the Restorative Nursing Assistant (RNA) 3, the Weekly and Monthly Weights for November 2025 to December 2025 were reviewed. RNA 3 stated the RNAs complete the weekly and monthly weights for new admissions and readmissions, residents on dialysis, and any resident with an order for weekly weights on paper and place them in the Weekly and Monthly Weights Binder. The Weekly and Monthly Weights for November 2025 and December 2025 indicated the following weights for Resident 101: 11/19/2025 - 111 pounds (lbs - a unit of measurement)11/26/2025 - 101 lbs12/3/2025 - 96 lbs12/10/2025 - 95 lbsThe RNA stated a copy of the weekly weights was given to the Director of Nurses (DON), the Registered Nurse Supervisor, the Dietary Supervisor, Medical records, and the MDS Nurse. RNA 3 stated they are unsure who enters the weights into the resident's medical record. During a concurrent interview and record review on 2/19/2026 at 2:05 p.m. with the Registered Nurse Supervisor (RNS) 1, the Weekly and Monthly Weights for November 2025 and December 2025 and Resident 101's medical record was (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	reviewed. RNS 1 stated Resident 101 experienced a 10 lbs weight loss from 11/19/2025 (111 lbs) to 11/26/2025 (101 lbs). RNS 1 stated there is no documentation indicating the physician was notified of Resident 101's 10 lbs weight loss. RNS 1 stated all every weight loss noted should be reported to the physician so that interventions can be order to prevent further weight loss. 3. During a concurrent interview and record review on 2/18/2026 at 2:57 p.m. with the Registered Dietician (RD), the Weekly and Monthly Weights for November 2025 and December 2025, and Resident 101's weights and nutrition assessments and notes were reviewed. The RD stated Resident 10110 lbs (9%) weight loss in one week from 11/20/2025 (111 lbs) to 11/26/2025 (101 lbs) and 15 lbs (13.5%) weight loss in two weeks from 11/20/2025 (111 lbs) to 12/3/2025 (96lbs).The RD stated there was no documentation indicating that Resident 101 was being monitored by the Weight Variance IDT Committee. During an interview on 2/20/2026 at 2:20 p.m. with the Director of Nursing (DON), the DON stated the physician should have been notified of Resident 101's poor oral intake on 12/11/2025. The DON stated the physician should be notified when there is a weight change of 3 or more lbs in one week. The DON stated it is important to conduct Weight Variance IDT's with nursing, dietary, and other departments to ensure that all contributing factors are considered when determining cause or factors contributing to weight loss and implement interventions to prevent further weight loss. During a review of the facility's policy and procedure (P&P), titled Assessment and Management of Resident Weights, dated 10/1/2023, the P&P indicated the weight of residents will be monitored for variance and the Nutrition & Weight Variance Committee, made up by the Interdisciplinary Team embers, and will meet at least monthly to assess and review and resident identified as at risk for unplanned weight loss. The P&P indicated, the Director of Nursing Services or designee will compile a list of residents who are at risk for, or in need of, weight change. Residents that meet the following criteria may be included on the list for discussion:A. Persistent weight loss over a period of three (3) monthsB. 2% weight change in 1 weekC. 5% weight change in 1 monthD. 7.5% weight change in 3 monthsE. 10% weight change in 6 monthsThe P&P indicated the nutrition & Weight Variance Committee will document resident based review and recommendations form the meeting.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to maintain a medication error rate of less than 5% (percent) during medication pass for two of five sampled residents (Residents 95 and 15) by failing to:1. Ensure Resident 95's carvedilol's (a medication used to treat high blood pressure) hold parameters regarding blood pressure were clarified with a physician.2a. Ensure Resident 15's bismuth subsalicylate (a medication used to treat diarrhea, bloating and abdominal discomfort) was available in stock to administer to Resident 15.2b. Clarify Resident 15's diclofenac gel's (a medication used topically to relieve pain and inflammation) dose and/or amount to be applied before applying it on the resident's lower back. These deficient practices resulted in a medication error rate of 9.68% which exceeded the five (5) percent threshold and placed Residents 15 and 95 at risk for hypertension (high blood pressure), hypotension (low blood pressure), cardiovascular complications, abdominal discomfort and inadequate pain management. Findings: 1. During a review of Resident 95's admission Record dated 2/18/2026, the admission record indicated Resident 95 was admitted to the facility on [DATE] with diagnoses that included but not limited to chronic systolic (congestive) heart failure (CHF - a heart disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling), unspecified atrial fibrillation (a heart condition characterized by a rapid, chaotic, and irregular beating of the heart's upper chambers [atria]), personal history of transient ischemic attack (TIA - a brief episode of neurological dysfunction resulting from an interruption in the blood supply to the brain or the eye sometimes as a precursor of a stroke [CVA-stroke, loss of blood flow to a part of the brain]) and cerebral infarction (a type of ischemic stroke caused by a blockage in brain blood vessels, resulting in tissue necrosis [death] due to lack of oxygen) without residual deficits, hypotension and essential (primary) hypertension.During a review of Resident 95's History and Physical (H&P), dated 5/15/2025, the H&P indicated Resident 95 had fluctuating capacity to understand and make decisions.During a review of Resident 95's Minimum Data Set (MDS - a resident assessment tool), dated 11/18/2025, the MDS indicated Resident 95's cognition (mental action or process of acquiring knowledge and understanding through thought and the senses) was severely impaired. The MDS indicated Resident 95 needed moderate assistance from the facility staff for performing activities of daily living (ADLs - routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves) such as upper and lower body dressing and personal hygiene, needed supervision or touching assistance for showering and putting on/taking off footwear, needed setup or clean-up assistance for oral hygiene and toileting hygiene, and Resident 95 was independent in performing ADL of eating. During a concurrent observation and interview on 2/18/2026 at 8:26 a.m., with Licensed Vocational Nurse (LVN) 2, LVN 2 prepared and administered seven medications to Resident 95. LVN 2 stated she (LVN 2) checked Resident 95's blood pressure on 2/18/2026 at 8:22 a.m., and Resident 95's blood pressure reading was 106/83 (systolic blood pressure [SBP - measures the pressure in the arteries when the heart contracts to pump blood] at 106) and (diastolic blood pressure [DBP - measures the pressure in the arteries when the heart muscle relaxes between beats] at 83 and heart rate (HR) was at 74 beats per minute. During a concurrent interview and record review on 2/18/2026 at 8:26 a.m., with LVN 2, the pharmacy label on morning medication bubble pack (sealed card containing individual, daily, or weekly doses of medication in clear, push-through plastic bubbles) for Resident 95's carvedilol 3.125 milligrams ([mg] metric unit of measurement, used for medication dosage and/or amount) was reviewed. The pharmacy label dated 1/12/2026 indicated, carvedilol 3.125 mg, give one tablet orally two times a day for hypertension, hold if SBP is less than 110, HR is less than 60. LVN 2 stated she needed to hold Resident 95's carvedilol 3.125 mg because Resident 95's SBP was 106 and the hold parameters on the pharmacy label indicated to hold carvedilol if SBP was less than 110.During a subsequent observation and interview on 2/18/2026 at 8:26 a.m., with LVN 2, LVN 2 prepared the following seven medications (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	to be administered to Resident 95. LVN 2 stated she did not have PreserVision (a multivitamin used to reduce the risk of progression in moderate to severe age-related macular degeneration [a progressive eye disease affecting the macula, causing central vision loss in adults over 50]) tablets in stock to administer to Resident 95. a. One tablet of spironolactone (a medication used to treat CHF, high blood pressure and other heart conditions) 25 mgb. One tablet of furosemide (a medication used to treat edema [fluid retention] and high blood pressure [hypertension] 20 mgc. One tablet of Jardiance ([generic name - empagliflozin] a medication used to treat diabetes [DM-a disorder characterized by difficulty in blood sugar control and poor wound healing] and heart failure) 10 mgd. One tablet of sacubitril 24 mg - valsartan 26 mg (a medication used to treat high blood pressure and heart failure)e. One tablet of magnesium gluconate (a dietary supplement used to promote relaxation, improve nerve function and sleep) 250 mgf. One tablet of vitamin E (a vitamin used to support immune function, skin health and blood vessel health) 180 mg (400 international units [IU - a unit of measurement for mass])g. One tablet of calcium 500 mg plus vitamin D 5 microgram ([mcg] a unit of measurement for mass) (a vitamin used to treat low level of calcium and vitamin D to maintain strong bones) During a medication reconciliation review on 2/18/2026, Resident 95's Order Summary Report (a document containing a summary of all active physician orders), dated 2/18/2026 was reviewed. The order summary report indicated, but not limited to the following physician orders: Calcium + vitamin D3 oral tablet 500 mg - 5 mcg (calcium carbonate - cholecalciferol), give 1 tablet orally one time a day for supplement, order date 5/14/2025, start date 5/15/2025. Carvedilol oral tablet 3.125 mg, give 1 tablet by mouth orally two times a day for hypertension, hold if SBP is less than 100, or Pulse is less than 60, order date 2/4/2026, start date 2/5/2026. Empagliflozin oral tablet 10 mg, give 1 tablet orally one time a day for DM, order date 5/14/2025, start date 5/15/2025. Furosemide oral tablet 20 mg, give 1 tablet orally one time a day for heart failure, order date 5/14/2025, start date 5/15/2025. Magnesium gluconate oral tablet 250 mg, give 1 tablet orally one time a day for supplement, order date 5/14/2025, start date 5/15/2025. PreserVision AREDS 2 oral capsule (multiple vitamins with minerals), give 1 capsule orally two times a day for supplement, order date 5/14/2025, start date 5/14/2025. Sacubitril-Valsartan oral tablet 24-26 mg, give 1 tablet orally two times a day for heart failure, order date 5/14/2025, start date 5/14/2025. Spironolactone oral tablet 25 mg, give 1 tablet orally one time a day for heart failure, order date 5/14/2025, start date 5/15/2025. Vitamin E oral capsule 180 mg (400 units), give 1 capsule orally in the morning for supplement, order date 5/14/2025, start date 5/15/2025. During a review of Resident 95's Medication Administration Record (MAR - a daily documentation record used by a licensed nurse to document medications and treatments given to a resident) dated 2/1/2026 to 2/18/2026, the MAR indicated two entries for carvedilol 3.125 mg administration documentation. The MAR dated 2/18/2026 at 9:00 a.m. indicated: Carvedilol oral tablet 3.125 mg, give 1 tablet orally two times a day for hypertension, hold if SBP is less than 100, or Pulse is less than 60, start date 2/5/2026 0900, BP of 106/83 and Pulse at 74 with 4 for 0900 administration which was indicated as vitals outside of parameters for administration. Carvedilol oral tablet 3.125 mg, give 1 tablet orally two times a day for hypertension, hold if SBP is less than 110 or Pulse is less than 60, start date- 1/15/2026 0900, discontinue (D/C) date- 2/4/2026 2322 (11:22 p.m.). This entry was documented from 2/1/2026 to 2/4/2026. During a concurrent interview and record review on 2/18/2026 at 2:11 p.m., with LVN 2, the administration details dated 2/18/2026 for Resident 95's PreserVision was reviewed. LVN 2 stated she found PreserVision tablets in another medication cart and administered them to Resident 95 on 2/18/2026 at 11:42 a.m. During a concurrent interview and record review on 2/18/2026 at 2:20 p.m., with LVN 2, the pharmacy label on medication bubble pack for Resident 95's carvedilol 3.125 mg and physician order on electronic medical record were reviewed. LVN 2 stated the pharmacy label instructed to hold carvedilol 3.125 mg when Resident 95's SBP was less than 110, but the physician order instructed to hold carvedilol 3.125 mg when Resident 95's SBP was less than 100. LVN 2 stated she (LVN 2) would need to call the physician to clarify carvedilol's hold parameters for blood pressure readings and subsequently inform pharmacy. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	LVN 2 stated Resident 95's carvedilol 3.125 mg should have been administered, as per physician's order in electronic medical record but according to the pharmacy label, carvedilol was held and not administered to Resident 95. LVN 2 stated there was a risk of mismanagement of high and low blood pressure for Resident 95. LVN 2 stated this mismanagement placed Resident 95 at risk for either hypertension or hypotension, which increased the potential risk for stroke and hospitalization due to hypertension, and dizziness and falls due to hypotension. During an interview on 2/20/2026 at 4:04 p.m., with the Director of Nursing (DON), the DON stated carvedilol's hold parameters for blood pressure readings should be the same on the pharmacy label and the physician order. DON stated if there was a change in the order after doctor assessed the resident, it was the facility nurses' responsibility to put a sticker and indicate change in administration directions and inform pharmacy so that they could send a new pharmacy label. DON stated there was a risk of high blood pressure, leading to headaches, dizziness and hypertensive crisis when the resident did not receive carvedilol based on an updated physician order. 2a. and 2b. During a review of Resident 15's admission Record, dated 2/18/2026, the admission record indicated Resident 15 was admitted to the facility on [DATE] with diagnoses including but not limited to neuromuscular dysfunction of bladder, generalized muscle weakness, Type 2 Diabetes Mellitus (DM) with hyperglycemia (high blood glucose) and gastro-esophageal reflux disease ([GERD] a chronic condition where stomach acid frequently flows back into the esophagus, causing persistent heartburn, chest pain, and regurgitation] without esophagitis (inflammation or swelling of the esophagus [a muscular tube that transports food and liquids from the pharynx to the stomach) lining. During a review of Resident 15's H&P dated 4/30/2025, the H&P indicated Resident 15 had capacity to make decisions.During a review of Resident 15's MDS dated [DATE], the MDS indicated Resident 15's cognition was intact. The MDS indicated Resident 15 was dependent on facility staff for performing ADLs such as toileting hygiene, lower body dressing and putting on/taking off footwear, needed partial assistance for showering, supervision or touching assistance for oral hygiene, upper body dressing and personal hygiene, and was independent in performing ADL such as eating.During an observation on 2/18/2026 at 9:11 a.m. outside of Resident 15's room, LVN 1 prepared and administered the following eight medications to Resident 15. The LVN 1 did not indicate, prepare or administer bismuth subsalicylate to Resident 15.a. One capsule of vitamin D2 ([ergocalciferol] a formulation of vitamin D used to treat low levels of vitamin D, support bone health, immune function and calcium absorption) 1.25 mgb. One tablet of famotidine (a medication used to reduce stomach acid production) 20 mg c. One capsule of pregabalin (a medication used to treat nerve pain) 150 mgd. One tablet of multivitamins with mineralse. One table of simethicone (a medication used to relieve symptoms of bloating and gas) 80 mgf. One tablet of vitamin B1 (a vitamin used to treat low levels of vitamin B1 to support nerve and muscle function) 100 mgg. 15 milliliters ([mL] a unit of measurement for volume) of Biotene (a mouth rinse used to relieve dry mouth) oral rinse h. An unmeasured amount of diclofenac gel 1 percent ([%] a unit of measurement to show strength or potency) after stating that she (LVN 1) usually just calculated for Resident 15's back.During a subsequent observation on 2/18/2026 at 2:11 p.m., in Resident 15's room, LVN 1 administered oral medications to Resident 15. LVN 1 was not observed applying diclofenac gel 1% to Resident 15's lower back. Before exiting Resident 15's room, surveyor asked LVN 1 whether she (LVN 1) planned to administer diclofenac gel. LVN 1 stated she threw away the medicine cup containing diclofenac gel in the trash by mistake and then started looking for diclofenac gel medicine cup in the trash can. LVN 1 then prepared an unmeasured amount of diclofenac gel 1% again and administered and applied to Resident 15's lower back. During a review of Resident 15's Order Summary Report, dated 2/18/2026, the summary report indicated the above listed medications as well as the following physician order to be administered at 9:00 a.m.: Bismuth Subsalicylate oral suspension 525 mg / 15 mL, give 15 mL by mouth four times a day for + (positive) H Pylori (a stomach infection caused by a bacterium called Helicobacter pylori), order date 1/28/2026, start date 1/29/2026. Ergocalciferol oral capsule 1.25 mg (5000 UT), give 1 capsule by mouth one time a day (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	every Wednesday for vitamin D deficiency, order date 4/28/2025, start date 4/30/2025. Famotidine oral tablet 20 mg, give 1 tablet by mouth two times a day for gastric upset, order date 4/28/2025, start date 4/28/2025. Lyrica (generic name - pregabalin) oral capsule 150 mg, give 1 capsule by mouth three times a day for pain management, order date 2/2/2026, start date 2/2/2026. Multiple Vitamins-Minerals tablet, give 1 tablet by mouth one time a day for supplement, order date 5/7/2025, start date 5/8/2025. Simethicone oral tablet 80 mg, give 1 tablet by mouth two times a day for excess/bloating, order date 8/29/2025, start date 8/29/2025. Thiamine hydrochloride (HCl) oral tablet 100 mg, give 1 tablet by mouth one time a day for supplement, order date 4/28/2025, start date 4/29/2025. Voltaren external gel 1% (diclofenac sodium topical), apply to lower back topically one time a day for pain, order date 1/25/206, start date 1/26/2026. During a review of Resident 15's MAR, dated 2/1/2026 to 2/18/2026, the MAR indicated, LVN 1 documented bismuth subsalicylate oral suspension 525 mg/15 mL, as administered on 2/18/2026 at 9:00 a.m. During a concurrent interview and record review on 2/18/2026 at 1:36 p.m., with LVN 1, the administration details for Resident 15's bismuth subsalicylate, dated 2/18/2026 were reviewed. The administration details indicated, effective date as 2/18/2026 9:14 a.m., amount administered 15 mL administered by LVN 1, documented 2/18/2026 9:26 a.m. LVN 1 stated bismuth subsalicylate was not in stock and was not administered to Resident 15. LVN 1 stated bismuth subsalicylate was for Resident 15's infection and that she (Resident 15) finished antibiotics but was still on bismuth. LVN 1 stated bismuth subsalicylate was important for Resident 15's stomach to kill the bacteria and help recover from the H. Pylori infection and she did not receive the full regimen. LVN 1 stated she (LVN 1) was not supposed to document bismuth subsalicylate oral suspension as administered when she (LVN 1) did not administer to the resident and did not have the medication (bismuth subsalicylate) in stock. LVN 1 stated this could be misleading for other nurses, and it was a risk for Resident 15 because she would not be treated as prescribed by physician. During an interview on 2/18/2026 at 1:19 p.m., with LVN 1, LVN 1 stated Resident 15's diclofenac gel did not indicate a dose to be applied to resident's lower back. LVN 1 stated every medication order should have had the medication name, strength, dose, quantity to apply or administer, route and frequency. LVN 1 stated she should have called the physician to clarify order instructions as well as the pharmacy so that they could deliver the correct order. LVN 1 stated there was a risk that Resident 15 could get a higher dose of diclofenac gel than necessary, possibly leading to numbness of the body area or could receive a lower dose and might not treat resident's pain. During an interview on 2/20/2026 at 4:04 p.m., with the DON, the DON stated the documentation would be inaccurate about bismuth subsalicylate being administered when it was not in stock and not administered. DON stated there would be a delay in infection treatment and healing and risk for abdominal discomfort for Resident 15 if she (Resident 15) did not receive bismuth subsalicylate as per physician's orders. During an interview on 2/20/2026 at 4:04 p.m., with the DON, the DON stated each medication order should have strength, dose, frequency, location where medication should be applied and route of the medication. DON stated there was a risk that the resident could have received lower dose than necessary or a higher dose than necessary of the diclofenac gel if the facility nurse did not use the dosing card to measure its dose. DON stated the facility nurse should have verified the medication order with a physician. During a review of the facility's policy and procedure (P&P) titled Medication - Administration, dated 10/1/2023, the P&P indicated, To provide practice standards for safe administration of medications for residents in the Facility. The P&P indicated, Medication will be administered by a Licensed Nurse per the order of an Attending Physician or licensed independent practitioner.The licensed nurse must know the following information about any medication they are administering: A. The drug's name (generic and trade).E. The drug's usual dosage.G. Any precautions and special considerations. The P&P indicated, If the Attending Physician increases or changes a medication order, this is an automatic stop or discontinue order for the original order. The P&P indicated, Nursing staff will keep in mind the seven rights of medication when administering medication: A. The right medication, B. The right amount. Additional (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	considerations include: C. The Rule of 3: the Licensed Nurse administering medications will perform 3 checks comparing the physician's order, pharmacy label, and Medication Administration Record (MAR). The P&P indicated, The resident's MAR will be reviewed for allergies and.including: A. Manufacturer's specifications (not recommendations) regarding the preparation and administration of the drug or biological. B. Accepted professional standards and principles. C. Vital sign parameters and lab results as appropriate. The P&P indicated, VIII. Compare the Licensed Practitioner's prescription/order with the MAR (first check). IX. Compare the licensed practitioner's order with the pharmacy label on the medication package (second check). X. Compare the pharmacy label and MAR (third check). XI. Any discrepancies identified during the first, second, and/or third check must be resolved prior to the administration of any medication.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to:1. Ensure the Emergency Kit ([E-Kit] emergency drugs supply) in one of one inspected medication rooms (Station 2 Medication Room) containing controlled (prescribed medication that carries a risk of misuse, abuse, or dependence) and noncontrolled medications was sealed and locked. 2a and 2b. Ensure Resident 122's unopened vial of Lantus ([generic name - insulin glargine] a type of insulin [a hormone that removes excess sugar from the blood, can be produced by the body or given artificially via medication] used to treat high blood glucose) and unopened vial of Novolog [(generic name - insulin aspart] a type of insulin used to treat high blood glucose), and Resident 33's opened prefilled syringe of Lantus Solostar ([generic name - insulin glargine] a type of insulin [a hormone that removes excess sugar from the blood, can be produced by the body or given artificially via medication] used to treat high blood sugar) in the Station 2 Medication Cart were stored in the refrigerator and/or labeled with an open date, in accordance with the manufacturer specifications and as per facility's policy and procedure (P&P) titled, Dating and Destruction of Solutions, dated 12/2023 and Storage of Medications, dated 12/2023, affecting one of two inspected medication carts (Station 2 Medication Cart).3. Ensure an expired vial of Resident 13's insulin lispro (a type of insulin used to treat high blood glucose) was removed from the Station 3 Medication Cart and discarded, in accordance with the manufacturer specifications and as per facility's policy and procedure (P&P) titled, Dating and Destruction of Solutions, dated 12/2023 and Storage of Medications, dated 12/2023, affecting one of two inspected medication carts (Station 3 Medication Cart).These deficient practices failed to secure and lock the E-Kit that contained controlled and non-controlled medications, increased the risk of unauthorized access, medication misuse, drug loss and diversion, and there was a potential risk of administering medications that had become expired, ineffective, or toxic due to improper labeling and/or storage, leading to adverse health consequences such as abnormal blood glucose levels and hospitalization for Residents 13, 33 and 122. Findings: During a concurrent observation and interview on [DATE] at 12:47 p.m., with the Director of Staff Development (DSD), the Station 2 Medication Room was inspected. The Station 2 Medication Room had a white and orange colored E-Kit box with a tamper proof white zip tie placed on top of the box, but it was not used to lock and secure the E-Kit. The E-Kit's four drawers were easily accessible by sliding them out. The E-Kit label indicated, Orange Kit - PO (by mouth) / IM (intramuscular) E-Kit #1, fill date [DATE]. The DSD stated the E-Kit was open and unsecure. The DSD stated her concern was an unauthorized person having access to and taking medications. The DSD stated she would inform the Director of Nursing (DON) that the E-Kit was not secured, immediately. The DSD stated she needed to reconcile and review medications and investigate if something was not logged. The DSD stated she (DSD) could not figure out based on the E-Kit log if any medications were removed from the E-Kit. The DSD stated there was a risk of unauthorized access to the E-Kit and medication misuse and abuse.The E-Kit contained 44 medications out of which the following seven medications were controlled medications:a. Four tablets of zolpidem (a medication used to treat insomnia [difficulty falling or staying asleep]) 5 milligrams ([mg] metric unit of measurement, used for medication dosage and/or amount)b. Four tablets of Ativan ([generic name - lorazepam] a medication used to treat anxiety) 1 mgc. Eight tablets of Lomotil ([generic name - diphenoxylate and atropine] a medication used to treat diarrhea) 2.5-0.025 mgd. Four tablets of Restoril ([generic name - temazepam] a medication used to treat insomnia) 15 mge. Eight tablets of Tylenol #3 ([generic name - acetaminophen and codeine] a medication used to treat pain) 30-300 mgf. Eight tablets of Ultram ([generic name - tramadol] a medication used to treat pain) 50 mgg. Six tablets of Xanax ([generic name - alprazolam] a medication used to treat anxiety) 0.25 mgThe E-Kit (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	paper posted outside on the E-Kit box indicated, Skilled Nursing Facility (SNF) Emergency Box, Injectable and Oral Drugs, for Emergency Use Only. Open only upon Physician's Order. How to use the e-kit: Record dose (s) taken on e-kit dose slip. Fax order and call.to report the opening of the e-kit to open. Clip Black ties. Take dose(s) and reseal e-kit with [NAME] ties. During an interview on [DATE] at 3:46 p.m., with the DON, the DON stated the E-Kit should have been sealed and locked. The DON if the E-Kit was unsealed, the medications could have been misused with no checking and documentation. The DON stated the unlocked E-Kit contained antibiotics, antiemetics (medications for nausea), anti-anxiety medications, controlled and noncontrolled medications. The DON stated there was a risk of misuse of medications. The DON stated, if the red tag was on the E-Kit, it was supposed to be sealed and since that was opened, it meant the E-Kit was opened for use and the facility staff forgot to reseal it. 2a. During a review of Resident 122's admission Record dated [DATE], the admission record indicated Resident 122 was admitted to the facility on [DATE] with diagnosis that included but not limited to Type 2 Diabetes Mellitus (DM - a disorder characterized by difficulty in blood sugar control and poor wound healing) without complications. During an inspection on [DATE] at 1:22 p.m., with Licensed Vocational Nurse (LVN) 5 of the Station 2 Medication Cart, the following medications were stored in a manner contrary to the manufacturer's requirements or were not labeled with an open date as required by their respective manufacturer's specifications:a. One unopened vial of Lantus 100 units/mL for Resident 122 with no open date.According to the manufacturer's product labeling, unopened / not in-use multiple-dose vial of Lantus, if stored at room temperature (below 86-degree Fahrenheit [(F) is a unit of temperature]) [30-degree Celsius [(C) is a unit of temperature]) and opened / in-use Lantus vial must be used within 28 days. b. One unopened vial of Novolog 100 units/mL for Resident 122 with no open date.According to the manufacturer's product labeling, unopened / not in-use multiple-dose vial of Novolog, if stored at room temperature (below 86 F) [30 C] and opened / in-use Novolog vial must be used within 28 days. During a review of Resident 122's Order Summary Report (a document containing a summary of all active physician orders), dated [DATE], the order summary report included the following physician orders: Insulin Aspart Injection Solution 100 units/milliliters ([mL] a unit of measurement for volume), inject as per sliding scale: if 0-149 = 0 unit, <blood sugar (BS) is less than 70; 150-199 = 1 unit; 200-249 = 2 units; 250-299 = 3 units; 300-349 = 4 units; 350-399 = 5 units, >400 BS = 6 units then call medical doctor (MD), subcutaneously (under the skin) before meals and at bedtime for DM, order date [DATE], start date [DATE]. Insulin Glargine Subcutaneous Solution 100 units/mL, inject 6 units subcutaneously one time a day for DM, order date [DATE], start date [DATE]. 2b. During a review of Resident 33's admission Record, dated [DATE], the admission record indicated Resident 33 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included but not limited to Type 2 Diabetes Mellitus without complications. During an inspection on [DATE] at 1:22 p.m., with LVN 5 of the Station 2 Medication Cart, the following medication was stored in a manner contrary to the manufacturer's requirements or was not labeled with an open date as required by their respective manufacturer's specifications:a. One opened (in-use) prefilled syringe of Lantus Solostar 100 units/mL for Resident 33 with no open date.According to the manufacturer's product labeling, unopened / not in-use Lantus Solostar pen if stored at room temperature (below 86 F) [30 C] and opened / in-use Lantus Solostar pen must be used within 28 days. During a review of Resident 33's Order Summary Report, dated [DATE], the order summary report included the following physician orders: Insulin Glargine Solution 100 units/mL, inject 15 units subcutaneously one time a day for diabetes, order date [DATE], start date [DATE]. During an interview on [DATE] at 1:22 p.m., with LVN 5, LVN 5 stated Resident 122 was transferred out from the facility to the hospital the night of [DATE] due to an emergency 911 call. LVN 5 stated Resident 122's Lantus and Novolog vials should have been labeled with an open date if they were stored in the medication cart instead of the refrigerator, so that the nursing staff could determine when to remove the insulin vials after 28 days. LVN 5 stated Resident 33's Lantus Solostar pen should have been labeled with an open date to be (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	able to determine the 28-days expiration date. LVN 5 stated there was a risk that Residents 122 and 33 would not be treated for the high blood glucose levels which could cause hyperglycemia (high blood glucose) and hospitalization. 3. During a review of Resident 13's admission Record, dated [DATE], the admission record indicated Resident 13 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included but not limited to Type 2 Diabetes Mellitus without complications.During a review of Resident 13's H&P, dated [DATE], the H&P indicated Resident 13 had fluctuating capacity to understand and make decisions.During a concurrent inspection and interview on [DATE] at 2:26 p.m., with LVN 4 of the Station 3 Medication Cart, the following medication was stored in a manner contrary to the manufacturer's requirements or was not labeled with an open date as required by their respective manufacturer's specifications:a. One opened (in-use) vial of insulin lispro 100 units/mL for Resident 13 with a pharmacy label that indicated fill date as [DATE], and a handwritten note that indicated exp (expiration date) [DATE] and no open date.According to the manufacturer's product labeling, once opened / in-use or once stored at room temperature, below 86 F (30 C), insulin lispro vial must be used within 28 days or be discarded. LVN 4 stated Resident 13's insulin lispro would not be safe or effective to administer to the resident because it was unclear when it (insulin lispro vial) was opened, and the vial indicated an expiration date of [DATE]. LVN 4 stated there was a risk that the insulin would not be effective to manage Resident 13's blood glucose and could result in hyperglycemia, severe diabetic ketoacidosis ([DKA] a life-threatening, rapid-onset complication of diabetes caused by a severe lack of insulin, which forces the body to burn fat for fuel, producing acidic ketones) and hospitalization. During a review of Resident 13's Order Summary Report, dated [DATE], the order summary report indicated included the following physician order: Humalog (generic name - insulin lispro) 100 units/mL, inject as per sliding scale: if 70-200 = 0 unit, Accucheck (checking blood glucose using a blood glucose monitor) before meals and every night at bedtime (QHS), <70 BS Call MD; 201-250 = 3 units; 251-300 = 4 units; 301-350 = 6 units; 351-400 = 9 units for BS >400, give 12 units and call MD, subcutaneously before meals and at bedtime for DM 2, order date [DATE], start date [DATE].During a review of Resident 13's Medication Administration Report (MAR - a daily documentation record used by a licensed nurse to document medications and treatments given to a resident) dated [DATE] to [DATE], the MAR indicated Resident 13 received insulin lispro 12 times. During an interview on [DATE] at 3:46 p.m., with the DON, the DON stated the sealed insulin vials should have been stored in the refrigerator instead of the medication cart. The DON stated if the insulins were not labeled with an open date after they were opened or taken out of the refrigerator, then the facility nursing staff wouldn't know how long it (insulins) had been out. DON stated if the insulins were not properly stored and administered to the residents to control blood sugar, they (insulins) would not be effective and could result in hyperglycemia and hospitalization for the residents. During a review of the facility's P&P titled, Emergency Kit Medications, dated [DATE], the P&P indicated, The Ekit is a portable container which is sealed in such a manner that the tamper-proof seal must be broken to gain access to the drugs. The contents of the supply shall be listed on the outside of the container. The P&P indicated, The Director of Nursing Services or Charge Nurse will notify the Consultant Pharmacist when medications have been used from the Ekit or when the seal has been broken.During a review of the facility's P&P titled, Dating and Destruction of Solutions, dated 12/2023, the P&P indicated, To set forth guidelines for safe use, storage, and destruction of solutions. A label will be attached at the time of opening containing date, time, and initials of the nurse who opened it. All insulin vials will be marked with date of opening. Insulin will be removed and discarded/destroyed within 28 days of first opening.During a review of the facility's P&P titled, Storage of Medications, dated 12/2023, the P&P indicated, Medications requiring refrigeration are stored between 2 and 8 centigrade (between 36 and 46 Fahrenheit).Drugs stored outside of proper temperature range must be removed for destruction.During a review of the facility's P&P titled, Labeling of Medication Containers, dated 4/2019, the P&P indicated, All medications maintained in the facility are properly labeled in accordance with current state and federal guidelines and regulations.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to ensure to store food in a safe and sanitary manner to prevent growth of microorganisms that could cause foodborne illness (food poisoning: any illness resulting from the food spoilage of contaminated food, pathogenic bacteria, and viruses for 94 out of the 98 residents in the facility by failing to: Ensure the facility failed to date and label produce and storage goods.Ensure the facility failed to discard expired food items in the dry storage.These deficient practices had the potential to result in pathogen (germ) exposure to residents and placed residents at risk for developing foodborne illness (food poisoning) with symptoms including upset stomach, stomach cramps, nausea, vomiting, diarrhea and fever and can lead to other serious medical complications and hospitalization.Findings:During a concurrent observation and interview on 2/17/2026 at 8:37 a.m. with the Dietary Supervisor (DS), the following was observed in the dry storage: Potatoes stored in the bin with no date and label on it.Two [NAME] Prune cans had a received date of 3/22/2025 with the best by date of 7/3/2025.A bag of regular tortilla chips with no received date.Two cans of Pork and Beans had a received date of 12/13/2024. The DS stated the cans were expired.Two country style gravy mix had a received date of 2/12/2024 with best by date of 5/23/2025.Barbeque seasoning in a plastic bag with no date.Cayenne pepper seasoning bottle opened with no date.The DS stated he did not get to check and throw everything that is expired away and indicated expired items should be thrown away as he does not want the residents to get sick. The DS stated items need to be labeled to know what is being labeled and how long the items are good for. During a review of the facility's policy and procedure (P&P) titled, Food Storage, date revised 7/24/2025, the P&P indicated cans should be stored with labels exposed for easy identification. Recommended use is within 12 months. Dry storage guidelines: label and date storage products.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility and/or facility licensed nurse failed to follow infection control and prevention procedures by failing to:1. Wear personal protective equipment ([PPE] - specialized clothing designed to protect workers from injury, illness, and infection) before entering Resident 15's room that required Enhanced Barrier Precautions ([EBP] - infection control measures in nursing homes, requiring gown and glove use during high-contact care for residents with chronic wounds, indwelling devices, or known MDRO colonization, aiming to reduce multidrug-resistant organism (MDRO) transmission) and before administering and/or applying medications for Resident 15.2. Wash hands after going through trash and before applying diclofenac gel (a topical medication used to treat inflammation and pain) on Resident 15's lower back.3. Ensure Restorative Nursing Aide 1 (RNA 1) wore an isolation gown (protective apparel used to protect the wearer from the transfer of microorganisms and body fluids) while assisting with range of motion (ROM, full movement potential of a joint) exercises to Resident 42's both arms and both legs which required direct contact with Resident 42 who was on EBP.4. Implement the facility's Water Management Plan (plan that identifies hazardous conditions and steps to take to minimize the growth and spread of bacteria[germs]) thereby affecting 94 out of 94 residents. 5. Implement their Infection Prevention and Control Program when two of three sampled residents (Resident 101 and Resident 121) were not included in the facility's infection surveillance plan while receiving antibiotics (medication used to fight infections).These failures had the potential to result in cross contamination and spread of infection. Findings: 1. & 2. During a review of Resident 15's admission Record dated 2/18/2026, the admission record indicated Resident 15 was admitted to the facility on [DATE] with diagnoses including but not limited to neuromuscular dysfunction of bladder and generalized muscle weakness. During a review of Resident 15's History & Physical (H&P) dated 4/30/2025, the H&P indicated Resident 15 had capacity to make decisions. During a review of Resident 15's Minimum Data Set (MDS – a resident assessment tool), dated 11/7/2025, the MDS indicated Resident 15's cognition (mental action or process of acquiring knowledge and understanding through thought and the senses) was intact. The MDS indicated Resident 15 was dependent on facility staff for performing activities of daily living (ADLs – routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves) such as toileting hygiene, lower body dressing and putting on/taking off footwear, needed partial assistance for showering, supervision or touching assistance for oral hygiene, upper body dressing and personal hygiene, and was independent for eating. During an observation on 2/18/2026 at 9:11 a.m. in Resident 15's room, Licensed Vocational Nurse (LVN) 1 measured Resident 15's blood pressure (force used by the heart to pump blood around the body) using a wrist blood pressure monitor and blood oxygen saturation using a pulse oximeter. LVN 1 then returned to the medication cart and prepared the following eight medications and/or products to be administered to Resident 15. LVN 1 did not wear PPE before entering Resident 15's room to check blood pressure and to administer medications. a. One capsule of vitamin D2 ([ergocalciferol] a formulation of vitamin D used to treat low levels of vitamin D, support bone health, immune function and calcium absorption) 1.25 milligrams ([mg] metric unit of measurement, used for medication dosage and/or amount) (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	b. One tablet of famotidine (a medication used to reduce stomach acid production) 20 mg c. One capsule of pregabalin (a medication used to treat nerve pain) 150 mg d. One tablet of multivitamins with minerals e. One table of simethicone (a medication used to relieve symptoms of bloating and gas) 80 mg f. One tablet of vitamin B1 (a vitamin used to treat low levels of vitamin B1 to support nerve and muscle function) 100 mg g. 15 milliliters ([mL] a unit of measurement for volume) of Biotene (a mouth rinse used to relieve dry mouth) oral rinse h. An unmeasured amount of diclofenac gel 1 percent ([%] a unit of measurement to show strength or potency) after stating that she (LVN 1) usually just calculated for Resident 15's back. LVN 1 administered oral medications to Resident 15. LVN 1 was not observed applying diclofenac gel 1% to Resident 15's lower back. Before exiting Resident 15's room, surveyor asked LVN 1 whether she (LVN 1) planned to administer diclofenac gel. LVN 1 stated she threw away the medicine cup containing diclofenac gel in the trash by mistake and then started looking for diclofenac gel medicine cup in the trash can. LVN 1 stated she needed to prepare a new dose of the diclofenac for Resident 15. LVN 1 did not wash hands before preparing and applying the diclofenac gel on Resident 15's lower back. During a review of Resident 15's Order Summary Report (a document containing a summary of all active physician orders), dated 2/18/2026, the order summary report included the following physician orders: Change Foley catheter as needed (PRN) if leaking, clogged or pulled out as needed, order date 1/19/2026, start date 1/19/2026. Foley Catheter Care every shift for care, order date 4/28/2025, start date 4/28/2025. May be on Enhanced Barrier Precautions (EBP) for Foley Catheter use, order date 2/3/2026, start date 2/3/2026. Voltaren External Gel 1% (Diclofenac Sodium Topical), apply to lower back topically one time a day for pain, order date 1/25/2026, start date 1/26/2026. During a review of Resident 15's care plan dated 6/12/2025, the care plan indicated, Focus: resident is on Enhanced Barrier Precautions (EBP) as per Centers for Disease Control and Prevention (CDC) guidelines for foley catheter use. Goal: to reduce transmission of MDRO until next review date. Interventions: Encourage/assist resident as needed with hand hygiene.Staff to don/doff appropriate PPE when performing direct high-contact patient care activity as per EBP. During an interview on 2/18/2026 at 1:19 p.m. with LVN 1, LVN 1 stated she (LVN 1) was supposed to wear PPE such as a gown, pair of gloves, face shield barrier or mask while administering medications to Resident 15 because Resident 15 was on EBP due to foley catheter. LVN 1 stated it was important (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	to wear the PPE because of the risk of foley catheter falling out and/or risk of exposure to urine on the floor. LVN 1 stated there was a risk of spreading communicable and infectious diseases such as methicillin resistant staphylococcus aureus [MRSA] - a bacteria that does not respond to antibiotics), Vancomycin Resistant Enterococci ([VRE] a severe infection of intestines, urinary tract or wounds), hepatitis (liver inflammation caused by viruses), and cross contamination while caring for other facility residents. During an interview on 2/20/2026 at 4:04 p.m. with the Director of Nursing (DON), the DON stated the LVN 1 should wear PPE before administering medications to residents on EBP because there was a risk of spread of infection and susceptibility to infection due to open areas. DON stated the nurse should have washed hands before applying diclofenac gel to resident's lower back. During a review of the facility's policy and procedure (P&P) titled, Standard and Enhanced Precautions, dated 4/1/2024, the P&P indicated, Enhanced Barrier Precautions (EBP) refers to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and glove use during high contact resident care activities. apply and/or transmission such as presence of indwelling devices (e.g., urinary catheter, feeding tube, endotracheal or .catheters) and wounds. ulcers. The P&P indicated, EBP are intended to be in place for the duration of a resident's stay in the Facility.or discontinuation of the indwelling medical device that placed them at high-risk. During a review of the facility's P&P titled, Administration of Topical Medications, dated 12/2023, the P&P indicated, Procedure: Wash hands. Wear gloves. Gloves will prevent medication from being absorbed by nurse if accidentally touches patch or ointment. Inspect condition of skin. Wash affected areas with solvent or non-drying soap.Apply topical agent to affected area.Wash hands. 3. During a review of Resident 42's admission Record, the admission Record indicated the facility initially admitted Resident 42 on 6/26/2023 with diagnoses including quadriplegia (weakness or paralysis of all four extremities), polyneuropathy (damage of the nerves that can cause weakness, numbness, and burning pain), and muscle spasm (involuntary tightening or contraction of one or more muscles). During a review of Resident 42's Physician Order Report, the Physician Order Report indicated a physician's order, dated 8/1/2024, for Resident 42 to be placed on EBP due to Resident 42's suprapubic catheter (tube inserted directly into the bladder to drain urine) per Centers for Disease Control guidelines. During an observation of a Restorative Nursing Aide (RNA, nursing aide program that helps residents maintain any progress made after therapy intervention to maintain their function) session on 2/18/2026 at 8:48 am in Resident 42's room, Resident 42 was lying in bed while RNA 1 assisted with passive range of motion (PROM, movement at a given joint with full assistance from another person) exercises to Resident 42's both arms and both legs. RNA 1 was not wearing an isolation gown. Once exercises were complete, RNA 1 placed pillows under Resident 42's both knees, rearranged the blankets, propped Resident 42's mobile phone onto a stand next to the bed, removed both gloves, performed hand hygiene, and exited Resident 42's room. During an interview on 2/18/2026 at 9:18 am with RNA 1, RNA 1 confirmed she did not wear an isolation gown while assisting Resident 42 who was on EBP with PROM exercises. RNA 2 stated she should have worn an isolation gown while assisting Resident 42 with ROM exercises because she had (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	direct contact with Resident 42 who was on EBP. RNA 1 stated it was important to follow infection control protocols to prevent the spread of infection. During an interview on 2/20/2026 at 2:12 pm with the Infection Preventionist Nursing (IPN), the IPN stated the purpose of EBP precautions was to reduce the transmission of infection for residents with wounds (injury to the body that typically involves a laceration or breaking of a membrane) and indwelling devices (medical devices inside the body) such as gastrostomy tube (G-tube- a tube placed directly into the stomach for long-term feeding) and catheters. The IPN stated all staff providing direct patient care which included assisting with ROM to residents on EBP must wear the appropriate personal protective equipment (PPE, equipment worn to minimize exposure to hazards that can cause serious injuries and illnesses) which included an isolation gown and gloves to prevent the spread of infection. The IPN stated it was important staff wore an isolation gown and gloves when providing direct care to residents on EBP to prevent the spread of infection. During an interview on 2/20/2026 at 4:36 pm, the DON stated staff should wear an isolation gown and gloves when providing direct care to residents on EBP to reduce the risk of Multi-Drug Resistant Organisms (MRDO, bacteria resistant to many antibiotics) exposure and to prevent the spread of infection. During a review of the facility's Policy and Procedure (P/P) titled, Standard and Enhanced Precautions, dated 4/1/2024, the P/P indicated it was the facility's policy to ensure the use of appropriate PPE to improve infection control as required in the care of residents. The P/P indicated EBP referred to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and glove use during high contact resident care activities that are associated with a high risk of MDRO colonization when contact precautions do not otherwise apply and/or transmission such as presence of indwelling devices (e.g. urinary catheter, feeding tube, endotracheal or tracheostomy tube, vascular catheters) and wounds or presence of unhealed pressure ulcers. 4. During an interview on 2/20/2026 at 11:50 a.m., with the Environmental Services Director (ESD), the ESD stated he just measures water temperatures, makes sure the ice machine was clean, and there were no other tasks regarding the water management plan. The ESD stated there was no documentation of evidence of Water Management Plan implementation. During a concurrent interview and record review on 2/20/2026 at 12:19 p.m. with the Administrator (Admin), the facility's Water Management Plan, 2023 was reviewed. The Admin confirmed the Plan had tasks and procedures that needed to be implemented. The Admin stated there was no documented evidence of the performance of tasks outlined in detail in the Water Management Plan. During a review of the facility's Water Management Plan, 2023, the plan indicated: a. Specific control measures and procedures (actions implemented to eliminate or minimize risks) were provided in the plan. b. All Standard Operating procedures and Protocols were also developed in detail. c. A task planning chart was provided that summarizes control tasks throughout the year. Log sheets/ Verification Forms were provided to help document performance of tasks. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	d. The plan indicated preventative measures and steps to be performed routinely. 5a. During a review of Resident 101's admission Record (Face Sheet), the admission Record indicated the facility admitted the resident on 11/18/2025 with diagnoses including muscle weakness, and urinary tract infection (UTI- infection caused by bacteria entering the urinary system). During a concurrent interview and record review on 2/19/2026 at 12:17 p.m. with the Infection Prevention Nurse (IPN), Resident 101's Medication Administration Record, (MAR- a daily documentation record used by a licensed nurse to document medications given to a resident) was reviewed. The MAR indicated Resident 101 received cefdinir (medication used to treat infections) for UTI starting 11/19/2025 and ending on 11/25/2025. b. During a review of Resident 121's admission Record, the admission Record indicated the facility admitted the resident on 2/17/2026 with diagnoses including cardiomegaly (enlarged heart), and UTI. During an interview on 2/19/2026 at 12:17 p.m. with the IPN, the IPN stated she kept track of infections by analyzing residents' medical records for factors including signs and symptoms of infection and laboratory results. During a concurrent interview and record review on 2/19/2026 at 12:30 p.m. with the IPN, Resident 121's MAR and physician orders were reviewed. The MAR indicated Resident 121 received doxycycline (medication used to treat infections) and Invanz Injection Solution (medication used to treat infections given directly into the vein) simultaneously starting on 2/17/2026. The physician order dated 2/17/2026 indicated Resident 121 was on contact isolation (precautions taken to prevent the spread of infection and/or germs) for Extended-Spectrum Beta-Lactamase (ESBL- a shield used by bacteria to defend itself form antibiotics [medication used to fight infections]) of urine. During a concurrent interview and record review on 2/19/2026 at 12:45 p.m. with the IPN, the Infection Prevention and Control Surveillance Log (surveillance log), dated November 2025 and February 2026 were reviewed. The surveillance log indicated Resident 101 was not listed on the November 2025 log, and Resident 121 was not listed on the February 2026 log. The IPN stated she did not add these residents' infections to the surveillance logs. The IPN stated that logging infections was important to monitor trends and help prevent the spread in infection. During an interview on 2/20/2026 at 2:15 p.m. with the Director of Nursing (DON), the DON stated the IPN tracked facility infections using the surveillance log. The DON stated logging infections was necessary to identify trends, guide the plan of action, and prevent the spread of infections and failing to log infections could lead to inaccurate data and increased resident exposure. During a review of the facility's policy and procedure (P&P) titled, Infection Prevention and Control Program, dated 10/1/2023, the P&P indicated, .the Infection Preventionist will collect and document data on the incidence of infections.Monthly Infection Report for all nursing units. During a review of the facility's P&P titled, Antibiotic Stewardship Program, dated 10/1/2023, the P&P indicated, The IP [infection preventionist] will collect and analyze infection surveillance data and monitor the adherence to the ASP [antibiotic stewardship program] and create a report.The IP will be responsible for review of infection surveillance.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to implement their Antibiotic Stewardship Program (a plan to promote the appropriate use of medication to fight infection) when two of three sampled residents (Resident 101 and Resident 121) received antibiotics without meeting McGeer Criteria (set of guidelines used by medical staff to determine if a person has an infection).This failure had the potential to place Resident 101 and Resident 121 at risk for receiving unnecessary antibiotics, which can lead to adverse effects such as antibiotic resistance, side effects, and complications related to inappropriate use.Findings:a. During a review of Resident 101's admission Record (Face Sheet), the admission Record indicated the facility admitted Resident 101 on 11/18/2025 with diagnoses including muscle weakness, and urinary tract infection (UTI- infection caused by bacteria entering the urinary system).During an interview on 2/19/2026 at 12:17 p.m. with the Infection Prevention Nurse (IPN- a nurse who develops, implements, and monitors ways to prevent infections within healthcare facilities), the IPN stated her duties included monitoring residents and staff for vaccinations, conducting infection surveillance programs, and overseeing the antibiotic stewardship program. The IPN stated she monitored residents' records for signs and symptoms of infection, lab results, and culture (a test used to detect the growth of bacteria) results. The IPN stated she used McGeer Criteria to determine the presence of infection and the appropriateness of antibiotic treatment.During a concurrent interview and record review on 2/19/2026 at 12:17 p.m. with the IPN, Resident 101's physician's order dated 11/18/2025, Medication Administration Record (MAR- a daily documentation record used by a licensed nurse to document medications given to a resident), and medical records were reviewed. The physician's order indicated, cefdinir [medication used to treat infection] oral [by mouth] capsule 300 milligram [mg- unit of measurement]. The MAR indicated Resident 101 received cefdinir daily starting on 11/19/2025 and ending on 11/25/2025. The IPN stated there was no urine test documented in Resident 101's chart to show the resident had a UTI. The IPN stated there was no record showing that Resident 101 met McGeer criteria and stated she did not keep record of McGeer criteria assessment for residents on antibiotics.b. During a review of Resident 121's admission Record (Face Sheet), the admission Record indicated the facility admitted Resident 121 on 2/17/2026 with diagnoses including dementia (group of symptoms that affect brain function), and urinary tract infection.During a review of Resident 121's Care Plan Report dated 2/17/2026, the care plan indicated the resident was on antibiotic therapy related to UTI.During a concurrent interview and record review on 2/19/2026 at 12:30 p.m. with the IPN, Resident 121's physician's orders dated 2/17/2026, MAR, and medical records were reviewed. The physician's orders dated 2/17/2026 indicated:1. Invanz Injection Solution (antibiotic medication used to treat infections).Use 1 gram (GM- a metric unit of measurement) intravenously (delivering medicine directly into a vein).for UTI-ESBL (Extended-Spectrum Beta-Lactamase - a shield that bacteria used to defend itself from antibiotics) urine until 2/25/2026 11:59 p.m.2.100 milligram [mg- a unit of measurement] doxycycline hyclate (antibiotic used to treat wide variety of bacteria) Give 1 tablet orally two times a day for active infection until 2/26/2026 11:59 p.m.3. Contact Isolation (safety measures used in healthcare facilities to stop the spread of germs) every shift for ESBLResident 121's MAR indicated the resident started receiving doxycycline and Invanz on 11/18/2025. The IPN stated she helped with Resident 121's admission on [DATE] and remembered the resident had cloudy urine. The IPN stated the cloudy urine was a sign of infection, but it was not documented in the resident's medical record. The IPN stated she did not complete a McGeer criteria assessment for Resident 121 to determine infection and the appropriateness of antibiotic use.During an interview on 2/19/2026 at 12:45 p.m. with the IPN, the IPN stated that monitoring antibiotic treatment was important because if the residents received unnecessary antibiotics, the residents could build resistance, including MDRO (multi drug-resistant organisms), which could have spread and affected other residents. During an interview on 2/20/2026 (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	at 2:15 p.m. with Director of Nursing (DON), the DON stated antibiotic use was determined by using McGeer criteria to identify infections and the need for antibiotics. The DON stated monitoring antibiotic use was important to prevent the residents from developing increased resistance, which could lead to secondary infections.During a review of the facility's policy and procedure (P&P) titled, Antibiotic Stewardship Program dated 10/1/2023, the P&P indicated The Antibiotic Stewardship Program (ASP) is designed to promote appropriate use of antibiotics while optimizing the treatment of infections, and simultaneously reducing the possible adverse events associated with antibiotic use.During a review of the facility's policy and procedure (P&P) titled, Infection Prevention and Control Program dated 10/1/2023, the P&P indicated, The criteria for identifying HAIs (Healthcare-associated infections) are based on the current standard definitions if infections according to McGeer Criteria.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures for flu and pneumonia vaccinations. Based on interview and record review, the facility failed to ensure one of three sampled residents (Resident 101) and resident representative (RP) consented to and were educated on the risks and benefits of the influenza (flu- a respiratory infection that affects the nose, throat, and lungs) vaccine prior to administration.This failure had the potential to result in an increased risk of adverse reactions or complications to the flu vaccine due to undisclosed allergies, medical conditions, or contraindications.Findings:During a review of Resident 101's admission Record (Face Sheet), the admission Record indicated the facility admitted the resident on 11/18/2025 with diagnoses including muscle weakness, and urinary tract infection (UTI- infection caused by bacteria entering the urinary system).During a review of Resident 101's History and Physical (H&P), dated 11/18/2025, the H&P indicated diagnoses including acute encephalopathy (a sudden brain condition causing confusion, altered mental state, or loss of consciousness) and dementia (a group of brain diseases that cause trouble with thinking, memory, and reasoning).During a concurrent interview and record review on 2/19/2026 at 12:17 p.m. with the Infection Prevention Nurse (IPN), Resident 101's Immunization Report was reviewed. The Immunization Report indicated Resident 101 received the flu vaccine on 12/05/2025. The IPN stated there was no consent on file for Resident 101's flu vaccine administration. The IPN stated the flu vaccine's risks and benefits were listed on the consent form that the resident or the resident's representative should sign before the flu vaccine was administered.During an interview on 2/20/2026 at 2:15 p.m. with Director of Nursing (DON), the DON stated it was important for residents and representatives to understand the risks and benefits of vaccines and be given the chance to consent or decline prior to vaccine administration. The DON stated that without a documented vaccine consent, it was difficult to ascertain if Resident 101 and/or resident representative accepted the Flu vaccine.During a record review of the facility's policy and procedure (P&P) titled, Influenza Prevention & Control, dated May 19, 2025, the P&P indicated Before offering the influenza vaccine, each resident or the resident representative receives education regarding the benefits and potential side effects of the vaccination.The resident's medical record includes documentation that includes, at minimum, the following: That the resident or resident representative was provided education regarding the benefits and potential side effects of influenza vaccination;.That the resident was given a copy of.Influenza Vaccination - Informed consent/Refusal which is to be placed in the resident's medical record.

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. Based on interview and record review, the facility failed to provide documented evidence of COVID-19 (a contagious respiratory disease that spreads from person to person through coughing, sneezing, or talking) vaccine screening, education, administration, and/or declination for two of four sampled staff members Medical Director (MD) 1 and Pharmacist (PH).This failure had the potential for increased risk of COVID-19 exposure to staff and residents from delayed identification of vaccine status and missed opportunities to prevent the spread of COVID-19 within the facility.Findings:During a concurrent interview and record review on 2/19/2026 at 12:17 p.m. with the Infection Prevention Nurse (IPN), the facility's Employee Tracking Template (record that includes vaccination status of all employees) was reviewed. The IPN stated there was no COVID-19 vaccine documentation for MD 1 and PH. The IPN stated vaccine declination forms were obtained and filed by the Director of Staff Development (DSD).During a concurrent interview and record review on 2/19/2026 at 1:45 p.m. with DSD, the employee vaccine files were reviewed. The DSD stated there was no record of COVID-19 vaccine screening, education, administration, and/or declination for MD 1 and PH. The DSD stated the facility did not screen for, or offer COVID-19 vaccines to MD 1 and PH. The DSD stated vaccine screening and administration was important because MD 1 and PH had direct contact with the residents and the residents needed to be protected against exposure to COVID-19.During an interview on 2/20/2026 at 2:15 p.m. with the Director of Nursing (DON), the DON stated that all facility staff should have been screened for COVID-19 vaccine status and administration. The DON stated COVID-19 vaccines and record-keeping was important to help prevent the spread of COVID-19 to the residents and within the facility.During a review of the facility's policy and procedure (P&P) titled, COVID-19 Vaccination, dated October 1, 2023, the P&P indicated, The Facility will educate and offer COVID-19 vaccinations to.Facility staff, and consultants.the facility will offer each.Facility Staff member the COVID-19 vaccine.The Facility will provide education to Facility Staff.The Infection Preventionist, or designee, will maintain documentation in the personnel file that each Facility Staff member was educated on the benefits and potential side effects of the COVID-19 vaccine and offered vaccination.The Facility will maintain consent/declination/exemption request forms.in the personnel file for Facility Staff.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to provide a safe and functional environment by failing to:Ensure two out of four sampled residents' (Resident 42 and 82) bathroom sink was clogged.Ensure one out of two showers (Shower 1) water temperatures did not fluctuate (be irregular).These deficient practices had the potential to result in creating a hazardous environment which could result in residents' injury and discomfort.Findings:A. During a review of Resident 42's admission Record, the admission Record indicated Resident 42 was originally admitted to the facility on [DATE] with diagnosis including quadriplegia (paralysis from the neck down, including legs, and arms, due to a spinal cord injury).During a review of Resident 42's Minimum Data Set ([MDS] resident assessment tool) dated 12/5/2025, the MDS indicated Resident 42's cognition was intact.During a review of Resident 82's admission Record, the admission Record indicated Resident 82 was originally admitted to the facility on [DATE] with diagnosis including nontraumatic intracerebral hemorrhage (bleed in the brain).During a review of Resident 82's MDS, dated [DATE], the MDS indicated Resident 82's cognition was severely impaired.During an interview on 2/17/2026 at 10:44 a.m. with Resident 82, Resident 82 complained the bathroom sink had been clogged all weekend and it kept overflowing.During a concurrent observation and interview on 2/17/2026 at 10:45 a.m. with Certified Nurse Assistant (CNA) 4, in Resident 82 and 42's bathroom, wet linen was observed on the floor and there was a tube connected to the bidet (bathroom fixture low to the ground wash basin near the toilet to clean private parts) that was leaking and a bucket collecting the water drips. The bathroom sink was clogged. CNA 4 stated sink was clogged and needed to be fixed.B. During an interview on 2/17/2026 at 3:37 p.m., with Resident 42, Resident 42 stated Shower 1 water temperature would fluctuate from hot to cold. Resident 42 stated Shower 1 had been broken for a while.During an interview on 2/19/2026 at 7:19 a.m., with CNA 5, CNA 5 stated Shower 1 water temperature would fluctuate from hot to cold so they would have to bring residents to Shower 2 to for hygiene.During an interview on 2/19/2026 at 8:06 a.m., with CNA 6, CNA6 stated Shower 1 water temperature would fluctuate from hot to cold so the staff would use Shower 2. CNA 6 they constantly had to check the temperature, so they ended up not using Shower 1. CNA 6 stated it had been broken for about a year. During an interview on 2/20/2026 at 11:54 a.m. with the Environmental Services Director (ESD), the ESD stated the facility needed to ensure sinks and showers were working properly.During an interview on 2/20/2026 at 5:10 p.m., with the Director of Nursing (DON), the DON stated shower temperatures fluctuating was unsafe and can cause discomfort or harm if too cold or too hot. The DON stated clogged sinks can result in flooding and become an unsafe accident hazard.During a review of the facility's policy and procedure (P&P) titled, Resident Rooms and Environment, revised 2/26/2025, the P&P indicated the facility will provide resident with a safe, clean, and comfortable environment.During a review of the Facility Assessment Tool, reviewed 4/9/2025, the tool indicated building structures, and equipment will be maintained to protect and promote health and safety of the residents.

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F 0559 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to share a room with spouse or roommate of choice and receive written notice before a change is made. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to accommodate husband's and wife's (Resident 89 and Resident 90) wish to live together in the same room. This deficient practice resulted in (or had potential to cause) moral distress for both residents as well as to other residents because Resident 89, is searching for Resident 90, wandering from room to room, which caused disturbance to other residents. Findings: During a record review on 02/20/2026 of the admission record of Resident 90 was admitted on [DATE] with diagnoses of muscle weakness, and past medical history of neuropathy (damage to nerves causing numbness, tingling, burning pain, and weakness), atrial fibrillation (irregular, rapid heart rate), hypertension (high blood pressure), osteoarthritis (stiffness in joints), hyperlipidemia (high blood lipids), gout (joint pain), cardiomyopathy (enlarged heart muscles). During record review of Resident 90's Minimum Data Set (MDS) dated [DATE] indicated Brief Interview for Mental Status (BIMS) score is 14, (the individual is cognitively intact, understands concepts) and Functional Abilities indicated Resident 90 requires walker and wheelchair, and supervision and partial assistance with activities of daily living, and supervision or touching assistance for transfers from chair/bed to chair, toilet, and walking, partial assistance for showering. During a record review of the admission record of Resident 89 was admitted on [DATE], with diagnoses of dementia (short term memory impaired), Parkinson's, (uncontrollable muscle movements and stiffness) gastrostomy (opening and tube in the stomach for feeding), diabetes mellitus type 2 (chronic metabolic disorder affecting blood sugar levels), generalized anxiety (uncontrollable and excessive worry). During record review 2/20/2026 of Resident 89's MDS dated [DATE] indicated BIMS score is 4 (the individual with severe cognitive impairment, is unable to understand concepts). The MDS indicated that Resident 89 requires supervision for all activities of daily living, and mobility device use of a walker, partial assistance (helper does less than half the effort) with chair/bed to chair transfers, and walking, dependent for toileting and showering. During a concurrent observation and interview on 2/19/2026 at 08:16 a.m. with Resident 90, Resident 90 stated they both came to the facility since the place was closer to their family and the facility originally agreed to have the couple in the same room. For eight(8) months, Resident 90 and Resident 89 were living in the same room until recently they moved Resident 89 to a different room. Resident 89 wheels himself and starts looking for Resident 90 since he does not remember what room his wife is staying in. During a subsequent interview on 2/19/2026 at 08:20 a.m. with Resident 90, Resident 90 stated, that Resident 89 was eating Pureed (a way to change the texture of solid food so that it is smooth with no lumps and has a texture like pudding)diet, it was splats on the plate, and he would eat a bit and throw it up, but it was more mucus than food. Resident 90 stated I never attended IDT or any meetings. Resident 90 stated she's been requesting to SSD and Admin before to put her and him back in the same room but never got an answer back. Resident 90 stated I never signed consent to have a room change. During an observation on 02/19/2026 at 08:35 a.m. Resident 90, currently, was in bed 208-C, and Resident 89, was in room [ROOM NUMBER] A, six rooms away down the hallway. During concurrent interview and record review on 02/19/2026 10:51 a.m. with Admissions coordinator (AC). Census for 7/25/2025 and for 12/03/2025 were reviewed. Resident 90 and Resident 89 were admitted in the same room until 12/3/2025, AC stated the facility accommodates the couples to be in the same room to keep a home-like environment especially since they have been married for 27 years. AC stated that it is the SSD who knows the reason why they were moved to different rooms. During a concurrent interview and record review with Social Services Designee (SSD), on 02/19/2026 at 11:26 a.m., SSD stated that rooms are changed on as needed basis, or per resident requests, per resident rights, they can refuse, can request to be together. SSD stated, Process for room change - we talk to patient inform them and make sure they are in agreement, and there is room change notification paper, but not a consent form, (continued on next page)

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F 0559 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	not signed by a resident. No documented consent signed for room change in resident records. During a review of Care Conference Interdisciplinary Team (IDT) meeting, section named Social Services Summary dated 12/03/25 11:44 stated IDT members had care plan meeting to discuss resident non-compliance with husband diet. But no documentation the wife attended the IDT. SSD stated that Resident 90 is self-responsible. SSD stated, If residents request to be moved together, we should respect because that's there right. During record review on 2/20/26 11:37 a.m. the facility's Policy and Procedure (P&P) titled Residents Rights - Accommodation of Needs was reviewed. The P& P indicated Facility provides an environment and services that meet residents' individual needs. Residents' individual needs and preferences are accommodated to the extent possible, except when the health and safety of the individual or other residents would be endangered.

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure one of one sampled residents (Resident 8's) medical information was kept private from unintended public view.This deficient practice had the potential to result in a breach of Resident 8's health care information, privacy and confidentiality. Findings: During a review of Resident 8's admission Record dated 2/18/2026, the admission record indicated, Resident 8 was originally admitted to the facility on [DATE] and readmitted on [DATE].During a review of Resident 8's History and Physical (H&P) dated 5/1/2025, the H&P indicated Resident 8 had fluctuating capacity to understand and make decisions. During an observation on 2/18/2026 at 9:32 a.m., outside of Resident 37's room, Resident 8's medication bubble pack (sealed card containing individual, daily, or weekly doses of medication in clear, push-through plastic bubbles) was left unattended in public view on the medication cart managed by Licensed Vocational Nurse (LVN) 1. Resident 8's medication bubble pack indicated, Eliquis ([generic name - apixaban)] a medication used to prevent blood clots) 5 milligrams ([mg] metric unit of measurement, used for medication dosage and/or amount), give 1 tablet by mouth one time a day for DVT ([deep venous thrombosis] a serious condition involving a blood clot in a deep vein, usually the leg or thigh, causing swelling, pain, warmth, and redness).LVN 1 was not available for interview on 2/19/2026. During an interview on 2/20/2024 at 1:54 p.m., with LVN 3, LVN 3 stated the medication card should not have been left for public view because that would be a risk for violation of Resident 8's private medical information. LVN 3 stated there would also be a risk that another resident could take the medication off the cartDuring an interview on 2/20/2026 at 4:04 p.m., with the Director of Nursing (DON), the DON stated it would be a violation of resident's private medical information if their medication card was left unattended in public view because it had resident identifiers. The DON stated the nurse should have kept the card with them or shredded the information if not needed. During a review of the facility's policy and procedure (P&P) titled, Privacy and Dignity, dated 10/1/2023, the P&P indicated, To ensure that care and services provided by the Facility promote and/or enhance privacy, dignity and overall quality of life. The P&P indicated, Resident rights to privacy and confidentiality of medical information and the clinical record is outlined in HP-01-Form A-Notice of Privacy Practices.

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure one of five sampled residents (Resident 106) was free from physical restraint by placing an abdominal binder (a wide, stretchy belt that wraps around the stomach area) on the resident without an order, informed consent from the family member, or an assessment indicating the need for the abdominal binder. These deficient practices had the potential to result in injury and inhibit the residents' freedom of movement or activity. Findings: During a review of Resident 106's admission Record, the admission Record indicated Resident 106 was admitted to the facility on [DATE] with diagnoses including down syndrome (congenital condition characterized by a distinctive pattern of physical characteristics including a flattened skull, pronounced folds of skin in the inner corners of the eyes, large tongue, and short stature, and by some degree of limitation of intellectual ability and social and practical skills), depression (mood disorder that causes persistent feeling of sadness and loss of interest), and unspecified psychosis (a severe mental condition in which thought, and emotions are so affected that contact is lost with reality). During a review of Resident 106's history and physical (H&P) dated 2/15/2026, the H&P indicated Resident 106 did not have the capacity to understand and make decisions. During a review of Resident 106's Minimum Data Set (MDS, a resident assessment tool), dated 2/20/2026, the MDS indicated Resident 106 had severe cognitive impairment. The MDS indicated Resident 106 was dependent on all aspects of activities of daily living (ADL, basic activities such as eating, dressing, toileting, shower transfer, chair/bed-to-chair transfer), and required substantial assistance (helper does more than half the effort) to roll left and right, sit to lying, and lying to sitting on side of bed. The MDS indicated Resident 106 had impairments on both sides of the lower extremity (hips/legs) During a concurrent observation, interview, and record review on 2/17/2026 at 11:43 a.m., with Licensed Vocational Nurse 6 (LVN 6), LVN 6 stated Resident 106 had an abdominal binder. LVN 6 stated there was no physician's order for Resident 6's abdominal binder. LVN 6 stated Resident 106 should not have an abdominal binder on without a physician's order. LVN 6 stated Resident 106 had tried to remove her gastrostomy tube (g-tube: a surgical opening fitted with a device to allow feedings to be administered directly to the stomach common for people with swallowing problems), but indicated she has not had any episodes of trying to remove her g-tube and does not need an abdominal binder. During an interview on 2/18/2026 at 10:54 a.m., with Licensed Vocational Nurse 4 (LVN 4), LVN 4 stated a physician's order for an abdominal binder is needed as anything provided to the resident requires a physician's order. LVN 4 stated if there are no abdominal binder orders for Resident 106, it was not acceptable to put the abdominal binder on the resident as they do not know how it will affect the resident if an abdominal binder is placed on the resident without an order. During an interview on 2/19/2026 at 3:32 p.m., with the Director of Nursing (DON), the DON stated a restraint is a device that limits the freedom of movement and indicated an abdominal binder that is used to prevent a resident from pulling on the g-tube would restrict the movement of the upper extremities is considered a restraint and would require an order and an informed consent. The DON stated an order is needed to know what the abdominal binder is used for and an informed consent is obtained by the doctor from the residents' representative to verify if they are aware of the use, the risks and benefits of the abdominal binder. The DON stated if the resident came from the hospital with an abdominal binder, they would have to verify the order with the doctor, inform the family of the device, and based on assessment (observe movement, remove binder to check skin integrity) would enter the order if indicated. The DON stated a resident should not have an abdominal binder on without a physician's order and placing an abdominal binder without an order may make the resident uncomfortable may cause complications if it is not indicated. During a review of the facility's policy and procedure (P&P) titled, Restraints/Seclusions, date revised 7/24/2025, the P&P indicated (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	informed consent will be obtained from the resident or responsible party if a restraint will be used during a treatment or diagnostic procedures. Before any type of restraint is used, the Licensed Nurse will verify that informed consent has been obtained from the resident/responsible party and that the resident/responsible party was educated regarding the risks and benefits of restraint use. During a review of the facility's P&P titled, Informed Consents, dated 4/1/2024, the P&P indicated the Attending Physician/LHP will then obtain an informed consent from the resident or authorized representative before administration of a therapy of procedure that requires an informed consent. The use of an informed consent will be done for but not limited to the following: Physical Restraints. Physical Restraint means any physical or mechanical device or material attached or adjacent to a resident's body that the resident cannot remove easily, which has the effect of restricting the resident's freedom of movement. An informed consent is required but not limited to physical restraints. The informed consent must be signed by the resident or the resident's representative and the physician/LHP who provided the material information. The Facility verifies that informed consent was obtained prior to the administration of a medical intervention or change in medical intervention that requires informed consent.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure one of seven sampled residents (Resident 3) who had communication difficulties was provided access to a communication aid (tool designed to assist persons with speech and language difficulties in expressing their needs and understanding to others) and/or alternative communication strategies to facilitate communication with residents and staff.This deficient practice had the potential to prevent Resident 3 from communicating his needs, resulting in frustration, isolation, and delay in care. Findings: During a review of Resident 3's admission Record, the admission Record indicated Resident 3 was initially admitted to the facility on [DATE] and re-admitted on [DATE] with diagnoses including dysarthria (motor speech disorder in which the muscles used to produce speech are da.m.aged or weak), anarthria (total loss of the ability to articulate speech), and cerebral palsy (group of neurological disorders that affect a person's ability to move and maintain balance and posture).During a review of Resident 3's Minimum Data Set (MDS, a resident assessment tool), dated 12/11/2025, the MDS indicated Resident 3 was cognitively (mental action or process of acquiring knowledge and understanding) intact and had unclear speech.During an observation on 2/17/2026 at 10:14 a.m., in Resident 3's room, Resident 3 was lying in bed. Resident 3's speech was initially slow and slurred and became rapid and increasingly difficult to understand as Resident 3 continued to speak. Certified Nursing Aide 7 (CNA 7) walked into the room to assist with removing the blankets from Resident 3's both legs. Resident 3 looked at CNA 7 and spoke several phrases to CNA 7. CNA 7 looked at Resident 3 and shrugged his shoulders. CNA 7 stated it was difficult to understand what Resident 3 wanted and needed because Resident 3 had unclear speech. CNA 7 stated he thought Resident 3 could benefit from a communication board (tool with pictures, symbols, letters, or words that individuals with limited speech can point to, gesture at, or gaze at to express needs, feelings, and choices) to assist with communicating his needs but could not find one in Resident 3's room. During an interview on 2/18/2026 at 4:12 p.m., with Speech Therapist 1 (ST 1), ST 1 stated she recently evaluated Resident 3 and stated Resident 3 had unclear speech and difficulty communicating. ST 1 stated the Activities Department or Social Services Department were responsible for evaluating and providing communication boards as needed for residents identified as having communication difficulties upon admission to the facility. ST 1 stated she did not know if Resident 3 was offered or issued a communication aid such as a communication board upon admission as she did not see one at the bedside. ST 1 stated Resident 3 needed alterative communication strategies to effectively communicate his needs and wants such as a communication board, simple yes or no questions, cueing to slow down speech when talking, and asking questions with few word choices and was unsure if staff were aware. ST 1 stated it was important for residents to be able to effectively communicate to ensure they could get their needs met. During an interview on 2/20/2026 at 3:01 p.m., with the Activities Director (AD), the AD stated the Social Services Department was responsible for evaluating and providing communication boards as needed for residents identified as having communication difficulties upon admission to the facility. The AD stated Resident 3 had unclear speech and difficulty communicating with staff. The AD stated she was able to understand what Resident 3 was trying to communicate about 60 percent of the time. The AD stated Resident 3 could benefit from a communication board to improve communication, but it was never provided by the facility. During an interview on 2/20/2026 at 3:05 p.m., with the Social Service Director (SSD), the SSD stated the Social Services Department was responsible for evaluating and providing communication boards as needed for residents identified as having communication difficulties upon admission to the facility. The SSD stated Resident 3 had unclear speech and difficulty communicating. The SSD stated she evaluated Resident 3 upon re-admission to the facility on 2/16/2026, identified him as having (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	communication difficulties, recommended a communication board, but did not issue the communication board until a couple days later. The SSD stated she should have issued the communication board at the time of admission to ensure Resident 3 was able to communicate his needs with staff. The SSD stated staff must evaluate residents and provide communication aids to ensure residents can effectively communicate and have their needs met. During an interview on 2/20/2026 at 4:36 p.m., with the Director of Nursing (DON), the DON stated Social Services was responsible for assessing a resident's communication and issuing communication aids such as communication boards as needed upon admission to the facility. The DON stated residents who had communication difficulties should be assessed and issued communication aids as soon as possible to facilitate communication with staff to get their needs met and prevent any delays in care. During a review of the facility's Policy and Procedure (P/P) titled, Communication Barriers, dated 10/1/2023, the P/P indicated the purpose of the P/P was to facility communication and ensure equal opportunity to services and activities for residents with hearing and speech disabilities. The P/P indicated when a resident was identified as a person with a disability that affected the ability to communicate or to access or manipulate written materials, or requests an auxiliary aid or other service, the facility staff would collaborate with the resident to determine what aids or services were necessary to provide effective communication.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the G-tube feeding (a way of providing essential nutrients, fluids, and medications when a person cannot eat or drink by mouth) formula was labeled with a start date and time for one of three sampled residents (Resident 72).This failure had the potential to place the resident at risk of receiving expired tube formula, which could compromise nutritional status, increase the likelihood of illness or infection, and result in avoidable adverse outcomes. Findings:During a review of Resident 72's admission Record (Face Sheet), the admission Record indicated the facility admitted the resident on 4/28/2024 and was re-admitted on [DATE] with diagnoses including dysphagia (difficulty swallowing or moving food and drinks from mouth to throat), gastrostomy (medical procedure that creates a small opening through the skin of the belly directly into the stomach), and dementia (brain disease affecting memory, thinking abilities, and ability to do daily tasks).During a review of Resident 72's Minimum Data Set (MDS- a resident assessment tool) dated 2/4/2026, the MDS indicated Resident 72's ability to make decisions regarding tasks of daily life was severely impaired. The MDS indicated the resident was dependent (resident does no effort to complete task) on staff for oral hygiene, toileting, showering, dressing, personal hygiene, and putting on/off footwear.During an observation on 2/17/2026 at 10:46 a.m. in Resident 72's room, Resident 72 was lying in bed with eyes closed, Diabetic Source tube feeding was infusing at 50 milliliters per hour (mL/hr- a metric unit of rate) and the feeding pump showed 970 mL was delivered. The feeding container label did not indicate a start date and time. During a review of Resident 72's Care Plan Report revised 7/4/2025, the care plan report indicated the resident required tube feeding, to maintain adequate nutritional and hydration status.During a review of Resident 72's physician order dated 1/6/2026, the physician order indicated Enteral nutrition [tube feeding] via Pump-Diabetic Source 1.2 (type of feeding formula) at 50 mL per hour for 20 hours via feeding pump to provide 1000 mL.Start infusion at 2:00 p.m. and continue until complete.During a concurrent observation and interview on 2/17/2026 at 3:30 p.m. with Licensed Vocational Nurse (LVN) 1, in Resident 72's room, LVN 1 stated Resident 72's tube feeding was running at 50 mL/hr. LVN 1 stated she started tube feeding at 2:00 p.m. LVN 1 stated the tube feeding bag label did not have a start date and time. LVN 1 stated the tube feeding label should have included the resident's full name, room, date/time started, and rate of formula, LVN 1 stated this helped make sure the resident received the appropriate amount of formula.During a concurrent interview and record review on 2/20/2026 at 2:15 p.m. with Director of Nursing (DON), the manufacturer's Directions for Use for Diabetic Source 1.2 were reviewed. The DON stated the directions indicated the feeding was to be used for a maximum of 48 hours after connection. The DON stated the feeding container label should have included the start date and time. The DON stated the feeding was no longer usable after 48 hours, and if the feeding was not properly labeled, the staff would not have known when to change the feeding bag, placing the resident at risk for receiving expired formula that could have led to adverse reactions and inadequate nutrition.During a review of the facility's policy and procedure (P&P) titled, Enteral Feeding-Safety Precautions, revised November 2018, the P&P indicated, On the formula label document initials, date and time the formula was hung, and initial that the label was checked against order.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure one of three sampled residents (Resident 37) received respiratory care as ordered by the physician when:a. The resident did not receive the prescribed oxygen concentration (the percentage of oxygen delivered through an oxygen device) as ordered by the physician.b. The resident's oxygen humidifier bottle (container filled with water that adds moisture to the dry oxygen before it is breathed in) was not changed in accordance with the physician's order and facility policy.This failure had the potential to place the resident at risk of harm, including complications related to receiving oxygen at a higher flow rate than ordered and adverse effects associated with the use of an outdated humidifier bottle.Findings:During a review of Resident 37's admission Record (Face Sheet), the admission Record indicated the facility admitted the resident on 4/28/2025 and was re-admitted on [DATE] with diagnoses including chronic obstructive pulmonary disease (COPD- lung diseases that make breathing difficult).During a review of Resident 37's physician's order, dated 9/19/2025, the physician's order indicated Change o2 [oxygen] / Nebulizer [machine that turns liquid into mist] tubing, humidification bottle, and clean filter every week every night shift every Fri [Friday].During a review of Resident 37's Care Plan Report, dated 2/14/2026, the care plan report indicated the resident had shortness of breath and was started on 2 liters per minute (L/min- unit of measurement describing flow rate), of oxygen.During an observation on 2/17/2026 at 11:51 a.m. in Resident 37's room, Resident 37's was receiving oxygen via nasal cannula (small plastic tube that delivers oxygen into the nose) at 3.5 L/min with a humidifier bottle attached to the oxygen machine that was dated 11/29/2025.During a concurrent observation and interview on 2/17/2026 at 12:30 p.m. with Licensed Vocational Nurse (LVN) 1 in Resident 37's room, LVN 1 stated the resident was receiving oxygen at 3.5 L/min and the humidifier in use was dated 11/29/2025. LVN 1 stated the resident was started on oxygen two days prior to this observation, and stated she was unsure why the humidifier was dated 11/29/2025. LVN 1 stated that humidifier containers and nasal cannula tubing were changed every Friday by night shift. LVN 1 stated that using an outdated or inappropriate humidifier could cause the resident to have dry nose, dry mouth, and possible bleeding.During a concurrent interview and record review on 2/18/2026 at 3:30 p.m. with LVN 1, Resident 37's physician's order, dated 2/14/2026 was reviewed. LVN 1 stated the order indicated the resident was to receive oxygen at 2 L/min via nasal cannula. LVN 1 stated she did not verify how many liters of oxygen the resident was receiving the day prior (2/17/2026) and she did not check the humidifier bottle. LVN 1 stated she should have checked the oxygen flow rate and humidifier because the resident has COPD and could be placed at risk for harm if given too much oxygen.During an interview on 2/20/2026 at 2:15 p.m. with Director of Nursing (DON), the DON stated that oxygen administration should reflect the physician's orders. The DON stated the residents were placed at risk for respiratory distress if given an inadequate amount of oxygen, as this affected the resident's breathing reservoir. The DON stated the humidifier containers were changed every Friday by the night shift staff. The DON stated that not changing the humidifier bottles as ordered could have resulted in the growth of bacteria and placed the residents at risk for contamination and infection.During a review of the facility's policy and procedure (P&P) titled Oxygen Administration, dated 10/1/2023, the P&P indicated, All oxygen tubing, humidifiers, masks, and cannulas used to deliver oxygen:.Will be changed weekly and when visibly soiled.Check physician's order.

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observe each nurse aide's job performance and give regular training. Based on interview and record review, the facility failed to ensure one of two Certified Nurse Assistants (Restorative Nurse Assistant 1 [RNA 1]) had an annual performance evaluation (process organizations follow to assess an employee's work quality and skills over a specific period) from 2022 to 2025.This failure had the potential to result in the provision of inadequate care and services to residents to help them attain highest practicable physical, mental, and psychosocial well-being. Findings:During a concurrent interview and record review on 2/20/2026 at 8:30 a.m., with the Director of Staff Development (DSD), RNA 1's personnel files were reviewed and there was no documented evidence of a CNA performance evaluation/ skills competency for 2025. The DSD stated the last CNA performance evaluation for RNA 1 was in 2021.During an interview on 2/20/2026 at 5:10 p.m., the Director of Nursing (DON) stated performance evaluations were important to ensure staff was competent.During a review of the facility's policy and procedures (P&P) titled, Competency Evaluation, dated 7/2019, the P&P indicated the facility will evaluate all employees performance competencies annually. The P&P indicated the review will include the most common procedures performed in the facility.During a review of the Facility Assessment Tool, reviewed 4/9/2025, the tool indicated staff training and education will be provided at least monthly and on as needed basis. Competency and performance evaluations were completed at least annually.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to:1. Ensure one of two inspected medication carts (Station 2 Medication Cart) maintained accurate documentation of Resident 74's hydrocodone-acetaminophen (a controlled medication [medications that the use and possession of are controlled by the federal government] in combination with acetaminophen [APAP - a medication used to treat pain] used to treat severe pain) on accountability record or controlled medication count sheet/controlled drug record ([CDR] - a document indicating perpetual inventory and administration of controlled substances after the hydrocodone-APAP was administered, as per facility's policy and procedure (P&P) titled, Controlled Medications, dated 10/1/2023.2. Ensure that the discarded medications in two of two inspected medication carts (Station 2 Medication Cart and Station 3 Medication Cart) were stored in a closed-lid container and/or disposed of in an irretrievable, safe and secure manner.These deficient practices failed to destroy the unidentifiable discarded medications and maintain accurate documentation of administered controlled medications for Resident 74, and had the potential risk for medication errors, medication misuse, accidental exposure and diversion of medications.1. During a review of Resident 74's admission Record dated 2/19/2026, the admission record indicated Resident 74 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included but not limited to Type 2 Diabetes Mellitus (DM - a disorder characterized by difficulty in blood sugar control and poor wound healing) and end stage renal disease (chronic kidney disease which is a permanent failure of kidney function).During a review of Resident 74's History and Physical (H&P), dated 10/6/2025, the history and physical indicated Resident 74 had fluctuating capacity to understand and make decisions. During a review of Resident 74's Minimum Data Set (MDS - a resident assessment tool), dated 1/2/2026, the MDS indicated Resident 74's cognition (mental action or process of acquiring knowledge and understanding through thought and the senses) was intact. The MDS indicated Resident 74 was independent in performing activities of daily living (ADLs - routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves) such as eating, needed maximal assistance from the facility staff for putting on/taking off footwear, moderate assistance for toileting hygiene, showering and lower body dressing, supervision assistance for upper body dressing, and needed setup or clean-up assistance from the facility staff for oral hygiene and personal hygiene. During a review of Resident 74's Order Summary Report (a document containing a summary of all active physician orders), dated 2/19/2026, the document indicated but not limited to the following physician order: Pain monitoring using verbal/non-verbal 0-10 Scale, 0 = no pain, 1-3 = mild pain, 4-6 = moderate pain, 7-10 = severe pain, every shift for monitoring level of comfort, order date 2/9/2026, start date 2/9/2026. Hydrocodone-Acetaminophen Oral Tablet 5-325 milligrams ([mg] metric unit of measurement, used for medication dosage and/or amount), give 1 tablet by mouth every 6 hours as needed for severe pain, order date 1/8/2026, start date 1/8/2026. During a concurrent inspection, interview and record review on 2/19/2026 at 1:22 p.m., with Licensed Vocational Nurse (LVN) 5 of Station 2 Medication Cart, Resident 74's hydrocodone-acetaminophen bubble pack (sealed card containing individual, daily, or weekly doses of medication in clear, push-through plastic bubbles), facility's controlled medication count sheet (CDR) and the medication administration details in electronic medical record (eMAR) for hydrocodone-APAP 5-325 mg were reviewed. Resident 74's hydrocodone-APAP 5-325 mg bubble pack contained 24 tablets. The facility's CDR indicated a quantity of 25 tablets remaining with the last dose administered on 2/9/2026 at 9:10 a.m., The administration details in eMAR indicated the last dose of one tablet was documented as administered on 2/19/2026 at 10:39 a.m., LVN 5 stated she (LVN 5) should have documented the hydrocodone-APAP in the controlled drug record book as administered right after she administered the medication. LVN 5 stated it was always important that the quantities (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	on controlled drug record log and medication card matched and accounted for the administered doses of controlled medications to prevent the risk for misuse, addiction and accidental exposure to controlled medications.During an interview on 2/20/2026 at 3:46 p.m., with the Director of Nursing (DON), the DON stated the licensed nursing nurse should have signed the controlled drug record after it (hydrocodone-APAP) was removed from the bubble pack and should have signed the eMAR after hydrocodone-APAP was administered. The DON stated if the medication was not documented after it was administered, it could mislead the incoming nurse, cause misinterpretation of the record, and increase the risk of medication errors and misuse of controlled medications. During a review of the facility's P&P titled, Controlled Medications, dated 10/1/2023, the P&P indicated, The facility complies with all laws, regulations and other requirements related to handling, storage, disposal, and documentation of controlled medications. The P&P indicated, Upon Administration: A. The nurse administering the medication is responsible for recording: i. name of the resident receiving the medication; ii. name, strength and dose of the medication; iii. time of administration; iv. method of administration; v. quantity of the medication remaining; and vi. signature of nurse administering medication. 2a. During a concurrent observation and interview on 2/19/2026 at 1:22 p.m., with LVN 5, of Station 2 Medication Cart, the medication cart contained one red container filled with several tablets and capsules with an open lid in the bottom drawer such that the medications were retrievable. LVN 5 stated the red biohazard container should have been emptied or sealed. LVN 5 stated there was a risk that residents could remove medications from the red bin if the medication cart was not locked. LVN 5 stated there was an increased the risk for misuse or unintended exposure to medications for the facility staff because of the open/unsealed red bin. 2b. During a concurrent observation and interview on 2/19/2026 at 2:26 p.m., with LVN 4, of Station 3 Medication Cart, the medication cart contained one red container filled with several tablets and capsules with an open lid in the bottom drawer such that the medications were retrievable. LVN 4 stated there was a risk that someone could grab the bin or the tablets from the medication cart and result in an unintended exposure.During an interview on 2/20/2026 at 3:46 p.m., with the DON, the DON stated ?loose' tablets and capsules should have been discarded in a manner that made them irretrievable to prevent any risk of misuse. During a review of the facility's P&P titled, Destruction of Medications, dated 10/1/2023, the P&P indicated, The facility to be able to destroy controlled and non-controlled medications in accordance with stated and federal laws. The P&P indicated, Non-controlled medications and Schedule V (non-hazardous) controlled substances will be disposed of in accordance with state regulations and federal guidelines regarding disposition of non-hazardous medications. The P&P indicated, For unused, non-hazardous medications-controlled substances that are not disposed of by an authorized collector, the EPA recommends destruction and disposal.following the steps below: A. Take the medication out of the original containers. B. Mix medication, either liquid or solid with an undesirable substance. Undesirable substances include sand, coffee grounds, kitty litter, or other absorbent materials. Place the waste.to prevent leakage. C. Dispose with the.two witnesses. D. Document the disposal on the medication disposition record. E. Include the signature(s) of at least two witnesses.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to follow the consultant pharmacist's (a professional responsible for reviewing each resident's medication profile monthly to identify and report changes) recommendation for one of five residents reviewed for unnecessary medications, dated 1/12/2026 to consider an alternative option to Resident 3's tramadol (a controlled medication [medications that the use and possession of are controlled by the federal government] used to treat moderate to severe pain) for pain management and to discontinue tramadol because tramadol could lower Resident 3's seizure (a sudden, uncontrolled electrical disturbance in the brain which can cause uncontrolled jerking, blank stares, and loss of consciousness) threshold.This deficient practice of failing to respond to recommendations from the consultant pharmacist placed Resident 3 at an increased risk of seizures, falls and hospitalization.Findings: During a review of Resident 3's admission Record (a document containing demographic and diagnostic information) dated 2/20/2026, the admission record indicated Resident 3 was originally admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included but not limited to epilepsy, unspecified, not intractable, without status epilepticus (general seizure disorder that responds to treatment and does not involve continuous seizing) spastic quadriplegic cerebral palsy (severe form of cerebral palsy, characterized by extreme muscle stiffness [spasticity] in all four limbs, the trunk, and the face due to brain injury) and bell's palsy (temporary, sudden-onset paralysis or weakness of muscles on one side of the face caused by inflammation of the 7th cranial nerve, likely due to viral infection). During a review of Resident 3's History & Physical (H&P) dated 2/17/2026, the H&P indicated Resident 3 had capacity to understand and make decisions.During a review of Resident 3's Minimum Data Set (MDS - a resident assessment tool), dated 12/11/2025, the MDS indicated Resident 3's cognition (mental action or process of acquiring knowledge and understanding through thought and the senses) was intact. The MDS indicated Resident 3 needed supervision or touching assistance from the facility staff for performing activities of daily living (ADLs - routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves) such as eating, maximal assistance for oral hygiene, upper and lower body dressing, putting on/taking off footwear and personal hygiene, and was dependent on facility staff for toileting hygiene and showering.During a review of Medication Regimen Review (MRR - a monthly evaluation of the medication regimen of a resident, with the goal of promoting positive outcomes and minimizing adverse consequences associated with medication), dated 1/12/2026, the review indicated the consultant pharmacist recommended to consider an alternative option to tramadol for pain management. The consultant pharmacist indicated, Resident 3 has order for Ultram (generic name - tramadol) as needed (PRN) with a diagnosis of seizure disorder. Please note that Ultram has the potential to lower seizure threshold. Please evaluate if an alternative analgesic to Ultram is warranted. The physician response indicated, Agree and D/C (discontinue). During a review of Resident 3's Order Summary Report (a document containing a summary of all active physician orders) dated 2/18/2026 and 2/20/2026, the order summary report indicated but not limited to the following physician orders: Tramadol hydrochloride (HCl) oral tablet 50 milligrams ([mg]- metric unit of measurement, used for medication dosage and/or amount), give 1 tablet by mouth every 8 hours as needed for severe pain 7-10 document NPI: 1- Reposition, 2-Relaxation Techniques 3-Hot/Cold applications/massage, 4-Other document result of NPI: E-effective, N-non-effective, order date 2/16/2026, start date 2/16/2026. Phenytoin (a medication used to treat seizures) oral tablet chewable 50 mg, give 3 tablets by mouth two times a day for seizure disorder take with 50 mg chewable, 3 tablets = 150 mg, order date 2/16/2026, start date 2/17/2026. Valproic acid (a medication used to treat seizures) oral solution 250 mg / 5 milliliters ([mL] a unit of measurement for volume), give 10 ml by mouth two times a day for seizure disorder, order date (continued on next page)

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	056425	A. Building B. Wing	02/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Studebaker Healthcare Center	13226 Studebaker Rd Norwalk, CA 90650

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2/16/2026, start date 2/17/2026. During a concurrent interview and record review on 2/20/2026 at 11:00 a.m., with Licensed Vocational Nurse (LVN) 6, Resident 3's tramadol bubble packs (sealed card containing individual, daily, or weekly doses of medication in clear, push-through plastic bubbles), dated 10/2/2025 and 11/12/2025 and current physician orders were reviewed. Resident 3's tramadol bubble pack dated 10/2/2025 indicated, tramadol hydrochloride (HCl) 50 mg tablet, take 1 tablet by mouth every 8 hours as needed x severe with a quantity of five tablets remaining in the bubble pack. Resident 3's tramadol bubble pack dated 11/12/2025 indicated, tramadol hydrochloride (HCl) 50 mg tablet, take 1 tablet by mouth every 8 hours as needed x severe with a quantity of 30 tablets remaining in the bubble pack. LVN 6 stated there was a physician order to administer tramadol 50 mg to Resident 3 if needed for severe pain. LVN 6 stated Resident 3 had seizure order and was being treated with phenytoin. LVN 6 stated she could not find consultant pharmacist notes regarding tramadol use and was not aware of any changes or discontinuation of Resident 3's tramadol. During a concurrent interview and record review on 2/20/2026 at 4:04 p.m., with the Director of Nursing (DON), the MRR document dated 1/12/2026 for Resident 3 was reviewed. The DON stated once the consultant pharmacist had reviewed the medication regimen, the pharmacist would the DON and facility nurses, after which the DON and/or the facility's nursing staff would inform the physician regarding the recommended changes. DON stated the MRR indicated the physician agreed with discontinuation of Resident 3's tramadol but it looks like the nurse wrote on the bottom ?hosp' which meant Resident 3 was at the hospital during that time. The DON stated Resident 3's tramadol should have been discontinued when he (Resident 3) returned to the facility. DON stated Resident 3 was placed at risk for seizure complications. During a review of the facility's policy and procedure (P&P) titled Pharmacy Consultant Monthly Report, dated 12/2023, the P&P indicated, To set forth procedures related to the pharmacy consultant monthly report. The P&P indicated, Physicians may respond to pharmacy clinical recommendations in the following manner: a. Agree, b. Disagree, c. Other with space to provide reasoning. Responses to clinical recommendations must be made within 14 days and noted in the patient's chart.During a review of the facility's P&P titled, Psychotherapeutic Drug Management, dated 5/19/2025, the P&P indicated, The Facility supports the goal of determining the underlying cause of behavioral symptoms so the appropriate treatment of .individual resident. The Facility will make every effort to comply with state and federal.to include regular review for continued need, appropriate dosage, side effects, risks and/or benefits.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to prevent a significant medication error for one out of five (Resident 95) sampled residents during medication administration, by failing to clarify hold parameters for Resident 95's carvedilol (a medication used to treat high blood pressure) with a physician before deciding whether to administer or hold the medication.This deficient practice failed to ensure Resident 95's carvedilol was administered in accordance with physician's orders or professional standards of practice and had the potential to result in high blood pressure and/or low blood pressure, cardiovascular complications and hospitalization.Findings:(Cross-reference with F759)During a review of Resident 95's admission Record dated 2/18/2026, the admission record indicated Resident 95 was admitted to the facility on [DATE] with diagnoses that included but not limited to chronic systolic (congestive) heart failure (CHF - a heart disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling), unspecified atrial fibrillation (a heart condition characterized by a rapid, chaotic, and irregular beating of the heart's upper chambers [atria]), personal history of transient ischemic attack (TIA - a brief episode of neurological dysfunction resulting from an interruption in the blood supply to the brain or the eye sometimes as a precursor of a stroke [CVA-stroke, loss of blood flow to a part of the brain]) and cerebral infarction (a type of ischemic stroke caused by a blockage in brain blood vessels, resulting in tissue necrosis [death] due to lack of oxygen) without residual deficits, hypotension and essential (primary) hypertension.During a review of Resident 95's History and Physical (H&P), dated 5/15/2025, the H&P indicated Resident 95 had fluctuating capacity to understand and make decisions.During a review of Resident 95's Minimum Data Set (MDS - a resident assessment tool), dated 11/18/2025, the MDS indicated Resident 95's cognition (mental action or process of acquiring knowledge and understanding through thought and the senses) was severely impaired. The MDS indicated Resident 95 needed moderate assistance from the facility staff for performing activities of daily living (ADLs - routine tasks/activities such as bathing, dressing and toileting a person performs daily to care for themselves) such as upper and lower body dressing and personal hygiene, needed supervision or touching assistance for showering and putting on/taking off footwear, needed setup or clean-up assistance for oral hygiene and toileting hygiene, and Resident 95 was independent in performing ADL of eating. During a concurrent observation and interview on 2/18/2026 at 8:26 a.m., with Licensed Vocational Nurse (LVN) 2, LVN 2 prepared and administered seven medications to Resident 95. LVN 2 stated she (LVN 2) checked Resident 95's blood pressure on 2/18/2026 at 8:22 a.m., and Resident 95's blood pressure reading was 106/83 (systolic blood pressure [SBP - measures the pressure in the arteries when the heart contracts to pump blood] at 106) and (diastolic blood pressure [DBP - measures the pressure in the arteries when the heart muscle relaxes between beats] at 83 and heart rate (HR) was at 74 beats per minute. During a concurrent interview and record review on 2/18/2026 at 8:26 a.m., with LVN 2, the pharmacy label on morning medication bubble pack (sealed card containing individual, daily, or weekly doses of medication in clear, push-through plastic bubbles) for Resident 95's carvedilol 3.125 mg was reviewed. The pharmacy label dated 1/12/2026 indicated, carvedilol 3.125 milligrams ([mg] metric unit of measurement, used for medication dosage and/or amount), give one tablet orally two times a day for hypertension, hold if SBP is less than 110, HR is less than 60. LVN 2 stated she needed to hold Resident 95's carvedilol 3.125 mg because Resident 95's SBP was 106 and the hold parameters on the pharmacy label indicated to hold carvedilol if SBP was less than 110.During a subsequent observation on 2/18/2026 at 8:26 a.m., LVN 2 prepared seven medications but did not include or administer carvedilol 3.125 mg to Resident 95. During a medication reconciliation review on 2/18/2026, Resident 95's Order Summary Report (a document containing a summary of all active physician orders), dated 2/18/2026 was reviewed. The order summary report indicated, but not limited to the following physician orders: Carvedilol oral tablet 3.125 mg, give 1 (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	tablet by mouth orally two times a day for hypertension, hold if SBP is less than 100, or Pulse is less than 60, order date 2/4/2026, start date 2/5/2026. During a review of Resident 95's Medication Administration Record (MAR - a daily documentation record used by a licensed nurse to document medications and treatments given to a resident) dated 2/1/2026 to 2/18/2026, the MAR indicated two entries for carvedilol 3.125 mg administration documentation. The MAR dated 2/18/2026 at 9:00 a.m. indicated: Carvedilol oral tablet 3.125 mg, give 1 tablet orally two times a day for hypertension, hold if SBP is less than 100, or Pulse is less than 60, start date 2/5/2026 0900, BP of 106/83 and Pulse at 74 with 4 for 0900 administration which was indicated as vitals outside of parameters for administration. Carvedilol oral tablet 3.125 mg, give 1 tablet orally two times a day for hypertension, hold if SBP is less than 110 or Pulse is less than 60, start date- 1/15/2026 0900, discontinue (D/C) date- 2/4/2026 2322 (11:22 p.m.). This entry was documented from 2/1/2026 to 2/4/2026. During a concurrent interview and record review on 2/18/2026 at 2:20 p.m., with LVN 2, the pharmacy label on medication bubble pack for Resident 95's carvedilol 3.125 mg and physician order on electronic medical record were reviewed. LVN 2 stated the pharmacy label instructed to hold carvedilol 3.125 mg when Resident 95's SBP was less than 110, but the physician order instructed to hold carvedilol 3.125 mg when Resident 95's SBP was less than 100. LVN 2 stated she (LVN 2) would need to call the physician to clarify carvedilol's hold parameters for blood pressure readings and subsequently inform pharmacy. LVN 2 stated Resident 95's carvedilol 3.125 mg should have been administered, as per physician's order in electronic medical record but according to the pharmacy label, carvedilol was held and not administered to Resident 95. LVN 2 stated there was a risk of mismanagement of high and low blood pressure for Resident 95. LVN 2 stated this mismanagement placed Resident 95 at risk for either hypertension or hypotension, which increased the potential risk for stroke and hospitalization due to hypertension, and dizziness and falls due to hypotension. During an interview on 2/20/2026 at 4:04 p.m., with the Director of Nursing (DON), the DON stated carvedilol's hold parameters for blood pressure readings should be the same on the pharmacy label and the physician order. DON stated if there was a change in the order after doctor assessed the resident, it was the facility nurses' responsibility to put a sticker and indicate change in directions and inform pharmacy so that they could send a new pharmacy label. DON stated there was a risk of high blood pressure, leading to headaches, dizziness and hypertensive crisis when the resident did not receive carvedilol based on an updated physician order. During a review of the facility's policy and procedure (P&P) titled Medication - Administration, dated 10/1/2023, the P&P indicated, To provide practice standards for safe administration of medications for residents in the Facility. The P&P indicated, Medication will be administered by a Licensed Nurse per the order of an Attending Physician or licensed independent practitioner.The licensed nurse must know the following information about any medication they are administering: G. Any precautions and special considerations. The P&P indicated, If the Attending Physician increases or changes a medication order, this is an automatic stop or discontinue order for the original order. The P&P indicated, Nursing staff will keep in mind the seven rights of medication when administering medication: A. The right medication, B. The right amount. Additional considerations include: C. The Rule of 3: the Licensed Nurse administering medications will perform 3 checks comparing the physician's order, pharmacy label, and Medication Administration Record (MAR). The P&P indicated, The resident's MAR will be reviewed for allergies and.including: A. Manufacturer's specifications (not recommendations) regarding the preparation and administration of the drug or biological. B. Accepted professional standards and principles. C. Vital sign parameters and lab results as appropriate. The P&P indicated, VIII. Compare the Licensed Practitioner's prescription/order with the MAR (first check). IX. Compare the licensed practitioner's order with the pharmacy label on the medication package (second check). X. Compare the pharmacy label and MAR (third check). XI. Any discrepancies identified during the first, second, and/or third check must be resolved prior to the administration of any medication.

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F 0773 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain laboratory tests/services when ordered and promptly tell the ordering practitioner of the results. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to notify the physician of abnormal lab values on 12/16/2025 for one of three sampled residents (Resident 101).This had the potential to result in delayed care or interventions for Resident 101.Findings: During a review of Resident 101's admission Record, the admission Record indicated Resident 101 was admitted to the facility on [DATE] with diagnoses including atrial fibrillation (an irregular, rapid heart rate that may cause symptoms like heart palpitations), severe protein-calorie malnutrition, and dysphagia (difficulty swallowing). During a review of Resident 101's Minimum Data Set (MDS - a resident assessment tool), dated 11/1/2025, the MDS indicated Resident 101 had severe cognitive (ability to learn, reason, remember, understand, and make decisions) impairment, required supervision when eating, required moderate assistance (helper does less than half the effort) for oral hygiene, and was dependent (helper does all the effort) for toileting hygiene, bathing, and lower body dressing. During a record review of Resident 101's physician orders dated 12/13/2025, the physician orders indicated an order for laboratory to draw Complete Blood Count (CBC - blood test to detect anemia or infection), Basic Metabolic Panel (BMP - test measuring electrolytes and kidney markers used to evaluate fluid balance and organ function), and Liver Function Tests (LFT - measures liver health) on 12/13/2025. During a concurrent interview and record review on 2/19/2026 at 2:05 p.m. with Registered Nurse Supervisor (RNS) 1, Resident 101's 12/16/2025 lab values and Change of Condition (COC) documentation on 12/16/2025 were reviewed. RNS 1 stated Resident 101's potassium level was low at 2.9 millimole per Liter (mmol/L - a unit of measurement; normal range is 3.5-5.1 mmol/L), Blood Urea Nitrogen level (BUN - lab test to evaluate kidney function and hydration status) was high at 33 milligrams per deciliter (mg/dL - a unit of measurement; normal range is 7-25 mg/dL), and albumin level (lab test to evaluate liver/kidney function or nutritional status) was low at 2.9 grams per deciliter (g/dL - a unit of measurement; normal range 3.7-5.3 g/dL). RNS 1 stated all abnormal lab values should be reported to the physician and documented in the COC documentation. RNS 1 stated the COC documentation dated 12/16/2025 indicated only the potassium level was reported to the physician and the other lab results were not.During an interview on 2/20/2026 at 2:20 p.m. with the Director of Nursing (DON), the DON stated the facility is to notify the physician of all the lab values that resulted including the abnormal lab values.During a review of the facility's policy and procedure (P&P), titled Change of Condition Notification, dated 10/1/2023, the P&P indicated the Licensed Nurse will notify the resident's attending physician when there is a need to alter treatment significantly, based on lab/x-ray results, and a need to discontinue an existing form of treatment due to change of condition.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to honor dietary preferences for one of five sampled residents (Resident 21) when Resident 21 received eggs despite the resident's documented dislike for eggs.This placed Resident 21 at risk of not eating and decreased nutritional intake.Findings:During a review of Resident 21's admission Record, the admission Record indicated Resident 21 was admitted to the facility on [DATE] with diagnoses including depression (persistent sadness and a lack of interest or pleasure in previously rewarding or enjoyable activities) and osteoarthritis (a progressive disorder of the joints, caused by a gradual loss of cartilage). During a review of Resident 21's Minimum Data Set (MDS - a resident assessment tool), dated 10/24/2025, the MDS indicated Resident 21 cognition (ability to learn, reason, remember, understand, and make decisions) was intact, and was independent with eating, required setup assistance for oral hygiene, and required moderate assistance (helper does less than half the effort) for toileting hygiene, bathing, and dressing. During an interview on 2/17/2026 at 10:10 a.m. with Resident 21, Resident 21 stated they do not like eggs, and the facility gave Resident 21 scrambled eggs for breakfast on 2/17/2026. Resident 21 stated the facility knows they will not eat eggs.During a concurrent observation and interview on 2/18/2026 at 7:42 a.m. with Certified Nurse Assistant (CNA) 8, Resident 21's breakfast tray was observed with eggs and tray card (printed document that indicated resident's physician ordered diet, allergies, and food preferences) was reviewed. CNA 8 stated Resident 21 received scrambled eggs for breakfast. CNA 8 stated the tray card indicated Resident 21 disliked eggs.During an interview on 2/18/2026 at 2:16 p.m. with the Dietary Supervisor (DS), the DS stated Resident 21's dietary preferences are assessed on admission, annually, and as needed. The DS stated if a resident does not like eggs, the resident does not receive eggs and is offered an alternative.During an interview on 2/20/2026 at 2:20 p.m. with the Director of Nursing (DON), the DON stated Resident 21's dietary preferences should be honored. The DON stated if the resident dislikes eggs, they should not receive eggs. The DON stated if a resident's dietary preference is not followed, there is a risk the resident will not eat and have decreased nutritional intake.During a review of the facility's policy and procedure (P&P), titled Resident Preference Interview, dated 10/1/2023, the P&P indicated the Dietary department will provide residents with meals consistent with their preferences as indicated on the tray card.