STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056436	A. Building B. Wing	02/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medical Center Convalescent Hospital	467 E Gilbert St San Bernardino, CA 92404

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 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 adhere with established food safety and sanitation standards when:1. A plastic wrapped container of beef roast was observed without a label indicating the preparation date, freeze by date, or discard date.2. Clean wet dishes were stacked on top of each other and not air dried.These had the potential to place susceptible residents who receive food from Dietary Services at risk for food-borne illnesses.Findings: 1. During an initial observation tour of the kitchen and interview, on 2/23/26, at 8:20 AM, with the Dietary Supervisor (DS), a plastic wrapped container of beef roast was observed in the walk-in freezer, without a label indicating the preparation date, freeze by date, or discard date.During an interview on 2/23/26 at 8:24 AM with the DS, the DS stated that the facility's policy was to ensure all food stored in the freezer was properly labeled and dated. The DS confirmed the facility's policy was not followed.A review of the facility's policy and procedure (P&P) titled, Food Storage, revised 12/14 indicated, . 5. Prepared food stored in the refrigerator until service shall be dated with an expiration date. Such food will be tightly sealed with a plastic wrap, foil or a lid.2. During a concurrent follow up observation and interview of the kitchen on 2/25/26, at 11:10 AM, with the DS, wet dishes were found stacked on top of each other and not air dried. The DS stated that all dishes should be air dried before storing.A review of the facility's undated P&P titled, 3 Compartment Procedure for Manual Dishwashing was reviewed. The P&P indicated, . Step 6: All items are air-dried, which means no water droplets are present.A review of the 2022 FDA (Food and Drug Administration) Food Code, 4-901.11 indicated, Equipment and Utensils, Air-Drying Required .After cleaning and SANITIZING, EQUIPMENT and UTENSILS: ((A) Shall be air-dried or used after adequate draining as specified in the first paragraph of 40 CFR 180.940 Tolerance exemptions for active and inert ingredients for use in antimicrobial formulations (food-contact surface SANITIZING solutions), before contact with FOOD; and (B) May not be cloth dried except that UTENSILS that have been air-dried may be polished with cloths that are maintained clean and dry.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure one of one sampled residents (Resident 17) did not self-administer medication, when the facility assessment indicated Resident 17 was unable to do so. Resident 17 was given medications to self-administer while out on pass ([OOP] a temporary, authorized absence from a medical facility for social, family, or therapeutic reasons, with the explicit requirement that they return for continued treatment from the facility). This failure had the potential for Resident 17 to have adverse effects.Findings:A review of Resident's admission Record, (a document showing a summary of the resident's information) dated 2/25/26 indicated Resident 17 was admitted to the facility on [DATE].A review of Resident 17's History and Physical (H&P), dated 11/18/25, indicated Resident 17 had a surrogate decision maker and was noted to have confusion in the Neurological Exam portion. The H&P also indicated Resident 17 had diagnoses including right sided weakness, seizures, and hypertension (high blood pressure). Further review of the H&P indicated Resident 17 had fluctuating capacity to understand and make decisions.During an observation on 2/25/26 at 8:10 AM, Resident 17's bed was made and Resident 17 was not in the room.A review of Resident 17's Social Services Notes, dated 2/24/26 at 1:51 PM, indicated Resident 17 was out on pass for four days.A review of Resident 17's Order Summary Report, dated 2/25/26, showed a physician's order dated 2/23/26, May go OOP (out on pass) overnight from 2/24/26 to 2/28/26 one time only for 4 days. Further review of The Order Summary Report, dated 2/25/26 also indicated the following physician's orders:- Order dated 1/21/26, for Keppra (a medication used to treat seizures) oral tablet 500 mg ([milligrams] - unit of measurement), give 500 mg by mouth every 12 hours related to conversion disorder with seizures or convulsions.- Order dated 1/21/26, for Nifedipine (medication used to treat high blood pressure or chest pain) oral tablet extended release 24 hr (hours) 30 mg.A review of Resident 17's Self Administration of Medication Assessment, dated 10/31/25, indicated Resident 17 was not a candidate for safe self-administration of medications. Further review of Resident 17's Self Administration of Medication Assessment, indicated the facility assessed the resident as No for mental and physical capacity to self administer medications.During a concurrent interview and record review with Director of Nursing (DON), Resident 17's medical record was reviewed. The DON stated Resident 17 went out on pass on 2/24/26. The DON stated Resident 17 was sent with medications to self-administer, as evidenced by the medication being removed from the bubble pack (a card that packages doses of medication within small, clear, or light-resistant, amber-colored plastic bubbles, usually organized by day and time). The DON reviewed Resident 17's Self Administration of Medication Assessment, dated 10/31/25, and confirmed Resident 17 was unable to safely self-administer medication.A review of the facility's policy titled, Policy and Procedure on Self-Administration of Medications, indicated .as part of their overall evaluation, the staff and practitioner will assess each resident's mental and physical abilities, to determine whether a resident is capable of self-administering medications.If the staff determines that a resident cannot safely self-administer medications, the nursing staff will administer the residents medications.Cross Reference to F689 #1.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the call light was accessible for use for one of one sampled resident (Resident 2).This failure had the potential for Resident 2's care needs not being met. Findings:During an observation on 2/23/26 at 9:20 AM inside Resident 2's room, Resident 2 was observed sitting up in bed. Resident 2's call light was observed on the floor to the left side of Resident 2's bed. The Licensed Vocational Nurse (LVN 1) was observed exiting Resident 2's room.During a concurrent observation and interview on 2/23/26 at 9:50 AM with LVN 1 inside Resident 2's room, Resident 2's call light was observed on the floor to the left side of Resident 2's bed. LVN 1 verified the call light was not within Resident 2's reach and acknowledged it should have been accessible. LVN 1 stated Resident 2 was at risk for falls and having the call light within reach was important for Resident 2 to request assistance.A review of Resident 2's admission Record, (a document showing a summary of the resident's information) dated 2/25/26, indicated Resident 2 was readmitted to the facility on [DATE].A review of Resident 2's Minimum Data Set ([MDS], a standardized assessment tool) dated 12/23/25, indicated Resident 2 was dependent (helper did all the effort, resident did none of the effort to complete the activity) on staff with toileting, showering and lower body dressing.A review of Resident 2's Care Plan Report, indicated a Focus area titled Resident at risk for falling . dated 6/18/25, indicated an intervention to Keep call light in reach.During an interview on 2/26/26 at 7:40 AM, with the Director of Nursing (DON), the DON stated the importance of call lights was to ensure residents were able to alert and communicate with staff.A review of the facility's policy and procedure (P&P) titled Call Light/Bell, revised 12/14, indicated 6. Place the call device within resident's reach before leaving room.

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F 0577 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. Based on observation, interview, and record review, the facility failed to ensure the survey binder (a binder containing the results of the most recent survey which includes the Statement of Deficiencies (Form CMS-2567) which contains any deficiencies resulting from a complaint investigation or recertification survey) was readily accessible to the residents and visitors. This failure had the potential to limit residents' and visitors' ability to review the facility's compliance history and make informed decisions regarding care and services. Findings:During an interview on 2/24/26 at 1:30 PM at the Resident Council meeting, the residents were asked if they were able to review the results of the survey without having to ask a staff member. All 10 residents were present (Resident 4, Resident 6, Resident 16, Resident 27, Resident 34, Resident 37, Resident 38, Resident 62, Resident 65, and Resident 75) during the meeting and stated they did not know where the survey binder was located.During an observation on 2/24/26 at 2:30 PM, on the wall across from the nurses' station, a plastic shelf holding the survey binder was observed approximately 5.6 feet above the floor. During a concurrent interview and record review on 2/26/26 at 1:24 PM with the Director of Nursing (DON), the DON confirmed residents have the right to ask for and see the results of the survey binder. The DON acknowledged the survey binder was placed in an area that was not readily accessible to residents. A review of the facility's policy and procedures (P&P), titled Resident Rights, revised 11/14, indicated, . You may examine survey results and the plan of correction. These, or a notice of location, will be posted in a readily accessible place.

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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 interview and record review, the facility failed to provide written information concerning the right to formulate an Advance Directive (a written document specifying an individual's medical care wishes) for 4 of 14 sampled residents (Residents 1, 11, 49, 83).This failure had the potential for the residents' decisions regarding their healthcare and treatment options not being honored.Findings:1. A review of Resident 1's admission Record, (a document showing a summary of the resident's information) dated 2/24/26, indicated Resident 1 was readmitted to the facility on [DATE]. A review of Resident 1's POLST, (Physician Orders for Life-Sustaining Treatment-a form that documents an individual's preferences for end-of-life care), dated 5/10/24 was signed by the legally Recognized Decisionmaker and indicated Resident 1 did not have an Advance Directive. During a concurrent interview and record review on 2/24/26 at 3:56 PM with the Social Services Designee (SSD), Resident 1's POLST was verified and the SSD confirmed Resident 1 did not have an Advance Directive and the legally Recognized Decisionmaker was not provided information on Advance Directives. The SSD reviewed the facility's policies and procedures (P&P) titled, Assisting with Health Care Directives, dated 12/14 and confirmed it was the SSD's responsibility to ensure information regarding Advance Directives were provided to the residents and the residents' families. A review of the facility's policies and procedures (P&P) titled, Assisting with Health Care Directives, dated 12/14 indicated, Social Services designee will assist residents in completing an advanced directive form if they wish to execute one. Social Services will assist residents by arranging for the Ombudsman to visit if they wish to prepare a Durable Power of Attorney for Health. 2. A review of Resident 11's admission Record, dated 2/25/26, indicated Resident 11 was admitted to the facility on [DATE]. A review of Resident 11's Initial History and Physical, dated 2/12/26, indicated Resident 11, Had the capacity to understand and make decisions. A review of Resident 11's POLST, dated 9/4/25, indicated Resident 11 did not have an Advance Directive. A review of Resident 11's signed Acknowledgement of Advance Directive, form dated 9/9/25, indicated Resident 11 Had not executed an Advance Directive. Resident 11's Acknowledgement of Advance Directive, form did not indicate documented evidence that Resident 11 was provided with additional written information concerning the right to formulate an Advance Directive. The box for I received information on my rights about formulating an Advance Directive was not checked. 3. A review of Resident 49's admission Record, dated 2/24/26, indicated Resident 49 was readmitted to the facility on [DATE]. A review of Resident 49's Initial History and Physical, dated 1/23/26 indicated, This resident has the capacity to understand and make decisions. A review of Resident 49's POLST, dated 1/23/26, indicated Resident 49 did not have an Advance (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Directive. A review of Resident 49's signed Acknowledgement of Advance Directive, form dated 12/6/24, indicated Resident 49, Had not executed an Advance Directive. Resident 49's Acknowledgement of Advance Directive, form did not indicate documented evidence that Resident 49 was provided with additional written information concerning the right to formulate an Advance Directive. The box for I received information on my rights about formulating an Advance Directive was not checked. 4. A review of Resident 83's admission Record, dated 2/24/26, indicated Resident 83 was admitted to the facility on [DATE]. A review of Resident 83's History and Physical, (H&P) dated 2/19/26, indicated, Patient is able to make own decisions. A review of Resident 83's POLST, dated 2/19/26, indicated Resident 4, Did not have an Advance Directive. A review of Resident 83's signed Acknowledgement of Advance Directive, form dated 2/24/26, indicated Resident 83, Had not executed an Advance Directive. Resident 83's Acknowledgement of Advance Directive, form did not indicate documented evidence that Resident 83 was provided with additional written information concerning the right to formulate an Advance Directive. The box for I received information on my rights about formulating an Advance Directive was not checked. During a concurrent interview and record review on 2/24/26 at 11:23 AM, with the SSD, the SSD was asked about the procedure for Advance Directives. The SSD stated that she was responsible for talking to the residents if they wanted help to formulate an Advance Directive, and it would be documented in the resident's chart. The SSD reviewed the medical records for the residents above and was unable to show written documentation help had been offered to formulate an Advance Directive. During a concurrent observation, interview and record review with the Director of Nursing (DON) on 2/25/26 at 2:30 PM at the nurses' station by the front lobby area, the DON stated facility P&Ps were reviewed annually and revised and updated as needed. The DON further stated facility P&Ps were also reviewed during Quality Assurance and Performance Improvement (QAPI - a data driven proactive approach to improvement used to ensure services are meeting quality standards) meetings. A review of the facility's policies and procedures (P&P) titled, Advanced Directives, revised 7/12, indicated, .1. Prior to or upon admission of a resident to our facility, the Social Services Director or designee will provide written information to the resident concerning his/her right to make decisions concerning medical care, including the right to accept or refuse medical surgical treatment, and the right to formulate advance directives.

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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** Based on interview and record review, the facility failed to follow up with the Preadmission Screening and Resident Review ([PASARR] - a federal assessment requirement to help ensure that individuals who have a mental disorder or intellectual disabilities are placed in facilities that can provide the appropriate care) to determine the resident's needs for specialized services and appropriate placement for one of one sampled resident (Resident 6).This failure had the potential to result in inappropriate placement and unidentified specialized services for Resident 6. Findings:A review of Resident 6's admission Record, (a document showing a summary of the resident's information), indicated Resident 6 was admitted to the facility on [DATE] with diagnoses including schizoaffective disorder depressive type (a mental health condition that combines symptoms of Schizophrenia [a mental disorder causing hallucinations, delusions, and disorganized thinking]) with major depressive episodes (a mood disorder that causes persistent feeling of sadness and loss of interest). A review of Resident 6's Progress Note, (a formal, often daily, record documenting a resident's clinical status, medical necessity, and response to treatment), dated 2/16/26, indicated Resident 6 had a diagnosis of Schizoaffective disorder.A review of Resident 6's Preadmission Screening and Resident Review (PASRR) Level 1 Screening, dated 10/17/25, indicated a level one screening was completed following a status change. Further review indicated under Section III -Serious Mental Illness, Resident 6's PASSR Level 1 screening was marked Yes to a diagnosed serious mental illness and the specified diagnoses included schizoaffective disorder, depressive type, major depressive disorder. A review of Resident 6's Notice of Attempted Evaluation, dated 10/21/25, indicated facility staff were unresponsive to two or more separate attempts of communication within 48 hours of the level one screening, therefore California Department of Health Care Services was unable to complete a level two evaluation for serious mental illness to determine if the individual could benefit from specialized services. During a concurrent interview and record review with Registered Nurse 2 (RN 2) on 2/24/26 at 10:59 AM, RN 2 reviewed Resident 6's Preadmission Screening and Resident Review PASSR - Level 1 Screening, dated 10/17/25, and Resident 6's Notice of Attempted Evaluation, dated 10/21/25. RN 1 stated they were responsible for completing and following up on the PASRR for the residents in the facility. RN 1 stated the process of the PASSR determined if residents required special services or if the residents were appropriate to stay in the facility. RN 1 was asked to provide documented evidence that the facility followed up on the attempted PASSR Level II Screening. RN 1 was unable to provide such evidence and stated it was missed, and it should have been completed.During a concurrent interview and record review with the Director of Nursing (DON) on 2/26/26 at 7:51 AM, the DON verified the PASSR was not completed. The DON stated completing the PASSR was important to ensure the services and placement at the facility was appropriate for Resident 6.A review of the facility's policy and procedure (P&P) titled PAS/PASSAR, revised 03/05, indicated, .PASARR should be completed for all residents . For the residents found to be mentally ill . this screening is used to determine whether the nursing facility care is appropriate and whether the resident needs specialized services.

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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** Based on observation, interview and record review, the facility failed to ensure one of two sampled residents (Resident 3) with an indwelling urinary catheter (a catheter inserted through the urethra into the bladder to drain urine) had accurate intake and output (I&O) monitored and documented as ordered.This failure had the potential to result in delayed identification of changes in urinary output, fluid imbalance, and other complications related to the use of an indwelling catheter.Findings:During an observation on 2/23/26 at 9:02 AM inside Resident 3's room, Resident 3 was observed lying in bed with an indwelling urinary catheter in place.A review of Resident 3's admission Record, (a document showing a summary of the resident's information), dated 2/25/26, indicated Resident 3 was admitted to the facility on [DATE]. A review of Resident 3's History and Physical (H&P), dated 12/26/25, indicated Resident 3 had diagnoses including benign prostatic hyperplasia ([BPH] - enlarged prostate gland causing obstruction and/or difficulty with urinating), urinary retention (the inability to fully empty the bladder), and obstructive uropathy (a condition in which the flow of urine is blocked).A review of Resident 3's Order Summary Report, dated 2/25/25, indicated Resident 3 had physician's orders dated on 12/25/25, for, Indwelling catheter for obstruction and to monitor intake and output every shift.A review of Resident 3's Care Plan Report, indicated a Focus area titled At risk for urinary tract infection related to indwelling foley catheter use, dated 12/29/25, indicated an intervention to monitor I&O.A review of Resident 3's Medication Administration Record, (MAR - a daily documentation record used by a licensed nurse to document medications and treatments given to a resident), dated January 2026 and February 2026, indicated intake and output monitoring were not consistently documented on certain shifts on the following dates: 1/25/26, 1/27/26 - 1/30/26, 2/16/26, and 2/20/26. During a concurrent interview and record review on 2/24/26 at 5:08 PM with the Licensed Vocational Nurse 3 (LVN 3), Resident 3's MAR for January and February 2026 were reviewed. LVN 3 verified the missing signatures on the MAR and stated licensed staff were responsible for monitoring and documenting the input and output of residents who had an order for an indwelling urinary catheter. LVN 3 stated that documenting the intake and output on the MAR would ensure the monitoring was completed. During a concurrent interview and record review on 2/26/26 at 7:43 AM with the Director of Nursing (DON), the DON acknowledged the missing MAR documentation for January and February 2026 and stated the licensed staff must ensure intake and output monitoring was documented in the MAR. The DON further stated the importance of monitoring the intake and output included assessing Resident 3's hydration status and the quality, color, odor, and consistency of Resident 3's urine.A review of the facility's policy and procedure (P&P) titled, Intake and Output, revised 07/2012, indicated It is the policy of this facility to maintain an intake and output record when needed to monitor residents for adequate fluid balance for resident admitted with indwelling foley catheter . I&O assessments will be documented in the resident's medical record. Include average intake, average output, quality, color, odor, consistency of urine, resident's hydration status.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure three out of three residents (Residents 17, 25, and 84) were kept free from accident hazards. 1. The facility failed to ensure Resident 17 was properly assessed to be safe prior to sending the resident out on pass ([OOP] - a temporary, authorized absence from a medical facility for social, family, or therapeutic reasons, with the explicit requirement that they return for continued treatment from the facility.) 2. The facility failed to ensure Resident 25's had a physician order for floor mats and failed to implement care plan interventions. 3. The facility failed to identify and assess Resident 84 as a smoker upon admission and was observed smoking in the patio without a smoking assessment. These failures posed a risk for an unsafe environment for the residents. Findings:1. A review of Resident 17's admission Record, (a document showing a summary of the resident's information), dated 2/24/26, indicated the resident was admitted to the facility on [DATE]. A review of Resident 17's History and Physical, (H&P), dated 11/18/25, indicated Resident 17 had some confusion and Resident 17 had fluctuating capacity to understand and to make decisions. A review of the facility's Job Description and Performance Standards for the Position Title of Nursing Supervisor and Charge Nurse, (undated), indicated the Supervisor and the nurse were responsible for the safety of residents under his/her supervision During an observation on 2/25/26 at 8:10 AM inside Resident 17's bedroom, Resident 17 was not in the room and Resident 17's bed was observed to be freshly made. During an interview on 2/25/26 at 8:11 AM with the Medical Records Director, the Medical Records Director stated Resident 17 was OOP, left the faciity on 2/24/26, and would return to the facility on 2/28/26. During an interview on 2/25/26 at 8:22 AM with the Licensed Vocational Nurse 4 (LVN 4), LVN 4 acknowledged Resident 17 was currently OOP for several days. LVN 4 stated a residents who went OOP would require a physician's order indicating the date and the length of time the resident would be out of the facility. LVN 4 stated a licensed nurse should have performed a physical assessment and provided instructions to Resident 17 prior to leaving the facility. LVN 4 stated Resident 17's vital signs and skin condition should have been assessed prior to leaving the facility. During a concurrent interview and record review on 2/25/26 at 8:33 am with the Registered Nurse 2 (RN 2), Resident 17's Order Summary Report, dated 2/23/26, was reviewed and RN 2 verified the Order Summary Report indicated a physician's order dated 2/23/26, May go OOP overnight from 2/24/26 to 2/28/26 one time only for 4 days. RN 2 stated a licensed nurse should have performed a physical assessment and provided instructions to Resident 17 prior to Resident 17 leaving the facility. RN 2 further reviewed Resident 17's record and acknowledged there was no documented evidence indicating an assessment was conducted or instructions were provided to Resident 17 prior to leaving the facility. During a follow-up and concurrent interview and record review on 2/26/26 at 9:55 am with RN 2, (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident 17's Release for Temporary Absence was reviewed. The Release for Temporary Absence, indicated Resident 17 departed the facility on 2/24/26 at 10:08 AM with the destination of the resident listed as Family. Resident 17 signed the form and RN 2 acknowledged signing as a witness. RN 2 stated the purpose of the Release of Temporary Absence form was to ensure Resident 17 was assessed and provided instructions by a licensed nurse prior to leaving the facility. However, RN 2 acknowledged there was no documentation indicating an assessment or instructions were provided prior to Resident 17 leaving the facility. RN 2 further stated they could not recall the name or relationship of the individual who picked up Resident 17 from and did not assess the location of where Resident 17 was going. During a concurrent interview and record review on 2/26/26 at 1:30 pm with the Director of Nursing (DON) and Minimum Data Set (MDS) Coordinator, Resident 17's Out on Pass Safety Checklist, (unfilled) was reviewed. The DON stated staff must ensure the Out on Pass Safety Checklist was completed prior to Resident 17 leaving the facility OOP and that the form was maintained in a binder with Resident 17's Release for Temporary Absence form located in the nurses' station. The safety checklist indicated Resident 17 should be assessed for the resident's name, destination address, length of time away from the facility, a contact phone number, and an emergency contact name and address. The DON and MDS Coordinator verified there was no completed Out on Pass Safety Checklist form in the binder to indicate Resident 17 was assessed for the required information prior to Resident 17 leaving the facility. 2. A review of Resident 25's admission Record, (a document showing a summary of the resident's information) dated 2/24/26, indicated Resident 25 was admitted to the facility on [DATE]. A review of Resident 25's History and Physical, (H&P) dated 2/9/26, showed Resident 25 was status post ([s/p] - after or following a significant event, procedure, or diagnosis) hip replacement. During an observation on 2/23/26 at 9:55 AM, Resident 25 was observed in bed with a floor mat on the left side. During an observation on 2/24/26 at 10:32 AM, Resident 25 was again observed in bed with a floor mat on the left side. During a concurrent observation, interview, and record review on 2/24/26 at 10:47 AM with RN 1, RN 1 was asked about Resident 25's care. RN 1 stated Resident 25 was a fall risk, because she was recovering from hip surgery. RN 1 verified Resident 25 had a floor mat on the left side of the bed. When asked about the process, RN 1 stated a physician's order was required for the use of floor mats. RN 1reviewed Resident 25's medical record and physicians orders dated 2/24/26, and was unable to find a physician's order for the use of floor mats. RN 1 reviewed Resident 25's plan of care and noted a care plan problem dated 2/8/26, for resident at risk for falling. Interventions included assure the floor is free from glare, liquids, and foreign objects. RN 1 stated the floor mat could be considered a foreign object in the absence of a physician's order. During an interview on 2/24/26 at 10:26 AM, with the DON, the DON was asked about the process for a resident using floor mats. The DON stated there should be a physician's order, care plan, and informed consent. The DON stated the floor mat could not be used without a physician's order in place. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. During the Entrance Conference on 2/23/26 at 9:16 AM with the Administrator and DON, a list of residents who smoke in the facility was requested. A review of Smoking List, dated 2/21/25 indicated 20 residents smoked in the facility. Resident 84 was not listed on the Smoking List provided by the Administrator. A review of Resident 84's admission Record, dated 2/24/26, indicated Resident 84 was admitted to the facility on [DATE]. A review of Resident 84's History and Physical, dated 2/19/26, indicated Resident 84, Was able to make own decisions. During an observation on 2/23/26 at 3:56 PM, Resident 84 was smoking on the patio. During a concurrent interview and record review on 2/24/26 at 3:28 PM, the Admissions Director was asked about the process for residents who wish to smoke at the facility. The Admissions Director stated the facility had to complete a smoking assessment to determine if the resident smoked and was safe to smoke at the facility. The Admissions Director reviewed Resident 84's medical record and stated Resident 84 did not have a smoking assessment completed until 2/24/26 and should not have been smoking prior to that time. A review of the facility's policy and procedures (P&P) titled Smoking Policy, dated 7/12, showed that .Facility attempt to keep and maintain our residents, staff, and visitors free from any hazardous accidents. This includes but not limited to fire which could be due to unsafe smoking practice.

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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** Based on observation, interview and record review, the facility failed to ensure one of two sampled residents (Resident 3) with an indwelling urinary catheter (a catheter inserted through the urethra into the bladder to drain urine) received proper care and services by failing to ensure indwelling catheter care was consistently completed and documented as ordered. This failure had the potential to result in Resident 3 developing a urinary tract infection (UTI - an infection in the bladder/urinary tract) and other complications related to the use of an indwelling catheter. Findings: During an observation on 2/23/26 at 9:02 AM inside Resident 3's room, Resident 3 was observed lying in bed with an indwelling urinary catheter in place.A review of Resident 3's admission Record, (a document showing a summary of the resident's information), dated 2/25/26, indicated Resident 3 was admitted to the facility on [DATE]. A review of Resident 3's History and Physical (H&P), dated 12/26/25, indicated Resident 3 had diagnoses including benign prostatic hyperplasia ([BPH] - enlarged prostate gland causing obstruction and/or difficulty with urinating), urinary retention (the inability to fully empty the bladder), and obstructive uropathy (a condition in which the flow of urine is blocked).A review of Resident 3's Urinary Incontinence and Indwelling Catheter, dated 1/19/26 with an observation date of 12/25/25, indicated Resident 3 was admitted to the facility with a catheter from acute hospitalization for chronic urinary retention and BPH. A review of Resident 3's Minimum Data Set, ([MDS], a standardized assessment tool), dated 1/1/26, indicated Resident 3 was dependent (helper did all the effort, resident did none of the effort to complete the activity) on staff with toileting and personal hygiene. The MDS further indicated Resident 3 had an indwelling catheter.A review of Resident 3's Order Summary Report, dated 2/25/25, indicated Resident 3 had physician's orders dated on 12/25/25, for, Indwelling catheter for obstruction and Indwelling catheter care: wash with water and soap around urinary meatus (external opening where urine exits the body) every shift (Q shift) and as needed (PRN).A review of Resident 3's Care Plan Report, indicated a Focus area titled At risk for urinary tract infection related to indwelling foley catheter use, dated 12/29/25, indicated an intervention for foley catheter care every shift . cleanse with soap and water around the urinary meatus.A review of Resident 3's Treatment Administration Record, (TAR - a daily documentation record used by a licensed nurse to document treatments given to a resident), dated January 2026 and February 2026, indicated indwelling catheter care was not consistently documented as completed on certain shifts on the following dates: 1/5/26 - 1/11/26, 1/13/26 - 1/23/26, 1/27/26, 1/28/26, 2/9/26, and 2/10/26. During a concurrent interview and record review on 2/23/26 at 10:00 AM with the Licensed Vocational Nurse 2 (LVN 2), Resident 3's TAR for January and February 2026 were reviewed. LVN 2 verified the missing signatures on the TAR and stated licensed staff were responsible for signing the TAR after the urinary catheter care was completed. LVN 2 stated that documenting information on the TAR would ensure the urinary catheter care was completed and who the care was completed by. During a concurrent interview and record review on 2/26/26 at 11:19 AM with the Director of Nursing (DON), the DON acknowledged the missing TAR documentation for January and February 2026 and stated the licensed staff must ensure indwelling catheter care was documented to verify that the care was provided. The DON further stated failure to provide catheter care placed residents with an indwelling catheter at risk for infection.A review of the facility's policy and procedure (P&P) titled, Urinary Tract Infections (Catheter-Associated), Guidelines for Preventing, revised June 2014, indicated The following catheter-associated urinary tract infections (CAUTI) prevention strategies have been adopted and are to be followed by clinical staff: . 7. Perform daily meatal (external opening where urine exits the body) hygiene with soap and water for residents with indwelling catheter.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on observation, interview, and record review, the facility failed to ensure safe and effective pharmaceutical services when:1. For one of four residents (Resident 84), a medication was not administered in accordance with prescriber's orders.This failure resulted in a medication error and the potential to result in unnecessary medications.2. In one of two medication rooms (Medication Room A), four normal saline (saltwater) IV (intravenous - into a resident's vein) solution bags were stored undated outside the plastic overwrap.This failure had the potential to compromise the stability of the IV solution bags.3. In one of two medication rooms refrigerators (Medication Room A), two opened and undated multiple-dose Aplisol (tuberculin purified protein derivative - aid to diagnose the tuberculosis infection) vial was observed stored in the medication refrigerator.This failure had the potential for the resident(s) to be exposed to ineffective Aplisol due to possible oxidation (chemical process) and degradation (reduced quality) which may affect potency (effectiveness) if the opened and undated vials were not discarded according to the drug manufacturer's instructions.Findings:1. During a concurrent observation and interview on 2/24/26, at 8:50 AM, with Registered Nurse (RN) 1, at the medication cart outside of Resident 84's room, two tablets of Senna S (combination medication of two laxative drugs to manage constipation - sennosides 8.6 milligrams (mg - a unit of dose for measurement) (total dose = sennosides 17.2 mg) and docusate 50 mg (total dose = 100 mg) were prepared at the medication cart. RN 1 acknowledged two tablets of the combination medication Senna S was poured into the medication cup for Resident 84.During a concurrent interview and record review on 2/24/26, at 11:45 AM, Resident 84's current physician orders were reviewed with RN 1. The medication orders indicated a medication order for sennosides 17.2 mg but not for the combination medication Senna S. RN 1 reviewed the current medication orders. RN 1 acknowledged the wrong medication was given during medication pass observation at 8:50 AM (on 2/24/26). During an interview on 2/26/26, at 9:54 AM, with the Director of Nursing (DON), the DON stated the expectation was to follow the 8 Rights of Medication Administration (safety practices to prevent medication errors) including administering the right medication to the resident.During a review of the facility's policy and procedure (P&P) titled, PREPARATION FOR MEDICATION ADMINISTRATION, reviewed 1/21/26, the P&P indicated, Procedure - Preparation.Prior to administration, the medication and dosage schedule on the resident's MAR is compared with the medication label. If the label and the MAR are different and the container is not flagged indicating a change in directions or if there is any other reason to question the dosage or directions, the physician's orders are checked for the correct dosage schedule.Procedure - Administration.Medications are administered in accordance with written orders of the attending physician.2. During a concurrent observation and interview on 2/23/26, at 7:56 AM, an inspection of Medication Room A was conducted with the Minimum Data Set Coordinator ([MDS] - specialized nurse who ensures accurate resident data collection). Four undated normal saline IV solution 100 milliliters ([mLs] - a unit of measurement for volume) bags were observed stored outside the plastic overwrap in the compartment BED HOLD MEDICATIONS. The MDS acknowledged the four undated normal saline solution bags were stored outside of the plastic overwrap in Medication Room A. During an interview on 2/23/26, at 3:58 PM, with the MDS, the MDS stated the four undated normal saline bags observed in the Medication Room A at 7:56 AM 2/23/26) should have been dated with a 20 day beyond use date (BUD - the date or time the product should not be stored and when it should be discarded).During an interview on 2/26/26, at 9:54 AM, with the DON, the DON stated the expectation is that the unlabeled and undated normal saline bags should have been discarded.During a review of the undated manufacturer's literature, titled APPENDIX D, the manufacturer's literature indicated Stability outside of overwrap. Intravenous solutions are packaged with an overwrap that prevents evaporation through the walls of the bag. Stability of the solution can be compromised if unwrapped for a length of time prior to use. Overwrap should ideally be removed (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	just prior to use. However solutions that have been removed from the overwrap may be given the below beyond use dates as long as the manufacturer expiry date is not exceeded. [the name of the drug manufacturer] .Bag Size.100 mL and greater.Beyond use date once removed from overwrap.20 days.During a review of the facility's P&P titled, MEDICATION STORAGE IN THE FACILITY, reviewed 1/21/26, the P&P indicated, Policy: Medications and biologicals are stored safely, securely, and properly, following the manufacturer's recommendations or those of the supplier.3. During a concurrent observation and interview on 2/23/26, at 7:56 AM, an inspection of Medication Room A was conducted with the MDS. Two opened and undated multiple-dose vials of tuberculin purified protein derivative (Aplisol) were observed stored in the medication refrigerator. The MDS acknowledged the opened and undated Aplisol vials were stored in the Medication Room A refrigerator.During an interview on 2/26/26, at 9:30AM, with the Infection Preventionist (IP), the IP stated Aplisol vial is to be dated because it is only good for a certain time.During an interview on 2/26/26, at 9:37 AM, with RN 2, RN 2 stated the Aplisol vial is labeled with the date when it is opened to determine when to discard it.During an interview on 2/26/26, at 9:54 AM, with the DON, the DON stated the expectation is once the Aplisol vial is opened, it should be dated and kept no longer than 30 days.During a review of the Aplisol package insert (PI - document on how to safely use medications) dated May 2024, provided by the facility, the PI indicated, Vials in use more than 30 days should be discarded due to possible oxidation and degradation which may affect potency.During a review of the facility's P&P titled, Medication Labeling and Storage, revised 2/23, the P&P indicated, Multi-dose vials that been opened or accessed (e.g., needle punctured) are dated and discarded within 28 days unless the manufacturer specifies a shorter or longer date for the open vial.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on the observation, interview, and record review, the facility failed to ensure safe medication labeling practices and medications were stored at the proper temperature range in accordance with accepted standards of practice and/or manufacturer's instructions when:1. One of one opened inhaler mouthpiece for Resident 36 was not properly labeled with sufficient information to clearly identify the specific resident.This failure had to potential to cause medication errors and preventable infections from cross-contamination (transfer of germs) if accidently mixed up with other residents' similar or same drugs.2. Medications were observed stored at the incorrect temperature.a. An undated insulin (drug to manage high blood sugars) pen (portable device) for Resident 39 in one of three medication carts.b. Two medication cartons containing bisacodyl (laxative drug to manage constipation) in one of two medication rooms refrigerators.This failure had the potential for residents to be given deteriorated (reduced quality) medications if stored outside the temperature range specified by the drug manufacturer and for the suppositories to take longer to melt in the body which could result in suboptimal treatment.3. In one of one Central Supply (department which stocks and manages the inventory of medical supplies and drugs) storage areas, there was no room temperature monitoring logs to demonstrate medications were stored within the correct temperature range.This failure placed residents at risk for receiving ineffective medications and the potential for adverse clinical outcomes.Findings:1. During a concurrent observation and interview on 2/24/26, at 3:45 PM, an inspection of Medication Cart B was conducted with Licensed Vocational Nurse (LVN) 3. When the medication cart was opened, Resident 36's tiotropium (drug for chronic breathing problems) inhaler mouthpiece was not labeled with the resident-specific information. LVN 3 stated Normally, I would label it [the inhaler mouthpiece] with the resident's name.During an interview on 2/26/26, at 9:30 AM, with the Infection Preventionist (IP), the IP stated the inhaler mouthpiece should be labeled so it would not get mixed up with another resident.During an interview on 2/26/26, at 9:37 AM, with Registered Nurse 2 (RN 2), RN 2 stated the inhaler mouthpiece was labeled with resident's name when it was opened to prevent mix-ups with other residents.During an interview on 2/26/26, at 11:12 AM, with the Director of Nursing (DON), the DON acknowledged the inhaler mouthpiece should be labeled with resident specific information because the box could be ruined.During a review of the facility's policy and procedure (P&P) titled, Medication Labeling and Storage, revised February 2023, the P&P indicated, Medication Labeling.Labeling of medications and biologicals dispensed by the pharmacy is consistent with applicable federal and state requirements and currently accepted pharmaceutical practices.2a. During a concurrent observation and interview on 2/23/26, at 2:55 PM, an inspection of Medication Cart C was conducted with LVN 1. When the medication cart was opened, there was an undated and unused Humalog (rapid-acting) insulin pen for Resident 39 with a blue refrigerate sticker stored inside at room temperature. LVN 1 stated the unused insulin pen should be trashed.During an interview on 2/26/26, at 9:37 AM, with RN 2, RN 2 stated insulin was labeled with the date when it was stored in the medication cart at room temperature. RN 2 stated to also check with the manufacturer's instructions.During an interview on 2/26/26, at 9:54 AM, with the DON, the DON stated the undated insulin pen should have been kept in the refrigerator. The DON expectation stated it should be dated when it is stored in the medication cart.During a review of the Humalog insulin package insert (PI - document on how to safely use medications) dated April 2025, provided by the facility, the PI indicated, Storing your Pen.Store unused Pens in the refrigerator.Unused Pens may be used until the expiration date printed on the Label, if the Pen has been kept in the refrigerator. During a review of the facility's P&P titled, MEDICATION STORAGE IN THE FACILITY, reviewed 1/21/26, the P&P indicated, Policy: Medications and biologicals are stored safely, securely, and properly, following the manufacturer's recommendations or those of the supplier.2b. During a (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	concurrent observation and interview on 2/23/26, at 7:56 AM, an inspection of Medication Room A was conducted with the Minimum Data Set Coordinator (MDS - specialized nurse who ensures accurate resident data collection). Two boxes containing bisacodyl 10 milligrams (mg - a unit of measurement for dose) suppositories (medications inserted into body cavities designed to melt) were observed stored inside the medication refrigerator at a temperature of 45 degrees Fahrenheit (F - a temperature scale). The product labeling on the two bisacodyl cartons indicated to store the medication at room temperature between 59 to 86 degrees F. The MDS acknowledged the two bisacodyl medication cartons were stored inside the refrigerator when the product labeling indicated to store at room temperature.During an interview on 2/26/26, at 9:54 AM, with the DON, the DON stated the expectation was to store the suppositories at room temperature.During a review of the bisacodyl PI dated April 2025, provided by the facility, the PI indicated, Store at 15C [Celsius - a temperature scale] to 30C (59F to 85F).During a review of the facility's P&P titled, MEDICATION STORAGE IN THE FACILITY, reviewed 1/21/26, the P&P indicated, Procedure.Medications requiring storage at room temperature are kept at temperatures ranging from 15C (59C) to 30C (86F).3. During a concurrent observation and interview on 2/25/26, at 7:56 AM, an inspection of the Central Supply storage area was conducted with the Environmental Services Director (ESD) and Central Supply Staff (CSS). Multiple bottles of Dakins Quarter (to treat and prevent skin and tissue infections) solution with a National Drug Code (NDC) 0436-0672-16 and multiple cartons of triple antibiotic ointment (to treat and prevent minor skin infections) with a NDC 67777-217-14 were observed stored in the Central Supply storage area. The product labeling on the Dakins Quarter solution indicated to store at room temperature between a range of 20-25C (68-77F). The product labeling on the triple antibiotic ointment to store at room temperature between a range of 15-30C (59-86F). The ESD acknowledged the temperature range indicated on the product labeling on the bottles of Dakins Quarter solution and the cartons of triple antibiotic ointment. The ESD stated there were no temperature logs for the medications stored in the Central Supply storage area.During an interview on 2/26/26, at 9:54 AM, with the DON, the DON stated the facility threw away medications observed in the Central Supply storage area on February 25, 2026, because there were no temperature logs.During a review of the Dakins Quarter solution PI dated June 2025, provided by the facility, the PI indicated, Store at room temperature.During a review of the triple antibiotic ointment PI dated June 2025, provided by the facility, the PI indicated, Store at room temperature between 15C - 30C (59 - 86F).During a review of the facility's P&P titled, Medication Labeling and Storage, revised February 2023, the P&P indicated, The facility stores all medications and biologicals in locked compartments under proper temperature.During a review of the facility's P&P titled, MEDICATION STORAGE IN THE FACILITY, reviewed 1/21/26, the P&P indicated, Procedure.Medications requiring storage at room temperature are kept at temperatures ranging from 15C (59C) to 30C (86F).

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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** The facility failed to maintain an accurate Medication Administration Record ([MAR] - a daily documentation record used by a licensed nurse to document medications and treatments given to a resident) for one of one sampled resident (Resident 17) when the facility indicated Resident 17 was hospitalized , while the resident was out on pass ([OOP] - a temporary, authorized absence from a medical facility for social, family, or therapeutic reasons, with the explicit requirement that they return for continued treatment from the facility).This failure had the potential for omission of necessary medications.Findings:A review of Resident 17's admission Record, (a document showing a summary of the resident's information) dated 2/24/26, indicated Resident 17 was admitted to the facility on [DATE].A review of Resident 17's Release for Temporary Absence form undated, indicated Resident 17 departed the facility on 2/24/26 at10:08 AM.During an observation on 2/25/26 at 8:10 AM Resident 17 was not in the room and the bed was made.During a concurrent interview and record review on 2/25/26 at 10:58 AM with the Director of Nursing (DON), Resident 17's Medication Administration Record, dated 2/1/26 - 2/28/26, was reviewed.Resident 17's MAR indicated:- On 2/25/26, the dose at 7:00 am for losartan potassium (a medication for high blood pressure) 100 milligrams (mg - unit of measurement) was marked with a number 6 with an initial of KB08,- On 2/25/26, the dose at 7:00 am for carvedilol (a medication for high blood pressure) 3.125 mg was marked with a number 6 with an initial of KB08.Further review of Resident 17's MAR, the record chart codes indicated the number 6 meant the resident was hospitalized .The DON verified the above findings. The DON acknowledged Resident 17 was provided with the resident's medications while out on pass. The DON further stated the resident would be out on pass until 2/28/26. The DON stated the medications above should have been marked with number 11 since the resident was out on pass. The number 6 documented in Resident 17's MAR was not an accurate code to reflect the status of the resident. The DON further stated the initial KB08 was the initial of the licensed nurse who documented the in the resident's MAR as described above.