STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056428	A. Building B. Wing	03/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
California Nursing & Rehabilitation Center	2299 North Indian Canyon Drive Palm Springs, CA 92262

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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 0551 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give the resident's representative the ability to exercise the resident's rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50864 Based on interview and record review, the facility failed, for one of one resident reviewed (Resident 23), to ensure Resident 23 was appointed a resident representative (RR- someone who can act on behalf of a resident, typically a family member, guardian, or someone with legal authority, to make decisions regarding the resident's care and rights). This failure had resulted in Resident 23 not having a resident representative to exercise their rights or delegate Resident 23's medical decisions. Findings: On February 25, 2025, at 10:57 a.m., Resident 23's record was reviewed. Resident 23 was admitted to the facility on [DATE], with diagnoses that included altered mental status (change in a person's level of consciousness, awareness, and cognitive functions), disorder of the brain (conditions that impact the brain's normal functioning), psychosis (a mental health condition characterized by a loss of contact with reality). The document titled, History and Physical (H&P) dated July 2, 2020, indicated, .can make needs known but cannot make medical decisions .no capacity-psychiatry history-lack right . The document titled, Multidisciplinary Care Conference dated January 8, 2025, indicated, .Resident has no Family/Friends on File . The document titled, Interdisciplinary Team (IDT) Note dated February 24, 2025, indicated, .Resident family member stated .has not been in contact with brother for [AGE] years .Can only be supportive via facetime . The document titled, Minimum Data Set (MDS- a federally mandated assessment tool used to evaluate the health of residents in nursing homes) dated January 8, 2025, indicated, Resident 23's BIMS (Brief Interview for Mental Status - a score from 0 to 15 that measures a person's cognitive functioning) score of 6 (which indicated severe cognitive impairment). (continued on next page)

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

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F 0551 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On February 27, 2025, at 3:26 p.m., a concurrent interview and record review was conducted with the Social Service Director (SSD). The SSD stated the facility process for a resident that did not have the capacity to make medical decisions and did not have a legal RR. The SSD stated the facility staff was to hold an IDT meeting addressing the appointment of a legal RR or conservatorship for the resident. The SSD stated she spoke with Resident 23's family member, via phone, on February 24, 2025, and the family member stated she does not want to be Resident 23's legal representative. The SSD further stated Resident 23's history and physical dated July 2, 2020, indicated Resident 23 can make needs known but lacks capacity to make medical decisions. The SSD stated Resident 23 should have had a legal RR or conservatorship (a court-ordered arrangement that gives a responsible person the power to make decisions for another adult) in place since the history and physical indicated, on July 2, 2020, Resident 23 could not make medical decisions. The SSD stated the facility should have had a Bioethics Committee (a group that examines the ethical, legal, and social implications of healthcare providing guidance and recommendations to institutions, healthcare providers, and patients on difficult ethical issues) to discuss Resident 23's lack of legal representation and decide who would be making medical decisions for Resident 23. The SSD stated this process was not done for Resident 23. On February 27, 2025, at 5:13 p.m., a concurrent interview and record review was conducted with the Director of Nursing (DON). The DON stated the facility process was if a resident did not have a legal RR the IDT Team would meet to plan and obtain a legal representative or conservatorship for the Resident 23. The DON stated Resident 23's history and physical dated, July 2, 2020, indicated he was not able to make decision for himself. The DON stated the facility's process should have been followed. The DON further stated Resident 23 had the right to a legal RR and that was not met. The facility policy and procedure titled Surrogate Decision Maker -Informed Consent dated July 31, 2024, indicated .Process for obtaining Informed Consent when the resident lacks capacity and does not have a surrogate decision-maker .Provide a notice to the resident that their Attending physician determined lack of capacity to make healthcare decisions .Written notice must also be provided to at least one other competent person whose interests are aligned with the resident .The facility will identify a person (who is unaffiliated with the facility) to serve as a representative of the Resident .Efforts to identify a representative will be documented in the resident medical record .If no representative can be found, a referral will be made to the Office of Long Term Care Patient Representatives to appoint a Patent Representatives .

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44173 Based on observation, interview, and record review, the facility failed to exercise reasonable care for the protection of resident's property from theft and loss for one of two residents reviewed for personal property (Resident 21). This failure resulted in Resident 21's violation of resident's rights of having a safe environment. Findings: On February 24, 2025, Resident 21 was observed lying in bed, awake and alert. She stated she was missing some personal belongings since she was transferred from another room two weeks ago. Resident 21 stated she was missing a hairbrush, expensive make-up, house slippers and pajamas. She stated she told a staff the day she noticed some of her personal belongings were missing. Resident 21 stated she could not remember the exact date she talked to a staff about her missing personal belongings and who she talked to. She stated she talked to another staff this morning, but she could not recall the staff's name. On February 25, 2025, at 9:13 a.m., Resident 21 was observed lying in bed with her eyes closed. Resident 21 opened her eyes when her name was called. She stated nobody from the facility had talked to her regarding her missing personal belongings. She stated her family brought in the slippers two days after her admission. She stated she was not sure if the slippers and the make-up were listed in her inventory list. On February 26, 2025, at 9:08 a.m., during an interview with Certified Nursing Assistant (CNA) 1, she stated personal inventory list should be done on admission. She stated the staff should check the resident's personal belongings and list down each item, including dentures, eyeglasses and hearing aids. She stated when a resident was transferred to another room, the staff should check the room for the resident's belongings and should transfer the personal belongings with the resident. On February 26, 2025, at 9:24 a.m., during an interview with Licensed Vocational Nurse (LVN) 3, she stated when a resident was transferred to a different room, the resident's personal belongings should transfer with the resident and the inventory sheet should be updated. On February 26, 2025, Resident 21's record was reviewed. Resident 21 was admitted to the facility on [DATE], with diagnoses which included hypertension (high blood pressure) and anxiety disorder. The history and physical dated January 24, 2025, indicated Resident 21 was alert and oriented. The personal effects inventory sheet, signed and dated by Resident 21 on January 23, 2025, indicated the resident had the following personal belongings: - one Apple phone charger cord; - one black pajama pants; (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- 1 sock; - 1 white brush; - 1 black phone; - 1 pink wallet; - $50.00; and - 3 credit cards. The document indicated the wallet was given to the charge nurse. On February 26, 2025, at 2:29 p.m., during an interview and record review with the Social Service Director (SSD), she stated she was responsible to follow-up when there was a report for missing personal belongings. She stated the nurses would inform her when there was a report for missing personal belongings. The facility's list of residents with missing personal belongings did not include the name of Resident 21. The SSD stated she was not aware Resident 21 was missing some personal belongings. On February 26, 2025, at 2:34 p.m., the SSD was observed to enter Resident 21's room to conduct an interview. Resident 21 stated she had spoken to a staff regarding her missing personal belongings, but nothing was done. The SSD explained to Resident 21 she would try to search for the missing personal belongings and if not found, the facility will try to replace the missing items. Resident 21 stated when she was admitted in room [ROOM NUMBER], she had with her the following personal belongings: - one white hairbrush; - one set of black pajamas; - several pieces of expensive make-up; and - slippers. On February 26, 2025, at 3:03 p.m., the SSD was observed to visit Resident 21 in her room. The SSD informed Resident 21 she did not find her missing personal belongings and the administrator was notified. The SSD opened a sealed yellow envelope in front of Resident 21. The sealed yellow envelope had Resident 21's name on it and inside was a pink wallet. The SSD handed the pink wallet to Resident 21. Resident 21 stated the pink wallet was hers and inspected the pink wallet. Resident 21 stated the $50 was missing. The SSD and Resident 21 inspected the pink wallet and did not find the $50. The SSD asked Resident 21 for the estimated value of the personal belongings including the $50. The SSD stated the police will be notified since the estimated value was more than $100. On February 27, 2025, at 8:37 a.m., during an interview with the SSD, she stated Resident 21's $50.00 was missing. She stated the incident was under investigation. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility document titled, Personal Property, revised July 14, 2017, indicated, .To ensure the facility takes reasonable steps to protect resident's personal property .The facility will make every effort to maintain the security of the resident's property .Money and other valuables should be taken to the business office for safe keeping .

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50864 Based on interview and record review, the facility failed, for one of one resident reviewed (Resident 23), to ensure a follow-up with the local authority for the completion of a Level II Preadmission Screening and Resident Review (PASARR- a federally mandated process ensuring individuals with mental illness, intellectual/developmental disabilities, or related conditions receive appropriate placement and services in Medicaid-certified nursing facilities) was performed. This failure had the potential for Resident 23 to not receive the appropriate care according to his mental and behavioral needs. Findings: On February 24, 2025, at 10:48 a.m., Resident 23 was observed in bed, alert, confused, and yelling. On February 25, 2025, at 10:57 a.m., Resident 23's record was reviewed. Resident 23 was admitted to the facility on [DATE], with diagnosis that included altered mental status (change in a person's level of consciousness, awareness, and cognitive functions), disorder of the brain (conditions that impact the brain's normal functioning), and psychosis (a mental health condition characterized by a loss of contact with reality). The document titled, State Department of Health Care Services dated August 11, 2022, indicated Resident 23's Level I PASRR (PASARR) was positive and would need a Level II referral. There was no documented evidence a PASSR Level II referral was performed on Resident 23. The document titled, State Department of Health Care Services addressed to the facility dated August 24, 2022, indicated Resident 23 was unable to participate in the Level II evaluation .After reviewing the Positive Level 1 Screening .Speaking with staff . Level II Mental Health Evaluation was not scheduled .individual was isolated as a health or safety precaution .The case is now closed .To reopen .submit new Level I Screening . There was no documented evidence a new PASSR Level I Screening was performed and submitted to the State Department of Health Care Services. On February 27, 2025, at 3:45p.m., a concurrent interview and record review was conducted with the Social Service Director (SSD). The SSD stated there was no evidence a new PASSR level I was performed in order for Resident 23 to be referred for Level II screening. The SSD stated this was not done on Resident 23. The SSD stated the expectation was for the residents to be evaluated and scheduled with the proper agency for placement in the appropriate facility. The SSD further stated if a resident was not properly assessed this would result to the resident's mental health needs not being accommodated. The SSD stated she should have followed up and scheduled a new evaluation so that the needs for proper placement of resident would have been meet. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's policy and procedure titled, Pre-Admission Screening Level II Resident Review dated September 2017, indicated, .The facility staff will coordinate the recommendations from the level II PASRR determination and the PASRR evaluation report with the resident's assessment, care planning, and transitions of care .The PASRR will be completed in accordance with the Pre-Screening Resident Review (PASRR) .

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 51080 Based on observation, interview and record review, the facility failed to ensure for one of two residents reviewed for care planning a care plan was initiated for toe nail fungus (Resident 43). This failure had the potential to result in ineffective treatment of foot care and cause pain or discomfort to resident 43. Findings: On February 28th, 2025, at 10:47 a.m. an observation was conducted of Resident 43's feet. Resident 43's was laying in bed, both feet had dry flaking skin and hypertrophic nails. (thickened from toenail fungus). A review of Resident 43's record indicated Resident 43 was admitted to the facility on [DATE], with diagnoses which included Peripheral Vascular Disease (PVD - a slow progressive narrowing of the blood flow to the arms and legs). Resident 43's podiatry (medical doctor who specializes in feet and toe nails) note dated February 19, 2025, indicated, .Dermatologic Evaluation: Onychomycosis (type of toe nail fungus) . Right and left toenails 1-5, . Onychohypertrophy (thickened toenails related to toenail fungus) .right and left toenails 1-5 .painful nail borders .right and left toe nails 1-5 . - .Diagnosis of: onychomycosis. Onychohypertrophy, Peripheral Artery Disease, atherosclerosis of extremities, rest pain . - .Treatment Plan: Procedures Trimmed and electrical Debridement (removal of tissue) with Dremel drill (type of drill): a.) 10 onychomycotic, hypertrophic, painful, incurvated (ingrown) toenails There was no care plan initiated for onychomycosis or toenail fungus. On February 28, 2025, at 11:25 a.m., an interview was conducted with treatment nurse, Licensed Vocational Nurse(LVN) 2. LVN 2 stated the care plan for toenail fungus should have been initiated. A review of facility policy and procedure titled, Comprehensive Person-Centered Care Planning, dated November 2018, indicated, .Additional changes or updates to the resident's comprehensive care plan will be made based on the assessed needs of the resident .the comprehensive care plan will be reviewed and revised at the following times .onset of new problems .to address changes in behavior and care .

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44173 Based on observation, interview, and record review, the facility failed to ensure services provided met professional standards of practice for two of 72 residents (Residents 57 and 58) reviewed when: 1. For Resident 57, one Albuterol Sulfate inhaler (medication used to treat breathing problems caused by lung disease) was observed on top of the resident's nightstand: and 2. For Resident 58, the facility did not clarify a physician's order for Vitamin D3 (a type of Vitamin supplement). These failures had the potential for Resident 57 to receive the Albuterol Sulfate inhaler without a physician's order, and for Resident 58 to receive a wrong dose for the Vitamin D3. Findings: 1. On February 24, 2025, at 9:58 a.m., Resident 57 was observed sitting in bed, leaning on the bedside table while reading a paper. Resident 57 was using oxygen at 4 liters (unit of measurement) per minute via a nasal canula (a device that delivers oxygen through a tube and into the nose). A bottle of Albuterol Sulfate inhaler was observed on Resident 57's nightstand. In a concurrent interview with Resident 57, he stated he would take two puffs two times a day. Resident 57 stated the nurses were aware he was taking his own medication. On February 25, 2025, at 9:11 a.m., Licensed Vocational Nurse (LVN) 3 was observed preparing medications in front of Resident 57's room. She stated Resident 57 went out of the room for a walk. She stated Resident 57 no longer had the Albuterol inhaler at bedside. She stated the Director of Nursing (DON) took the Albuterol inhaler from Resident 57. LVN 2 also stated Resident 57 should not have any medication at bedside. On February 27, 2025, at 9:07 a.m., during a concurrent interview and record review with the DON, he stated the admitting nurse should gather all medications brought in by the resident to the facility and set them aside for safekeeping. The DON stated an assessment for self-administration of medication should be conducted for residents who wish to administer their own medications. He also stated there should be a physician's order to self-administer the medication. A review of Resident 57's current medication profile with the DON included Albuterol Sulfate inhalation solution 2 puffs by mouth every 4 hours as needed. He stated Resident 57 did not have an assessment for self-administration for the Albuterol Sulfate inhaler. He also stated Resident 57 did not have an order to self-administer the Albuterol Sulfate. The DON stated Resident 57 should not have any medication at bedside. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On February 27, 2025, Resident 57's record was reviewed. Resident 57 was admitted to the facility on [DATE], with diagnoses which included Chronic Obstructive Pulmonary Disease (COPD - a group of lung diseases that block airflow and make it difficult to breathe). The history and physical dated December 16, 2024, indicated Resident 57 was alert and oriented. The MDS (Minimum Data Set - an assessment tool) indicated a BIMS (Brief Interview for Mental Status - measures a person's cognitive function) score of 12 (moderately impaired cognition). The physician's order dated December 6, 2024, indicated, .Albuterol Sulfate .inhale 2 puffs by mouth every 4 to 6 hours if needed . Resident 57's record did not indicate a self-administration for medication was conducted and there was no physician's order to self-administer the Albuterol Sulfate inhaler. The facility document titled, MEDICATIONS BROUGHT TO THE FACILITY BY PHYSICIANS OR RESIDENTS/FAMILY MEMBERS, dated October 2012, indicated, .All medication supplies dispensed by a physician or brought in by the resident or family member are labeled, packaged and stored in accordance with product requirements, state and/or federal regulations and facility policies . The facility document titled, SELF-ADMINISTRATION OF MEDICATIONS, dated October 2012, indicated, . In order to maintain the residents' high level of independence , residents who desire to self- administer medications are permitted to do so if the facility's interdisciplinary team has determined that the practice would be safe for the resident and other residents of the facility and there is a prescriber's order to self-administer .If the resident desires to self-administer medications, an assessment is conducted by the interdisciplinary team of the resident's cognitive (including orientation to time), physical, and visual ability to carry out this responsibility during the care planning process .The results of the interdisciplinary team assessment of resident skills and of the determination regarding bedside storage are recorded in the resident's medical record, on the care plan. For each medication authorized for self-administration, the label contains a notation that it may be self-administered . 50610 2. During the medication administration observation on February 25, 2025, at 9:57 a.m. with licensed vocational nurse (LVN) 3, LVN 3 was observed preparing seven medications for Resident 58. During the medication preparation process, LVN 3 did not administer Vitamin D3 and stated Resident 58's Vitamin D3 order did not have a strength (the amount of medication) indicated. LVN 3 stated she needed to clarify the order. A review of the Resident 58's Admission Record, dated February 27, 2025, indicated, Resident 58 was admitted on [DATE], with diagnoses that included, chronic kidney disease (a long-term condition in which the kidneys are damaged and cannot filter blood properly). A review of Resident 58's physician's order, dated January 23, 2025, indicated Vitamin D3, give 1 tablet by mouth one time a day for supplement. During a review of Resident 58's medication administration record (MAR) dated January and February 2025, it indicated nursing staff administered Resident 58 one Vitamin D3 tablet daily on the following days: - January 24, 2025 to January 29, 2025, and on January 31, 2025; and (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- February 1, 2025 to February 24, 2025. During a concurrent interview and record review on February 25, 2025, at 12:54 p.m. with LVN 4, Resident 58's medical record, including the physician's order for Vitamin D3 and MARs dated January and February 2025 were reviewed. LVN 4 acknowledged there was no strength indicated on the physician's order for Vitamin D3. Additionally, LVN 4 acknowledged Resident 58 was administered one Vitamin D3 tablet on the days as listed above. When asked what he would have done if the strength was not indicated on the physician's order for Vitamin D3, LVN 4 stated he would have not given the Vitamin D3 and would have called the physician to clarify the order. LVN 4 further stated nursing staff should have clarified the order with the physician, documented the clarification, and entered the updated order in Resident 58's medical record. During a concurrent interview and record review on February 25, 2025, at 5:11 p.m. with the Director of Nursing (DON), the DON acknowledged the above findings and stated nursing staff were expected to have identified and clarified the missing strength for the Vitamin D3 order on January 23, 2025 when the order was received by nursing staff for Resident 58. The DON further stated it was important to clarify the physician's order to ensure accurate dosage, effective treatment and to prevent an unsafe use from administering too much or too little medication. During a review of the facility's policy and procedure (P&P) titled, Physician Orders, revised August 21, 2020, it indicated, The licensed nurse will confirm that physician orders are clear, complete and accurate as needed .Medication orders will include the following .Name of the medication .Dosage .Frequency .Duration . Route of administration, Condition or diagnosis for which the mediation is ordered .the licensed nurse receiving the order will be responsible for documenting and carrying out the order .Medication and treatment orders will be transcribed onto the appropriate resident administration record .Documentation pertaining to physician orders will be maintained the Resident's medical record . During a review of the facility's P&P titled, Medication Administration, revised January 1, 2012, it indicated, Nursing staff will keep in mind the seven rights of the medication when administering medication .The right amount .

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50864 Based on observation, interview, and record review, the facility failed to ensure for one of 18 residents reviewed (Resident 224), multiple dry scabs located on bilateral (both) forearms was referred to the physician for treatment orders. This failure had the potential to result in Resident 224's skin condition to persist without prompt intervention thereby causing a possible further decline in health condition. Findings: On February 25, 2025, at 8:47 a.m., an observation with a concurrent interview was conducted with Resident 224. Resident 224 was observed to have multiple dry scabs, brownish black in color, and variable in size, on both upper extremities (arms). Resident 224 stated he had the scabs prior to his admission to the facility. On February 25, 2025, at 11:54 a.m., an interview was conducted with Resident 224's family member. The family member stated Resident 224 was admitted to the facility with the multiple scabs to his bilateral forearms and he was treating the scabs with his own Neosporin (type of antibiotic ointment) during visits. On February 25, 2025, Resident 224's record was reviewed. Resident 224 was admitted to the facility on [DATE], with diagnoses that included obesity (chronic complex disease defined by excessive fat deposits that can impair health), cerebral infarction (condition where blood flow to the brain is interrupted), prediabetes (condition in which blood sugar levels are higher than normal). The document titled, History of Present Illness, indicated, Resident 224 was self-responsible (takes ownership of their health by making informed decisions regarding their treatment plans and actively participates in their healthcare). The document titled, Advanced Skin Check, dated February 20, 2025, indicated, .Skin Check .No Skin Issues .Skin Issues Note Edema to left hand and arm, discoloration, scabbing to antebrachial (refers to the forearm) left and scabbing to above brachial area (refers to the forearm) to right arm . There was no documented evidence the multiple scabs on Resident 224's left and right arm, were referred to the physician for treatment orders. In addition, there was no documented evidence a care plan was developed and initiated to address the multiple scabs on Resident 224's left and right arm, since identified on February 20, 2025. On February 26, 2025, at 3:13 p.m., a concurrent interview and record review was conducted with Licensed Vocational Nurse (LVN) 2. LVN 2 stated she was the Treatment Nurse assigned to Resident 224. LVN 2 stated Resident 224 was admitted with multiple scabs on both left and right arm as indicated on the initial skin check dated February 20, 2025. LVN 2 stated the following description on Resident 224's scab wounds: (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Scab Wound 1 - left outer forearm with discoloration, 1.5 cm (centimeter a metric unit) length x 1cm width x 0 depth .eschar (dead tissue that is hard or soft in texture; usually black, brown, or tan in color, and may appear scab-like, usually firmly attached to the base, sides and/or edges of the wound and over time falls off) 100%, surrounding skin is dry and flaky; - Scab Wound 2 - left inner forearm, 1.5 cm length x 1 cm width x 0 cm depth, eschar 100%, surrounding skin is dry and flaky; - Scab Wound 3 - left inner forearm, 0.5 cm length x 0.5 cm width x 0 cm depth, eschar 100%, surrounding skin dry and flaky; - Scab Wound 4 - left inner forearm, 0.3 cm length x 0.3 cm width x 0 cm depth, eschar 100% surrounding skin fragile; and - Scab Wound 5 - right inner forearm, skin intact, light pink colored from scab. LVN 2 stated the multiple scabs on Resident 224's left and right arm were not referred to the physician for skin treatment orders upon admission. LVN 2 stated a care plan was not developed and initiated to address the multiple scabs. LVN 2 stated Resident 224's multiple scabs identified on admission should have been referred to the physician for treatment orders and a care plan should have been developed and initiated. LVN 2 stated this was not done until February 26, 2025. LVN 2 stated it should have been referred to the physician right away. On February 27, 2025, at 9:39 a.m., an interview with a concurrent review of Resident 224's medical record was conducted with the Director of Nursing (DON). The DON stated the facility's process on skin assessment was for the admitting licensed nurse to perform a head-to-toe assessment, identify concerns, document findings, and notify treatment nurse of areas of concerns. The treatment nurse would evaluate and get physician treatment orders. The DON stated the process was not followed on February 20, 2025. The DON further stated the treatment nurse was not involved with multiple scab wounds until February 26, 2025. The DON further stated the admitting nurse should have followed the process of notifying the physician on Resident 224's multiple scab wounds so that a treatment could have been implemented and care plan developed. The facility's policy and procedure titled, Skin Integrity Management, dated July 27, 2024 was reviewed. The policy indicated, . License Nurse will complete a skin evaluation .Treatments .other skin integrity . will be ordered by .physician .

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 39920 Based on observation, interview, and record review, the facility failed to ensure safe smoking practices were observed and implemented for one of eight residents reviewed for smoking (Resident 12), when Resident 12 had cigarettes and lighter in his possession. This failure had the potential to result in accidents or injuries to the facility residents. Findings: On February 24, 2025, at 12:33 p.m., a concurrent observation and interview was conducted with Resident 12. Resident 12 was observed in his room, sitting on his bed, with oxygen on via nasal cannula (NC - a tube that delivers oxygen to the nose). A pack of cigarettes was observed in Resident 12's nightstand drawer. Resident 12 stated the pack of cigarettes was his and he went out to smoke on the smoking patio every day. Resident 12's roommate was also observed in his bed, with oxygen on via NC. On February 25, 2025, at 8:30 a.m., an observation was conducted on the smoking patio. Resident 12 was observed taking a cigarette lighter out of his pocket, handing it to another resident who lit up a cigarette, and who returned it to Resident 12, who put it back in his pocket. On February 25, 2025, at 9:20 a.m., a concurrent observation and interview was conducted with Resident 12. Resident 12 was observed sitting on his bed, with a pack of cigarettes in his hand. Resident 12 stated the cigarettes have been in his possession and placed them in the back pocket of his wheelchair. On February 25, 2025, at 9:23 a.m., a concurrent observation and interview was conducted with Licensed Vocational Nurse (LVN) 1. LVN 1 stated Resident 12 was not allowed to have cigarettes or a lighter in his possession. LVN 1 stated Resident 12 was using oxygen. LVN 1 went to Resident 12's room and asked him if he had any cigarettes in his possession. Resident 12 stated yes. LVN 1 asked Resident 12 to hand over the cigarettes, for safekeeping by the activity staff. LVN 1 stated Resident 12 should not have possession of cigarettes or a lighter because a confused resident could get the cigarettes from Resident 12, and Resident 12 was on oxygen, and these were safety issues. On February 25, 2025, at 9 a.m., a concurrent observation, interview, and record review was conducted with Activities Assistant (AA). The AA stated residents' cigarettes and lighters were kept by activities staff in a plastic box which was observed to be locked and handed to the residents during smoking times on the patio. The Smoker List record was reviewed with the AA. The record indicated Resident 12 could smoke under supervision and cannot hold cigarettes or lighter in his possession. The AA stated Resident 12 should not have had cigarettes or lighter in his possession or in his room. On February 26, 2025, at 4:30 p.m., an interview was conducted with the Director of Nursing (DON). The DON stated Resident 12 was not supposed to have cigarettes or lighter in his possession for his own safety and the safety of other residents. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident 12's record was reviewed. Resident 12 was readmitted at the facility on June 2, 2024, with diagnoses which included, chronic obstructive pulmonary disease (COPD - a disease that causes obstructed airflow from the lungs), major depressive disorder (mood disorder), anxiety disorder, and other stimulant dependence. The care plan for smoking, initiated on February 17, 2025, indicated: .Resident non-compliant for smokers policy: refused to give his cigarettes and lighter to Activity for safe keeping .Resident will free from any harm/injury .Continue providing reeducation on smokers policy. Monitor resident for safety issues . The facility policy and procedure titled, Smoking Residents, revised July 27, 2023, was reviewed. The policy indicated, .The IDT (Interdisciplinary Team) will develop an individualized plan of care for safe storage, use of smoking materials, assistance and/or required supervision, for residents who smoke .

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50864 Based on observation, interview, and record review, the facility failed, for one of one resident reviewed (Resident 23), to ensure bowel and bladder assessment and evaluation was performed for ascheduled toileting program. This failure resulted in no bladder training program for Resident 23 which had the potential to lead to further decline of bladder function. Findings: On February 24, 2025, at 10:48 a.m., an observation with a concurrent interview was conducted with Resident 23. Resident 23 was in bed, alert, and interviewable. Resident 23 stated he used incontinence pads and needed a nurse to help him change. On February 24, 2025, at 9:47 a.m., Resident 23's record was reviewed. Resident 23 was admitted to the facility on [DATE], with diagnoses that included altered mental status (change in a person's level of consciousness, awareness, and cognitive functions), diabetes mellitus (chronic condition characterized by high blood sugar). The document titled, Care Plan, dated January 19, 2022, indicated, .Focus .risk for bladder incontinence . Goal .resident will be continent during waking hours .Interventions .clean peri-area with each incontinence episode . The following Minimum Data Set (MDS-an assessment tool) were reviewed: The Annual MDS dated [DATE], indicated, Resident 23 had a BIMS Score (Brief Interview for Mental Status-an assessment tool used by facilities to screen and identify memory, orientation, and judgement status of the resident, a score from 0 to 15 that measures a person's cognitive functioning) of 8 (8- moderate cognitive impairment). The MDS further indicated Resident 23 was frequently incontinent (unable to voluntarily control retention of urine or feces in the body) of bowel and occasionally incontinent of bladder. The Quarterly MDS dated [DATE], indicated, a BIMS score of 9 (9- moderate cognitive impairment). The MDS further indicated Resident 23 was occasionally incontinent of bowel and bladder. The Quarterly MDS dated [DATE], indicated, a BIMS score of 6 (6- severe cognitive impairment). The MDS further indicated Resident 23 was occasionally incontinent of bowel and frequently incontinent of bladder. The document titled, Bowel and Bladder Program Screener, dated July 8, 2024, October 10, 2024, and January 8, 2025, indicated, Resident 23 was a candidate for scheduled toileting (timed voiding). There was no documented evidence a bowel and bladder evaluation was performed and/or scheduled toileting was done on Resident 23. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On February 26, 2025, at 9:12 a.m., an interview with a concurrent record review was conducted with the MDS Nurse. The MDS Nurse stated Resident 23 was alert and did not have the capacity to understand and make medical decisions for himself. The MDS Nurse stated the MDS Bowel and Bladder Screener identified Resident 23 as a good candidate for scheduled toileting on July 8, 2024, October 10, 2024, and January 8, 2025. The MDS Nurse stated the facility process was when the Bowel and Bladder Screen identified Resident 23 as a good candidate for scheduled toileting, the licensed nurses should have conducted a bowel and bladder assessment and evaluation on Resident 23 to determine if scheduled toileting was appropriate. The MDS Nurse stated there was no documented evidence this process was followed for Resident 23. The facility's policy and procedure Bowel and Bladder Training/Toileting Program dated August 21, 2020, indicated, .provide residents .bowel and/or bladder appropriate treatment .to restore as much bowel and/or bladder function as possible .Procedure .assessment .implementation .evaluation .weekly .licensed nurse will document the residents progress or lack of progress .The IDT will meet weekly to evaluate the resident 's progress or lack of progress .

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F 0692 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38924 Based on observation, interview, and record review, the facility failed to implement a comprehensive systematic approach to ensure effective monitoring to maintain acceptable parameters of nutritional status for 5 of 5 sampled Residents (23, 43, 51, 58, and 673) when: 1. Resident 23 experienced a severe unplanned weight loss of 16 lbs. (pounds- a measurement of weight), 8. 04% from the weights obtained on 11/5/24 to 2/26/25. Weights were obtained but a weight loss change of condition was not completed, the resident was not placed on weekly weights, the Registered Dietitian (RD) did not reassess the resident to determine appropriate interventions, weight loss was not communicated to the Physician, the IDT (IDT- an interdisciplinary team comprised of professionals from various disciplines who work in collaboration to address a Resident with multiple physical and psychological needs) did not address the severe unplanned weight loss, and the care plan did not reflect the severe unplanned weight loss for the interventions to be implemented. Resident 23 was diagnosed with uncontrolled diabetes mellitus (condition in which the body has trouble controlling blood sugar). 2. Resident 43 experienced a severe unplanned weight loss of 14 lbs. or 11.67% from the weights obtained on 11/5/24 to 2/7/25. Weights were obtained but a weight loss change of condition was not completed, the resident was not placed on weekly weights, the RD did not reassess the resident to determine appropriate weight loss interventions, weight loss was not communicated to the Physician, the IDT did not address the severe unplanned weight loss, and the care plan did not reflect the severe unplanned weight loss for the interventions to be implemented. Resident 43 was diagnosed with hyperlipidemia (elevated blood fat levels) and a body mass index (BMI) of 16.5 (less than 18 is underweight). 3. Resident 51 experienced a severe unplanned weight gain of 16 lbs., 10.26% from the weights obtained on 11/5/24 to 2/7/25. Weights were obtained but the resident was not placed on weekly weights, the weight loss was not addressed by the Physician, the IDT did not address the severe unplanned weight loss, and the care plan did not reflect the severe unplanned weight loss for the interventions to be implemented. Resident 51 was diagnosed with chronic kidney disease (CKD) (when the kidneys cannot filter waste). 4. Resident 58 experienced a severe unplanned weight loss of 23 lbs., 12.3% from the weights obtained on 12/24/24 to 2/20/25. Weights were obtained but the resident was not reassessed by the RD to determine appropriate interventions, and the IDT did not follow up with the Physician to address the severe unplanned weight loss to ensure appropriate interventions were implemented. Resident 58 was diagnosed with hypothyroidism (condition which the thyroid gland does not produce enough thyroid hormone). 5. Resident 673 experienced a severe unplanned weight loss of 8.6 lbs., 5.78% from the weights obtained on 11/5/24 to 2/6/25. Weights were obtained but a change of condition for severe unplanned weight loss was not completed, the Physician or the RD did not address the severe weight loss with the IDT to determine effective interventions to prevent further weight loss, and the care plan did not reflect goals to address the severe unplanned weight loss. Resident 673 was diagnosed with dysphagia (difficulty swallowing) and hemiplegia (paralysis of one side of the body). (continued on next page)

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F 0692 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	As a result of these failures, these five (5) residents compromised nutritional status was not addressed which could have resulted in further medical complications including but not limited to dehydration, loss of muscle mass with decreased mobility and negatively affect the diagnoses for each resident, which could include death. Because of the severe unplanned weight losses for Residents 23, 43, 51, 58, and 673 and the facility lacking a comprehensive systematic approach to ensure effective monitoring to maintain acceptable parameters of nutritional status, an Immediate Jeopardy (IJ- a situation in which the provider's noncompliance with one or more requirements of participation has caused or is likely to cause serious injury, harm, impairment, or death to a resident) situation was called on 2/27/25 at 7:45 PM, under Code of Federal Regulations (CFR) S483.25 Nutrition/Hydration Status Maintenance (F692) with the Administrator (ADM), Director of Nursing (DON), and Dietary Services Manager/Registered Dietitian (DSM-RD) in attendance. The IJ template was provided to the ADM. The facility submitted an acceptable IJ Removal Plan (Version 3) on 2/28/25, at 4:53 PM. The IJ Removal Plan included but was not limited to the following: 1) Notify the Physicians for Residents 23, 43, 51, 58, and 673 of significant and severe weight change. 2) Re-weigh all five residents and place on weekly weights for four weeks. 3) Review labs (clinical blood tests), weights, physician visits, PO (eating by mouth) intake, and therapy orders for the five identified weight loss residents 23, 43, 51, 58, and 673. 4) The RD will re-assess and re-evaluate Residents 23, 43, 51, 58, and 673 nutrition status. 5) Immediate training for Certified Nursing Assistants (CNAs) and Licensed Vocational Nurses (LVNs) on monitoring and recording meal intake percentages and supplement orders. 6) The RD will monitor the weekly weights and residents with significant weight loss of 5% /5# (pounds) x 30 days, 7.5% x 90 days, 10% x 180 days, and 3# or more for residents who are under 100# x 30 days were reevaluated by the Senior (Sr.) Regional Registered Dietitian and followed up by the Facility RD, as well as the Weight Variance and Nutrition Condition Interdisciplinary team (IDT) weekly for 4 weeks, then, bi-monthly for 2 months. 7) IDT will monitor for sustainable compliance to determine weight variances/significant weight losses and accuracy of assessments to meet weight loss resident's nutritional needs and goals of care such as improved PO intake or weight goals are met. Identified concerns will be addressed immediately and reported to the DON and Administrator for follow-up as warranted. 8) Senior Regional Registered Dietitian provided one to one (1:1) re-education to the Registered Dietitian on Evaluation of Weight & Nutritional Status Policy and Procedures and an RD competency with current facility's RD. 9) Regional Quality Management Compliance (RQMC) and Senior RD completed education on Evaluation of Weight and Nutritional Status policy with IDT members. 10) the Medical Director was notified by the Administrator and Director of Nursing (DON) of the concerns related to Weight Loss and Nutritional Assessments and presented and discussed the immediate action plan for implementation. 11) Pharmacy medication regimen review completed for the five (5) identified weight loss residents 23, 43, 51, 58, and 673 for review of weight change related medications. The components of the IJ Plan of Removal were validated through observations, interviews, and record review and the IJ was removed on 3/3/25 at 12:50 PM with the ADM and DON in attendance. Findings: According to a 2002 American Academy of Family Physicians Journal article, Involuntary weight loss can lead to muscle wasting, decreased immunocompetence, (the ability for the body to develop an immune response) depression and an increased rate of disease complications. Research has shown institutionalized elderly patients who lost 5 percent of their body weight in one month were found to be four times more likely to die within one year. (www.aafp.org/afp) (continued on next page)

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F 0692 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	According to a literature review of the Academy of Nutrition & Dietetics, Nutrition Care Manual, dated 2022, . Unintended weight loss is linked to increased mortality (death) among older adults . residents in long-term-care facilities who continue losing weight have a higher mortality rate compared with those who stop losing weight. Weight loss of 5% or more within 30 days is associated with a tenfold increase in the likelihood of death . https://www.nutritioncaremanual.org/ 1. A record review of Resident 23's Facility Admission Record indicated the resident was admitted to the facility on [DATE] with diagnoses that included dysphagia (difficulty swallowing), diabetes mellitus, hypertension (elevated blood pressure levels), gastro-esophageal reflux disease-GERD (a condition where stomach contents flow back up into the esophagus, causing irritation) and hyperlipidemia (abnormally high levels of fat in the blood). Record review of Resident 23's minimum data set (MDS- a standardized comprehensive assessment of residents' health conditions, functional abilities, and care needs) report dated 1/8/25 indicated the resident's brief interview of mental status-BIMS (a short cognitive screening test) score was 6, whereby a score of 0-7 refers to severe impairment. Review of Resident 23's Weights and Vitals Summary report on 2/28/25 indicated: 8/06/24 - 198 lbs. 9/03/24 - 200 lbs. 10/2/24 - 198 lbs. 11/5/24 - 199 lbs. 12/5/24 - 197 lbs. 01/6/25 - 203 lbs. 02/7/25 - 185 lbs. 2/26/25 - 183 lbs. Resident 23 experienced a 16-pound, 8.04% severe weight loss in ninety days or 3 months, from 11/5/24 to 2/26/25. Review of Resident 23's eInteract Change in Condition (COC) Evaluation dated 1/30/25 completed by Licensed Vocational Nurse (LVN) 7 indicated the .Signs and symptoms . Food and/or fluid intake (decreased or unable to eat and/or drink adequate amounts) and Functional decline (worsening mobility). Weight loss was not checked. Review of Resident 23's physician's diet order dated 2/10/25 indicated NAS (no added salt) CCHO (consistent carbohydrate) diet, Mechanical Soft texture, Regular/Thin consistency and supplement order dated 2/8/25 indicated 4 ounce (oz.) House Supplement/Milk Shake three times a day for Malnutrition risk with meals. (continued on next page)

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F 0692 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 2/28/25 at 12:40 PM, a joint observation and interview of resident 23's lunch meal intake was conducted in the resident's room. Resident 23's lunch meal tray was on his bedside table. Certified Nursing Assistant (CNA) 2 and CNA 5 were feeding the resident his lunch meal which was beef goulash with spaghetti noodles, bite-sized coin carrots, and a parsley garnish on the plate. The resident drank thickened milk in 8-ounce cup with his meal. The CNA 5 stated the resident generally eats 50%-100% of his meals, depending on the meal. Review of Resident 23's January 2025 - February 2025 Meal Intake percentage (%) report indicated the resident consumed an average of 25% to 100% of meals, 25% of his house supplements. The facility's Diet Manual indicated the CCHO diet provided 2200 calories and 70-90 grams of protein per day, which led to Resident 23 consuming up to 550 fewer calories and 20 fewer grams of protein per day required to meet his estimated daily nutrition needs. Review of Resident 23's Nutrition Risk assessment dated [DATE] completed by the DSM-RD, indicated the resident's usual body weight was 206 lbs., estimated daily nutrition needs were 1800-2250 kcal (calories) and 90-108 grams of protein. Nutrition Goal: 1) stable wt. (weight) (fluct.- fluctuation) < 5%/month) within goal weight range: 195-205 lbs. through review date. 2) Maintain adequate nutrition & hydration status as evidenced by no new signs and symptoms of malnutrition, skin breakdown or dehydration. 3) Tolerate diet; average PO meets 75%-100% est. (estimated) needs. During a concurrent interview and record review with the Dietary Services Manager- Registered Dietitian (DSM-RD) on 2/27/25 at 3:06 PM, the DSM-RD stated resident 23's weight loss interventions should have been reassessed to address his continual weight loss. The DSM-RD further stated the resident should have remained on weekly weights and the change of condition form should have indicated weight loss as a sign and symptom so the IDT could have evaluated the resident's weight changes with the physician to avoid further loss. 2. A review of Resident 43's Facility Admission Record indicated the resident was admitted to the facility on [DATE] with diagnoses that included chronic obstructive pulmonary disease-COPD (a condition involving restricted airflow in the lungs and difficulty breathing), hypertension (elevated blood pressure levels) and hyperlipidemia (abnormally high levels of fat in the blood). Record review of Resident 43's MDS report dated 12/28/24 indicated the BIMS score was 11, whereby a score of 8-12 refers to moderate impairment. Review of Resident 43's Weights and Vitals Summary report on 2/28/25 indicated: 11/05/24- 120 lbs. 12/05/24 -117 lbs. 01/07/25 -105 lbs. 02/07/25 -106 lbs. Resident 43 experienced a 14-pound, 11.67% severe weight loss in ninety days or 3 months, from 11/5/24 to 2/7/25. (continued on next page)

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F 0692 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of Resident 43's eInteract Change in Condition (COC) Evaluation dated 11/26/24 completed by LVN 1 indicated the signs and symptoms was 31. Other Change in Conditions . Low Hemoglobin 3.2 g/dL (normal range 12.1 g/dL to 15.1 g/dL). Weight loss was not checked. Review of Resident 43's physician's diet order dated 11/29/23 indicated Fortified (addition of calories to meals to reduce weight loss) Diet, Regular texture diet, Regular thin consistency; supplement order: 4 oz House Supplement/Milk Shake two times a day for Malnutrition risk w/ Lunch and dinner dated 1/8/25, 8 oz High Protein Nourishment two times a day dated 11/30/24, and Prostat (protein rich item) one time a day for Supplement for Wound Healing 30 ml PO, started 11/27/23. On 3/3/25 at 7:49 AM, an observation of resident 43's breakfast meal intake was conducted. Resident 43 received a Banana, Toast, Cereal, Bacon, and chocolate health shake. The resident did not have assistance and fed herself. Resident 43's January 2025 - February 2025 Meal Intake percentage (%) reports were requested by Surveyors on 2/28/25 and 3/3/25 but were not provided by the facility. Review of Resident 43's Nutrition Risk assessment dated [DATE] completed by the DSM-RD, indicated the resident's weight was 103 lbs., height 5 feet 7.5 inches tall, BMI (body mass index) 16.5 (below 18 is underweight), No labs indicated, PI (Pressure Injury) sacrum (large bone at bottom of spine) stage 2 pressure wound, estimated daily nutrition needs 1410-1645 kcal and 47-57 grams of protein.Nutrition Risk Related To: The resident has risk for unplanned/unexpected weight loss and risk for malnutrition r/t chronic conditions: COPD (chronic obstructive pulmonary disease), HTN (hypertension), HLD (hyperlipidemia), Muscle weakness; increased protein/calorie needs for wound healing; variable food intake with low BMI =16. 5. Nutrition Goal: The resident will consume 75% two of three meals/day to maintain weight within goal range: 103-113# (pounds). The resident will consume >75% of nutrition supplements ordered. The resident will maintain adequate hydration status. Nutritional Intervention: Continue all supplements for wound healing and monitor prn (as needed) . Review of Resident 43's Lab's Results Report dated 11/26/24 indicated the resident's Albumin (a protein in blood that transport nutrients and maintains fluid balance) = 3.2 g/dL (grams/deciliter) was low, where 3.5 g/dL to 5.7 g/dL is the normal range. During a concurrent interview and record review on 2/27/25 at 3:06 PM about resident 43's lab results on 11/26/24 with the DSM-RD, the DSM-RD stated the resident's albumin was borderline low and recent weight loss was unintentional. The DSM-RD further acknowledged the resident's nutritional needs should have been addressed by completing a reassessment of the resident's nutrition interventions and change of condition for the weight loss when it was identified. The DSM-RD also stated modifying the resident's nutrition interventions may have prevented further weight loss. 3. A review of Resident 51's Facility Admission Record indicated the resident was admitted to the facility on [DATE] with diagnoses that included dysphagia (difficulty swallowing), hypertension (elevated blood pressure levels), hyperlipidemia (abnormally high levels of fat in the blood), rhabdomyolysis (breakdown of muscle tissue), and chronic kidney failure (the kidneys cannot filter waste). Review of Resident 51's minimum data set (MDS) report dated 11/22/24 indicated the resident's brief interview of mental status-BIMS (a short cognitive screening test) score was 14, where a score of 11-15 refers to intact cognition. (continued on next page)

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	056428	A. Building B. Wing	03/03/2025

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F 0692 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of Resident 51's Weights and Vitals Summary report on 2/28/2025 indicated: 8/19/24 - 177 lbs. 9/03/24 - 167 lbs. 10/1/24 - 160 lbs. 11/5/24 - 156 lbs. 12/5/24 - 149 lbs. 01/7/25 - 148 lbs. 02/7/25 - 140 lbs. Resident 51 experienced a 16-pound, 10.26% severe weight loss in ninety days or 3 months, from 11/5/24 to 2/7/25, and a 20.9% severe loss in 180 days or 6 months from 8/19/24 to 2/7/25. Review of Resident 51's eInteract Change in Condition (COC) Evaluation dated 12/6/24 completed by LN 4 indicated the .Signs and symptoms .30. Weight loss . was checked. The COC also stated Resident noted with 7 lbs. weight loss x 30 days & 18 lbs. weight loss x 90 days .no s/s (signs and symptoms) of dehydration noted. Communicated with RD & MD (medical doctor), no new orders/ recommendations at this time. Review of Resident 51's physician's diet order dated 9/5/24 indicated CCHO - Standard Portion diet Regular texture, Regular Thin liquid consistency, fortify meals; Supplement order: 4 oz House Supplement/Milk Shake three times a day for Malnutrition risk with meals. Review of Resident 51's December 2024 - February 2025 Meal Intake percentage (%) report indicated the resident consumed 51% to 100% of meals. Resident 51's Nutrition Assessment completed in 2024 by the Registered Dietitian was requested by Surveyors but not provided by the facility. Review of Resident 51's IDT Progress Notes dated 11/8/24 completed by the DSM-RD indicated .Note Text: IDT Reviewed d/t: significant wt loss WT/BMI: 156#/23.7 kg/m2 WT TREND: -21#/-11.9% x 90 days; DIET: CCHO - Standard Portion diet, Regular texture, Regular/Thin consistency SNACK/SUPPLEMENT: Pro-stat, Vit C, Zinc, Vit D3 MEAL PO: Mostly 76-100%, 51-75% at times. EVAL: At risk for malnutrition d/t: spinal stenosis, sepsis, enterocolitis d.t c diff, AKF, BPH, HLD Weight loss likely r/t poor PO intake at times and compromised skin integrity. Resident currently has a L- posterior knee . Supplements for wound healing in place. Goal weight 155-165#. No new recommendations at this time. RECS: 1) Continue POC (plan of care) . (continued on next page)

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F 0692 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During a concurrent interview and record review on 2/27/25 at 3:06 PM with the DSM-RD about resident 51's weight loss, the DSM-RD acknowledged a nutrition assessment was not completed for resident 51 when weight loss was identified at thirty and sixty days in 2024. The DSM-RD further stated the IDT progress notes were completed in September and November 2024 that mentioned resident 51's weight loss but the recommendations should have been modified with weekly weights and other interventions to avoid further weight loss. 4. A record review of Resident 58's Facility Admission Record indicated the resident was admitted to the facility on [DATE] with diagnoses that included GERD (gastro-esophageal reflux disease), hypertension, and hyperlipidemia, type 2 diabetes with hyperglycemia, and hypothyroidism (condition which the thyroid gland does not produce enough thyroid hormone). Review of Resident 58's minimum data set (MDS) report dated 12/27/24 indicated the resident's brief interview of mental status- BIMS (a short cognitive screening test) score was 11, whereby a score of 8-12 refers to moderate impairment. Review of Resident 58's Weights and Vitals Summary report on 2/28/25 indicated: 12/24/24 -187 lbs. 01/22/25- 176 lbs. 02/07/25 -163 lbs. 02/20/25 -164 lbs. Resident 58 experienced a 23 pound, 12.3%, severe weight loss in ninety days or 3 months from 12/24/24 to 2/20/25. Review of Resident 58's eInteract Change in Condition (COC) Evaluation dated 2/7/25 completed by LN 4 indicated .Signs and symptoms .30. Weight loss .Resident noted with 25 lbs. weight loss within 30 days. no s/s of dehydration noted. Offered fluids & snacks as tolerated. Notified MD, no new orders at this time, RD aware . Continue to monitor .resident Review of Resident 58's physician's diet order dated 12/23/24 indicated CCHO - Standard Portion diet, Regular texture, Regular/Thin consistency; Supplement order dated 2/9/25, 4 oz House Supplement/Milkshake one time a day for Malnutrition risk w/ Dinner . Review of Resident 58's December 2024 - February 2025 Meal Intake percentage (%) report indicated the resident consumed 51% to 100% of meals and 75% to 100% of liquids, not including supplements. The daily supplement percentage intake was requested by Surveyors but not provided by the facility. Resident 58's initial Nutrition Risk Assessment completed by the RD was requested but not provided. (continued on next page)

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F 0692 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During a review of Resident 58's IDT Weight and Nutrition Condition progress notes dated 1/22/25 and signed by the DSM-RD, indicated Note Text: IDT Reviewed d/t:significant wt loss WT/BMI: 176#/27.6 kg/m2, WT TREND: -9#/-4.9% x 1 week. DIET: CCHO - Standard Portion diet, Regular texture, Regular/Thin consistency SNACK/SUPPLEMENT: Snack HS, MEAL PO: 76-100% poor PO x 2 days likely r/t high k+ (potassium) abnormal labs. EVAL:73 yo (year old) male at risk for malnutrition r/t (related to) a-fib (atrial fibrilation), DM2 (diabetes mellitus), ASHD (atherosclerotic heart disease- abnormal heart functioning), CKD (chronic kidney disease) .hypothyroidism, HLD (hyperlipidemia). Weight loss likely r/t COC for hyperkalemia sent out for immediate care returned same day 1/21/2024. RECS: 1) 4oz Health Shake QD w/ Dinner. IDT will continue to monitor. MD and Family made aware . During a joint interview and record review on 2/27/25 at 3:06 PM with the DSM-RD about Resident 58's weight loss, the DSM-RD stated resident 58's nutrition interventions should have been modified and follow up with the physician should have occurred to prevent further weight loss. 5. A record review of Resident 673's Facility Admission Record indicated the resident was admitted to the facility on [DATE] with diagnoses that included hypertension, and hyperlipidemia, dysphagia, depression, and hemiplegia and hemiparesis (paralysis or weakness on one side of the body). Review of Resident 673's minimum data set (MDS) report dated 11/30/24 indicated the resident's brief interview of mental status- BIMS (a short cognitive screening test) score was 7, whereby a score 0-7, severe cognitive impairment. Review of Resident 673's Weights and Vitals Summary report on 2/27/25 indicated: 8/26/24 - 150 lbs. 9/24/24 - 142 lbs. 10/5/24 - 138 lbs. 11/5/24 - 135 lbs. 12/05/24-121 lbs. 01/3/25 - 121 lbs. 02/6/25 - 123 lbs. Resident 673 experienced a 12-pound, 8.89% severe weight loss in ninety days or 3 months, from 11/5/24 through 2/6/25, and an 18% severe weight loss in 6 months from 8/26/24 to 2/6/25. Resident 673's eInteract Change in Condition (COC) Evaluation was requested by Surveyors but not provided by the facility. Review of Resident 673's physician's diet order dated 2/10/25 indicated NAS (no added salt) diet, Pureed texture, Thin liquids, Nectar thick consistency; Supplement order dated 12/07/24, 4 oz. House supplement/Milk shake three times a day for Malnutrition risk with all meals . (continued on next page)

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F 0692 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Resident 673's December 2024 - February 2025 Meal Intake percentage (%) report was requested from Surveyors but not provided by the facility. On 2/28/25 at 12:30 PM, an observation and interview of resident 673' lunch meal was conducted in the resident's room. Resident 673 stated she did not like mashed potatoes, and they serve them 3 to 4 times a week, or almost every other day. The meal tray was placed on the resident's bedside table, and it had pureed beef goulash, pureed mashed potatoes, and pureed carrots. The tray also had a chilled 8 ounce thickened 2 % milkshake drink carton. Resident 673 ate 25% to 50% of her lunch meal and drank 0% of the milkshake drink. On 3/3/25 at 7:47 AM, an observation and interview of resident 673's breakfast meal intake was conducted in the resident's room. CNA 5 stated the resident consumed 50% of her meal and needed minimal assistance. CNA 5 further stated the resident did not like her meals and the food choices. CNA 5 stated the resident was offered alternate meals for lunch and dinner, and the charge nurse was notified each time. Review of Resident 673's Nutrition Risk Assessment completed by the DSM-RD dated 9/4/24, indicated the resident's usual weight was 145-150 lbs., goal weight: 140-150 pounds, labs: Albumin 2.5 g/dL (Low) dated 8/30/24, estimated daily calorie and protein intake to meet needs: 1600-1920 kcal and 80-96 grams of protein; Nutrition Intervention: hydration status a/e/b (as evidenced by) no new s/s of malnx (malnutrition), skin b/d (breakdown), or dehydration. 3) Tolerate diet; avg (average) PO meets 75-100% of est. needs through next review date. Nutrition Goal: 1) 4 oz Health Shake QD (once a day) with Dinner 2) Weekly weights x 4 then monthly when stable 3) Update food preference as needed. During a concurrent interview and record review on 2/27/25 at 3:06 PM with the DSM-RD about resident 673's weight loss, the DSM-RD acknowledged she completed a nutrition assessment on 9/6/24 and identified weight loss, and stated a change of condition for weight loss should have been completed to notify the physician and IDT. The DSM-RD stated she did not reevaluate or assess resident 673 to determine if the nutrition interventions were successful to prevent further weight loss. During an interview on 2/27/25 at 4:05 PM with the RD-C (Corporate Registered Dietitian), the RD-C stated her expectation is for the facility's Dietitian to reassess the resident's weight history, clinical conditions, person-centered care plans, a calculated goal weight, and lab values to make nutrition recommendations and set goals to prevent further weight loss. The RD-C stated this information should be documented in the resident's medical chart for members of the IDT to view what the resident's nutrition goals are to prevent weight loss. During an interview on 2/27/25 at 5:19 PM with the Director of Nursing (DON) about residents' weight loss, the DON stated residents with significant or severe weight loss should be addressed with appropriate interventions with the RD, physician, nursing and IDT according to the facility's policy. (continued on next page)

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F 0692 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	During an interview on 3/3/25 at 11:41 AM with the facility's medical physician (FMP), the FMP stated it was important for residents to maintain a certain weight because they're an aging population who could lose lean body mass if the weight loss was not addressed. The FMP stated she was recently notified in February of Resident 43 and Resident 51's weight loss but had not spoken to the IDT about the reason for the weight loss. The FMP stated she knows Resident 43 had a low BMI (body mass index), does not like the facility's food and recently declined an appetite stimulant but did not know there was severe weight loss. The FMP also stated she expected to be notified when a significant or severe weight loss occurred for a resident so she could follow-up with a nutrition consult, request lab tests, and address the weight loss to prevent further problems. During an interview on 3/3/25 at 12:18 PM with the medical director (MDR), the MDR stated there should be a process for how weight losses of 2% to 3% are reported to the physician depending on the resident's underlying condition. The MDR stated they need to make sure there are no 15-pound weight losses experienced in one month and the policies and procedures be followed to prevent or avoid further weight loss. He stated physicians should be documenting how they address the resident's weight loss in the chart and to make sure the interventions are appropriate and the RDs need to be involved to address the weight loss. The MDR further stated weight is a very important component of a resident's medical and nutrition status because it helps them gain strength to fight off diseases. During an interview on 3/03/25 at 3:29 PM with the DSM-RD, the DSM-RD stated it was important for resident weight loss issues to be appropriately addressed to ensure the care of the resident. The DSM-RD further stated all tools should be used including fortified diets, supplements and shakes, additional portions and possible appetite medications to help improve a resident's food intake and nutrition status, and prevent more weight loss. Review of the facility's policy titled Change of Condition dated April 1, 2015, indicated .Procedure . III. A Licensed Nurse will notify the resident's Attending Physician and legal representative or an appropriate family member when there is an: .D. A change in weight of five pounds or more within a 30 day period unless a different stipulation has been stated in writing by the patient's physician . (continued on next page)

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F 0692 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Review of the facility's policy titled Evaluation of Weight and Nutritional Status dated 2022 revised 1/30/25, indicated .1. The facility will maintain an acceptable nutritional status for residents per professional standards by a) Assessing the residents nutrition status and the factors that put the resident at risk of not maintaining acceptable parameters of nutritional status. b) Analyzing the assessment information to identify the medical conditions, causes and/or problems related to the resident's condition and needs. c) Implementing interventions for maintaining or improving nutrition status that are consistent with the resident's needs, preferences, goals, and professional standards of practice. d) Developing interventions involving the resident and/or resident representative to ensure the resident's needs .are accommodated. e) Monitoring and evaluating the resident's response .to interventions. PROCESS 1 .b. Weight Loss- Unplanned weight loss in a resident. Significant weight loss (5% &/or 5 lb. in one month, 7.5%in three months, or 10% in six months), . c. Insidious weight loss refers to gradual, unintended, progressive weight loss over a three (3) or twelve (12) month period. 2 .b. Any resident weight that varies from the previous reporting period by 5% in 30 days, 7. 5% in 90 days or 10% in 180 days, or is considered insidious weight loss, with be evaluated by the IDT to determine the cause of the weight loss .and the intervention(s) required. c. The resident's Attending Physician will be notified when there is a weight variance of 5 pounds in 1 month .d.Residents at risk who should be weighed weekly include (but are not limited to) the following: .2. Significant weight loss or gain identified .3. Residents demonstrating insidious weight loss; .5. Residents on dialysis .ii. Weekly weights will be discontinued when the resident's weight has been within stable range for a period of four (4) weeks . Review of the facility's policy titled Nutritional Status Evaluation dated May 19, 2022, indicated .I. A registered dietitian will complete a nutritional evaluation upon admission .readmission, annually, and upon a significant change of condition.The Dietitian will use information from the Resident's medical record to complete the nutritional evaluation .including but not limited to: .A. diagnosis, B. diet order .E. skin condition, F. Ability to chew and swallow . H. Meal intake percentage .K. pertinent medications, L. laboratory data, M. usual body weight, N. BMI, O. estimated nutrition needs range .IV. The registered dietitian will provide recommendations in narrative and identify any risk factors for weight loss or dehydration and complete a clinical recommendation . Review of the facility's policy titled Nutritional Status Evaluation Committee dated June 2018, indicated . Purpose: [TRUNCATED]

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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** 51080 Based on observation, interview, and record review, the facility failed to provide respiratory care and treatment for one resident reviewed for oxygen administration (Resident 43), when the physician's order for oxygen administration was not followed. This failure had the potential to result in ineffective oxygen therapy, respiratory distress, and decline in the resident's health condition. Findings: On February 25, 2025, at 10:59 a.m., Resident 43 was observed in bed with oxygen (O2) via nasal cannula (NC - a tube used to deliver oxygen through the nose). Resident 43's oxygen administration was observed at 4 liters per minute (LPM). On February 27, 2025, at 10:33 a.m., a concurrent observation, interview and record review was conducted with Licensed Vocational Nurse (LVN) 1. LVN 1 confirmed the O2 level for Resident 43 was at 4 LPM. LVN 1 verified the physician order and stated the O2 level should be at 2 LPM, as per physician's order. LVN 1 stated the physician's order was not followed. On February 27, 2025, at 3:51 p.m., an interview was conducted with the Director of Nursing (DON). The DON confirmed the O2 level should be followed per physician's orders. The DON stated the physician's order was not followed. Resident 43's record was reviewed. Resident 43 was admitted to the facility on [DATE], with diagnoses which included heart failure (a condition when the heart does not pump enough blood), asthma (a chronic lung disease) and Chronic Obstructive Pulmonary Disease (COPD-a chronic lung disease causing difficulty in breathing). The physician's order dated May 9, 2023, indicated, .Oxygen at 2 L/min (LPM) via nasal cannula . The facility policy and procedure titled, Oxygen Therapy, revised November 2017, was reviewed. The policy indicated, .Administer Oxygen per Physician orders .

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 46393 Based on observation, interview and record review, the facility failed to ensure provision of pharmacy services met the needs of the residents when: 1. An emergency supply kit (E-kit, a sealed container with various medications for use in emergencies) containing controlled substance (CS, those with high potential for abuse and addiction) medications was stored opened and unsealed; 2. Residents 17 and 50 were missing documentation for the administration of CS medications. The CS medications were signed out of the Individual Narcotic Record (count sheet, an inventory sheet that keeps record of the usage of CS medications) but not documented on the Medication Administration Records (MAR) to indicate they were administered to the residents; Additionally for Resident 17 the CS medications were documented on the MAR but not signed out of the count sheet; and 3. For Resident 50, nursing staff did not ensure the CS medication received from the pharmacy matched the current physician's order according to the facility's policy and procedures. These failures had the potential for CS medication misuse or abuse. Findings: 1. During a concurrent observation and interview on February 26, 2025 at 2:38 p.m. with the Registered Nurse Supervisor (RNS) in the Medication Room, one e-kit labeled Narcotic [CS medications with high potential for abuse and addiction] Emergency Kit was observed to have been opened and stored unsealed without a lock. The RNS acknowledged the Narcotic e-kit had been opened by nursing staff. The RNS stated after the e-kit was opened by nursing staff there should have been a yellow lock on the Narcotic e-kit. The RNS described the facility's Narcotic e-kit use process was as follows: -Nursing staff needed to obtain pharmacy authorization to open the Narcotic e-kit; -Two licensed nurses were required to witness the removal of the CS medication from the Narcotic e-kit; -Nursing staff should have filled out the medication slip, left one copy of the slip in the logbook and one copy of the slip inside the Narcotic e-kit; - Nursing staff should have resealed the Narcotic e-kit with a yellow lock; and - Nursing staff should have immediately called the pharmacy to reorder the e-kit, and the pharmacy would have been expected to replace the e-kit within 72 hours. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During the same observation and interview, an inspection of the Narcotic e-kit identified one slip of paper inside. The slip of paper indicated the Narcotic e-kit was opened one time on February 26, 2025, and one hydrocodone-acetaminophen (a potent controlled medication for pain) 5/325 milligrams (mg, unit of measurement) tablet was removed for one resident. The RNS said, Nurse should have relocked the e-kit. During an interview on February 26, 2025, at 5:58 p.m. with the Director of Nursing (DON), the DON stated the expectation was for nursing staff to have relocked the e-kit after a medication was removed from the e-kit. During a review of the facility's policy and procedure (P&P) titled, Medication Ordering and Receiving from Pharmacy - Emergency Pharmacy Service and Emergency Kits, revised June 2016, indicated, Emergency oral medications are kept in a sealed, portable container .Emergency .controlled substances are kept in a sealed, portable container .nurse records the medication use from the emergency kit on the medication order and E-Kit use form and calls the pharmacy for replacement of the kit and flags the kit with a color-coded lock to indicate need for replacement of kit as soon as possible after the medication has been administered. 2. During an interview on February 26, 2025 at 3:17 p.m. with Licensed Vocational Nurse (LVN) 6, LVN 6 stated the facility's process for CS pain medication administration and documentation was as follows: - Ask the resident about pain severity and location; - Check the physician's order in the MAR; - Remove from locked drawer of medication cart; and - Sign the count sheet and MAR at the same time, to document the administration to the resident. During an interview on February 26, 2025 at 5:41 p.m. with the DON, regarding the CS administration and documentation process, the DON stated nursing staff were expected to sign-out the CS medication on the count sheet and chart the administration to the residents on the MAR at the same time. 2a. Resident 50 had a physician's order, dated October 4, 2024, for hydrocodone-acetaminophen 10/325 mg, 1 tablet by mouth every 6 hours as needed for severe pain. During a concurrent interview and record review on February 28, 2025 at 4:20 p.m. with the DON, a review of Resident 50's count sheet for hydrocodone-acetaminophen 10/325 mg tablets and MARs dated November 2024, December 2024, and January 2025 indicated the nursing staff signed out one tablet on the following dates and times but did not document the administration on the MAR: - November 13, 2024, at 00:10 (12:10 a.m.); - November 20, 2024, at 00:30 (12:30 a.m.); - November 27, 2024, at 00:24 (12:25 a.m.); (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- December 3, 2024, at 01:34 (1:34 a.m.); - December 26, 2024, at 01:20 (1:20 a.m.); - January 7, 2025, at 04:00 (4 a.m.); and - January 9, 2025, at 21:22 (9:22 p.m.). During this interview and record review, the DON acknowledged three hydrocodone-acetaminophen 10/325 mg tablets for Resident 50 were unaccounted in November 2024, two hydrocodone-acetaminophen 10/325 mg tablets were unaccounted in December 2024, and two hydrocodone-acetaminophen 10/325 mg tablets were unaccounted in January 2025. The DON stated the administrations should have been documented on the MAR and it was important for nursing staff to follow the proper procedures to ensure accurate controlled substance accountability. 2b. Resident 17 had a physician's order, dated January 29, 2025, for hydrocodone-acetaminophen 5/325 mg, 1 tablet by mouth every 6 hours as needed for severe pain. During a concurrent interview and record review on February 28, 2025 at 4:33 p.m. with the DON, a review Resident 17's narcotic count sheet for hydrocodone-acetaminophen 5/325 mg and MAR dated February 2025 indicated the nursing staff signed out one tablet from the count sheet on the following dates and times but did not document the administration on the MAR: - February 13, 2025, at 09:21 (9:21 a.m.); - February 14, 2025, at 06:00 (6 a.m.); - February 18, 2025, at 8:31 a.m.; and - February 19, 2025, at 00:46 (12:46 a.m.). During the same interview and record review, Resident 17's narcotic count sheet for hydrocodone-acetaminophen 5/325 mg and MAR dated February 2025 indicated the nursing staff did not sign on the count sheet when they removed the hydrocodone-acetaminophen 5/325 mg tablet but documented the administration on the MAR on the following dates and times: - February 1, 2025, at 10:30 (10:30 a.m.); - February 5, 2025, at 10:01 (10:01 a.m.); - February 6, 2025, at 09:00 (9 a.m.); - February 6, 2025, at 20:55 (8:55 p.m.); - February 7, 2025, at 23:16 (11:16 p.m.); - February 10, 2025, at 06:05 (6:05 a.m.); (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- February 10, 2025, at 13:20 (1:20 p.m.); - February 11, 2025, at 05:11 (5:11 a.m.); and - February 22, 2025, at 15:44 (3:44 p.m.). Additionally, during the same interview and record review, Resident 17's narcotic count sheet for hydrocodone-acetaminophen 5/325 mg and MAR dated February 2025 indicated the nursing staff signed-out one tablet on February 23, 2025 at 6:30 p.m. and crossed it out on the count sheet, but documented the administration on the MAR. The DON stated, the nursing staff should have updated the documentation on the MAR when the tablet was not given to reflect the cancelled administration of the hydrocodone-acetaminophen 5/325 mg tablet on February 23, 2025 at 6:30 p.m. During a review of the facility's P&P titled, Preparation and General Guidelines - Controlled Substances, revised February 2020, indicated, Accurate accountability of the inventory of all controlled drugs is maintained at all times. When a controlled substance is administered, the licensed nurse administering the medication immediately enters the following information on the accountability record and the medication administration record (MAR) .Date and time of administration (MAR, Accountability Record) .Amount administered (Accountability Record) .Remaining quantity (Accountability Record) .Initial of the nurse administering the dose, completed after the medication is actually administered (MAR, Accountability Record). During a review of the facility's P&P titled, Medication Administration, revised January 1, 2012, 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 Medication Administration Record (MAR). 3. During an interview on February 26, 2025 at 5:30 p.m. with the DON, the DON stated the process for receiving CS medication bubble packs (a card that packages doses of medication within small plastic bubbles) delivered from the pharmacy using the Narcotic Black Book was as follows: - When the pharmacy arrived with the CS medication delivery, two licensed nurses should have counted the CS medications and verified the accuracy of the delivery; - Both licensed nurses should have signed the Packing Slip and filed the Packing Slip with medical records; - Nursing staff should have verified that all the information on the pharmacy medication bubble pack label matched with the physician's order; - Then nursing staff should have transferred all resident and medication information from the pharmacy medication bubble pack label onto the CS count sheet in the Narcotic Black Book; and - Nursing staff should have written the count sheet page number from the Narcotic Black Book on the medication bubble pack. Review of Resident 50's medical records indicated a physician's order, dated October 4, 2024, for hydrocodone-acetaminophen 10/325 mg, 1 tablet by mouth every 6 hours as needed for severe pain. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility's document titled Packing Slip, dated November 6, 2024, indicated Resident 50's RX (prescription number) 5766730 for 28 tablets of hydrocodone-acetaminophen 10-325 mg was delivered by the pharmacy and received by the facility on November 7, 2024. Review of Resident 50's RX 5766730 pharmacy medication bubble pack label, dated November 6, 2024, indicated 28 tablets of hydrocodone-acetaminophen 10-325 mg were dispensed by the pharmacy with the following instructions Take one tablet every 8 hours as needed for severe pain . Additionally, the pharmacy medication bubble pack had the number 40 handwritten in the upper left corner and a white sticker label that indicated, Q (every) 8 (eight) H (hours). Review of Resident 50's CS count sheet on page 40 in the Narcotic Black Book, dated November 7, 2024, indicated Hydroco [hydrocodone]/APAP [acetaminophen] 10/325 mg as needed 1 tab [tablet] q [every] 8 [eight] hours was received by nursing staff. Review of Resident 50's Order Audit Report, dated February 27, 2025, indicated the pharmacy dispensed Resident 50's RX 5766730 on November 7, 2024 for hydrocodone-acetaminophen 10-325 mg tablet, take 1 [one] tablet by mouth every 8 [eight] hours as needed for severe pain. During a concurrent interview and record review on February 27, 2025 at 6:25 p.m. with the DON, Resident 50's medical record was reviewed, including the following documents related to RX 5766730: -Pharmacy Packing Slip dated November 6, 2025; -Medication bubble pack label dated November 6, 2025; - CS count sheet on page 40 in the Narcotic Black Book dated November 7, 2025; and - Order Audit Report dated November 7, 2025. During the same interview, the DON acknowledged Resident 50's RX 5766730 for hydrocodone-acetaminophen 10-325 mg tablets that was delivered on November 7, 2024 by the pharmacy had a frequency of every 8 hours which did not match the current physician's ordered frequency of every 6 hours. The DON acknowledged the nursing staff should have checked the current physician's order upon delivery and called the pharmacy to clarify the discrepancy with the frequency. The DON stated the medication delivered by the pharmacy should have matched the current physician's order for hydrocodone-acetaminophen 10/325 mg, 1 tablet by mouth every 6 hours as needed for severe pain, dated October 4, 2024 During an interview on February 28, 2025 at 4:39 p.m. with the DON, the DON stated the expectation was for the pharmacy to have dispensed the medications as ordered by the physician. Additionally, the DON stated the expectation was for nursing staff to have reconciled what was delivered by the pharmacy with the physician's order to ensure everything matched. The DON stated the potential adverse outcome was the resident could have run out of pain medication sooner than expected and could have had to wait for more pain medication to get delivered. During a telephone interview on February 28, 2025 at 4:47 p.m. with the Consultant Pharmacist (CP), regarding RX 5766730 for Resident 50, the CP stated the processing pharmacist should have checked the physician's order and what was ordered by the physician should have been what was delivered to the resident. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a telephone interview on February 28, 2025 at 5:11 p.m. with the Director of Pharmacy (DOP) of the dispensing pharmacy, regarding RX 5766730 for Resident 50, the DOP stated upon receipt of the delivery, the nurse at the facility should have clarified with the pharmacy if they did not have the order for hydrocodone-acetaminophen 10/325 mg every 8 hours as needed for pain. During a review of the facility's P&P titled, Receiving Controlled Substances, dated October 2012, indicated, Only licensed personnel may receive controlled substances from the pharmacy driver/courier. Procedures for receiving controlled substances include .A nurse reconciles controlled substance orders and refill requests against what has been received from the pharmacy .A nurse notifies the pharmacy if controlled substance orders or doses are missing or incorrect .Controlled substance inventory sheets are completed .

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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** 50610 Based on interviews and record reviews, the facility failed to ensure the Consultant Pharmacist (CP) identified and reported irregularities during the monthly Medication Regimen Review (MRR) for one of six randomly selected residents (Resident 58) when the facility did not clarify the physician's order for Vitamin D3 (a type of Vitamin supplement). This failure had the potential for Resident 58 to receive a wrong dose of Vitamin D3. Findings: During the medication administration observation on February 25, 2025, at 9:57 a.m. with licensed vocational nurse (LVN) 3, LVN 3 was observed preparing seven medications for Resident 58. During the medication preparation process, LVN 3 did not administer Vitamin D3 and stated Resident 58's Vitamin D3 order did not have a strength (the amount of medication) indicated. LVN 3 stated she needed to clarify the order. A review of the Resident 58's Admission Record, dated February 27, 2025, indicated, Resident 58 was admitted on [DATE], with diagnoses that included, chronic kidney disease (a long-term condition in which the kidneys are damaged and cannot filter blood properly). A review of Resident 58's physician's order, dated January 23, 2025, indicated Vitamin D3, give 1 tablet by mouth one time a day for supplement. During a review of Resident 58's medication administration record (MAR) dated January and February 2025, it indicated nursing staff administered Resident 58 one Vitamin D3 tablet daily on the following days: - January 24, 2025 to January 29, 2025, and on January 31, 2025; and - February 1, 2025 to February 24, 2025. During a concurrent interview and record review on February 25, 2025, at 12:54 p.m. with LVN 4, Resident 58's medical record, including the physician's order for Vitamin D3 and MARs dated January and February 2025 were reviewed. LVN 4 acknowledged there was no strength indicated on the physician's order for Vitamin D3. Additionally, LVN 4 acknowledged Resident 58 was administered one Vitamin D3 tablet on the days as listed above. When asked what he would have done if the strength was not indicated on the physician's order for Vitamin D3, LVN 4 stated he would have not given the Vitamin D3 and would have called the physician to clarify the order. LVN 4 further stated nursing staff should have clarified the order with the physician, documented the clarification, and entered the updated order in Resident 58's medical record. A review of the CP's January 2025 MRR for Resident 58, dated February 3, 2025, indicated there were no recommendations related to the missing strength on Resident 58's Vitamin D3 order. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on February 25, 2025, at 5:11 p.m. with the Director of Nursing (DON), the DON acknowledged the above findings and stated nursing staff were expected to have identified and clarified the missing strength for the Vitamin D3 order on January 23, 2025 when the order was received by nursing staff for Resident 58. The DON further stated it was important to clarify the physician's order to ensure accurate dosage, effective treatment and to prevent an unsafe use from administering too much or too little medication. Additionally, the DON acknowledged there were no irregularities reported by the CP in the January 2025 MRR dated February 3, 2025 related to Resident 58's Vitamin D3 order and stated it should have been reported. During the telephone interview on February 28, 2025, at 4:47 p.m. with the CP, the CP acknowledged he did not identify and report the irregularity related to the missing strength for Resident 58's Vitamin D3 order during the monthly MRR for January 2025 on February 3, 2025 and stated he should have. During a review of the facility's policy and procedure titled Consultant Pharmacist Reports - Medication Regimen Review, dated October 2012, indicated, The consultant pharmacist identifies irregularities through a variety of sources including Medication Administration Records (MARs), prescribers' orders .The consultant pharmacist's evaluation includes but is not limited to reviewing and/or evaluating the following .The prescribed dose is appropriate to the resident's clinical status .Resident-specific irregularities and/or clinically significant risks resulting from or associated with medications are documented in the resident's [active record] and reported to the Director of Nursing and/or prescriber as appropriate .

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38924 Based on observations, interviews, and record review, the facility failed to ensure a Registered Dietitian (RD) carried out the functions of the registered dietitian when: 1. Timely monitoring of nutrition interventions was not conducted to meet the needs of 5 sampled residents, (23, 43, 51, 58 and 673) who experienced severe unintentional weight losses greater than 7.5% in three months; 2. The Diet manual was not updated, and facility menus were not followed; and 3. Unsanitary and unsafe food practices were conducted in the kitchen. These failures placed vulnerable residents at risk to poor improper practices that had the potential to further weaken and compromise their nutrition and health status based on their medical diagnoses. The facility census was 72. Cross reference F692, F803, F804, F812 Findings: 1. During a review of The Academy of Nutrition and Dietetics Evidence Analysis Library regarding Unintended Weight Loss for Older Adults Evidence-Based Nutrition Practice Guidelines, dated 2007-2009, . The Registered Dietitian should monitor and evaluate weekly body weights of older adults with unintended weight loss, until body weight has stabilized, to determine effectiveness of medical nutrition therapy (MNT) . During the facility's recertification survey from 2/24/25 - 3/3/25, multiple observations, interviews and record reviews were conducted with residents and staff and a sample of five residents (23, 43, 51, 58 and 673) were found to have experienced severe, unintentional and unplanned weight losses within three months, which led to an immediate jeopardy being called. a) Resident 23 experienced a severe unplanned weight loss of 16 lbs. (pounds- a measurement of weight), 8. 04% from the weights obtained on 11/5/24 to 2/26/25. Resident 23 was diagnosed with uncontrolled diabetes mellitus (condition in which the body has trouble controlling blood sugar). The resident was not placed on weekly weights, the Registered Dietitian (RD) did not reassess the resident to determine appropriate interventions to address the weight loss, and the weight loss was not communicated to the Physician. b) Resident 43 experienced a severe unplanned weight loss of 14 lbs. or 11.67% from the weights obtained on 11/5/24 to 2/7/25. Resident 43 was diagnosed with hyperlipidemia (elevated blood fat levels) and a body mass index (BMI) of 16.5 (less than 18 is underweight). The resident was not placed on weekly weights, the RD did not reassess the resident to determine appropriate weight loss interventions, and the weight loss was not communicated to the Physician. (continued on next page)

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	c) Resident 51 experienced a severe unplanned weight gain of 16 lbs., 10.26% from the weights obtained on 11/5/24 to 2/7/25. Resident 51 was diagnosed with hypothyroidism (condition which the thyroid gland does not produce enough thyroid hormone) and chronic kidney failure (CKD) (when the kidneys cannot filter waste). Weekly weights were not implemented for the resident and the weight loss was not addressed by the Physician. d) Resident 58 experienced a severe unplanned weight loss of 23 lbs., 12.3% from the weights obtained on 12/24/24 to 2/20/25. The resident was not reassessed by the RD to determine appropriate interventions, and the Physician did not address the weight loss. e) Resident 673 experienced a severe unplanned weight loss of 8.6 lbs., 5.78% from the weights obtained on 11/5/24 to 2/6/25. Resident 673 was diagnosed with dysphagia (difficulty swallowing) and hemiplegia (paralysis of one side of the body). The RD did not reassess the resident to address the severe weight loss to determine if the interventions were effective to prevent further weight loss. During an interview with the facility's Registered Dietitian (RD) on 2/24/25 at 4:53 PM, the RD stated she recently became the full-time Dietary Services Manager a few weeks ago but previously worked at the facility as a clinical RD part-time, up to 20 hours a week. The RD stated since she has been the full-time DSW, she spent 70% to 75% of her time on clinical nutrition care and 25% to 30% of time on food service tasks. During an interview on 2/27/25 at 4:05 PM with the RD-C (Corporate Registered Dietitian), the RD-C stated her expectation is for the facility's Dietitian to reassess the resident's weight history, clinical conditions, person-centered care plans, a calculated goal weight, and lab values to make nutrition recommendations and set goals to prevent further weight loss. The RD-C stated this information should be documented in the resident's medical chart for members of the IDT to view what the resident's nutrition goals are to prevent weight loss. During an interview on 2/27/25 at 5:19 PM with the Director of Nursing (DON) about residents' weight loss, the DON stated residents with significant or severe weight loss should be addressed with appropriate interventions by the RD, physician, nursing and IDT, according to the facility's policy. During an interview on 3/3/25 at 12:18 PM with the medical director (MDR), the MDR stated the facility needs to make sure there are no 15-pound weight losses experienced in one month and the policies and procedures be followed to prevent or avoid further weight loss. He stated physicians should be documenting how they address the resident's weight loss in the chart and to make sure the interventions are appropriate and the RDs are involved to address the weight loss. The MDR further stated weight is a very important component of a resident's medical and nutrition status because it helps them gain strength to fight off diseases. During an interview on 3/03/25 at 3:29 PM with the DSM-RD, the DSM-RD stated it was important for resident weight loss issues to be appropriately addressed to ensure the care of the resident. The DSM-RD further stated all tools should be used including fortified diets, supplements and shakes, additional portions and possible appetite medications to help improve a resident's food intake and nutrition status and prevent more weight loss. (continued on next page)

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the California Code, Business and Professions Code - BPC S 2586, section (a)(1) indicated .a registered dietitian .may, upon referral by a health care provider authorized to prescribe dietary treatments, provide nutritional and dietary counseling, conduct nutritional and dietary assessments, and develop and recommend nutritional and dietary treatments, including therapeutic diets, for individuals or groups of patients in licensed institutional facilities . The referral for medical nutrition therapy shall be accompanied by a written prescription signed by the health care provider detailing the patient's diagnosis and including either a statement of the desired objective of dietary treatment or a diet order may .initiate nutritional interventions within the parameters of the prescribed diet order .shall collaborate with a multidisciplinary team, which shall include the treating physician and the registered nurse, in developing the patient's nutrition care plan.may individualize the patient's nutritional or dietary treatment, when necessary, by modifying the distribution, type, or quantity of food and nutrients within the parameters of the diet order. Any modification, and the rationale for the modification, shall be documented in the patient's record for review by the practitioner, or other licensed health care professional . 2. During the facility's recertification survey from 2/24/25 - 3/3/25 multiple observations, interviews, and record reviews were conducted regarding the facility's Diet Manual and following the facility's menus for renal diets. a) On 2/26/25 at 8:32 AM at the Nursing Station, a record review of the facility's Diet Manual titled Diet Manual for Long Term Care and Residential Facilities 2020 was conducted. The Diet Manual indicated This manual has been evaluated and approved by the Patient Care Policy Committee of CNRC dated 1/8/20 . signed by a facility's registered dietitian and medical director (MDR). During a concurrent interview and record review on 3/3/25 at 3:30 PM with the Dietary Services Manager-Registered Dietitian (DSM-RD), the DSM-RD acknowledged the facility's Diet Manual was not current or updated. The signature line for 2025 on the signature page titled Yearly Reviews was blank and not signed off by the RD and MDR. The DSM-RD stated it was important for the diet manual to be updated per regulation standards to ensure residents receive appropriate diets. b) During a review of the facility's Cook's Spreadsheet Winter Menus- (Pg 2) the menu indicated .Week 1 . Tuesday .2/25/25, indicated .Renal Diets .Herb Crusted Beef Gravy 2 oz. meat, [NAME] with margarine #12 (1/3 cup), Zucchini with margarine 1/2 cup .Garlic Bread 1 slice . During a review of the facility's Compact Roster by Name Report, dated 2/25/25, the report indicated Resident 66's diet was .Diet . Renal, CCHO (consistent carbohydrates), Fluid Restriction 1500 mL (milliliters) per day, Lactose (milk sugar) Free .80 gram and indicated Resident 17's diet was .Renal 60 gram-Regular-Large . During an observation and interview on 2/25/25 at 11:59 A.M. of the lunch meal trayline service, [NAME] (CK 1) stated a renal diet meal tray would get .herb chicken, white rice, and zucchini . CK 1 stated they didn't have brown rice to serve and white rice is the same as brown rice. On 2/26/25 at 2:46 P.M., an interview was conducted with the Dietary Services Manager-Registered Dietitian (DSM-RD). The DSM-RD stated it is her expectation that the Cooks and kitchen staff follow the printed menus, so the resident receives the appropriate diet and nutrition to meet their needs. (continued on next page)

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During an interview on 3/03/25 at 3:29 PM with the DSM-RD, the DSM-RD stated it was important for the facility to follow the approved menus to ensure residents receive the appropriate therapeutic diet. According to M. [NAME] et al., Journal of Renal Nutrition, Vol 26, No 4 (July), 2016: pp e19-e22, .Brown rice: can be included in a renal diet . with careful consideration of overall daily intake of phosphorus and potassium . Review of the undated facility P&P titled Menus indicated To ensure that the Facility provides meals to residents that meet the requirements of the Food and Nutrition Board .Daily menus will include planning for three meals and an evening snack . 3. During the facility's recertification survey from 2/24/25 - 3/3/25 multiple observations, interviews and record reviews were conducted in the kitchen regarding unsafe and unsanitary food practices pertaining to a) unclean ice machines, high freezer temperatures, b) high chlorine dish machine sanitizer levels, and c) unclean dishes stored with clean dishes. a) On February 24, 2025, at 10:38 a.m., a joint observation and interview was conducted at the facility's ice machine. The ice machine had dark brown and black debris inside the bin, on and inside the ice cubes. There was a light brown pinkish colored slimy substance inside the internal rubber and metal ice making parts, as well as the external metal pan. The Maintenance Supervisor (MS) was in the process of removing parts of the outer and inner components of the machine. The MS stated he was cleaning the ice machine with green Palmolive dish soap and an aqua colored solution inside a clear plastic cleaning bottle. The MS stated he cleaned inside the ice machine bin and internal ice making parts, once a month. On February 24, 2025, at 10:45 a.m., a concurrent observation and interview with the Director of Nursing (DON), and the DSM-RD was conducted. The DON and the DSM-RD acknowledged the dirty brown, black and pinkish slime build-up and debris in the ice machine. The DSM-RD stated the condition of the ice machine was not acceptable because residents with weakened immune systems could get sick, be hospitalized , and even death if they consume the ice. b) During the initial kitchen tour on February 24, 2025, at 9:15 a.m., a concurrent observation and interview with [NAME] (CK) 1 was conducted at the reach in freezer. The freezer was full of bags of mixed vegetables on the middle shelf, cases of chicken and beef at the bottom shelf and large tubs of ice cream along with pre-cooked bread rolls. The ice cream was very soft, and tub was bendable. The temperature internal temperature of the freezer was 54 degrees Fahrenheit (F). A surveyor placed their digital thermometer inside the reach in freezer and the temperature was 49.8 degrees F. CK 1 acknowledged the refrigerator's internal temperature and stated, it should be 32 degrees. On 2/25/25 at 12:01 PM, an observation of the reach-in freezer internal thermometer indicated the temperature was 43 degrees F and the Surveyor's thermometer was 41.9 degrees F. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
California Nursing & Rehabilitation Center	2299 North Indian Canyon Drive Palm Springs, CA 92262

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On February 24, 2025, at 4:54 p.m., an observation and interview were conducted with the Dietary Services Manager-Registered Dietitian (DSM-RD) in the kitchen. The reach-in freezer thermometer read 55 degrees F. There was water condensation collection on the ceiling. The DSM-RD acknowledged the 55 degrees F and stated the reach-in freezer temperatures sometimes runs higher than normal, especially when the kitchen staff go in and out of it. The DSM-RD further stated the temperature should not be higher than 5 or 6 degrees above zero degrees to keep foods frozen. The DSM-RD also stated the internal thermometer may need to be changed. On February 25, 2025, at 9:08 a.m., a concurrent observation and interview was conducted in the kitchen. The temperature on the internal thermometer inside the reach in freezer was 16 degrees F. The DSM-RD further stated the temperature was 0 degrees or negative degrees F in the morning at 6:00 a.m. The DSM-RD also stated they may look into replacing the freezer in the future. c) On February 24, 2025, at 9:55 a.m., a concurrent observation and interview was conducted with the DSM-RD in the kitchen. The DSM-RD acknowledged there were three 3 large metal pans had water and food debris on them. The pans were dripping wet and stacked on top of each other. Four pie pans with water and debris on them, two (2) strainers with white dried residue and 2 skillets with dried particles on them were stored under a counter. There were four rubber cutting boards with multiple indented markings were found under the food prep counter. The DSM-RD stated the strainers were not clean and verified the dry white substance should not be there. The DSM-RD further stated the wet dishes should be dried before they were put away and not stored wet. During an interview with the Administrator (ADM) on 2/27/25 at 5:00 PM, the ADM stated the facility recently hired the DSM-RD to be the full-time RD. However, the ADM further stated the Registered Dietitian duties should still be completed appropriately to protect the health and safety of the residents, according to the RD contractual agreement. During an interview on 3/03/25 at 3:29 PM with the DSM-RD, the DSM-RD stated it was important for the kitchen and food service operations function under safe and sanitary conditions to protect the residents. According to the 2022 Federal Food Code, section 3-307.00 Miscellaneous Sources of Contamination, indicated, .Food shall be protected from contamination that may result from a factor or source not specified under Subparts 3-301 - 3-306. A review of the facility's policy and procedures titled, Dietary Department -Infection Control dated June 4, 2024, indicated, .Personal cleanliness is required in sanitary food preparation .cover hair, beard, and mustache with an effective hair restraint, such as hats, hair coverings, or nets while in any kitchen and food storage areas. During a review of the facility's monthly Kitchen Sanitation & Food Safety Inspection reports dated 8/30/24 to 1/25/25 completed by the RD, indicated the following concerns .Let silverware completely dry before putting away .Food debris observed in food bins .Coffee machine needs a deep cleaning .Cold Storage .44 .Freezer . Frost Observed and 0 degrees F or below .Partially Met . (continued on next page)

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of the facility's job description titled Registered Dietitian dated 10/10/23, indicated .Summary: Provide Medical Nutrition Therapy and work with the Dietary Supervisor to ensure that quality food service and nutritional care are being provided to residents by performing the following duties. Essential Duties and Responsibilities: Evaluates the Medical Nutrition Therapy needs of the residents and implements appropriate interventions to improve their nutritional status .Coordinates with the Nutrition Services Supervisor/Manager the review and customization of the regular and therapeutic menus .Routinely inspects the food service areas and practices for compliance with company policies, procedures, and standards with applicable federal, state, and local regulations . Review of the facility's Registered Dietitian Services Contractor Agreement contract dated 1/27/22, indicated . 1. Services .d. Assess all residents at the .facility on an annual basis and quarterly for residents .in regard to nutritional parameters such as weight variance .abnormal labs .e. Review Quarterly Assessments .for nutrition concern triggers - significant weight loss .abnormal labs .g. Complete Recommendations for Nutrition Interventional based on nutritional assessment to meet the estimated nutrition needs of the resident .j. Approve the .Menu System .k. Review and approve the Diet Manual on an annual basis .q. Conduct kitchen inspections for safety and sanitation .

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. 49113 Based on observation, interview, and record review, the facility did not ensure the kitchen staff in the food and nutrition services department were trained according to standards of practice for food safety, sanitation, and facility policy when: 1. A [NAME] did not know how to use the chlorine test strips to test the sanitizer in the dish machine. 2. A Dietary Aide did not know how to calibrate a food thermometer. These failures in staff competency resulted in exposing 72 residents who consume food from the kitchen to practices associated with food borne illness as well as bacterial and chemical cross contamination and had the potential to cause illness. Findings: 1. On February 24, 2025, at 10:32 a.m., [NAME] (CK) 2 demonstrated how to test the sanitizer in the dish machine and described how it operated. CK 2 dipped a test strip from the container and compared the color shades of lavender to purple. CK 2 stated it was dark purple which was 300 ppm to 400 ppm (parts per million, a measure of units), and it should be 100 ppm to 200 ppm, according to the test strip container. On February 24, 2024, at 4:10 p.m., an observation and interview were conducted with Dietary Aide (DA) 1. DA 1 dipped the test strip in the water in the dish machine basin. DA 1 stated it was okay to dip the test strip into the water residue. DA 1 compared the color shades to the lavender to purple colors on the test strip container, and stated the test strip was purple which indicated 100-200 ppm (parts per million-a unit of measurement). DA 1 stated the color was okay, and further stated he did not know the correct level should be 50-100 ppm. During an interview on February 24, 2025, at 4:21 p.m., with the Dietary Service Manager-Registered Dietitian (DSM-RD), the DSM-RD acknowledged CK 2 and DA 1 did not know how to correctly test the sanitizer in the low temperature dish machine and the concentration should be 50 ppm to 100 ppm. The DSM-RD further stated they should know how to correctly test the sanitizer and may need an in-service. According to the 2022 Federal Food Code, section 4-302.14, titled Sanitizing Solutions, Testing Devices, indicated, .Testing devices to measure the concentration of sanitizing solutions are required for 2 reasons: . the use of chemical sanitizers requires minimum concentrations of the sanitizer . to ensure sanitization, and 2, too much sanitizer in the final rinse water could be toxic . A review of the facility's policy and procedure titled, Dish Machine Operation and Cleaning dated October 1, 2014, indicated, .Routinely monitor soap, sanitizer and rise agent to ensure adequate supply throughout operation of the dish machine . (continued on next page)

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. On February 25, 2025, at 10:13 a.m. an observation and interview with Dietary Aide (DA) 2 and the DSM-RD, was conducted in the kitchen. DA 2 took the thermometer wiped it with an alcohol wipe, then stated she was not sure how to calibrate the thermometers because the cook calibrated the thermometers. DA 2 further stated it was important to know how to properly calibrate thermometers so food would be at a safe temperature for the residents to eat. The DSM-RD acknowledged DA 2 did not know how to calibrate the thermometer. According to the 2022 Federal Food Code, section 4-302.12, titled Food Temperature Measuring Devices. The presence and accessibility of food temperature measuring devices is critical to the effective monitoring of food temperatures. Proper use of such devices provides the operator or person in charge with important information with which to determine of temperatures should be adjusted or if foods should be discarded. A review of the facility's [NAME] Job Description, undated, indicated, .Technical .Basic understanding of cleanliness, organization, and safety .Qualifications .Performs job duties in a safe and sanitary manner . A review of the facility's Dietary Assistant/Dishwasher Job Description, undated, indicated, .Technical . Maintains a safe and sanitary work environment .Qualifications .Basic understanding of sanitation, organization, and safety . A review of the facility's policy and procedure titled, Calibrating a Thermometer dated July 1, 2014, indicated, .The purpose is to provide the dietary department with guidance for calibrating bi-metallic food thermometers . Food thermometers will be calibrated periodically to ensure proper food temperatures.

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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** 38924 Based on observation, interview and record review, the facility failed to ensure the therapeutic menu was followed for two residents, a sampled resident 66, and unsampled resident 17, on renal diets (a diet to protect the health of the kidneys). These failures led to the two residents receiving foods that did not meet their nutritional needs and may have further compromised their health status. The facility census was 72. Findings: Review of Resident 17's Admission Record dated 2/28/25 indicated Resident 17 was admitted on [DATE] and readmitted on [DATE] to the facility with diagnoses that included COPD (chronic obstructive pulmonary disease- difficulty breathing due to obstruction in the lungs), CKD (chronic kidney disease- inability of the kidneys to effectively filter wastes) and HLD (hyperlipidemia- high levels of fat in the blood). Review of Resident 17's minimum data set (MDS- standardized assessment tool used to assess and monitor resident health status, functional capabilities, and needs) Brief Interview Mental Status (BIMS) dated 2/28/25 indicated a score of 11. Review of Resident 66's Admission Record dated 2/28/25 indicated Resident 66 was admitted on [DATE] to the facility with diagnoses that included dependence on renal dialysis (a procedure to remove waste products and excess fluid from the blood when the kidneys stop working properly), acute kidney failure (inability of the kidneys to effectively filter wastes), type 2 diabetes (high levels of sugar circulating in the blood), hypertension (high blood pressure), and hyperlipidemia. Review of Resident 66's minimum data set (MDS) BIMS dated 2/28/25 indicated a score of 11. A review of the facility's Compact Roster by Name Report, dated 2/25/25 indicated Resident 66's diet was . Diet . Renal, CCHO (consistent carbohydrates), Fluid Restriction 1500 mL (milliliters) per day, Lactose (milk sugar) Free .80 gram and indicated Resident 17's diet was .Renal 60 gram-Regular-Large . A review of the facility's Cook's Spreadsheet Winter Menus- (Pg 2) .Week 1 .Tuesday .2/25/25, indicated . Renal Diets .Herb Crusted Beef Gravy 2 oz. meat, [NAME] with margarine #12 (1/3 cup), Zucchini with margarine 1/2 cup .Garlic Bread 1 slice . During an observation and interview on 2/25/25 at 11:59 A.M. of the lunch meal trayline service, [NAME] (CK 1) stated a renal diet meal tray would be get .herb crusted chicken, white rice, and zucchini . CK 1 stated they didn't have brown rice to serve and white rice is the same as brown rice. During an observation and interview on 2/25/25 at 12:30 P.M. in Resident 17's room, the resident was eating his lunch meal. Resident 17 ate the white rice and herb chicken and stated the food was okay, but it didn't have any flavor. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/26/25 at 2:46 P.M., an interview was conducted with the Dietary Services Manager-Registered Dietitian (DSM-RD). The DSM-RD stated it is her expectation that the Cooks and kitchen staff follow the printed menus, so the resident receives the appropriate diet and nutrition to meet their needs. During an interview on 3/03/25 at 3:29 PM with the DSM-RD, the DSM-RD stated it was important for the facility to follow the approved menus to ensure residents receive the appropriate therapeutic diet. According to M. [NAME] et al., Journal of Renal Nutrition, Vol 26, No 4 (July), 2016: pp e19-e22, .Brown rice: can be included in a renal diet . with careful consideration of overall daily intake of phosphorus and potassium . Review of facility document titled Renal Diet 40-60-80 Gram Protein, Low Potassium, Low Salt Menu dated 2020, indicated .This diet is used for the resident with renal insufficiency or for residents with renal failure not on dialysis. This diet regulates the dietary intake of sodium, potassium and protein to lighten the work of the diseased kidney . Review of the undated facility P&P titled Menus indicated .To ensure that the Facility provides meals to residents that meet the requirements of the Food and Nutrition Board .Daily menus will include planning for three meals and an evening snack .

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 49113 Based on observation, interview, and record review, the facility failed to ensure the food was served at an acceptable temperature and palatability taste to the residents, according to the facility policy. This failure had the potential to affect meal and food intake which could impair the nutrition status of the 74 residents who consumed food from the kitchen. Cross Reference F800, F801, F803 During a review of the facility's Winter Menu, Week 4, the Tuesday 2/25/25 lunch meal for the Regular diet included 3oz (ounces) of herb crusted beef roast, 1/2 oz brown gravy, 1/2 cup mashed potatoes, 1/2 cup zesty spinach, parsley sprig garnish, 1 slice of garlic bread, and 1 Sq. (square) triple fruit crisp. The pureed (food made into a creamy substance) meal included 1/2 cup pureed herb crusted beef roast, 1/3 cup mashed potatoes, 1/3 cup zesty spinach, 1/4 cup garlic bread, and 1/3 cup triple fruit crisp. On February 24, 2025, at 9:32 a.m., a Resident Council meeting was conducted. During the meeting, multiple residents anonymously stated the food is served cold. On February 24, 2025, at 11:06 a.m., an interview with Resident 18 was conducted. Resident 18 stated the breakfast meals are cold almost every day. On February 24, 2025, at 12:45 p.m., a concurrent interview and test tray evaluation of the Regular and Pureed diets was conducted. The Diet Service Manager/Registered Dietitian's (DSM-RD) facility's thermometer did not obtain the correct food temperatures on the test tray. The facility thermometer read 118 degrees F (fahrenheit) for the puree roast beef, and it was 125.3 degrees F on the Surveyor's thermometer. The facility's thermometer read 121.1 degrees F for the regular roast beef, and it was 121 degrees F on the Surveyor's thermometer. The facility's thermometer read 56.0 degrees F on the orange juice and 50.6 degrees F on the Surveyor's thermometer. When the regular diet spinach was tasted, it had no flavor, and the potato wedges were hard. Furthermore, garlic bread was dried out and hard to chew. The DSM-RD acknowledged the spinach needed more flavor, the potato wedges had hard ends, and the garlic bread was tough to eat. The DSM-RD further stated we need to do a better job with seasoning and cooking temperatures. Review of facility policy and procedure titled, Food Temperatures dated October 10, 2023, indicated, .it is recommended to use a thermometer with a practical range of 0 (degrees) F to 220 F . acceptable serving temperatures for Meat, entrees are > (greater than) 140 and preferable temperature is 160 -175 and for Milk, juice temperature required are < (less than) 41 .

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 49113 Based on observation, interview, and record review, the facility failed to ensure food safety and sanitation practices were maintained in the kitchen according to standards of practice and facility policy when: 1. The ice machine was not properly maintained and cleaned per manufacturer guidelines; 2. The dish machine sanitizer solution was outside of the correct chemical range and tested 300- 400 ppm (parts per million- a unit of measurement); 3. Kitchen staff did not wear beard nets while working in the kitchen; 4. Dishes and three (3) large metal pans with food debris and dripping water on them were stacked on top of each other in a drawer; and 5. Kitchen staff were using cloth oven mitts that were wet, soiled, and had food build-up/residue on them. These failures exposed resident's to contaminated food and unsanitary practices, which placed residents at risk of developing foodborne illness and compromise their health. The facility census was 72. Cross reference F802 and F908 Findings: 1. On February 24, 2025, at 10:38 a.m., a joint observation and interview was conducted at the facility's ice machine. The ice machine had an Out of Service sign on it. The ice machine had dark brown and black debris inside the bin, on and inside the ice cubes. There was a light brown pinkish colored slimy substance inside the internal rubber and metal ice making parts, as well as the external metal pan. The Maintenance Supervisor (MS) was in the process of removing parts of the outer and inner components of the machine. The MS stated he was cleaning the ice machine with green Palmolive dish soap and an aqua colored solution inside a clear plastic cleaning bottle. The MS stated he used both products to clean inside the bin, internal ice making parts, filters, and the outside of the ice machine once a month. On February 24, 2025, at 10:45 a.m., a concurrent observation and interview with the Director of Nursing (DON), and the DSM-RD was conducted. The DON and the DSM-RD observed the brown and black debris, brown pinkish colored slime inside the internal metal cover and rubber grid touching water component parts. The DSM-RD stated the condition of the ice machine was not acceptable. The DSM-RD also stated residents with weaken immune systems, could get sick, be hospitalized , and even death if they consume. The DON further stated, this was not acceptable, and residents could get sick. The DON also stated we will get this fixed. The DSM-RD and DON further stated the facility will need to get bags of ice from the store to provide ice to the residents until the ice machine is cleaned correctly. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On February 25, 2025, at 8:45 a.m., an observation and interview were conducted with the ADM (Administrator) and MS. The ice machine still had a sign Out of Service on it. The ADM and MS stated the ice machine was not in service because they were waiting for a service technician to clean the machine and replace parts. The ADM stated it was important to have a thoroughly cleaned and sanitized ice machine so residents do not receive ice that could make them sick. According to the HOSHIZAKI (Ice Machine Manufacturer), service manual dated 2/21/2019, and revised 7/19/2023, .Wipe down BC (Bin Control-sensor that monitors the ice level in the storage bin) with a mixture of 1 part Hoshizaki Scale Away and 25 parts warm water .Rinse the parts thoroughly with clean water .Float Switch Cleaning .scale may build up on float switch (FS-small device that monitors the water level in the ice machine's reservoir) .scale may cause FS to stick .wipe down FS assembly's housing, shaft, float, and retainer rod with a mixture of 1 part Hoshizaki Scale Away and 25 parts water .clean the inside of the rubber boot and hose with cleaning solution .rinse parts thoroughly with clean water . According to the 2022 Federal Food Code section 3-303.11, titled Ice Used as Exterior Coolant, Prohibited as Ingredient. Ice that has been in contact with unsanitized surfaces .may contain pathogens and other contaminants .if this ice is then used as a food ingredient, it could be contaminated . According to the 2022 Federal Food Code section 4-204.17, titled Ice Units, Separation of Drains. Liquid waste drain lines passing through ice machines and storage bins present a risk of contamination due to potential leakage of the waste lines and the possibility that contaminants will gain access to the ice through condensate migrating along the exterior of the lines. Liquid drain lines passing through the ice bin are, themselves, difficult to clean and create other areas that are difficult to clean where they enter the unit . The potential for mold and algal growth in this area is very likely due to the high moisture environment. Molds and algae that form on the drain lines are difficult to remove and present a risk of contamination to the ice stored in the bin. 2. During observations of the dish machine and the sanitizer at 10:10 AM and at 4:10 PM on February 24, 2025, in the kitchen, kitchen staff [NAME] (CK) 2 and Diet Aide (DA) 2 used a test strip to test the sanitizer concentration in the dish machine basin. They each compared the test strips to the color shades on the test container and they were dark purple, which indicated 300-400 ppm (parts per million). During an interview on February 24, 2025, at 4:21 p.m. with the Dietary Service Manager-Registered Dietitian (DSM-RD), the DSM-RD acknowledged the dish machine sanitizer concentration was higher than normal. The DSM-RD further stated the dish machine level should be adjusted to safe level for sanitizing the dishes. According to the 2022 Federal Food Code, section 4-302.14, titled Sanitizing Solutions, Testing Devices, indicated, .Testing devices to measure the concentration of sanitizing solutions are required for 2 reasons: . the use of chemical sanitizers requires minimum concentrations of the sanitizer . to ensure sanitization, and 2, too much sanitizer in the final rinse water could be toxic . A review of the facility's policy and procedures titled, Dish Machine Operation and Cleaning dated October 1, 2014, indicated, .Routinely monitor soap, sanitizer and rise agent to ensure adequate supply throughout operation of the dish machine . (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	3. On February 24, 2025, at 4:56 p.m., a concurrent observation and interview was conducted with DA 2 and the DSM-RD in the kitchen. DA 2 was not wearing a beard net to cover his facial hair. The DA 2 stated he should have had on a beard net. He further stated he forgot to put it on and that it is mandatory to wear the hair and beard nets. The DSM-RD also stated that DA 2 should have on a beard net to prevent contamination. According to the 2022 Federal FDA Food Code, Section 2-402.11, titled Effectiveness, (A) .FOOD EMPLOYEES shall wear hair restraints such as hats, hair coverings or nets, beard restraints, and clothing that covers body hair, that are designed and worn to effectively keep their hair from contacting exposed FOOD . 4. On February 24, 2025, at 9:55 a.m., a concurrent observation and interview was conducted with the DSM-RD in the kitchen. The DSM-RD acknowledged there were three 3 large metal pans had water and food debris on them. The pans were dripping wet and stacked on top of each other. Four pie pans with water and debris on them, two (2) strainers with white dried residue and 2 skillets with dried particles on them were stored under a counter. There were four rubber cutting boards with multiple indented markings were found under the food prep counter. The DSM-RD stated the strainers were not clean and verified the dry white substance should not be there. The DSM-RD further stated the wet dishes should be dried before they were put away and not stored wet. According to the 2022 Federal Food Code, Section 4-601.11, titled Cleaning of Equipment and Utensils. Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces, and Utensils. (A) EQUIPMENT FOOD-CONTACT SURFACES and UTENSILS shall be clean to sight and touch . 5. On February 24, 2025, at 10:17 a.m., a concurrent observation and interview was conducted with the DSM-RD in the kitchen. The DSM-RD acknowledged two gray cloth oven cooking mitts were wet, soiled with food debris and residue on them were on a food prep counter. The DSM-RD stated the oven mitts should not be used and thrown away because they had tons of dirt and potential bacteria built up on them. During an interview on 3/03/25 at 3:29 PM with the DSM-RD, the DSM-RD stated it was important for the kitchen and food service operations function under safe and sanitary conditions to protect the residents. According to the 2022 Federal Food Code, Section 4-602.11 titled Equipment Food-Contact Surfaces and Utensils. Microorganisms may be transmitted from a food to other foods by utensils, cutting boards, thermometers, or other food-contact surfaces. Food-contact surfaces and equipment used for time/temperature control for safety foods should be cleaned as needed throughout the day but must be cleaned no less than every 4 hours to prevent the growth of microorganisms on those surfaces. According to the 2022 Federal Food Code, section 3-307.00 Miscellaneous Sources of Contamination, indicated, .Food shall be protected from contamination that may result from a factor or source not specified under Subparts 3-301 to 3-306. A review of the facility's policy and procedures titled, Dietary Department -Infection Control dated June 4, 2024, indicated, .Personal cleanliness is required in sanitary food preparation .cover hair, beard, and mustache with an effective hair restraint, such as hats, hair coverings, or nets while in any kitchen and food storage areas.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
California Nursing & Rehabilitation Center	2299 North Indian Canyon Drive Palm Springs, CA 92262

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have a policy regarding use and storage of foods brought to residents by family and other visitors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50864 Based on observation, interview, and record review, the facility failed to implement their policy and procedure regarding food brought in from the outside, when one resident (Resident 66), who had a diagnosis of diabetes (chronic condition characterized by high blood sugar), had chocolate candies inside of his nightstand drawer that were brought in from the outside. This failure had the potential for Resident 66 to be non-compliant with the prescribed diet leading to high blood sugar. Findings: On February 25, 2025, at 8:32 a.m., an observation with a concurrent interview was conducted with Resident 66. Resident 66 was observed alert and conversant, Resident 66 was sitting on edge of the bed next to his nightstand. The nightstand drawer was observed to be open and inside were bite size chocolate candies. Resident 66 stated his family member brought in the chocoate candies and the staff were aware of it. On February 25, 2025, at 5:12 p.m., Resident 66's record was reviewed. Resident 66 was admitted to the facility on [DATE], with diagnoses that included diabetes mellitus and dependence on renal dialysis (relies on a machine and medical professionals to sustain life due to kidney failure). The history and physical dated January 24, 2025, indicated, Resident 66 can make needs know but can not make medical decisions. The Physician Order dated January 24, 2025, indicated diabetic renal diet (a dietary plan for individuals with diabetes and kidney disease managing blood sugar and protect kidney functions). The Care Plan dated January 23, 2025, indicated, Focus Diabetes Mellitus .Goal .resident free from signs and symptoms of hyperglycemia (high blood sugar) .Interventions .Dietary consult for nutritional regimen and ongoing monitoring .discuss . dietary restrictions, snacks allowed in daily nutritional plan, compliance with nutritional regimen . On February 27, 2025, at 10:26 a.m., a concurrent observation, interview, and record review was conducted with License Vocational Nurse (LVN) 5. LVN 5 stated she was the licensed nurse assigned to Resident 66. LVN 5 observed Resident 66's nightstand drawer and verified there were crackers, sweet bread and a bag of bite size chocolate candies inside. LVN 5 stated Resident 66 should not have those items at the bedside. LVN 5 stated Resident 66's dietary order was diabetic/renal diet. LVN 5 further stated there was no documentation in the progress notes, physician orders, or resident/family education related to Resident 66's chocolate candy and snacks not being compliant with the current diet orders. LVN 5 stated the policy was not followed. (continued on next page)

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On February 27, 2025, at 5:43 p.m., a concurrent interview and record review was conducted with the Director of Nursing (DON). The DON stated the expectation for outside food was for the family to inform the nurses of food brought in. The nurse should inspect food for appropriateness to care plan and if not appropriate, the nursing staff should educate the resident/family member and suggest alternative foods that are compliant with resident's care plan. The nurses should document and notify the physician.The DON further stated there was no documentation in the progress notes, physician orders, or resident/family education related to Resident 66's chocolate candy and snacks at his bedside. The facility's policy and procedure titled, Food Brought in by Visitors, dated June 2018 indicated, .Food may be brought to resident .if the food is compatible with the resident's plan of care .nurse will account for resident intake .

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 38924 Based on observations, interviews, and document reviews, the facility failed to ensure the physician's progress notes in the medical records were accurately completed for a sampled resident (Resident 673) and unsampled resident (Resident 3) with significant weight loss for the past one month. This failure had the potential to negatively impact health and nutrition status and lead to further decline of the two residents with significant weight loss. The facility census was 69. According to the April 10, 2010, Proceedings of the SIGCHI Conference on Human Factors in Computing Systems article Physician-Driven Management of Patient Progress Notes in an Intensive Care Unit; .A patient progress note is a clinical document, written by a .physician, describing a patient's status and the physician's assessments and care plan for the patient. An attending physician, who has primary responsibility for the patient's care, composes a daily note for each of their patients. These notes are referred to by other clinicians as care is transferred or shared, and are included in the official medical record for legal and billing purposes . Findings: 1. During a facility revisit for a previous immediate jeopardy in February 2025, one of the previously identified residents with severe weight loss, Resident 673, medical records were reviewed. Resident 673's facility Admission Record indicated the resident was admitted to the facility on [DATE] with diagnoses that included chronic kidney disease stage 3 (a moderate kidney damage, where the kidneys are not filtering blood as effectively as they should, leading to a build-up of waste in the body), hyperlipidemia (high levels of fat circulating in the blood), dysphagia (difficulty swallowing), and mild protein-calorie malnutrition (a condition where the body doesn't receive enough protein and calories to meet its energy needs, leading to a range of symptoms and health issues). A review of Resident 673's BIMs (brief interview of mental status- tool to assess cognitive functioning) section C for cognition indicated the resident's score was 7, which indicates severe cognitive impairment. This suggests the individual may need help with all daily tasks and/or specific tasks. During a record review of Resident 673's Weights & Vitals report, the resident weighed 119 pounds (Lbs.) on 3/19/25 and 112 Lbs. on 4/16/25, whereby Resident 673 experienced a seven (7) pound, 5.8% weight loss. During a record review of Resident 673's Physician/PA (Physician Assistant)/NP (Nurse Practitioner) progress notes from 3/1/25 to 4/16/25, the notes indicated the resident was seen for complaints of generalized pain. The physician progress notes did not mention the resident's weight loss to prevent further weight loss. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. A review of Resident 3's facility Admission Record indicated the resident was admitted to the facility on [DATE] with diagnoses that included chronic obstructive pulmonary disease (COPD) (a common lung disease causing restricted airflow and breathing problems), chronic kidney disease stage 3 (a moderate kidney damage, where the kidneys are not filtering blood as effectively as they should, leading to a build-up of waste in the body), and malignant neoplasm of unspecified part of unspecified bronchus or lung (cancerous tumor, also known as lung cancer, that originates in the bronchi or other parts of the lung, but where the specific location within the bronchus or lung is not identified). A review of Resident 3's BIMs (brief interview of mental status) section C for cognition indicated the resident's score was 8, which indicates moderate cognitive impairment, and suggests the individual may need extra help with daily tasks and/or specific tasks. During an observation and interview on 4/15/25 at 4 PM, in Resident 3's room, the resident was lying in her bed watching T.V. with a cup half-full of liquid that resembled milk, on her bedside table. Resident 3 stated she had not spoken to her doctor about her weight loss or the Registered Dietitian (RD) about food preferences she likes, which includes macaroni-n-cheese, vanilla milkshakes, chicken and fish. During a record review of Resident 3's Multidisciplinary and Interdisciplinary Team (IDT) meeting progress notes dated 4/11/25, the notes indicated Resident 3 experienced a six (6) pound, 7% significant weight loss in three months from February 2025- April 2025. The resident's IDT progress notes further stated .MD is aware with recommendations, and We are continuing monitoring resident's po intake . Resident 3's medical record did not have any physician's progress notes that mentioned the resident's weight loss or monitoring to prevent further weight loss. During a concurrent interview and record review on 4/15/25 at 4:22 p.m., with the RD and the Director of Nursing (DON) about Resident 673's and Resident 3's nursing progress notes, physician progress notes, and interdisciplinary team weight variance meeting notes, the DON and the RD both acknowledged the physician's progress notes did not mention the residents' weight loss. The DON and the RD further stated it was important for both residents' medical records physician's progress notes to include the resident's weight loss status in order for the IDT and weight variance team to monitor their weight loss. During an interview on 4/16/15 at 11:45 AM with the facility's Medical Director (PHYSDR), and Resident 3's physician, the PHYSDR stated it was important for the physicians to chart in the resident's medical record about the resident's weight loss status and monitoring. The PHYSDR further stated all the Nurse Practitioners and Physicians will be made to document any resident interactions about weight loss in the resident's medical charts. During an interview on 4/16/15 at 11:45 AM, with Resident 673's physician (PHYS), the PHYS stated she saw Resident 673 in February and March 2025 about other medical conditions that did not include weight loss, and the notes were entered in a different medical charting system not at the facility. The PHYS stated it was important to document a resident's weight loss monitoring and interventions in their facility medical record for interdisciplinary teams to use to enhance the resident's overall care. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a record review of the facility's policy and procedure (P&P) titled Completion and Correction, dated January 1, 2012, the P&P indicated .The Facility will work to complete and correct medical records in a standardized manner to provide the highest quality and accuracy in documentation .

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. 51080 Based on interview and record review, the facility failed to have a written Quality Assurance Performance Improvement (QAPI - a systematic, interdisciplinary, comprehensive, and data-driven approach to maintain and improve safety, quality of care, and quality of life of the residents) plan in place to address the facility's systemic process issues related to weight loss, kitchen and nutrition services, and broken call light systems. These failures resulted in multiple residents to not receive appropriate care and treatment for weight loss and delayed response to residents' call lights. In addition, these failures had the potential for other residents at risk to not achieve their highest physical, mental, psychosocial well-being. Findings: During the survey, systemic issues were identified with weight loss (see findings under F692), kitchen and nutrition services (see findings under F800, F801, F802, F803, F804, F812, F813, F908), and timely identification and repair of broken call light bell system (see findings under F919). On March 3, 2025, at 2:40 p.m., an interview and a concurrent record review with the Administrator (ADM) was conducted to discuss the facility's QAPI program. The ADM stated the QAPI committee consists of the ADM, Director of Nursing (DON), Medical Director, Radiology, Pharmacy, Laboratory, and the heads of the facility departments. The ADM stated the facility did not have a QAPI program which identified, corrected, and improved the issues related to the identified broken call light, kitchen and nutrition services. The QAPI program did identify issues with the weight loss but did not evaluate the interventions put in place for weight loss put in place prior to December 2024. A review of the facility document titled, Quality Assurance and Performance Improvement (QAPI) Program, dated March 20, 2024, and effective June 4, 2024, indicated, . the facility evaluates the effectiveness of its QAPI program at least annually and as needed, and presents their conclusions to the Governing Body for review .The QAPI Committee, Administrator, and the Governing Body shall review a summary ofproblems(sic) and corrective measures .Each department or service reviews its approaches to monitoring performance and outcomes andproviodes(sic) a summary of its findings to the QAPI committee annually and as needed .The QAPI committee evaluates these various reports to help define issues, plan and implementactions(sic), and ensure monitoring and follow-up .

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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. 39920 Based on observation, interview, and record review, the facility failed to ensure infection control practices were implemented when: 1. The laundry room door was closed and staff were observed passing through the clean area of the laundry from the hallway; 2. Nursing staff failed to properly clean and disinfect shared blood pressure (BP-pressure of blood in blood vessels) cuffs and stethoscopes for Residents 475 and 58, according to the disposable Sani-Cloth disposable wipe manufacturer's specified contact time (the time the resident equipment was to be in contact with the disposable wipes to kill micro-organisms). In addition, the facility failed to properly clean and disinfect the shared stethoscope after use according to facility's policy; and 3. The lunch meal trays for Residents 17 and 23 were placed in the residents' room next to unsanitary bodily equipment. These failures had exposed vulnerable residents to potentially hazardous substances due to cross-contamination, which could increase development of infections. Findings: 1. On February 27, 2025, at 8:53 a.m., a concurrent observation and interview was conducted with the Laundry Assistant (LA). The laundry door was observed open from the resident rooms' hallway, and staff were observed going in and out of the service entrance door (the exit door to the patio outside - service entrance). The LA was observed from the doorway, folding linens on the table. The LA stated she was folding clean linens. A Certified Nursing Assistant (CNA) was observed to have entered the clean area, because the laundry door was open from the hallway, and had a conversation with the LA. On February 27, 2025, at 9:35 a.m., a concurrent observation and interview was conducted with the LA. The LA was asked where the clean area of the laundry room was, and the LA pointed at the opposite end of the room, where the linen folding table for clean linen was, and the door was observed open to the resident rooms' hallway. The area where the LA pointed as the clean area did not have a sign posted as clean area. On February 27, 2025, at 9:55 a.m., a concurrent observation and interview was conducted with the Housekeeping Supervisor (HS). The HS stated the laundry room door leading to the resident rooms' hallway was always open. On March 3, 2025, at 2:43 p.m., an interview was conducted with the HS. The HS stated the door laundry door should stay closed, and when the door was open, the staff went through the clean area of the laundry, increasing the risk of contamination. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On March 3, 2025, at 2:52 p.m., an interview was conducted with the Infection Preventionist (IP). The IP stated when the laundry door was open, facility staff going through the clean area of the laundry was an infection control issue. The facility policy and procedure titled, Laundry-Route & Process, dated January 1, 2012, was reviewed. The policy indicated, .Purpose .To ensure that the Facility provides a sufficient supply of clean linens for all residents .Laundry Route and Process: On-site Laundry .A clean and safe environment is always maintained . 46393 2. During a medication pass observation on February 25, 2025, at 9:11 a.m. with Licensed Vocational Nurse (LVN) 4, LVN 4 was observed using a shared manual BP cuff and stethoscope to measure Resident 475's BP. LVN 4 was observed wiping the shared manual BP cuff with a Sani-Cloth disposable wipe and did not disinfect the manual BP cuff according to the manufacturer specified contact time. Additionally, LVN 4 was observed wiping the shared stethoscope with an alcohol pad. During another medication pass observation on February 25, 2025, at 10:04 a.m. with LVN 3, LVN 3 was observed using a shared manual BP cuff and stethoscope to measure Resident 58's BP. LVN 3 was observed wiping the shared manual BP cuff with a Sani-Cloth disposable wipe and did not disinfect the manual BP cuff and stethoscope according to the manufacturer specified contact time. During an interview on February 25, 2025, at 11:37 a.m. with the Infection Prevention (IP) nurse, the IP stated nursing staff were expected to clean and disinfect all shared resident care equipment after use with Sani-Cloth disposable wipes and stated the contact time was two (2) minutes. The IP stated contact time meant nurses were expected to saturate the shared equipment with the wipe, then let the equipment dry for two (2) minutes. The IP sated nurses were not instructed to keep the equipment wet for two (2) minutes. Additionally, the IP stated alcohol pads should not have been used to disinfect any resident care equipment. During the same interview, the IP reviewed the manufacturer's labeled instructions on the Sani-Cloth disposable wipe bottle and acknowledged nursing staff should have been instructed to keep equipment wet for two (2) minutes to achieve contact time when they wiped shared resident care equipment according to the manufacturer's instructions. During an interview on February 26, 2025, at 5:19 p.m. with the Director of Nursing (DON), the DON stated nursing staff were expected to follow the Sani-Cloth manufacturer's instructions for contact time to achieve proper kill time of organisms. Additionally, the DON stated nursing staff should not have used alcohol pads for cleaning or disinfecting shared resident care equipment because alcohol pads were not effective for killing organisms. The DON stated it was important to follow infection control procedures to prevent the spread of infections. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's policy and procedure (P&P) titled, Cleaning and Disinfection of Resident-Care Items and Equipment, dated January 1, 2012, the P&P indicated, Resident-care equipment, including reusable items and durable medical equipment will be cleaned and disinfected according to the current CDC (Centers for Disease Control and Prevention- a nationally recognized disease control and prevention organization) recommendations for disinfection .Non-critical items are those that come in contact with intact skin but not mucous membrane .Reusable items are cleaned and disinfected or sterilized between residents. (e.g., stethoscopes, durable medical equipment) .Reusable resident care equipment is decontaminated and/or sterilized between residents according to manufacturers' instructions. During a review of the manufacturer's instructions for contact time for the Sani-Wipes provided by the facility, the manufacturer's instructions indicated, Contact time .thoroughly wet surface. Allow surface to remain wet for two (2) minutes. Let air dry. 49113 3. A. On February 25, 2025, at 5:49 p.m., Resident 17's evening meal tray was observed on his bedside table next to his urinal (a container used to collect urine and is made for either male). On February 25, 2025, at 5:54 p.m., a concurrent observation and interview with CNA 5 was conducted. CNA 5 acknowledge Resident's 17 meal tray was placed on top of his bedside table next to his urinal. CNA 5 further stated, That should not be there, it is not sanitary, let me remove the urinal from the bedside table. B. On February 25, 2025, at 5:58 p.m., a concurrent observation and interview was conducted with Certified Nurse Assistant (CNA) 6. Resident 23's meal tray was observed placed on a visitor's chair. The CNA stated the meal tray should not be placed on a chair and stated there was no bedside table in the room. The CNA acknowledged placing the tray on the chair was not sanitary. On March 3, 2025, at 2:59 p.m., an interview with the Dietary Service Manager/ Registered Dietitian/ (DSM-RD) was conducted. The DSM-RD stated she expects the meals and food to be served to the residents in a sanitary manner to control and prevent infections. According to the 2022 Federal Food Code, section 3-307.11, titled Miscellaneous Sources of Contamination. Indicated, Food shall be protected from contamination that may result from a factor or source not specified under Subparts 3-301 - 3-306. A review of the facility's policy and procedures titled, Food Temperatures, dated 10/10/2023, indicated, .Food items will be handled in accordance with recommended sanitary practice .to prevent foodborne illnesses.

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Keep all essential equipment working safely. 38924 49113 Based on observation, interview, and record review, the facility failed to ensure essential food and nutrition services equipment, such as the reach in freezer, and ice machine were maintained in safe operating condition. These failures had the potential to impact the ability of dietary staff to prepare, store, and serve food in a safe and sanitary manner. Resident census was 72 at time of survey. Findings: 1. During the initial kitchen tour on February 24, 2025, at 9:15 a.m., a concurrent observation and interview with [NAME] (CK) 1 was conducted at the reach in freezer. The freezer was full of bags of mixed vegetables on the middle shelf, cases of chicken and beef at the bottom shelf and large tubs of ice cream along with pre-cooked bread rolls. The ice cream was very soft, and tub was bendable. The temperature internal temperature of the freezer was 54 degrees Fahrenheit (F). A surveyor placed their digital thermometer inside the reach in freezer and the temperature was 49.8 degrees F. CK 1 acknowledged the refrigerator's internal temperature and stated, it should be 32 degrees. On 2/25/25 at 12:01 PM, an observation of the reach-in freezer internal thermometer indicated the temperature was 43 degrees F and the Surveyor's thermometer was 41.9 degrees F. On February 24, 2025, at 4:54 p.m., an observation and interview were conducted with the Dietary Services Manager-Registered Dietitian (DSM-RD) in the kitchen. The reach-in freezer thermometer read 55 degrees F. There was water condensation collection on the ceiling. The DSM-RD acknowledged the 55 degrees F and stated the reach-in freezer temperatures sometimes runs higher than normal, especially when the kitchen staff go in and out of it. The DSM-RD further stated the temperature should not be higher than 5 or 6 degrees above zero degrees to keep foods frozen. The DSM-RD also stated the internal thermometer may need to be changed. On February 25, 2025, at 9:08 a.m., a concurrent observation and interview was conducted in the kitchen. The temperature on the internal thermometer inside the reach in freezer was 16 degrees F. The DSM-RD further stated the temperature was 0 degrees or negative degrees F in the morning at 6:00 a.m. The DSM-RD also stated they may look into replacing the freezer in the future. During an interview with the Administrator (ADM) and Maintenance Supervisor (MS) on 2/25/25 at 9:33 AM in the kitchen. The ADM stated the freezer temperature should be able to freeze foods at the correct temperature to keep foods frozen. The MS stated he would have to contact a technician and get a small freezer unit, if needed. During a kitchen observation of the reach-in freezer on 2/25/25 at 3:23 PM, the internal thermometer read 10 degrees F and the Surveyor's thermometer was 15 degrees F. (continued on next page)

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	A review of the facility's reach-in freezer temperature log dated 2/24/25 and 2/25/25 indicated the temperature was '0' degrees and -12 degrees signed by CK 1. During a review of the facility's monthly Kitchen Sanitation & Food Safety Inspection reports dated 8/30/24 to 1/25/25, completed by the RD, indicated .Cold Storage .44 .Freezer .Frost Observed, 0 degrees F or below . Partially Met . According to the 2022 Federal Food Code, section 3-302.11 titled Packaged and Unpackaged Food - Protection Separation, Packaging, and Segregation, .The freezer equipment should be designed and maintained to keep foods in the frozen state. Corrective action should be taken if the storage or display unit loses power or otherwise fails . According to the 2022 Federal Food Code, section 4-501.00, titled Good Repair and Proper Adjustment. (Equipment) Proper maintenance of equipment to manufacturer specifications helps ensure that it will continue to operate as designed. Failure to properly maintain equipment could lead to violations of the associated requirements of the Code that place the health of the consumer at risk . 2. On February 24, 2025, at 10:38 a.m., a joint observation and interview was conducted at the facility's ice machine. The Maintenance Supervisor (MS) was removing parts of the outer and inner components of the machine. The ice machine had an Out of Service sign on it. The ice machine had dark brown and black debris inside the bin, on and inside the ice cubes. There was a light brown pinkish colored slimy substance inside the internal rubber and metal ice making parts, as well as the external metal pan. The MS had green Palmolive dish soap and an aqua colored solution inside a plastic cleaning bottle. The MS stated he used both to clean products to clean inside the bin, internal ice making parts, filters, and the outside of the ice machine. On February 24, 2025, at 10:45 a.m., a concurrent observation and interview with the Director of Nursing (DON), and the DSM-RD was conducted. The DON and the DSM-RD observed the brown and black debris, brown pinkish colored slime inside the internal metal cover and rubber grid touching water component parts. The DSM-RD stated the condition of the ice machine was not acceptable. The DSM-RD also stated residents with weaken immune systems, could get sick, be hospitalized , and even death if they consume. The DON further stated, this was not acceptable, and residents could get sick. The DON also stated we will get this fixed. The DSM-RD and DON further stated the facility will need to get bags of ice from the store to provide ice to the residents until the ice machine is cleaned correctly. On February 25, 2025, at 8:45 a.m., an observation and interview were conducted with the ADM (Administrator) and MS. The ice machine still had a sign Out of Service on it. The ADM and MS stated the ice machine was not in service because they were waiting for a service technician to clean the machine and replace parts. The ADM stated it was important to have a thoroughly clean and sanitized ice machine so residents do not receive ice that could make them sick. (continued on next page)

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	According to the HOSHIZAKI (Ice Machine Manufacturer), service manual dated 2/21/2019, and revised 7/19/2023, indicated .Wipe down BC (Bin Control-sensor that monitors the ice level in the storage bin) with a mixture of 1 part Hoshizaki Scale Away and 25 parts warm water .Rinse the parts thoroughly with clean water .Float Switch Cleaning .scale may build up on float switch (FS-small device that monitors the water level in the ice machine's reservoir) .scale may cause FS to stick .wipe down FS assembly's housing, shaft, float, and retainer rod with a mixture of 1 part Hoshizaki Scale Away and 25 parts water .clean the inside of the rubber boot and hose with cleaning solution .rinse parts thoroughly with clean water . According to the 2022 Federal Food Code section 3-303.11, titled Ice Used as Exterior Coolant, Prohibited as Ingredient. Ice that has been in contact with unsanitized surfaces .may contain pathogens and other contaminants .if this ice is then used as a food ingredient, it could be contaminated . According to the 2022 Federal Food Code section 4-204.17, titled Ice Units, Separation of Drains. Liquid waste drain lines passing through ice machines and storage bins present a risk of contamination due to potential leakage of the waste lines and the possibility that contaminants will gain access to the ice through condensate migrating along the exterior of the lines. Liquid drain lines passing through the ice bin are, themselves, difficult to clean and create other areas that are difficult to clean where they enter the unit . The potential for mold and algal growth in this area is very likely due to the high moisture environment. Molds and algae that form on the drain lines are difficult to remove and present a risk of contamination to the ice stored in the bin. A review of the facility's policy and procedure titled, Ice Machine - Operation and Cleaning, dated October 1, 2014, indicated, .The dietary staff will operate the ice machine according to the manufacturer's guidelines, the ice machine will be cleaned regularly .On no less than a monthly basis, remove the ice to wash the inside of the machine .Maintenance staff will clean the ice making mechanism according to manufacturer's guidelines . A review of the facility's policy and procedure titled, Maintenance Service, dated January 1, 2012, indicated, . The Maintenance Department is responsible for maintaining the buildings, grounds, and equipment in a safe and operable manner at all times .Providing routinely scheduled maintenance serve to all areas .

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F 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms. 51080 Based on observation, interview, and record review, the facility failed to ensure that bedrooms measured at least 80 square feet per resident, in bedrooms occupied by multiple residents (Rooms 3, 17, 20, and 33). Findings: On February 24, 2025, at 9:21 a.m., the facility Administrator stated the rooms that had four residents per room did not meet the required 80 square feet per resident. This included the following rooms: 3, 17, 20, and 33. Rooms 3, 17, 20, and 33 housed four residents in each room and did not measure at least 80 square feet per resident, as required. All four rooms were measured as 310 square feet. During all days of the survey, no negative impact was observed to the health and safety of the residents. Residents residing in the rooms, who were interviewable, stated they were comfortable in the space provided. The survey team recommends the room variance continue provided that a yearly waiver is requested, and the health and safety of the residents is not adversely affected.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44173 Based on observation, interview, and record review, the facility failed to ensure the call light system (a communication system that allow the residents to call for staff assistance) was fully functional when: 1. The call light system panel did not have an audible sound; and 2. Resident 23 did not have a call light button installed, available, and within reach. These failures had the potential for Resident 23 and the residents in the facility not to receive assistance from the staff in a timely manner. Findings: 1. On February 26, 2025, at 9:45 a.m., the call light panel located on the wall of the nurse's station was observed with the light on for room [ROOM NUMBER]. The call light panel did not have an audible sound while the light was on in room [ROOM NUMBER]. On February 26, 2025, at 9:51 a.m., during a concurrent interview and record review with the Registered Nurse Supervisor (RNS), the RNS stated there should be an audible sound heard from the call light panel when a light is on. The RNS stated the maintenance department was aware the call light panel did not have an audible sound when a light is on. The equipment log located at the nurse's station for February 2025 did not indicate the call light panel was reported for repair. The RNS stated the maintenance department should have the copy for January 2025. On February 26, 2025, at 10:03 a.m., during an interview with the Director of Nursing (DON) he stated he was not sure if there should be an audible sound from the call light panel when a light is on. He stated he will have to check with the Maintenance Supervisor (MS) if he was aware the call light system was not fully functional. During an interview on February 26, 2025, at 10:11 a.m., with the MS, he stated he was aware the call light panel was not fully functional since January 3, 2025. He stated the call light panel did not have an audible sound when a light is on. He stated he received an estimate from an outside company to fix or replace the call light system and the previous administrator received a copy of the estimate. On February 26, 2025, at 10:45 a.m., during an interview with Licensed Vocational Nurse (LVN) 4, he stated he was not aware there should be an audible sound from the call light panel at the nurse's station when the call light was turned on from the resident's room. LVN 4 stated he was only alerted a call light button was turned on from the resident's room when he checked the call light panel. (continued on next page)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On February 26, 2025, at 11 a.m., during an interview with the administrator (ADM) and the DON, the ADM and the DON stated they were not aware the call light button, when turned on from the resident's room, did not have an audible sound at the nurse's station. The ADM stated the QAPI (Quality Assurance and Performance Improvement - a data driven approach to improving quality of care and services) meeting conducted in January 2025, did not indicate the facility's call light system was not fully functional. During the interview with the ADM and the DON, the call light panel at the nurse's station turned on for room [ROOM NUMBER]. The call light panel did not have an audible sound while the light was on. The facility document titled, Communication - Call System, revised January 1, 2012, indicated, .The facility will provide a call system to enable residents to alert the nursing staff from their rooms and toileting/bathing facilities . The facility document titled, Maintenance Service, revised October 1, 2024, indicated, .The Maintenance Department maintains all areas of the building, grounds, and equipment .The Maintenance Department is responsible for maintaining the buildings, grounds, and equipment in a safe and operable manner at all times . 50864 2. On February 24, 2025, at 10:48 a.m., an observation with concurrent interview was conducted with Resident 23. Resident 23 was observed, laying in bed, alert, confused, and yelling. Resident 23 stated he did not know how to use the call light and he needed to be changed. Observed no call light within reach of Resident 23. Observed no call light cord coming from the wall to Resident 23's bed. On February 24, at 10:56 a.m., a interview was conducted with CNA 2. CNA 2 stated Resident 23 constantly yells for help; yelling is how he communicates his need for help and has never used the call light. CNA 2 stated she could not locate Resident 23's call light within the bed or coming from the wall. CNA 2 further stated she makes rounds and checks for call lights each morning at the start of her shift. CNA 2 stated the facility policy is call lights should be within the resident's reach. On February 24, 2025, Resident 23's record was reviewed. Resident 23 was admitted to the facility on [DATE], with diagnosis that included psychosis (a mental health condition characterized by a loss of contact with reality), altered mental status (change in a person's level of consciousness, awareness, and cognitive functions), disorder of the brain (conditions that impact the brain's normal functioning), diabetes mellitus (chronic condition characterized by high blood sugar levels). The Quarterly Minimum Data Set (MDS-an assessment tool) dated January 8, 2025, indicated a BIMS score (Brief Interview for Mental Status-an assessment tool used by facilities to screen and identify memory, orientation, and judgement status of the resident, a score from 0 to 15 that measures a person's cognitive functioning) of 6 (6- severe cognitive impairment). The MDS further indicated Resident 23 was occasionally incontinent of bowel and frequently incontinent of bladder. On February 27, 2025, at 10:11 a.m., an interview was conducted with the Director of Nursing (DON). The DON stated the expectations for call lights are the call lights should always be accessible and in reach for every resident. The DON further stated the facility process was not followed because all residents should have a call light available at all times whether they know how to operate the call light or not. (continued on next page)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The facility policy and procedure titled Communication-Call System dated January 1, 2012, indicated, .The facility will provide a call system to enable residents to alert the nursing staff from their rooms .call cords will be placed within the resident's reach in the resident's room .if call bell is defective, it will be reported immediately to maintance and replaced immediately .