STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056429	A. Building B. Wing	03/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Laurel Convalescent Hospital	7509 N. Laurel Ave Fontana, CA 92336

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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 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. Based on observation, interview, and record review, the facility failed to ensure potentially hazardous foods were maintained at or above 140 degrees Fahrenheit (unit of measure) at the time of service to residents, when two of two test trays (test trays of food prepared by the facility for temperature and palatability testing) had hot food items which were served to the residents below 140 Degrees Fahrenheit. This failure had the potential to cause foodborne illness in a vulnerable population of 80 residents who reside in the facility.Findings: During a review of the facility's food menu titled, Good for Your Health Menus, dated March 9, 2026, through March 15, 2026, the menu indicated breakfast for Wednesday, March 11, 2026, was to include biscuits with gravy, scrambled eggs, oatmeal, and raisins, with orange juice.During a concurrent observation and interview on March 11, 2026, at 8:19 AM, with the Dietary Services Supervisor (DSS), and the Consultant Registered Dietician 1 (CRD 1) the last meal tray cart (a cart used by staff to transport multiple resident trays of food throughout the facility) was brought out of the kitchen. At the same time the last resident food tray was removed from the tray cart, the food temperatures were taken on the test tray with the DSS and CRD1. The test tray with foods that were of puree texture/consistency (foods that are blended to a smooth, uniform consistency with no lumps so they can be eaten safely without chewing) had eggs which were 108 degrees F, and biscuits which were 125 degrees F. The test tray with foods that were of regular texture/consistency had eggs which were 104 degrees F, and a biscuit which was 104 degrees F. All temperatures were verified by the DSS and CRD 1 using the facility's thermometer. When asked what temperatures the hot foods were supposed to be when served to residents, the CRD 1 stated hot food was required to be served at or above the danger zone. The CRD 1 further stated she knew what temperatures consisted of the danger zone was but was unable to recall the temperatures because she was nervous. The DSS stated hot foods should be served to residents at or above 140 degrees F.During a review of the facility's food menu titled, Good for Your Health Menus, dated March 9, 2026, through March 15, 2026, the menu indicated lunch for Wednesday, March 11, 2026, was to include sweet and sour chicken, sesame noodles, stir fry vegetables, mandarin Asian salad, and lemon snow bar.During a concurrent observation and interview on March 11, 2026, at 1:07 PM, with the DSS and CRD 1, the last meal tray cart was brought out of the kitchen. At the same time the last resident food tray was removed from the tray cart, the food temperatures were taken on the test tray with the DSS and CRD1. The test tray with foods that were of puree texture/consistency had sweet and sour chicken that was 130 degrees F, and puree pasta that was 135 degrees F. The test tray with foods that were of regular texture/consistency had sweet and sour chicken that was 130 degrees F. All temperatures were verified by the DSS and CRD 1 using the facilities thermometer. The DSS stated temperatures were better than they were at breakfast but still were not at 140 degrees F as was required by the facility's policy.During an interview on March 11, 2026, at 2:35 PM, with the DSS, the DSS stated the policy and procedure regarding what temperatures food was supposed to be served to the residents at was covered in the policy titled, Food Preparation Policy. The DSS further stated the facility considered the holding temperatures to be the same temperature the food should be provided to the resident when they are served their meal tray.During a review of the facility's policy and (continued on next page)

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

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

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	procedure (P&P) titled, Food Preparation Policy, (undated), the P&P indicated, All food will be prepared by methods that preserve nutritive value, flavor, and appearance, and will be attractively served at the proper temperature and in a form to meet the individual needs of the resident.Hold foods for the shortest time possible before service.Hot food must be >= [greater than or equal to] 140 F and cold food <= [less than or equal to] 40 F. Cover all food during holding.

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure proper and safe infection control practices were followed when:1. Certified Nursing Assistant 3 (CNA 3) removed a set of gloves after providing care for a resident and did not perform hand hygiene prior to putting on a new set of gloves to assist another resident.2. CNA 4 (CNA 4) did not wear a gown when changing linens or providing patient care for Resident 3 who was on enhanced barrier precautions (EBP - an infection control strategy that requires healthcare staff to wear gowns and gloves during high-contact care activities for residents who are known or suspected to be colonized/infected with multidrug-resistant organisms or who have wounds or indwelling devices which place them at increased risk for infection). 3. Resident 41's oxygen humidifier (small bottle attached to an oxygen tank that adds moisture to the oxygen before you breathe it in) was not changed based on the physician's order.4. The facility failed to provide tracking compliance for hand hygiene surveillance (systematic process of watching, measuring, and reporting how often healthcare workers clean their hands) for the months of November 2025, December 2025, January 2026 and February 2026.5. CNA 6 (CNA 6) did not wear a gown while holding Resident 45, who was on EBP (enhanced barrier precautions are infection control measures requiring staff to wear gowns and gloves during high contact activities to prevent multi-drug resistance organism transmission) while walking in his room with a walker and assisting him to sit on the edge of the bed. These failures had the potential to spread infectious disease (disease caused by bacteria, viruses, fungi or parasite) to 80 medically compromised residents and staff in the facility. Findings: 1. During a concurrent observation and interview on March 9, 2026, at 10:23 AM, with Certified Nursing Assistant 3 (CNA 3), CNA 3 removed a gown and gloves as she was exiting the room of a resident who was on enhanced barrier precautions. After removing her gown, and gloves, CNA 3 did not perform hand hygiene (handwashing or use hand sanitizer) and immediately went into another resident's room and put on a new set of gloves to assist another resident. CNA 3 stated she had just finished assisting a resident who was on enhanced barrier precautions because the resident needed assistance with changing her clothes. CNA 3 then stated she did not perform hand hygiene after removing her gloves and did not perform hand hygiene prior to putting on new gloves because she forgot and was in a rush. CNA 3 further stated she was supposed to perform hand washing or use alcohol-based hand sanitizer after removing her gloves but she did not. During an interview on March 12, 2026, at 1:39 PM, with the Director of Nursing (DON), the DON stated staff were supposed to perform hand hygiene immediately after removing gloves. During an interview on March 12, 2026, at 3:20 PM, with the Infection Preventionist (IP), the IP stated staff were supposed to remove gloves and then perform hand hygiene immediately after the gloves were removed. The IP further stated the importance of performing hand hygiene was to protect residents from harmful organisms or infections. During a review of the facility's policy and procedure (P&P) titled, Infection Prevention and Control Program, dated April 2023, the P&P indicated, An infection prevention and control program (IPCP) is established and maintained to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.a. important facets of infection prevention include: .8. Following established general and disease-specific guidelines such as those of the Centers for Disease control (CDC) and California Department of Public Health (CDPH). (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	During a review of the CDC's guidance titled, Clinical Safety: Hand Hygiene for Healthcare Workers, dated February 27, 2024, found at found at https://www.cdc.gov/clean-hands/hcp/clinical-safety/index.html the guidance indicated, .CDC provides the following recommendations for hand hygiene in healthcare settings.know when to clean your hands.immediately after glove removal. 2. During a review of Resident 3's Face Sheet (contains medical and demographic information), the Face sheet indicated Resident 3 was admitted to the facility on [DATE], with diagnoses which included dementia (an illness which causes a progressive decline in cognitive functions – such as memory, thinking, reasoning, and the ability to perform everyday activities), hemiplegia and hemiparesis (weakness and paralysis) of right dominant side, and encounter for attention to gastrostomy (G-tube- a medical device inserted through the abdominal wall directly into the stomach – used for delivering nutrition, hydration, or medications)healthcare involving the care of an existing gastrostomy). During a concurrent observation and interview on March 9, 2026, at 11:27 AM, with Certified Nursing Assistant 4 (CNA 4), CNA 4 was observed to be changing the dirty linens of Resident 3 who was on enhanced barrier precautions. CNA 4 was only wearing gloves and was not wearing a gown. When CNA 4 was finished, CNA 4 stated she had just finished changing Resident 3's diaper and dirty linens. CNA 4 stated she did not wear a gown while assisting Resident 3 or changing Resident 3's linens because she had forgotten. There was a sign posted above Resident 3's bed which indicated, Providers and staff must also.wear gloves and a gown for the following high contact resident care activities, dressing, bathing/showering, transferring, changing linens, changing briefs or assisting with toileting. During a review of Resident 3's Electronic Health Record (EHR – electronic medical record), the EHR indicated, Enhanced Barrier Precautions due to G-tube care, During an interview on March 12, 2026, at 1:39 PM, with the Director of Nursing (DON), the DON stated that staff were supposed to wear a gown and gloves when providing direct patient care or changing dirty linens for a resident on enhanced barrier precautions. During an interview on March 12, 2026, at 3:16 PM, with the Infection Preventionist (IP), the IP stated the importance of wearing appropriate Personal Protective Equipment (PPE – protective gear worn by staff to reduce exposure to hazards or prevent the spread of infection, such as gloves and gowns) was to protect residents from the spread of organisms and to prevent infections. During a review of the facility's policy and procedure (P&P) titled, Enhanced Barrier (standard) Precautions, dated January 2024, the P&P indicated, Enhanced barrier precautions (EBPs or ESPs) are used as an infection prevention and control intervention to reduce the spread of multi-drug-resistant organisms (MDROs) to residents.2. EBPs/ESPs employ targeted gown and glove use during high contact resident care activities.3. Examples of high-contact resident care activities requiring the use of gown and gloves for EBPs/ESPs include: .e. changing linens; f. changing briefs or assisting with toileting. 3. During a review of Resident 41's admission Record (contains medical and demographic information), the admission Record indicated Resident 41 was admitted to the facility on [DATE] with the diagnoses which included Chronic obstructive pulmonary disease (COPD- an ongoing lung condition caused by damage to the lungs), asthma (a long-term lung condition where the airways (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	become inflamed, narrow, and produce extra mucus, making it difficult to breathe) and pleural effusion(a collection of fluid around the lungs). During a review of Resident 41's Physician Order dated February 20, 2026, the Physician Order indicated, Change humidifier q [every] night shift, every Sunday. During an observation on March 9, 2026, at 11:11 AM in Resident 41's room, the resident's oxygen humidifier was observed labeled with a date of March 2, 2026. During a concurrent observation and interview conducted on March 9, 2026, at 11:24 AM with the licensed vocational nurse 1 (LVN 1) in Resident 41's room, the resident's oxygen humidifier was observed labeled March 2, 2026. The LVN 1 stated oxygen humidifiers are changed every Sunday and acknowledged the humidifier should have been changed on March 8, 2026, in accordance with the Physician order. During a concurrent interview and record review conducted on March 9, 2026, at 11:45 AM with the Director of Nursing (DON), Resident 41's physician order was reviewed and indicated to change the oxygen humidifier every Sunday on night shift. The DON confirmed the physician order was not followed and stated the oxygen humidifier should have been changed as ordered to reduce the risk of potential infections. 4. During an interview on March 11, 2026, at 11:28 AM, with the Infection Preventionist (IP), the IP stated she conducts daily hand hygiene surveillance weekly; however, she confirmed the surveillance activities had not been documented. The IP stated she did not have documentation available to verify ongoing hand hygiene surveillance. The IP further stated she had access to the California Department of Public Health healthcare-associated infection program adherence monitoring hand hygiene form, but acknowledged the form had not been utilized during her two months in the Infection Preventionist role. The IP stated she understood hand hygiene surveillance is an essential component of infection control monitoring within the facility. When requested to provide surveillance records, the IP was only able to produce hand hygiene monitoring documentation dated October 15, 2025, October 25, 2025, and October 31, 2025. During a concurrent interview and record review on March 11, 2026, at 11:42 AM, with the DON, the facility policy and procedure (P&P) titled, Monitoring Compliance with Infection Control, dated April 2023 was reviewed. The P&P indicated, 2. Monitoring includes regular surveillance of adherence to hand hygiene practices and availability of hand hygiene supplies, and the availability of personal protective equipment and its appropriate use.3. The infection preventionist conducts compliance surveys at least quarterly.4.Compliance surveillance includes the use of standardized assessment and observation tools. The DON further stated the facility's policy was not followed, the facility failed to provide tracking compliance for hand hygiene surveillance and it's important because hand hygiene is the most important infection prevention practice. 5. During a review of Resident 45's Face Sheet, the Face Sheet indicated Resident 45 was admitted to the facility on [DATE], with diagnoses of acute cholecystitis (sudden inflammation[the body's natural response to injury, infection, or irritation and swelling of the gallbladder), urinary tract infection (an infection in any part of the kidneys, ureters, bladder, and urethra), and difficulty of (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	walking. During an observation on March 9, 2026 at 9:04 AM in Resident 45's room, there was an EBP (Enhanced barrier Precautions- are infection control measures requiring staff to wear gowns and gloves during high contact activities to prevent multi-drug resistant organism transmission) sign posted above Resident 45's bed which indicated, Providers and staff must also.wear gloves and a gown for the following high contact resident care activities., transferring. During an observation on March 9, 2026, at 12:14 PM, Resident 45's foley catheter (flexible tube that is inserted into the bladder through the urethra to drain urine) bag and cholecystostomy tube (a tube inserted through the skin into the gallbladder to drain infected bile and fluids) bag were hanging from the resident's walker. CNA 6 was holding the resident and the walker while the resident was walking within the room. CNA 6 subsequently assisted by holding onto Resident 45 from a standing to a sitting position on the bed while wearing gloves with no gown. During an interview on March 9, 2026, at 12:20 PM, with CNA 6, CNA 6 stated that the facility's policy for caring for a resident on enhanced barrier precautions requires staff to wear both gloves and a gown. CNA 6 acknowledged and confirmed that she did not wear a gown when assisting Resident 45 and should have. During an interview on March 10, 2026, at 4:10 PM, with the infection preventionist (IP), the IP stated staff must wear both gloves and a gown when having direct contact with residents who are on enhanced barrier precautions to prevent the spread of infection. During a concurrent interview and record review on March 11, 2026, at 1:00 PM, with the DON, the facility's P&P titled, Enhanced Barrier (Standard) Precautions dated January 2024 was reviewed. The P&P indicated, . Policy Interpretation and Implementation . b. Gloves and gown are applied prior to performing the high contact resident care 3. Examples of high-contact resident care activities requiring the use of gown and gloves for EBPs/ESPs include: .c. transferring. The DON stated the P&P was not followed. The DON further stated it is important for staff to wear appropriate personal protective equipment (PPE) to ensure effective infection control and prevent the spread of infection.

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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. Based on observation, interview, and record review, the facility failed to ensure that two of two residents (Residents 86 and 47) received food served at an appetizing and palatable temperature when Residents 86 and 47 reported their hot foods were often served cold. This failure had the potential to negatively affect Residents 86 and 47 comfort, appetite, and overall satisfaction with meals due to not receiving food at the preferred temperature.Findings: During a review of the facility's resident council meeting minutes (meeting notes from a group of residents who meet regularly to discuss their rights and quality of care in a facility as well as to make recommendations, raise grievances, and influence decisions related to their daily living in the facility), the meeting minutes from January 27, 2026, indicated residents were complaining that their hot food was served cold during mealtimes.During a concurrent observation and interview on March 12, 2026, at 3:35 PM, with Resident 86, Resident 86 was lying in bed and stated often times, her food which was supposed to be hot, would be served cold. Resident 86 further stated when her food was cold she doesn't like to eat as much because she doesn't like it that way.During a concurrent observation and interview on March 12, 2026, at 3:38 PM, with Resident 47, Resident 47 was lying in bed and stated her food which is supposed to be hot is also served cold oftentimes but she has to eat to survive so she just eats it cold even though she does not like it that way.During an interview on March 12, 2026, at 3:50 PM, with Resident 57, Resident 57 stated she was the president of the resident council. Resident 57 further stated the resident council has brought up to the facility many times that the food which was supposed to be hot, was served cold during mealtimes. Resident 57 stated multiple residents have been complaining about the issue for a while now.During a review of the facility's food menu titled, Good for Your Health Menus, dated March 9, 2026, through March 15, 2026, the menu indicated breakfast for Wednesday, March 11, 2026, was to include biscuits with gravy, scrambled eggs, oatmeal, and raisins, with orange juice.During a concurrent observation and interview on March 11, 2026, at 8:19 AM, with the Dietary Services Supervisor (DSS), and the Consultant Registered Dietician 1 (CRD 1) the last meal tray cart (a cart used by staff to transport multiple resident trays of food throughout the facility) was brought out of the kitchen. At the same time the last resident food tray was removed from the tray cart, the food temperatures were taken on the test tray with the DSS and CRD1. The test tray with foods that were of puree texture/consistency (foods that are blended to a smooth, uniform consistency with no lumps so they can be eaten safely without chewing) had eggs which were 108 degrees F, and biscuits which were 125 degrees F. The test tray with foods that were of regular texture/consistency had eggs which were 104 degrees F, and a biscuit which was 104 degrees F. All temperatures were verified by the DSS and CRD 1 using the facilities thermometer. When asked what temperatures the hot foods were supposed to be when served to residents, the CRD 1 stated hot food was required to be served at or above the danger zone. The CRD 1 further stated she knew what temperatures consisted of the danger zone was but was unable to recall the temperatures because she was nervous. The DSS stated hot foods should be served to residents at or above 140 degrees F.During an interview on March 11, 2026, at 2:35 PM, with the DSS, the DSS stated the policy and procedure regarding what temperatures food was supposed to be served to the residents at was covered in the policy titled, Food Preparation Policy. The DSS further stated the facility considered the holding temperatures to be the same temperature the food should be provided to the resident when they are served their meal tray.During a review of the facility's policy and procedure (P&P) titled, Food Preparation Policy, (undated), the P&P indicated, All food will be prepared by methods that preserve nutritive value, flavor, and appearance, and will be attractively served at the proper temperature and in a form to meet the individual needs of the resident.Hold foods for the shortest time possible before service.Hot food must be >= [greater than or equal to] 140 F and cold food <= [less than or equal to] 40 F. Cover all food during holding.

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure a dignified dining experience for three of twelve residents (Residents 19, 76 and 1) when a Restorative Nursing Assistant (RNA 1), and two Certified Nursing Assistants (CNA 1 and 5) were standing while assisting them to eat during lunch time. These failures had the potential to negatively impact Resident 19, 76 and 1's dignity and psychosocial well-being by failing to provide a respectful, person-centered approach to their dining experience.Findings: 1. During a review of Resident 19's clinical record, resident Face Sheet (a summary page in a medical chart that lists a resident's basic information), and History & Physical (a medical document completed by a healthcare provider that describes a resident's past medical history, current health problems, and findings from a physical examination) indicated, Resident 19 was admitted on [DATE], with a history of dementia (decline in brain function resulting in memory loss, confusion), epilepsy (a brain condition that causes repeated seizures due to abnormal electrical activity in and is bedbound (unable to get out of bed without full assistance). During a concurrent observation and interview on March 9, 2026, at 12:42 PM, with Restorative Nursing Assistant 1 (RNA 1), in the dining room, RNA 1 was feeding Resident 19 while standing. RNA 1 stated she stands because the chair is too high and it's uncomfortable. 2. During a review of Resident 76's clinical record, resident Face Sheet and History & Physical indicated, Resident 76 was admitted on [DATE], with a history of schizophrenia (a longˆterm mental health condition that affects how a person thinks, feels, and understands reality, sometimes causing hallucinations, unusual beliefs, or trouble thinking clearly), chronic kidney disease (a slow, longˆterm loss of kidney function that makes it hard for the body to filter waste and excess fluid), and general weakness (a feeling of reduced strength or energy throughout the body, making it harder to move around or perform daily tasks). During an observation on March 9, 2026, at 12:42 PM, in the dining room, Certified Nursing Assistant 1 (CNA 1) was feeding Resident 76 while standing. During an interview on March 11, 2026, at 12:45 PM, CNA 1, stated she tried to sit down but she couldn't because there was no room. 3. During a review of Resident 1's admission Record it indicated Resident 1 was admitted to the facility on [DATE], with diagnoses of encephalopathy (condition that alters brain function resulting in confusion, memory loss or personality changes), lobar pneumonia (infection in the lungs), and dementia (decline in brain function resulting in memory loss, confusion and trouble performing daily living tasks). During an observation on March 9, 2026, at 1:19 PM, in Resident 1's Room, Resident 1 was lying in bed while CNA 5 (CNA 5) was standing next to her bed, feeding her lunch. During an interview on March 9, 2026, at 1:25 PM with CNA 5, CNA 5 stated she normally stands while feeding residents. CNA 5 further stated, She (Resident 1) is a slower eater, so I stand. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on March 11, 2026, at 11:51 PM, with the Director of Nursing (DON), the facility's Policy and Procedure (P&P), titled, Assistance with Meals, dated 2001 was reviewed. The P&P indicated, .Residents who cannot feed themselves will be fed with attention to safety, comfort and dignity, for example: a. not standing over residents while assisting them with meals. The DON stated, that based on the observations of the facility, the P&P was not being followed. The DON further stated the importance of following the facility's P&P was to promote resident safety and dignity. During a review of the facility provided RNA job description, dated January 27, 2022, the job description states, A RNA .Preserves the . dignity . of all residents at all times. During a review of the facility provided CNA job description, dated January 27, 2022, the job description states, A CNA .Provides assistance with supervision, eating . appropriate seating arrangement .

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the resident and/or the representatives (RP) was informed of psychotropic medication (medications that affect the mind, emotions, and behaviors) treatment for one of one resident (Resident 63) when Resident 63's informed consent (document signed by resident or RP to give permission for a proposed psychotropic medication and possible risks and benefits expected) was not updated and signed by a provider and by the resident and/or the RP for Resident 63's order of Divalproex Sodium (Depakote-antiseizure and mood stabilizer) 125 milligram (MG-unit of measurement). This failure resulted in Resident 63 and/or their RP not being informed of the psychotropic medication risks, benefits, adverse reactions, and the right to refuse the administration of medications.Findings: During a review of Resident 63's admission Record (clinical record with demographic information), the admission Record indicated, Resident 63 was admitted to the facility on [DATE], with diagnoses of chronic kidney disease (progressively kidneys are damaged and cannot filter blood properly) , Hemiplegia (complete or partial loss of muscle function on one side of the body) and Hemiparesis (mild or moderate muscular weakness or reduced control on one side of the body) following cerebral infraction (brain tissue death due to lack of oxygen and nutrients).During observation on March 9, 2026, at 12:07 PM, Resident 63 was in her room, lying on her left side, asleep.A review of Resident 63's physician order, dated July 25, 2025, indicated Resident 63 had an order for Divalproex Sodium Oral Capsule Delayed Release Sprinkle 125 MG (Divalproex Sodium) Give 4 Capsule by mouth two times a day for POOR IMPLUSE CONTROL M/B [manifested by] GETTING AGITATION EASILY, LEADING TO VERBAL AND PHYSICAL AGRESSION.During a review of Resident 63's Informed Consent, dated October 10, 2025, the Informed Consent was incomplete and lacked the required signatures of the physician and the resident and/or RP.During Interview on March 10, 2026, at 3:47 PM with the Registered Nurse (RN), the RN verified and acknowledged Resident 63 did not have a complete informed consent for Divalproex Sodium/Depakote. The RN further stated it is important for the physician to discuss the risks and benefits of the medication with the resident and/or RP before the medication is given.During a concurrent interview and record review on March 12, 2026, at 8:47 AM with the Director of Nursing (DON), the facility's policy and procedure (P&P) titled, Psychotherapeutic Drug Informed consent, dated January 2026 was reviewed. The P&P indicated, Purpose: to ensure that residents and their representatives are fully informed of the benefits, risks, frequency/duration, possible side effects and alternative approaches before initiating the administration of psychotherapeutic drugs. The DON stated the informed consent was not signed therefore P&P was not followed.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure implementation of their policy and procedure (P&P) for advance directive (a legal document that states a person's wishes about receiving medical care if that person is no longer able to make medical decisions) was completed for one of 24 residents (Resident 87) reviewed for advance directives. This failure had the potential to result in delay of treatment for the Resident 87 as related to advance directives, or for life sustaining measures to be rendered against what the resident wanted.Findings: During a review of Resident 87's admission Record (contains demographic and medical information), the admission Record indicated Resident 87 was admitted to the facility on [DATE], with diagnoses of acute respiratory failure with hypoxia (life-threatening, sudden inability of lungs to oxygenate blood that result in low oxygen levels), sepsis (life-threatening reaction to an infection that causes immune system to harm healthy tissues and organs), and generalized muscle weakness.During an observation, on March 9, 2026, at 4:50 PM, Resident 87 was in her room, lying in bed with the head of the bed elevated.During a record review of Residents 87's chart, there was no advance directives form found.During a concurrent interview and record review on March 10, 2026, at 3:20 PM with the social service director (SSD), Resident 87's medical record was reviewed and the SSD stated there was no Advance directives form completed and it should have been done. The SSD further stated, it is important to address advance directives and ensure documentation is completed in the medical record so that staff know the residents' code status and, if an advance directive exists, can obtain a copy and follow the instructions contained in it.During concurrent interview and record review on March 11, 2026, at 12:58 PM with the Director of Nursing (DON), the facility's Policy and Procedure (P&P) titled, Advance Directives, dated September 2022 was reviewed. The P&P indicated, .Determining Existence of Advance Directive, 1. Prior or upon admission of a resident, the social services director or designee inquires of the resident, his/her family members and/or his or her legal representative, about the existence of any written advance directives. The DON stated the P&P was not followed. The DON further stated the Advance directives form should have been completed upon admission or there should be a note in the resident's medical record indicating the Advance directives was addressed.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure staff documented the location of a resident's pain as required by the physician's order for 1 of 2 residents (Resident 18) reviewed for pain management.This failure had the potential to result in inaccurate pain assessment, inadequate monitoring, and unmet pain management needs for Resident 18.Findings: During a review of Resident 81's Face Sheet (contains medical and demographic information), the Face Sheet, indicated Resident 81 was admitted to the facility on [DATE], with diagnoses which included fracture of the left lower leg, age-related osteoporosis (disease which causes loss of bone density and strength), acute kidney failure (a sudden decrease in kidney function), and history of falling.During a review of Resident 81's Care Plan Report, (an individualized plan for the medical care of a resident), titled, Resident has potential for alteration in comfort/pain related to: dx [diagnosis] of.fracture left lower leg, osteoporosis.akf [acute kidney failure], hx [history] of falling.GERD [gastro-esophageal reflux disease - a digestive condition where stomach acids or contents flow back into the esophagus, causing symptoms like heartburn]. dated March 10, 2026, the care plan indicated, Interventions.Monitor s/s [signs and symptoms] of pain.Assess characteristics of pain: location, duration, quality.During a review of Resident 81's physician's orders, an order dated March 5, 2026, indicated, Hydrocodone-Acetaminophen [pain reliever medication] oral tablet 5-325 MG [milligrams - unit of measure] give 1 tablet by mouth every 6 hours as needed for pain.document pain site in the progress notes.During a review of Resident 81's Medication Administration Record (MAR), dated March 1, 2026, through March 31, 2026, the MAR indicated Resident 81 was administered the medication Hydrocodone-Acetaminophen a total of 16 times from March 6, 2026, through March 12, 2026. During a review of Resident 81's progress notes dated March 1, 2026, through March 12, 2026, the progress notes indicated the location of pain was not documented and was left blank for nine out of 16 (9 of 16) times the medication Hydrocodone-Acetaminophen was administered to the resident. Additionally, there was no other documentation in the clinical record regarding the location of pain for the times the medication was administered.During a concurrent interview and record review on March 12, 2026, at 9:47 AM, with the Director of Nursing (DON), Resident 81's MAR dated March 1, 2026, through March 12, 2026, was reviewed. The DON stated her expectation was that staff documents the pain location in the progress notes as indicated by the physician's order for Resident 81 every time the medication Hydrocodone was administered. The DON further stated the pain location should be in the progress notes section of the MAR or in the regular progress note for the resident in the Electronic Health Record (EHR). The DON reviewed both the MAR and also the progress notes of the EHR and stated staff did not document the location of pain for the administration of the hydrocodone medication as they were supposed to. The DON stated she was unable to find documentation regarding the location of pain for the administration of the hydrocodone on multiple days.During a review of the facility's policy and procedure (P&P) titled, Care Plans, Comprehensive Person-Centered, dated March 2023, the P&P indicated, A comprehensive person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial, and functional needs is developed and implemented for each resident.During a review of the facility's P&P titled, Charting and Documentation, dated July 2017, the P&P indicated, .The medical record should facilitate communication between the interdisciplinary team regarding the resident's condition and response to care.3. Documentation in the medical record will be objective.complete, and accurate.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure administered medications were accurately documented according to the facility's policies and procedures (P&P) for two out of 13 residents (Residents 45 and 82) when:1.Registered Nurse 2 (RN 2) did not document Resident 45's administration of Omeprazole (a medication used to treat acid reflex) on the Medication Administration Record (MAR- record for what medication a resident has received). This failure had the potential to result in medication errors, including double dosing and may adversely affect Resident 45's health and safety. 2. RN 2 inaccurately documented the administration time of Resident 82's Famotidine (a medication used to treat acid reflex) as 6:53 AM when the medication was observed to be administered at 5:19 AM. This failure had the potential to result in medication errors, including improper dosing intervals and inaccurate assessment of Resident 82's response to therapy.Findings: 1.During a review of Resident 45's admission Record (contains demographic and medical information), the admission record indicated Resident 45 was admitted to the facility on [DATE], with diagnoses of acute cholecystitis (sudden inflammation[the body's natural response to injury, infection, or irritation] and swelling of the gallbladder), urinary tract infection (an infection in any part of the kidneys, ureters, bladder, and urethra), and difficulty of walking.During a review of Resident 45's physician's order, dated March 10, 2026, it indicated Resident 45 had an order for Omeprazole DR (delayed release) 20 MG (milligram- unit of measurement) CAP (capsule) Give 1 capsule by mouth two times a day for GERD [gastroesophageal reflux disease- when stomach acid backs up into the throat] GIVE 30 MINUTES BEFORE MEAL.During a medication administration observation on March 11, 2026, at 5:50 AM, in Resident 45's room, the RN 2 administered Omeprazole 20 MG Delayed Release Oral Capsule to Resident 45.During a concurrent interview and record review on March 11, 2026, at 8:42 AM with the RN 2, the RN 2 reviewed Resident 45's MAR. The RN 2 stated the administered Omeprazole was not documented because it was not scheduled for her shift. The RN 2 confirmed and acknowledged she did not document the Omeprazole she administered.2. During a review of Resident 82's admission Record, the admission Record indicated Resident 82 was admitted to the facility on [DATE], with diagnoses of heart failure (the muscle of the heart too weak or stiff to pump blood efficiently), dysphagia (difficulty of swallowing), and muscle weakness.During a review of Resident 82's physician's order, dated February 27, 2026, it indicated Resident 82 had an order for Famotidine Oral Tablet 20 mg Give 1 tablet by mouth one time a day for GERD(acid reflex).During a medication administration observation on March 11, 2026, at 5:19 AM, in Resident 82's room, the RN 2 administered Famotidine 20 mg Oral Tablet to Resident 82.During a concurrent interview and record review on March 11, 2026, at 7:07 AM with the RN 2, the RN 2 reviewed Resident 82's MAR and noted Famotidine was documented as administered at 6:53 AM. The RN 2 stated she forgot to sign the MAR at the time the medication was administered and later documented the administration at 6:53 AM, despite the medication been administered at 5:19 AM.During a concurrent interview and record review on March 11, 2026, at 1:07 PM with the director of nursing (DON), the facility's Policy and Procedure (P&P) titled, Medication Administration-General Guidelines, dated October 2017 was reviewed. The P&P indicated, .c. Documentation . 1) The individual who administers the medication dose records the administration on the resident's MAR directly after the medication is given . The DON stated the P&P was not followed.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident?s drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility did not ensure one of one resident (Resident 85) medication order for Ambien (a medication used to help treat insomnia [the inability to maintain or initiate sleep]) had a frequency in which the medication could be administered. This had the potential for Resident 85 to experience an overdose of Ambien medication which can cause severe sedation, cognitive impairment, respiratory arrest or coma.Findings: During a review of Resident 85's Face Sheet (contains medical and demographic information), the Face Sheet, indicated Resident 85 was admitted to the facility on [DATE], with diagnoses which included encephalopathy (brain dysfunction which can appear as confusion, memory loss, or personality changes), depression, and history of traumatic brain injury.During a review of Resident 85's physician's orders, an order dated February 25, 2026, indicated Zolpidem Tartrate [Ambien - a sedative-hypnotic medication used to help adults fall asleep or stay asleep through the night] ER [extended release] oral tablet extended release 6.25 MG [milligrams - unit of measure] Give 1 tablet by mouth as needed for insomnia m/b [manifested by] inability to sleep. The order had no frequency indicated on to specify how frequently the medication could be administered to Resident 85. The order was discontinued on March 11, 2026 (it was an active order for 15 days).During a concurrent interview and record review on March 12, 2026, at 1:47 PM, with the Director of Nursing (DON), Resident 85's physician's orders were reviewed. The DON acknowledged the physician's order dated February 25, 2026, indicated, Zolpidem Tartrate [Ambien - a sedative-hypnotic medication used to help adults fall asleep or stay asleep through the night] ER [extended release] oral tablet extended release 6.25 MG [milligrams - unit of measure] Give 1 tablet by mouth as needed for insomnia m/b [manifested by] inability to sleep. The DON stated the order did not have a frequency to indicate how often the medication can be administered to the resident, but it should have one. The DON further stated all medication orders were supposed to have a frequency indicated in the order to ensure the resident is not overdosed by the medication. The DON stated Clinical Coordinator (CC) was the nurse who input the order into the Electronic Health Record (EHR - electronic medical record.)During a concurrent interview and record review on March 12, 2026, at 2:20 PM, with the CC, Resident 85's physician's orders were reviewed. The CC acknowledged the physician's order dated February 25, 2026, indicated, Zolpidem Tartrate [Ambien - a sedative-hypnotic medication used to help adults fall asleep or stay asleep through the night] ER [extended release] oral tablet extended release 6.25 MG [milligrams - unit of measure] Give 1 tablet by mouth as needed for insomnia m/b [manifested by] inability to sleep. The CC further stated she was the nurse who input the order into Resident 85's EHR and she must have forgot to enter in the frequency as part of the order.During an interview on March 12, 2026, at 4:37 PM, with the facility's Pharmacy Consultant (PC), the PC stated all medication orders were supposed to have a frequency indicated. The PC further stated it was important so staff know how often the medication could be administered to the resident.During a review of the facility's policy and procedure (P&P) titled, Medication and Treatment Orders, dated July 2016, the P&P indicated, Orders for medications and treatments will be consistent with principles of safe and effective order writing.9. Orders for medications must include: a. name and strength of the drug; b. number of doses, start and stop date, and or specific duration of therapy; c. dosage and frequency of administration.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure medication error rate was less than five percent. There were three medication errors observed out of a total of 29 opportunities for errors, affecting three out of 13 observed residents (Residents 27, 45, and 82), resulting in an overall medication error rate of 10.34 percent when:1. Famotidine (a medication to treat acid reflux) was not administered to Resident 82 within 60 minutes of scheduled time (one hour before and one hour after) according to the facility's policy and procedure (P&P).2. Omeprazole (a medication to treat acid reflux) was not administered to Resident 45 before 30 minutes of meal according to a physician order.These failures had the potential to result in unmet health care needs and increased risk of complications related to acid reflux for Residents 45 and 82. 3. Hydralazine (a medication to treat high blood pressure) was not administered to Resident 27 according to the physician-order parameters.This failure had the potential to result in ineffective or unsafe blood pressure management and increased risk of harm to Resident 27's health.Findings: 1. During a review of Resident 82's admission Record (contains demographic and medical information), the admission Record indicated Resident 82 was admitted to the facility on [DATE], with diagnoses of heart failure (the muscle of the heart too weak or stiff to pump blood efficiently), dysphagia (difficulty of swallowing), and muscle weakness.During a review of Resident 82's physician's order, dated March 10, 2026, it indicated Resident 45 had an order for Famotidine 20 mg (milligram- unit of measurement) Give 1(one) tablet by mouth one time a day for GERD [gastroesophageal reflux disease- when stomach acid backs up into the throat].During a review of Residents 82's Medication Administration Record (MAR- record for what medication a resident has received), it indicated the scheduled administration time for Famotidine was 6:30 AM.During a medication administration observation on March 11, 2026, at 5:19 AM, in Resident 82's room, the Registered Nurse 2 (RN 2) administered Famotidine 20 mg Oral Tablet to Resident 82.During an interview on March 11, 2026, at 7:07 AM with the RN 2, the RN 2 stated Resident 82's Famotidine should have been administered within 60 minutes of the scheduled time (one hour before or one hour after). The RN 2 further stated Resident 82 received Famotidine, scheduled for 6:30 AM, at 5:19 AM (11 minutes early), which falls outside the acceptable medicationˆadministration time range.2. During a review of Resident 45's admission Record, the admission record indicated Resident 45 was admitted to the facility on [DATE], with diagnoses of acute cholecystitis (sudden inflammation[the body's natural response to injury, infection, or irritation] and swelling of the gallbladder), urinary tract infection (an infection in any part of the kidneys, ureters, bladder, and urethra), and difficulty of walking.During a review of Resident 45's physician's order, dated March 10, 2026, it indicated Resident 45 had an order for Omeprazole DR (delayed release) 20 MG CAP (capsule) Give 1 capsule by mouth two times a day for GERD GIVE 30 MINUTES BEFORE MEAL.During a review of Residents 45's MAR (medication Administration Record), it indicated the scheduled administration time for Omeprazole was 7:30 AM.During a medication administration observation on March 11, 2026, at 5:40 AM, in Resident 45's room, the RN 2 administered Omeprazole 20 MG Delayed Release Oral Capsule to Resident 45.During an interview on March 11, 2026, at 8:42 AM with the RN 2, the RN 2 stated Omeprazole should have been administered 30 minutes before meal according to the physician order. The RN 2 further stated Resident 45 received Omeprazole, scheduled for 7:30 AM, at 5:40 AM (50 minutes early), which falls outside the 30 minutes before meal order.During a concurrent interview and record review on March 11, 2026, at 1:02 PM with the Director Of Nursing (DON), the facility's Policy and Procedure (P&P) titled, Medication Administration-General Guidelines dated October 2017 was reviewed. The P&P indicated, .B. Administration.10. Medications are administered within 60 minutes of scheduled time (1 hour before and 1 hour after), except before and after meal orders, which are administered based on mealtimes. The DON stated the P&P was not followed.3. During a review of Resident 27's admission Record, the admission Record indicated Resident 27 was admitted (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	to the facility on [DATE], with diagnoses of metabolic encephalopathy (impaired brain function caused by organ failure, chemical imbalance or toxins), Urinary tract infection, and pseudomonas aeruginosa (bacteria found in the environment) cause of disease.During a review of Resident 27's physician's order, dated January 19, 2026, it indicated Resident 27 had an order for hydralazine HCL Oral tablet 10 MG (Hydralazine HCl) Give 1 tablet by mouth every 6 hours as needed for HTN [hypertension- high blood pressure] GIVE WHEN SBP [systolic blood pressure- the top number in a blood pressure reading]>160mmHg. During a medication administration observation on March 11, 2026, at 5:47 AM, in Resident 27's room, the RN 2 administered Hydralazine 10MG Oral Tablet for blood pressure 160/110 to Resident 45.During an interview on March 11, 2026, at 7:09 AM with the RN 2, the RN 2 stated the administration parameter for Hydralazine was to give the medication only if the SBP is greater than 160. The RN 2 further stated Resident 27 received Hydralazine when the SBP was exactly 160, which did not meet the physicianˆordered parameters. The RN 2 stated, based on the order, the Hydralazine should not have been administered.During a concurrent interview and record review on March 11, 2026, at 1:05 PM with the DON, the facility's P&P titled Medication Administration-General Guidelines dated October 2017 was reviewed. The P&P indicated, .B. Administration .2. Medications are administered in accordance with written orders of the attending physician. The DON stated the P&P was not followed.

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F 0800 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure dietary staff prepared and served the large portion sizes, as specified in the resident's physician order, for one of one sampled resident (Resident 66) when Resident 66's breakfast tray was sent from the kitchen without the required large portions.This failure had the potential for Resident 66 to receive a meal inconsistent with the prescribed dietary order.Findings: During a review of Resident 66's Face Sheet (contains medical and demographic information), the Face Sheet, indicated Resident 66 was admitted to the facility on [DATE], with diagnoses which included hemiplegia and hemiparesis (weakness and paralysis), hypertension (high blood pressure), and malignant neoplasm of unspecified site of left breast (breast cancer).During a review of Resident 66's physician's orders, an order dated March 15, 2025, indicated Resident 66 was to receive, .Large portions TID [three times a day].During a review of Resident 66's Care Plan Report, (individualized plan for the medical care of a resident), a care plan titled, I, [name of Resident 66], have difficulty with my nutrition due to: aging process.missing teeth, muscle weakness. dated May 27, 2024, indicated, Goal.I will not have any unplanned weight changes through the next assessment.interventions.diet as ordered.During a review of the facility's food menu titled, Good for Your Health Menus, dated March 9, 2026, through March 15, 2026, the menu indicated breakfast for Wednesday March 11, 2026, was to include biscuits with gravy, scrambled eggs, oatmeal & raisins, and orange juice.During a review of the facility's food production worksheet titled, Cooks Spreadsheet - Spring Cycle Menus (document which indicates the amount of food residents were supposed to receive at each meal based upon their physician ordered portion sizes), undated, the document indicated residents with large portions ordered were supposed to receive two scoops of egg of the number 12 green scoop (1/3 cup serving) for a total of 2/3 a cup. Additionally, the document indicated residents were supposed to receive two biscuits.During a concurrent observation and interview on March 11, 2026, at 7:54 AM, with the Dietary Service Supervisor (DSS), during breakfast tray line (plating of food for residents), Resident 66's meal tray received only one green scoop (1/3 cup serving) of egg, and two biscuits. Resident 66's meal tray was not served a total of 2/3 cup of eggs for large portions as specified in the physician order. Resident 66's meal tray was then covered and placed on the meal cart (a cart used to transport multiple meal trays from the kitchen to the facility units) and pushed out of the kitchen and into the hallway for distribution to residents. Prior to Resident 66's meal tray being served to the resident, the DSS was asked to review Resident 66's meal tray. The DSS confirmed Resident 66's meal tray contained two biscuits and one scoop of eggs (size 1/3 cup portion). The DSS further stated residents who had large portions were supposed to get double of one item as part of the meal and for this meal, it was double the amount of biscuits but only one scoop of egg. The DSS was then asked to review the Cooks Spreadsheet - Spring Cycle Menus, undated. Upon Review of the Cooks Spreadsheet, the DSS stated that residents who were supposed to receive large portions were actually supposed to receive two scoops of egg (for a total of 2/3 cup) and not just one as she initially thought.During an interview on March 12, 2026, at 3:25 PM, with Resident 66, Resident 66 was lying on her right side while in bed. Resident 66 stated she was supposed to receive large portions of food but sometimes she felt as though she did not receive large portions like she was supposed to.During a review of the facility's policy and procedure (P&P) titled, Food Preparation Policy, (undated), the P&P indicated, .All meals must comply with the physician-ordered diet, approved menu, and portion control standards to ensure consistency, adequate nutrition, and regulatory compliance.a. Standardized portion sizes must be followed for all food items, including meats, in accordance with the approved menu and diet manual.c. portion utensils (e.g., scoops, serving utensils, ladles) must be labeled and used to ensure consistent portioning.D. dietary staff must refer to the production sheet or meal ticket to confirm proper portion for each resident (continued on next page)

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0800 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	diet.e. Dietary Supervisor or Lead [NAME] must monitor the meal service to ensure correct portion is being served.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056429	A. Building B. Wing	03/12/2026

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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 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep all essential equipment working safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure resident's equipment was maintained in safe operating condition for 1 of 2 residents (Resident 86) when Resident 86 bed malfunctioned such that the foot section would not elevate, the head and foot controls were reversed, and normal bed positioning could not be performed as intended. This failure had the potential to affect Resident 86 safety, comfort, and positioning needs, and create risk for confusion, distress, and delayed staff response during care.Findings:During a review of Resident 86's clinical record, the Record of Admission (contains demographic and medical information), the Record of Admission indicated, Resident 86 was admitted to the facility on [DATE] with diagnoses which included, Spinal Stenosis Lumbar Region(A narrowing of the tunnel in the lower back that houses nerves, causing pressure on nerves), Fibromyalgia (A chronic disorder characterized by widespread pain, fatigue, and tenderness throughout the body), Arthrodesis status(a surgical procedure that permanently connects two or more bones in a joint to stop them from moving).During observation on March 9, 2026, at 10:48 AM with Resident 86 in Resident 86's room, Resident 86 bed was tested and observed not to function properly. The foot section of the bed failed to elevate when activated. In addition, the hand control functions were reversed, such that activating the head control raised the foot section and activating the foot control raised the head section when operable. Resident 86 states the bed has not been functioning properly since I was admitted on [DATE] and staff have been notified. Resident 86 further states I was told the bed would be replaced. Resident 86 states I would really like to raise my feet for comfort.During a concurrent observation and interview on March 9, 2026 at 11:07 AM, with Certified Nurse Assistant 2 (CNA 2) in resident 86 room, CNA 2 confirmed the bed was not functioning as intended and acknowledged the controls were reversed. CNA stated the bed had not been removed from service or tagged for repair.During a concurrent observation and interview on March 11, 2026, at 8:05 AM with the Maintenance Director (MD), in Resident 86 room, the MD verified Resident 86's bed was not functioning in a safe operating condition. The MD further stated maintenance was not aware of resident 86 bed not functioning properly. During a concurrent interview and record review on March 11, 2026, at 8:11 AM with MD, March maintenance log for unit B was reviewed. The March maintenance log indicated Resident 86's bed repair was not documented as a work request. MD stated that the staff did not log a work request for Resident 86 bed repair.During a concurrent interview and record review on March 11, 2026, at 11:53 AM, with the MD, the facility's Policy and Procedure (P&P) titled Maintenance Service dated December 2009, was reviewed. The P&P indicated, .1. The maintenance department is responsible for maintaining the buildings, grounds, and equipment in a safe and operable manner at all times.8. The maintenance director is responsible for maintaining the following records and reports.l. work order request.10. Maintenance personnel shall follow established safety regulations to ensure the safety and well-being of all concerned. The MD acknowledged and stated the policy was not followed.