

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 07/18/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056443	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/30/2026
NAME OF PROVIDER OR SUPPLIER George L Mee Memorial Hospital D/P Snf		STREET ADDRESS, CITY, STATE, ZIP CODE 300 Canal Street King City, CA 93930	
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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observation, interview, and facility document review, the facility failed to provide and served food at an appropriate temperature. This failure placed the 40 residents eating at the facility at risk of poor food intake further compromising their nutritional status. Findings: During an interview with Resident 5 on 1/20/2026 at 10:54 a.m., Resident 5 stated he always received his morning breakfast cold. During an interview with Resident 23, the resident council (an organized group of people living in a residential facility-such as a nursing home, assisted living, or public housing-who meet regularly to discuss concerns, plan, activities, and advocate for improvements to their quality of life) president on 1/20/2026 at 11:44 a.m., Resident 23 stated, 97% of the food served to them were cold. During a concurrent observation of the resident council meeting on 1/21/2026 at 11:00 a.m., inside the facility's social dining room, there were 10 resident council members and the resident council president, Resident 23 were present at the meeting. When residents at that meeting were asked if their food was served hot? Resident 23 stated, no, and everyone agreed. Resident 23 further stated, they bring it (food) cold. Review of the facility document titled, Resident Council Meeting Minutes, dated 12/17/2025, it indicated there were 11 resident council members and their president attended the meeting. Further review indicated, Dietary, Residents state the food cold. They are wondering if there is better way to keep food warm. As a result of the residents' complaints about the food temperature, a test tray of regular and puree diet was conducted on 1/29/2026. During the test tray of the lunch meal on 1/29/2026 at 12:50 p.m., the test tray consists of a regular and pureed Shepherd's pie and citrus basil roasted vegetable which was served in the conference room with the dietary manager (DM). The DM checked the temperature of the regular Shepherd's pie first and he got 135 degrees Fahrenheit (F, a scale for measuring temperature) while the regular citrus basil roasted vegetable's temperature was 113.5 F. The DM then checked the temperature of pureed Shepherd's pie, which was 121.7 F and the pureed citrus basil roasted vegetable's temperature was 117.9 F. Two nurse surveyors and the DM tasted the food and all agreed they were not served hot. During a follow up interview with the DM on 1/29/2026 at 2:49 p.m., the DM confirmed the regular vegetables, pureed shepherd's pie and the pureed vegetable were not served hot and did not taste hot. The DM stated their steam table should maintain the food temperature and served at 135 F. During a review of the facility's policy and procedure titled, Steam Table Service, date revised 5/2023, indicated, A temperature log will be maintained for each steam table to assure hot foods are arriving and being held at 135 F or higher.		

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	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 facility document review, the facility failed to ensure food was stored, prepared, and served in accordance with professional standards for food safety when:1.The kitchen dry storage room temperature was not checked in the afternoon from 1/1 to 1/15/2026 and no logged temperature check from 1/16/2026 - 1/20/2026, as indicated in their dry storage temperature log;2. The box of lemons stored in the walk-in refrigerator had one lemon covered with whitish substance mixed with other lemons;3.The staff personal purse was stored in the clean plate storage rack;4.The black storage rack for plastic cups, clean plates and metal food containers had some dust like substances and food crumbs; and5.Food service worker K (FSW K) kept on touching her eyeglasses while mixing the batter of an apple sauce bar without changing gloves and performing hand hygiene.These failures had the potential to cause food contamination and spread food-borne illness to all 40 residents who received food from the kitchen.Findings:1.During the initial kitchen observation on 1/20/2026 at 10:07 a.m., with the dietary manager (DM), the dry storage room located at the back, right side of the kitchen, there was a temperature log that was hanging at the left side of the wall prior to the dry storage room entrance. The temperature log was observed to have some blank spaces from 1/16/2026 - 1/20/2026.During a concurrent interview with the DM and document review of the dry storage temperature log on 1/20/2026 at 10:17 a.m., the DM confirmed the dry storage temperature log was incomplete. The DM stated it is important to check and enter the dry storage room temperature to prevent food spoilage.During a review of the facility's document titled, HACCP [Hazard Analysis Critical Control Point - a systemic, preventive approach to food safety that identifies and controls potential biological, chemical, and physical hazards throughout the entire production process] DRY STORAGE TEMPERATURE LOG, dated 1/2026, indicated, Check and record temperature twice a day (i.e. at opening of the operation or during other stable time). Further review of the dry temperature log indicated, kitchen staff only checked the dry storage room temperature once a day, between 4:00 a.m. to 4:30 a.m. from 1/1 -1/15/2026 and no other temperature checks completed in the afternoon. It also revealed that the dry storage room temperature was not checked from 1/16-1/20/2026.2.During a concurrent observation and interview with the DM on 1/20/2026 at 10:23 a.m., inside the walk-in refrigerator, there was a box of lemons observed and there was one lemon covered with white colored substance mixed with other lemons. The DM took the lemon covered with white substance and stated, it's molds. He confirmed the lemon had mold. He stated they should have been checked twice a week and further stated, the molds can cause food contamination.During a review of the facility's policy and procedure in section titled, Sanitation & Infection Control, subject titled, Receiving & Storage, date revised 5/2023, indicated, Proper storage procedures will be utilized for all dry and refrigerated food storage.Food is inspected upon arrival, especially perishables, and prior to use in the production/cooking.Ventilation, humidity, and moisture are controlled in all storage areas to prevent condensation and growth of mold.3.During a concurrent observation and interview with both the DM and registered dietitian (RD) on 1/22/2026 at 9:34 a.m., inside the kitchen, there was a staff personal purse stored in the clean plate storage rack. Both DM and RD confirmed the above observation and stated the purse should not be stored where the clean plates were stored. The DM stated the staff have assigned area where to store their personal belongings.4.Further concurrent observation and interview with both the DM and RD on 1/22/2026 at 9:34 a.m., inside the kitchen, there was some dust like substance and food crumbs found in the same rack where the clean plates, disposable plastic cups and clean metal containers were stored. The DM stated the rack used to be their bread racks and converted it into a storage rack. Both the DM and RD stated the racks should be cleaned.During a review of the facility's policy and procedure in section titled, Sanitation & Infection Control, subject titled, Cleaning Schedules, date revised 5/2023, indicated, Cleaning schedules are used to maintain high levels of sanitation in the Food & Nutrition (continued on next page)		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Services department and serve to assign cleaning tasks to kitchen staff members based on job roles. The policy and procedure had an attached daily cleaning tasks assignment and log which indicated, in the dish section, Clean and organize all shelves in dish area daily.5. During meal preparation observation in the kitchen on 1/29/2026 at 10:50 a.m., FSW K was observed preparing the batter for the apple sauce bar, with gloves on. While mixing the batter, it was observed that FSW K touched and adjusted her eyeglasses twice with her gloved hand and continued mixing the batter without changing her gloves and performing hand hygiene. At 10:58 a.m., she touched and adjusted her eyeglasses again.During a concurrent observation and interview with the DM on 1/29/2026 at 11:00 a.m., inside the kitchen, when FSW K touched her eyeglasses again, the DM stopped her and had her removed her gloves and washed her hands with soap and water. The DM confirmed above observation and stated kitchen staff should refrain from touching their eyeglasses, hair or face during food preparation, and if they did, they should change their gloves and wash their hands.Review of Centers for Disease Control and Prevention (CDC - a federal agency, with goal to protect public health and safety through the control and prevention of disease, injury, and disability) topic in food safety titled, Preventing Food Poisoning, dated 11/24/2025, indicated, Keep hands and surfaces clean.Wash your hands and surfaces often. Germs that cause food poisoning can survive in many places and spread in your kitchen.Wash your hands before, during, and after preparing food.Wash for at least 20 seconds with soap and warm or cold water.		

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. Based on observation, interview, and record review, the facility failed to ensure three out of four residents (Residents 25, 9, and 1) were free from chemical restraints (the use of medications such as psychotropic medications [drugs that affects brain activities associated with mental processes and behaviors, example is antipsychotics, antidepressants, anti-anxiety, hypnotics] not for therapeutic reasons, but to restrict a person's freedom of movement or control their behavior) when:1.Resident 25 continued to receive quetiapine (brand name is Seroquel - an antipsychotic [AP] medication used to treat schizophrenia [a mental illness that is characterized by disturbances in thought], bipolar disorder [sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs] , and major depressive disorder [a mood disorder that causes a persistent feeling of sadness and loss of interest], improving mood, thought, and behavior) without adequate indications for its use and there was no scheduled Abnormal Involuntary Movement Scale (AIMS - a clinician rated tool used to detect and monitor severity of tardive dyskinesia [TD - a neurological condition causing involuntary, repetitive body movements, often in the face and limbs, resulting from long term use of certain medications like antipsychotics] and other involuntary movements in patients on antipsychotic [AP] medication) monitoring completed.2a. Resident 9 continued to receive quetiapine without clinical documentation of non-pharmacological interventions implemented and there were no scheduled AIMS monitoring completed; and2b. Resident 9 continued to receive trazodone (an antidepressant medication, used to treat depression [a mood disorder that causes a persistent feeling of sadness, and loss of interest] helping with sleep, mood and anxiety) for insomnia (a sleep disorder characterized by difficulty falling asleep, staying asleep, or experiencing poor quality sleep, leading to daytime impairment) without clinical documentation of non-pharmacological interventions and monitoring for hours of sleep.3a. Resident 1 continued to receive both aripiprazole (brand name: Abilify, an AP) and olanzapine (brand name: Zyprexa, an AP) without documentation of identified behaviors, side effect monitoring and no scheduled AIMS monitoring completed; and3b. Resident 1 continued to receive trazodone for insomnia without clinical documentation of non-pharmacological interventions, monitoring for hours of sleep and monitoring of trazodone's side effects.These failures had the potential for increased risks associated with the use of medications that could negatively affect the residents' physical, mental and psychosocial well-being.Findings:1.Review of Resident 25's face sheet (front page of the chart that contains a summary of basic information about the resident) indicated Resident 25 was admitted to the facility with diagnoses including dementia (a progressive state of decline in mental abilities), diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing) and atrial fibrillation (a common heart rhythm disorder where the heart's upper chambers [atria] beat irregularly and often rapidly).During an observation on 1/27/2026 at 9:46 a.m., with Resident 25 at the hallway in between her room and nurse station, Resident 25 was seated on her wheelchair, non-English speaking, calm and dressed appropriately.During an interview with registered nurse G (RN G) on 1/27/2026 at 9:47 a.m., RN G stated Resident 25 often thought that someone was always talking to her and she used to be aggressive to staff and her family.During a concurrent interview with the skilled nursing facility nurse manager (SNF NM) and minimum data set nurse (MDSN) on 1/27/2026 at 2:57 p.m., the SNF NM reviewed Resident 25's physician orders, nursing progress notes from 12/2025-1/27/2026, and medication administration record (MAR) from 12/2025-1/2026. The SNF NM stated Resident 25 had an order of Seroquel 100 milligram (mg, unit of measurement) every night for dementia and there was no identified behavior documented. The SNF NM further stated, Resident 25 hallucinated (an experience involving the apparent perception of something not present) before. The MDSN confirmed the diagnosis or indication of dementia was not appropriate for Resident 25's use of Seroquel.During a concurrent interview with the SNF NM and record review of Resident (continued on next page)		

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	25's electronic health record (EHR) on 1/29/2026 at 4:30 p.m., the SNF NM stated there was no AIMS completed for Resident 25. He further stated, AIMS should have been completed every six months.2a. Review of Resident 9's face sheet indicated Resident 9 was admitted with diagnoses including failure to thrive (a rapid decline in an older adult's physical and mental health), mild dementia and generalized osteoarthritis (a common, long term wear-and tear disease where protective cartilage breaks down in multiple joints throughout the body).During a concurrent interview with the SNF NM and record review of Resident 9's physician order, and nursing progress notes on 1/27/2026 at 11:16 a.m., the SNF NM stated Resident 9 had an order of quetiapine 100 mg at bedtime for psychosis (a state where a person loses touch with reality, experiencing disrupted thoughts and perceptions, often involving hallucinations and delusions [strong, false beliefs] and dementia. He further stated, they monitored Resident 9 for disruptive behaviors like yelling, and agitation, and staff should implement non-pharmacological interventions with every behavior. The SNF NM confirmed that on 12/26, 12.27, and 12/28/2025, Resident 9 was observed to have combativeness, and yelling behaviors and there were no documentation that non-pharmacological interventions were implemented. He also confirmed that on 1/1, 1/17, 1/18, 1/19 and 1/22/2026, Resident 9 had disruptive behaviors such as yelling, and agitation and there were no non-pharmacological interventions implemented.During a concurrent interview with the SNF NM and record review of Resident 9's EHR on 1/29/2026 at 4:35 p.m., the SNF NM stated there were no AIMS completed for Resident 9's use of quetiapine.During an interview with licensed vocational nurse D (LVN D) on 1/29/2026 at 4:45 p.m., when asked about monitoring of AIMS for residents on AP, she stated they did not have AIMS tool, and they did not complete one for residents receiving AP.2b. During a concurrent interview with the SNF NM and record review of Resident 9's physician order and nursing progress notes on 1/27/2026 at 11:58 a.m., the SNF NM confirmed Resident 9 had an order of trazodone 50 mg at bedtime for insomnia and stated there was no monitoring of Resident 9's hours of sleep. He also stated there were no non-pharmacological interventions implemented to help with Resident 9's problem with sleeping.3a. Review of Resident 1's face sheet indicated, Resident 1 was admitted to the facility with diagnoses including hyponatremia (a medical condition when the blood sodium [salt] level is too low), peripheral vascular disease (PVD, a circulation problem where narrowed blood vessels reduce blood flow to legs and organs leading to pain, cramping, and weakness), and schizoaffective disorder, depressive type (a serious mental illness).During a concurrent observation and interview with Resident 1 on 1/22/2026 at 10:34 a.m., inside Resident 1's room, he was seated on his wheelchair, and he wheeled himself inside his room with the use of his legs. Resident 1, non-English speaking, stated he had fallen before because his legs gave out but he can now walked everyday with the use of his front wheeled walker (FWW, a mobility aid designed for support and stability).During a concurrent interview with the SNF NM and record review of Resident 1's physician order, nursing progress notes, and MAR (12/2025 and 1/2026) on 1/28/2026 at 3:06 p.m., the SNF NM stated Resident 1 had an order of aripiprazole 5 mg daily for psychosis, and olanzapine 2.5 mg at bedtime for psychosis and agitation. The SNF NM confirmed there was no documentation of specific behaviors to monitor in the use of both APs. He stated the specific behaviors or manifestations should be in the indications of AP use. He also confirmed that nurses did not monitor Resident 1 for any possible effects of APs on 12/1, 12/3 to 12/10, 12/12 to 12/15, 12/19, 12/20, 12/21, 12/24 to 12/31/2025, 1/1/2026, and 1/4/2026 to 1/28/2026.During a concurrent interview with the SNF NM and record review of Resident 1's EHR on 1/29/2026 at 4:40 p.m., the SNF NM stated there were no AIMS completed for Resident 1's use of quetiapine.During an interview with the MDSN, who is currently the SNF assistant manager (SNF AM) on 1/30/2026 at 9:01 a.m., the MDSN/SNF AM stated the psychotropic team which consists of their social worker, consultant pharmacist, SNF NM and herself tried to review each resident on psychotropic medications and provide their recommendations to resident's physicians. She stated they did not complete the AIMS for residents on AP, and she also stated that it should have been done every six months. The MDSN/SNF AM stated, we are working on it.During a review of the facility's undated policy and (continued on next page)		

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	procedure titled, Antipsychotic Medication Use Policy, indicated, Antipsychotic medications may be used only when: A documented medical or psychiatric diagnosis supports their use. Target symptoms or behaviors are clearly identified and documented. Non-pharmacological interventions have been attempted and documented, unless clinically contraindicated. Further review indicated, Residents shall be monitored for: Therapeutic response, Adverse effects, Changes in condition. Ongoing documentation of effectiveness and side effects is required. Individualized, non-drug interventions shall be implemented and documented, including: Environmental modifications, Behavioral strategies, Staff approaches tailored to resident needs. These interventions shall be reviewed by the interdisciplinary team [IDT - a group of health care professionals from diverse fields who work toward a common goal for residents]. During a review of the facility's policy and procedure titled, Abnormal Involuntary Movement (AIMS) Test, dated revised 4/2024, indicated, Residents receiving medication(s) with the potential to cause abnormal involuntary movements (i.e. antipsychotics.) will receive evaluations every six months using a recognized assessment tool i.e. AIMS. Results of these evaluations shall be filed in the patients chart and brought to the attention of the attending physician who shall initial the evaluation form to acknowledge awareness of the evaluation. 3b. During a concurrent interview with the SNF NM and record review of Resident 1's physician order, nursing progress notes and MAR (12/20204 and 1/2026) on 1/28/2026 at 3:15 p.m., the SNF NM stated Resident 1 had an order of trazodone 300 mg at bedtime for insomnia. He confirmed there was no documented monitoring of Resident 1's hours of sleep, non-pharmacological interventions provided, and side effects of trazodone use. During a review of the facility's undated policy and procedure titled, Psychotropic Medication Policy, indicated, Each psychotropic medication must have: Supporting clinical rationale. Behavioral and environmental interventions must be attempted and documented prior to initiating psychotropic medication, unless contraindicated. Nursing staff shall monitor and document: Effectiveness of medication, Target symptom response, Adverse reactions or side effects. Abnormal findings must be promptly reported to the prescriber.		

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to accurately code the Minimum Data Set (MDS - a federally mandated resident assessment tool) assessment for two of 12 sampled residents (Resident 9 and Resident 5) when:1.Resident 9's quarterly MDS assessment dated [DATE] did not reflect her actual pressure injuries (PI - localized, pressure-related damage to the skin and/or underlying tissue usually over a bony prominence)at the time of assessment; and2.Resident 5's admission MDS assessment dated [DATE] did not reflect the actual pressure injuries he was admitted with.These failures resulted in inaccurate MDS assessments submitted to Centers for Medicare & Medicaid Services (CMS - a federal agency that provides coverage to more than 160 million through Medicare, Medicaid.works in partnership with the entire health care community to improve quality, equity and outcomes in the health care system) and had the potential to affect Resident 9 and Resident 5's care.Findings:1.Review of Resident 9's face sheet (front page of the chart that contains a summary of basic information about the resident) indicated Resident 9 was admitted to the facility on [DATE] with diagnoses including failure to thrive (a rapid decline in an older adult's physical and mental health), mild dementia and generalized osteoarthritis (a common, long term wear-and tear disease where protective cartilage breaks down in multiple joints throughout the body).Review of Resident 9's admission MDS assessment dated [DATE] indicated, Resident 9 was admitted with two unstageable (UTS) pressure injuries (a PI not stageable due to coverage of wound bed by slough[dead tissue that is usually yellow, tan, gray, or green in color, usually moist and stringy in texture, that may be found in wounds] and/or eschar [dead tissue that is hard or soft in texture; usually black, brown, or tan in color, and may appear scab-like, usually firmly attached to the base, sides and/or edges of the wound and over time falls off]).During a concurrent interview with the minimum data set nurse (MDSN) and record review of Resident 9's quarterly MDS assessment dated [DATE] on 1/21/2026 at 2:41 p.m., the MDSN confirmed Resident 9's quarterly assessment indicated she only had one UTS PI which was not present upon admission, which meant Resident 9 had developed one UTS PI while she was at the facility. The MDSN stated Resident 9 was admitted with two UTS PI which opened and became a Stage 4 PI (Full-thickness skin and tissue loss with exposed muscle, tendon, ligament, cartilage, or bone) on both right and left hips. The MDSN confirmed Resident 9's quarterly MDS assessment should have been coded that Resident 9 had two Stage 4 PI present upon admission. She stated, it was my mistake.During a concurrent interview with the skilled nursing facility nurse manager (SNF NM) and record review of Resident 9's wound/skin assessment from 12/20/2025 - 12/26/2025 on 1/27/2026 at 10:06 a.m., the SNF NM confirmed Resident 9 was admitted with two UTS PI on both hips. The SNF NM stated both UTS PI opened and was staged to Stage 4 PI. He confirmed that on 12/21/2025, the left hip PI was pink in color, and still considered Stage 4 PI and her right hip was still Stage 4.During a review of the Long-Term Care Facility Resident Assessment Instrument [RAI] manual - the official, federal instruction guide for nursing home staff on how to assess residents, identify their needs, and create individualized care plans] 3.0 User's Manual, Version 1.20.1, dated 10/2025, indicated, If the pressure ulcer/injury was unstageable on admission/entry or reentry, then becomes numerically stageable later, it should be considered as present on admission at the stage at which it first becomes numerically stageable.2.Review of Resident 5's face sheet, it indicated Resident 5 was admitted to the facility on [DATE] for wound care, with diagnoses including decubitus ulcer (also known as pressure injury) of sacral region (the triangular area at the base of the spine), and history of spina bifida (a birth defect in which an area of the spinal column doesn't form properly, leaving a section of the spinal cord and spinal nerves exposed through an opening in the back).Review of Resident 5's admission MDS assessment dated [DATE], indicated Resident 5 was admitted with one Stage 4 PI, and the number of Stage 3 PI was coded 0.During a concurrent interview with the facility's director of nursing (DON) and record review of Resident 5's skin assessment dated [DATE] on (continued on next page)		

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	1/27/2026 at 2:03 p.m., theDON stated Resident 5 was admitted with Stage 4 PI on his coccyx (tailbone area, the small triangular bone at the very bottom of the spine), and Stage 3 PI (Full-thickness loss of skin. Dead and black tissue may be visible) on his right ischial tuberosity (it is also known as the sitting bone, as this is where the weight of the body is held when seated).During a concurrent interview with the SNF NM and record review of Resident 5's skin assessment dated [DATE] and admission MDS assessment dated [DATE] on 1/27/2026 at 2:12 p.m., the SNF NM confirmed Resident 5 was admitted with one Stage 4 PI in the coccyx area and one Stage 3 in his right ischial tuberosity. He confirmed the wounds were not healed yet during the MDS assessment on 12/25/2025 and further confirmed, the MDS section with Stage 3 should have been coded 1 and 1 for number of these Stage 3 pressure ulcers present upon admission.During an interview with the MDSN, who was also the skilled nursing facility assistant manager (SNF AM) on 1/30/2026 at 8:49 a.m., the MDSN/SNF AM stated she completed their residents' MDS assessment and there was an agency that also helped in MDS completion, based in New York. She also stated they completed the MDS assessment remotely and she collaborated with them.During a review of the Long-Term Care Facility RAI 3.0 User's Manual, Version 1.20.1, dated 10/2025, indicated, Steps for Assessment 1. Review the medical record, including skin care flow sheets or other skin tracking forms, nurse's notes, and pressure ulcer/injury risk assessments. 2. Speak with the treatment nurse and direct care staff on all shifts to confirm conclusions from the medical record review and observations of the resident. 3. Examine the resident and determine whether any ulcers, injuries, scars.Assess key areas for pressure ulcer/injury development. Further review indicated, Visualization of the wound bed is necessary for accurate staging.For each pressure ulcer/injury, determine if the pressure ulcer/injury was present at the time of admission/entry or reentry and not acquired while the resident was in the care of the nursing home.		

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NAME OF PROVIDER OR SUPPLIER George L Mee Memorial Hospital D/P Snf		STREET ADDRESS, CITY, STATE, ZIP CODE 300 Canal Street King City, CA 93930	
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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to ensure care and services were provided to meet the professional standards of practice for seven of 12 sampled residents (Residents 22, 9, 34, 2, 3, 4, 35 and 21) when:1.Resident 22 had no care plan developed for used of apixaban (brand name: Eliquis, an anticoagulant drug known as blood thinners, prevent or reduce the formation of harmful blood clots in blood vessels);2.Resident 9 had no care plans developed for used of quetiapine (brand name is Seroquel - an antipsychotic medication used to treat schizophrenia [a mental illness that is characterized by disturbances in thought], bipolar disorder [sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs] , and major depressive disorder [a mood disorder that causes a persistent feeling of sadness and loss of interest], improving mood, thought, and behavior) and trazodone (an antidepressant medication, used to treat depression [a mood disorder that causes a persistent feeling of sadness, and loss of interest] helping with sleep, mood and anxiety);3.Resident 34 had no patient centered care plan developed for nutrition to address the possible weight loss;4. Resident 2 care plan was no initial signature of who reviewed or resolved the care plan;5. RESIDENT 3 did not update the care needed and the prevention regarding fall;6. RESIDENT 4 care plan for pain was no initial of who reviewed or resolved the care plan ; 7. RESIDENT 21 care plan was no initial signature of who reviewed or resolved the care plan ;and8.Resident 35 was given Potassium CL ER (Extended Release, drug formulation to last longer in the body) 20 meq (milliequivalent, a unit of measurement in medicine) tab twice a day (BID) without meals.These failures had the potential unmet care needs and jeopardize the health and safety of Residents 22, 9, 34, 2, 3, 4, and 21. Findings: 1.Review of Resident 22's face sheet (front page of the chart that contains a summary of basic information about the resident) indicated, Resident 22 was admitted to the facility with diagnoses including atrial fibrillation (a common heart rhythm disorder where the heart's upper chambers [atria] beat irregularly and often rapidly), hypertension (HTN &ndash; high blood pressure) and coronary artery disease (a common heart condition where major blood vessels supplying the heart become damaged, narrowed, or blocked by plaque buildup [cholesterol/fatty deposits]). During an interview with registered nurse G (RN G) on 1/27/2026 at 9:51 a.m., RN G stated Resident 22 was always in group activity and she was taking Eliquis for stroke prophylaxis (used to lower risk of stroke). RN G further stated, Resident 22's use of Eliquis should be care planned. During a concurrent interview with the skilled nursing facility nurse manager (SNF NM) and record review of Resident 22's physician order on 1/27/2026 at 1:57 p.m., the SNF NM stated Resident 22 had an order of Eliquis 5 milligram (mg, unit of measurement) to be taken twice a day and it started on 11/3/2025. During another concurrent interview with SNF NM and record review of Resident 22's list of care plans on 1/27/2026 at 2:30 p.m., SNF NM stated there was no care plan developed for Resident 22's used of Eliquis. SNF NM further stated, there should have been a care plan developed for Resident 22's use of Eliquis. 2. Review of Resident 9's face sheet indicated Resident 9 was admitted with diagnoses including failure to thrive (a rapid decline in an older adult's physical and mental health), mild dementia (a group (continued on next page)		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	of symptoms affecting thinking and social abilities interfering with daily functioning) and generalized osteoarthritis (a common, long term wear-and tear disease where protective cartilage breaks down in multiple joints throughout the body). During a concurrent interview with the SNF NM and record review of Resident 9's physician order, and list of care plans on 1/27/2026 at 11:16 a.m., the SNF NM stated Resident 9 had an order of quetiapine 100 mg at bedtime for psychosis (a state where a person loses touch with reality, experiencing disrupted thoughts and perceptions, often involving hallucinations and delusions [strong, false beliefs] and dementia, which started on 10/1/2025. He confirmed there was no care plan developed for Resident 9's use of quetiapine. SNF NM stated there should have been a care plan developed for Resident 9's use of quetiapine. The SNF NM further stated that long term care plans were developed by nurses, the initial care plans should have been developed by the admitting nurse, and the comprehensive care plans were being developed by the floor nurses. During a concurrent interview with the SNF NM and record review of Resident 9's physician order and list of care plans on 1/27/2026 at 11:58 a.m., the SNF NM confirmed Resident 9 had an order of trazodone 50 mg at bedtime for insomnia (a common sleep disorder characterized by persistent difficulty falling asleep, staying asleep, or waking up too early), which started on 12/11/2025. He confirmed there was no care plan developed for Resident 9's use of trazodone. 3. During a concurrent interview with the SNF NM and record review of Resident 34's face sheet, physician order and care conference dated 1/9/2026 on 1/21/2026 at 3:11 p.m., SNF NM stated Resident 34 was readmitted to their facility with diagnoses including aspiration pneumonia (an infection caused by inhaling something other than air into the lungs, which could be food, liquid, saliva or stomach contents), HTN, history of stroke (a medical emergency that happens when something prevents the brain from getting enough blood flow) and aphasia (a disorder that resulted from a stroke that impairs the expression and understanding of language, as well as reading and writing). He stated Resident 34 had been aspirating even with pureed diet and honey thickened liquids. He further stated they held a care conference with Resident 34's family on 1/9/2026 and talked about Resident 34's care and the risk of aspiration. SNF NM stated that the family wishes to feed Resident 34 for oral gratification only (providing food, drink, or oral stimulation aimed at enhancing the patient's quality of life, pleasure, and comfort, rather than providing sustenance or nutrition). During an observation on 1/22/2026 at 11:01 a.m. and 1/27/2026 at 9:40 a.m., inside Resident 34's room, Resident 34 was observed asleep, on left side lying position, and did not have signs of distress. During an interview with licensed vocational nurse B (LVN B) on 1/27/2026 at 10:28 a.m., LVN B stated Resident 34's family only wanted comfort measures for the resident and did not want any artificial nutrition for Resident 34. LVN B further stated Resident 34 had some time when he could eat by himself or hold his drinks and there were times when he needed some assistance with meals. She stated the family was aware that Resident 34 could decline if he was not getting enough nutrition and that he was at risk for aspiration. During a concurrent interview with the SNF NM and record review of Resident 34's list of care plans and the registered dietitians (RD) progress notes on 1/28/2026 at 3:51 p.m., he stated there was no care plan developed for Resident 34's risk in alteration in nutrition. The SNF NM further stated, the RD had documented assessment notes for Resident 34 in 9/2025, 10/2025, 12/2025 and 1/22/2026. SNF NM stated there should have been a care plan developed for Resident 34's potential risk in alteration in nutrition. (continued on next page)		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview with the minimum data set nurse, who is currently the skilled nursing facility assistant manager (MDSN/SNF AM) on 1/30/2026 at 8:49 a.m., the MDSN/SNF AM stated she completed their residents' minimum data set (MDS, a federally mandated resident assessment tool) assessment and there was an agency that also helped in MDS completion, based in New York. She also stated they completed the MDS assessment remotely and she collaborated with them. MDSN/SNF AM stated the nurses on the floor should develop resident's care plan. She further stated the residents scheduled MDS assessment were in each nurse station for nurses to know when they have to complete some resident's assessment and when to develop or revise their care plans. During a review of the facility's job description titled, Nurse Assess Coordinator (MDS), date signed 6/24/2024, indicated, The MDS Coordinator also has the responsibility of maintaining current documentation in the Electronic Medical Record (EMR), transmitting required data at appropriate times, writing care plans generated from the Care Area Assessment (CAA), chairing the weekly interdisciplinary team [IDT - a group of health care professionals from diverse fields who work toward a common goal for residents] meeting, and recapping monthly data. This individual will individualize patient care. Essential Function.g. Generate suggested care plans and personalize to the individual patient. h. Assure completed comprehensive interdisciplinary care plans are in the patient record no later than the 21st day after admission. i. Randomly audits patient records to assure care plans are updated as necessary. 2. Prepares comprehensive plan of care to include problems, goals, interventions, and responsible disciplines with appropriate time frames. Incorporate the long term care plan and the acute care plan into the patient's record. During a review of the facility's policy and procedure titled, Assessment and Comprehensive Plan of Care for SNF, date revised 6/20/24, indicated, Mee Memorial Healthcare System (MMHS) will complete an interdisciplinary resident assessment and implement a resident-centered care plan for the SNF Program resident. MMHS will develop an interdisciplinary resident-centered care plan in consultation with the resident or resident representative consistent with resident rights, which includes measurable objectives and time lines to meet the resident's medical, nursing, rehabilitation, and psychosocial needs which are identified in the interdisciplinary assessment. The resident-centered plan of care include: a. resident's preferences. b. The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychological well-being. c. Any interventions. d. Any services that would otherwise be required. e. Any specialized or rehabilitative services. f. Goals, Interventions and Time Lines. 4. Review of Resident 2's face sheet indicated, Resident 2 was admitted to the facility on [DATE] with diagnoses dementia (loss of memory, language, problem-solving and other thinking abilities that are severe enough to interfere with daily life) with mood disturbance , history of ischemic right posterior cerebral artery (PCA) stroke (a medical emergency where a blood clot blocks an artery (the Posterior Cerebral Artery) on the right side of the brain, stopping blood flow to the occipital lobe, thalamus, and parts of the temporal lobe), hypertension (high blood pressure), history of post-polio syndrome (a condition that causes gradual muscle weakness and muscle atrophy (loss) that can affect people who've had polio), hyperlipidemia, insulin-treated type 2 diabetes mellitus (a condition that happens when your blood sugar (glucose) is too high). During a concurrent interview and record review with the SNF NM on 1/27/2026 at 1:57 p.m., Resident 2's physician order of Quetiapine (used to treat mental health conditions like schizophrenia, bipolar disorder (manic and depressive episodes), and major depressive disorder) 50 mg, tab oral ,at bedtime (HS, used to indicate frequency of order hora somni) and started on 7/25/25. The SNF NM stated Resident 2 has delusion and confusion then it was resolved after taking the antipsychotic (continued on next page)		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	medication Quetiapine. During a record review another concurrent interview with SNF NM on 1/30/2026 at 8:34 a.m., the SNF NM reviewed Resident 2's list of care plans for antipsychotic care plan dated 7/25/25, SNF NM confirmed there was no initial of who reviewed or resolved the care plan. SNF NM further stated It is very important to evaluate if the goals and intervention is working or not working. Review of the facility's policy and procedure(P&P) titled Assessment and Comprehensive Plan of Care for SNF, dated 06/2024, the P&P indicated, A. Assessment 3. Any significant change in status, either mental or physical, will constitute the need for reassessment; B. Care plan and Multi -disciplinary Conferences: 6. The resident-centered plan of care will include.f. Goals, Interventions and Time Lines: Goal statement to be achieved and projected dates of completion, Time line for meeting goals. 5. Review of Resident 3's face sheet indicated, Resident 3 was admitted to the facility on [DATE] with diagnoses including functional gait abnormality(abnormal movement or positioning of part of the body due to the nervous system not working properly), muscle weakness (loss of strength) , frequent falls, history of traumatic brain injury (a brain injury that is caused by an outside force). During a record review and concurrent interview with the skilled nursing facility assistant manager and minimum data set nurse (SNF AM/MDSN) on 1/27/2026 at 1:24 p.m., the SNF AM/MDSN stated Resident 3 had an unsteady gait; impaired sensory, poor judgement and motor and sensory deficits. The SNF AM/MDSN confirmed during review of Resident 3's list of care plans, Resident refused to use call light, and there is no care plan for refusal of call light. During a concurrent interview and record review with the SNF NM on 1/28/2026 at 4:36 p.m., the SNF NM stated, no Interdisciplinary Team (IDT) meeting or notes for fall of Resident 3's was done. The SNF NM further stated IDT was needed to update the care needed and the prevention regarding fall. Review of the facility's policy and procedure(P&P) titled Assessment and Comprehensive Plan of Care for SNF, dated 06/2024, the P&P indicated, B. Care plan and Multi -disciplinary Conferences: 6. The resident-centered plan of care will include.g. The plan of care will be reviewed and modified by the interdisciplinary team at least quarterly after each care conference or more frequently as needed. The review will include an evaluation of the care plan and any modifications. 6. Review of Resident 4's face sheet indicated, Resident 4 was admitted to the facility on [DATE] with diagnoses including polymyalgia rheumatica (a disorder characterized by pain and stiffness in a number of muscles, often occurring in association with arteritis [inflammation of the walls of an artery]or other generalized inflammatory state), myelopathy (disease of spinal cord)due to cervical spondylosis (age-related wear and tear affecting the spinal disks in your neck), abdominal pain (discomfort anywhere in your belly region), alcoholism in remission. During a record review and concurrent interview with the SNF NM on 1/29/2026 at 4:03 p.m., review of Resident 4's list of paper care plans for pain, chronic related to polymyalgia rheumatica dated 12/17/24 and was reviewed by the facility on following dates 2/20/25, 5/13/25,7/9/25, and 10/21/25. The SNF NM confirmed there was no initial or signature of those staff who reviewed or resolved the care plan. The care plan paper form has several columns that indicated Reeval date and signature and was left blank. The SNF NM further stated whoever revised the care plan should have initialed them. (continued on next page)		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	7. Review of Resident 21's face sheet indicated, Resident 21 was admitted to the facility on [DATE] with diagnoses including low back pain (affects the lumbar region of your spine or back), HTN, migraine headache (a neurological condition causing recurrent, moderate-to-severe throbbing or pulsing pain, typically on one side of the head). Review of Resident 21's paper care plan titled Nursing Services/Multidisciplinary Care Plan/Problem List dated 10/10/24. The paper care plan form has a column indicated Outcome Date Signature with small boxes of resolved, improved, no change then date and initial. that were left blank. During a concurrent interview and record review with the SNF NM on 1/28/2026 at 9:40 a.m., review of Resident 21's list of paper care plans for pain dated 10/10/24 was done. The SNF NM confirmed that there are no names or signatures who did the quarterly revision or updates, and also missed three quarters for the care plan of chronic pain. The SNF NM stated, it is very important to complete the care plan revision and updates for patient care. Review of the facility's policy and procedure(P&P) titled Assessment and Comprehensive Plan of Care for SNF, dated 06/2024, the P&P indicated, B. Care plan and Multi -disciplinary Conferences: 6. The resident-centered plan of care will include.g. The plan of care will be reviewed and modified by the interdisciplinary team at least quarterly after each care conference or more frequently as needed. The review will include an evaluation of the care plan and any modifications. 8.During a medication pass observation and interview with Registered Nurse (RN) I on 1/21/26 at 4:51p.m., RN I administered one medication to Resident 35, RN I prepared Potassium CL ER 20 meq. tablet, on the blister pack written to give 1 tablet by mouth twice daily with meals. During a concurrent interview and record review with RN I on 1/21/26 at 4:55 p.m., RN I show the blister and was asked to verify should it be with meals? RN I stated the Resident will get her meals and it has apple sauce. Review of facility mealtimes are as follows: Dinner: Early trays * if requested 4:30 p.m., SNF/SNF Cart 1- 5:30 pm, Cart 2 -5:50 pm, and Cart 3- 6:00 p.m. During a concurrent interview and record review with the Quality Nurse Coordinator (QNC) on 1/22/26 at 10:35 a.m., the QNC confirmed the Potassium CL ER 20 mEq. tablets should be given with meals because it will affect the absorption. The QNC further stated the dinner start at 5:30 pm, the nurse should adjust the medication administration until the food comes. A review of drug resources, DailyMed(https://dailymed.nlm.nih.gov/dailymed). If you take Administration: Take potassium chloride extended-release tablets with meals and with a glass of water or other liquid. Do not take on an empty stomach because of its potential for gastric irritation. Review of the facility's policy and procedure(P&P) titled Medication Administration General Guidelines, dated 01/2023, the P&P indicated, Administration: 3. Medication administration timing parameters include the following: b. Medications to be given with meals are to scheduled for administration at the resident's mealtime,		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to implement their Leave of Absence (LOA) policy and procedures (PnP) for two of 45 residents (Resident 20 and 45) when licensed nurses (LN) did not complete and document Resident 20 and 45's mental, physical, and functional assessments prior to leaving and upon returning to the facility. This failure could potentially compromise Resident 20 and 45's safety and well-being. Findings: Review of Resident 45's face sheet indicated Resident 45 was admitted to the facility on [DATE] with diagnoses including alcoholic cirrhosis (the permanent scarring of the liver, where healthy tissue is replaced by scar tissue, making it hard for the liver to function properly, leading to potential liver failure), alcohol dependence (also known as alcoholism, is the most serious form of drinking problem and describes a strong, often uncontrollable desire to drink), ascites of liver (abnormal buildup of fluid in the abdominal (belly) cavity, causing swelling, discomfort, and rapid weight gain) and hepatic encephalopathy (brain dysfunction caused by a failing liver that can't filter toxins leading to confusion, personality changes, memory issues, and in severe cases, coma or death). Review of Resident 45's clinical record titled, Release of Responsibility for Leave of Absence, dated: 12/1/2025 - indicated Resident 45 signed himself out to go to the garden at 12:48 p.m., no documented Time in; 12/2/2025 - indicated Resident 45 signed himself out to go to the garden at 1:35 p.m., no documented Time in, and had no nurse initials. 12/3/2025 - indicated Resident 45 signed himself out to go to the garden at 2:20 p.m., and no documented Time in; 12/4/2025 - indicated Resident 45 signed himself out to go to the garden at 1:30 p.m., and no documented Time in; 12/6/2025 - indicated Resident 45 was signed out by a friend at 8:50 a.m., the destination was left blank and there was no documented Time in; 12/7/2025 - indicated Resident 45 was signed out by a friend at 9:30 a.m., the destination indicated, out, there was no documented Time in, and no nurse initials. 12/9/2025 - indicated Resident 45 signed himself out at 1:36 p.m., the destination indicated, out and there was no documented Time in; 12/10/2025 - indicated Resident 45 signed himself out at 1:00 p.m., Time in indicated 5:35 p.m., the destination was out, and no nurse initials; 12/11/2025 - indicated Resident 45 signed himself out at 2:54 p.m., no Time in documented, and the destination was out; 12/12/2025 - indicated Resident 45 signed himself out to go to the Garden, at 12:33 p.m., and no documented Time in; 12/13/2025 - indicated Resident 45 signed himself out to go to the Garden, at 12:43 p.m., and he was back at 5:25 p.m.; 12/15/2025 - indicated Resident 45 signed himself out to go, outside, at 1:56 p.m., and he was back 5:21 p.m.; 12/16/2025 - indicated Resident 45 signed himself out to go, outside, at 12:21 p.m., and he was back at 5:33 p.m.; 12/17/2025 - indicated Resident 45 signed himself out to go to the garden, at 2:00 p.m., and there was no documented Time in; 12/18/2025 - indicated Resident 45 signed himself out to go Downstairs, at 10:53 a.m., and there was no documented Time in; 12/19/2025 - indicated Resident 45 was signed out by a friend to go to town, at 11:19 a.m. and with Time in at 5:50 p.m.; 12/20/2025 - indicated Resident 45 signed himself out at 1:20 p.m., the documented destination was not legible, and there was no documented, Time in; 12/21/2025 - indicated Resident 45 was signed out by a friend at 8:40 a.m., no documented destination, no Time in, and no nurse initials; 12/22/2025 - indicated Resident 45 signed himself out to go to the Garden, at 12:30 p.m., and no documented Time in; and 12/23/2025 - indicated, Time out, 1028; Time in LOA - 1740 (military time for 5:40 p.m.), Destination: Garden, signed by Resident 45. During a concurrent interview and record review with the Skilled Nursing Facility Nurse Manager (SNF NM) on 1/23/2026 at 1:34 p.m., the SNF NM reviewed Resident 45's December 2025 nurse's notes, the SNF NM confirmed nurses did not complete and document Resident 45's assessment prior to leaving and upon returning to the facility. The SNF NM stated nurses should assess Resident 45 first before he left and when he came back to the facility. He confirmed that when Resident 45 signed out to the garden, it was considered LOA and he had a choice to leave the facility premises while he was at the garden. The SNF NM confirmed nurse's December 2025 progress notes did not indicate assessments were (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	completed before Resident 45 left and when he came back to the facility on the following dates: 12/1/2025 to 12/4/2025, 12/6, 12/7, 12/9, 12/10, 12/11, 12/12, 12/13, 12/15/20225 to 12/23/2025. During a review of Resident 20's face sheet, indicated Resident 20 was admitted to the facility on [DATE] and had a diagnoses of Alcoholism(persistent excessive consumption of alcohol resulting in impairment of health) , Diabetes mellitus (a chronic metabolic condition where the body has high blood sugar), Hemiplegia(paralysis of one side of the body) due to old stroke (medical condition in which poor blood flow to a part of the brain causes cell death), History of completed stroke , Hypercholesteremia (an excess of cholesterol in the bloodstream), Hypertension (a condition that affects the body's arteries), Wheelchair bound (people who is confined in a wheelchair). Review of Resident 20's clinical record titled, Skilled Nursing Facility release of responsibility for leave of absence, dated:10/30/25 - indicated Resident 20's signed himself out to go to the outside, at 5:50 a.m., no documented time in,10/31/25 - indicated Resident 20's signed himself out to go to the outside, at 5:38 a.m., no documented time in,11/7/25 - indicated Resident 20's signed himself out to go to the outside, at 12:55 p.m., and Resident 20 was back at 17:23 p.m.11/8/25 - indicated Resident 20's signed himself out to go to the downstairs, at 05:10 a.m., no documented time in, and no nurse initials11/9/25 - indicated Resident 20's signed himself out to go to the outside, at 06:00 a.m., and Resident 20 was back at 16:53 p.m.11/10/25 - indicated Resident 20's signed himself out to go to the bakery, at 06:00 a.m., no documented time in, 11/10/25 - indicated Resident 20's signed himself out to go to the outside, at 08:55 a.m., no documented time in, 11/11/25 - indicated Resident 20's signed himself out to go to the outside, at 08:20 a.m., no documented time in, 11/12/25 - indicated Resident 20's signed himself out to go to the outside, at 04:45 a.m., no documented time in, 11/13/25 - indicated Resident 20's signed himself out to go to the downstairs, at 04:15 a.m., no documented time in, 11/15/25 - indicated Resident 20's signed himself out to go to the outside, at 06:25 a.m., and Resident 20 was back at 16:15 p.m., no documented relationship11/18/25 - indicated Resident 20's signed himself out to go to the outside, at 08:23 a.m., no documented time in, 11/19/25 - indicated Resident 20's signed himself out to go to the downstairs, at 04:25 a.m., no documented time in, 11/20/25 - indicated Resident 20's signed himself out to go to the store, at 05:45 a.m., no documented time in,11/22/25 - indicated Resident 20's signed himself out to go to the downstairs, at 05:45 p.m., no documented time in,11/23/25 - indicated Resident 20's signed himself out to go to the outside(bakery), at 06:00 a.m., no documented time in, 11/24/25 - indicated Resident 20's signed himself out to go to the outside(bakery), at 05:45 a.m., no documented time in,11/25/25 - indicated Resident 20's signed himself out to go to the downstairs, at 05:00 a.m., no documented time in, and no nurse initial11/26/25 - indicated Resident 20's signed himself out to go to the downstairs, at 6:51a.m., no documented time in,11/27/25 - indicated Resident 20's signed himself out to go to the downstairs, at 05:00a.m., and Resident 20 was back at 07:00 a.m.11/28/25 - indicated Resident 20's signed himself out to go to the outside, at 6:00 p.m., no documented time in,11/30/25 - indicated Resident 20's signed himself out to go to the street market, at 8:50 a.m., no documented time in, relationship, and no nurse initial.12/1/25 - indicated Resident 20's signed himself out to go to the outside, at 05:00 p.m., no documented time in, and no nurse initial.12/3/25 - indicated Resident 20's signed himself out to go to the downstairs, at 05:20 p.m., no documented time in, and no nurse initial.12/5/25 - indicated Resident 20's signed himself out to go to the downstairs, at 05:20 p.m., no documented time in, and no nurse initial.12/6/25 - indicated Resident 20's signed himself out to go to the store, at 05:15 p.m., no documented time in, and no nurse initial.12/7/25 - indicated Resident 20's signed himself out to go to the bakery, at 06:00 p.m., no documented time in,12/8/25 - indicated Resident 20's signed himself out to go to the downstairs, at 04:57 a.m., no documented time in,12/8/25 - indicated Resident 20's signed himself out to go to the downstairs, no documented time out and time in,12/9/25 - indicated Resident 20's signed himself out to go to the downstairs, at 04:59 a.m., no documented time in,12/9/25 - indicated Resident 20's signed himself out to go to the out, at 08:49 a.m., no documented time in,12/10/25 - indicated Resident 20's signed himself out to go to the out, at 06:00 a.m., no (continued on next page)		

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NAME OF PROVIDER OR SUPPLIER George L Mee Memorial Hospital D/P Snf		STREET ADDRESS, CITY, STATE, ZIP CODE 300 Canal Street King City, CA 93930	
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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	documented time in, and no nurse initial12/11/25 - indicated Resident 20's signed himself out to go to the out, at 06:00 a.m., no documented destination, relationship and time in12/13/25 - indicated Resident 20's signed himself out to go to the out, at 06:45 a.m., no documented time in, and no nurse initial12/16/25 - indicated Resident 20's signed himself out to go to the out, at 5:54 p.m., no documented time in,12/16/25 - indicated Resident 20's signed himself out to go to the outside, at 09:00 a.m., no documented time in,12/18/25 - indicated Resident 20's signed himself out to go to the outside, at 1:26 p.m., no documented time in, and no nurse initials12/19/25 - indicated Resident 20's signed himself out to go to the downtown, at 12:35 p.m., no documented time in, and no nurse initials12/20/25 - indicated Resident 20's signed himself out to go to the out, at 5:28 p.m., and Resident 20 was back at 17:00 p.m.12/21/25 - indicated Resident 20's signed himself out to go to the out, at 05:45 p.m., no documented time in,12/24/25 - indicated Resident 20's signed himself out to go to the downstairs, at 06:15 p.m., no documented time in,12/25/25 - indicated Resident 20's signed himself out to go to the downstairs, at 05:02 a.m., no documented time in,12/26/25 - indicated Resident 20's signed himself out to go to the downstairs, at 06:12 a.m., no documented time in, 12/27/25 - indicated Resident 20's signed himself out to go to the outside, at 06:15 a.m., no documented time in,12/28/25 - indicated Resident 20's signed himself out to go to the outside, at 06:00 a.m., no documented time in,12/28/25 - indicated Resident 20's signed himself out to go to the outside, at 08:30 a.m., no documented time in,12/29/25 - indicated Resident 20's signed himself out to go to the 7/11 store, at 08:24 a.m., no documented time in, and no nurse initials12/30/25 - indicated Resident 20's signed himself out to go to the outside, at 08:12 a.m., no documented time in,12/30/25 - indicated Resident 20's signed himself out to go to the outside, at 05:13 a.m., no documented time in,12/31/25 - indicated Resident 20's signed himself out to go to the downstairs, at 21:05 p.m., no documented time in, and no nurse initials1/2/26 - indicated Resident 20's signed himself out to go to the downstairs, at 04:25 a.m., and Resident 20 was back at 05:20 a.m.1/3/26 - indicated Resident 20's signed himself out to go to the outside, at 05:45 a.m., no documented time in, 1/3/26 - indicated Resident 20's signed himself out to go to the plaza, at 8:22 a.m., no documented time in, 1/4/26- indicated Resident 20's signed himself out to go to the outside, at 05:30 a.m., and Resident 20 was back at 15:27 p.m.During a concurrent interview and record review with the SNF NM on 1/23/2026 at 11:30 a.m., the SNF NM reviewed Resident 20's clinical records and he confirmed Resident 20 had signed out and signed in the LOA form on the above dates.During an interview with Certified Nurse Assistant (CNA) E on 1/27/26 at 11:54 a.m. CNA E also stated Resident 20 signed the LOA form whenever he goes out of the facility. He went out of the facility by propelling his wheelchair with the use of his left arm and left leg. CNA E further stated staff did not take Resident 20's vital signs (measurable body functions used to detect or monitor medical problems, including heart rate, blood pressure, respiratory rate, and body temperature) every time he came back from LOA.During a review of the facility's policy and procedure titled, Patient Leave of Absence, date revised 8/2022, indicated, Leave of Absence (LOA): Any absence from the facility. If the patient is not present for the midnight census count, he/she is placed on a bedhold.For all patients going on a Leave of Absence (LOA) the criteria below must be met:The licensed nurse must do a complete mental, physical, and functional assessment immediately prior to (within 30 minutes) leaving and upon returning to the facility.Document assessment in the nursing progress notes in the EHR [Electronic Health Record].		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure proper labeling and storage of medications was followed according to the facility's policy and procedures (P&P) and/or manufacturer's specifications when: 1. One vials of tuberculin purified protein (Aplisol- a sterile aqueous solution of purified protein fraction for intradermal administration used in the diagnoses of tuberculosis) with expired date of [DATE]; 2. One vial of Admelog (insulin -lispro-a fast-acting mealtime insulin that helps to control blood sugar was expired on [DATE]; 3. A bottle of Latanoprost 0.005% (used to treat glaucoma [a condition in which increased pressure in the eye can lead to gradual loss of vision]) eye drop was open and undated. 4. A bottle of latanoprost 0.005% was identified inside a box unopened with seal and on the box label refrigerator until open. 5. Medication cart CC was left unlocked during medication administration; and 6. Controlled medication disposition was left in the med cart. These deficient practices had the potential for residents to receive medications with reduced potency and had the potential to result in medication errors. Findings: 1. During an inspection of a medication refrigerator in the medication storage room with Licensed Vocational Nurse (LVN) H on [DATE] at 1:10 p.m., there was one open vial of Tuberculin Purified Derivatives was identified with an open date of [DATE] and expired date of [DATE]. LVN H confirmed that the one Tuberculin vial was outdated. Review of the facility's policy titled Storage of Medication, dated 01/2023, indicated #14 Outdated, contaminated, discontinued or deteriorated medication and those in containers .are immediately removed from stock, disposed of according to procedures for medication disposal. 2. During an inspection of medication cart BB and interview with LVN D on [DATE] at 11:02 p.m., one vial of Admelog (medication to lower blood sugar) was inside the drawer of med cart BB with open date of [DATE] and expired on [DATE]. LVN D confirmed that the vial of Admelog was expired. 3. During a concurrent inspection of medication cart AA and interview with Registered Nurse (RN) J on [DATE] at 1:22 p.m., a bottle of latanoprost 0.005% eye drop was identified open and undated. RN J confirmed the bottle of latanoprost 0.005% eye drop was undated. During an interview with the SNF NM on [DATE] at 3:31 p.m., he stated once the vial or bottle of medication was open the anticipated date should be placed in the vials/bottle with the label. The SNF NM further stated that some of the expirations are 28 days or 30 days, and sometimes we follow the manufacturer date. During a review of the facility's policy and procedure (P&P) titled, Medication Administration, dated 01/2023, the P&P indicated, #8 No expired medication will be administered to a resident. b. The nurse shall place a ?date opened ?sticker on the medication if one is not provided by the dispensing pharmacy and enter the date opened. 4. An inspection of the medication cart AA, and interview with RN J on [DATE] at 1:39 p.m., an open box of bottle of latanoprost 0.005% eye drop was identified inside that was unopened and with seal, on the pharmacy box label refrigerator until open. RN J verified the medication was not used and should be kept inside the refrigerator. During an interview with the SNF NM on [DATE] at 3:37 p.m., stated medication with pharmacy box label refrigerator until open, should be refrigerated until open and use. During a review of the facility's policy and procedure (P&P) titled, Medication Storage -Storage of Medication, dated 01/2023, the P&P indicated, Medications and biologicals are stored properly, following manufacturers or provider pharmacy recommendations to maintain their integrity and support safe effective drug administration. 5. During a medication administration observation on 1/22 / 26 at 11:28 a.m., the medication cart CC was left unlocked, and the medication was left on top of the cart in the hallway outside of resident 3 and 40's room. LVN F confirmed the medication cart CC was left unlocked and stated it should always be locked at all times. A review of the facility's policy and procedures (P&P) titled Medication Administering General Guidelines, dated 01/2023, the P&P indicated, Medication Administered #17. (continued on next page)		

Department of Health & Human Services
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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During administration of medications, the medication cart is kept closed and locked when out of sight of the medication nurse. No medications are kept on top of the cart. The cart must be clearly visible to the personnel administering medications when unlocked. According to PharMerica Back to Basic Medication Administration , Documentation , and Medication Storage Nurse Consulting Services revised date [DATE], indicated Preparation and Safety of Medication Administration: Leaving /Walking Away from the Medication Cart , Ensure that: Drawers are closed, cart are locked , no medication s are left on top of cart , No identifying information is visible (cover MAR , log off or close computer screens). 6. During an interview with LVN F on [DATE] at 10:13 a.m., LVN F confirmed that Controlled drugs are kept in the med cart where the active narcotics are placed and until the pharmacy consultant came to the facility for the narcotic destruction. During an interview with LVN B on [DATE] at 10:34 a.m., LVN B stated Controlled drugs are placed inside the narcotic drawer of medication cart. The Pharmacy Consultant comes once a month and destroyed the narcotics with the nurse manager. LVN B stated active and discontinued controlled drugs are counted during endorsement and change of shift. During a concurrent interview and record review with the SNF NM on [DATE] at 9:04 a.m., the SNF NM stated the Pharmacy Consultant visit every other month and by zoom every other month, the last medication disposition was [DATE]. The SNF NM stated discontinued controlled drugs are kept in the med cart. The SNF NM further stated the facility had no double lock cabinet even before. He stated the Pharmacy Consultant would do the destruction of drugs with one of the licensed nurses. The other meds are in the drawer inside the medication room that the licensed nurse has access to. The SNF NM admitted the possibility of diversion of the controlled drugs. A review of the facility's policy and procedures (P&P) titled Medication Storage Controlled Medication Storage dated 01/2023, the P&P indicated, 4.2 Controlled Medication storage: Medications included in the state and federal Drugs Enforcement Administration (DEA) classification as controlled substances are subject to special handling, storage , disposal and record keeping in the nursing care center in accordance with federal , state and other applicable laws and regulations. 1. The director of nursing and the consultant pharmacist monitor for compliance with federal and state laws regulations in the handling of controlled medications. 11. Controlled medications remaining in the nursing care center after the order has been discontinued are retained in the nursing care center in a securely doubled locked area with restricted access until destroyed as outlined by state regulation.		

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have a policy regarding use and storage of foods brought to residents by family and other visitors. Based on observation, interview, and facility document review, the facility failed to ensure resident's foods brought from home were stored in a safe and sanitary manner, when one refrigerator with built in freezer designated for residents have perishable food (likely to spoil, decay or become unsafe to consume) that were not dated and discarded. This failure had the potential for the contamination of residents' food. Findings: During an observation and concurrent interview with licensed vocational nurse B (LVN B) on 1/27/2026 at 4:00 p.m., inside the locked room in the skilled nursing facility where the residents' refrigerator with built in freezer was located. LVN B stated residents' food brought from home should be labeled with resident's name, open date or date it was brought in, and she also stated, if the food was opened, it should be discarded after 72 hours. Inside the freezer, there were: 10 total homemade tamales stored in zip lock bags, two in each zip lock bags, they were placed on a plastic container with resident's room number and dated 1/4/2026; and one homemade tamale was found in a zip lock bag with resident's room number and not dated. LVN B confirmed the observation and stated the foods should be discarded. Inside the refrigerator was observed to have: a sauce in a small plastic container, not labeled; one plastic box container with pinto beans, it had resident's room number and dated 1/22/2026. LVN B confirmed above observation and stated they should be discarded. During a follow-up interview with LVN B on 1/27/2026 at 4:15 p.m., she stated dietary staff should check the food inside the freezer and refrigerator when they checked the temperature. LVN B further stated dietary staff should also discard the food as necessary. During an interview with the dietary manager (DM) on 1/29/2026 at 11:30 a.m., the DM confirmed the dietary staff were responsible in checking the temperature of the residents' refrigerator and freezer and stated the skilled nursing staff were responsible for making sure the foods brought from home were stored only for 72 hours. During an interview with the skilled nursing facility assistant manager (SNF AM) on 1/29/2026 at 11:55 a.m., the SNF AM stated the food from the residents' refrigerator and freezer were being checked by activity staff, nursing staff and herself. She stated, We are going to come up with a better system to make sure the food brought from home are safe for residents. She further stated the nurse who received the food should label it with resident's name and date received, and it should be discarded after three days. During a review of the facility's policy and procedure titled, Food From Outside Source Policy, date revised 9/2025, indicated, Any food which is not to be eaten right away should be stored in a disposable, sealed container supplied by the visitor in the refrigerator/freezer. Food must be labeled with resident name and date it was brought to the facility and stored in the pantry refrigerator. Disposal shall be consistent with policies related to food safety. Leftover food shall be discarded after 3 days. The nursing department is assigned responsibility for monitoring the pantry refrigerator and discarding outdated foods daily.		

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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 - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to implement infection control practices when:1. Resident room with enhanced barrier precaution (EBP - infection control measures that involve using gowns and gloves during high-contact resident care activities, in addition to standard precautions) signage did not have isolation cart;2. Licensed Vocation Nurse (LVN) did not follow the proper sequence of wearing Personal Protective Equipment (PPE) and touches LVN face area with clean gloves, did not clean the overbed table (an adjustable table designed to roll over a bed and provide a flat and stable surface) without placing a barrier first (such as a clean paper towel) before placing then glucometer (a portable device used to measure the concentration of glucose in the blood) and insulin syringe (a sterile , single -use device for injecting insulin);3. LVN did not clean the overbed table in the isolation room and did not place a barrier before placing the cup of medication in the table;4. Resident 38's and Resident 9's toothbrush and used basins were not cleansed and labeled; and5. Certified nursing assistant L (CNA L) did not perform hand hygiene (HH - essential practice of cleaning hands to remove germs, dirt, and viruses to prevent the spread of infections either by washing with soap and water or using alcohol-based hand sanitizer) when assisting two residents with meals, and the facility's volunteer did not perform HH after handling Resident 22's used napkin and empty small cup of coffee creamer.These failures had the potential to spread infection in the facility.Findings: 1.During an initial observation on 1/20/26 at 12:49 p.m., Resident 39's room has a signage of Enhanced Barrier Precaution (EBP - infection control measures used in nursing homes and skilled nursing facilities to reduce the transmission of multidrug-resistant organisms [MDROs- microorganisms, predominantly bacteria, that are resistant to one or more classes of antimicrobial agents]) in the door with the EBP signage. The EBP requires healthcare staff to use gowns and gloves during high-contact resident care activities (e.g., dressing, bathing, changing linens). During a an observation and concurrent interview with the Skilled Nursing Facility Nurse Manager (SNF NM) on 1/21/26 at 9:439 a.m., the SNF NM stated EBP are those residents who are with chronic wound, foley catheter, no active infection. There should be available isolation cart with gowns, gloves, face shield, and the signage. The SNF NM confirmed no isolation cart was found at Resident 39's room with the EBP signage. He further stated no available isolation cart, and we ran out and had no yellow gown. The SNF NM stated the isolation cart is very important because of the potential spread of infection. Review of the CDC's Long Term Care Facilities(LTCFs) Implementation of Personal Protective Equipment (PPE) Use in Nursing Homes to Prevent Spread of Multidrug-resistant Organisms(MDROs) last reviewed 4/2/24, indicated, Enhanced Barrier Precautions: Expand the use of PPE and refer to the use of gown and gloves during high contact resident care activities that provide opportunities for transfer of MDROs to staff hands and clothing.The use of gown and gloves for high contact resident care activities indicated.examples of high -contact resident care activities requiring gown and gloves use for EBP include: Dressing, bathing's/showering, transferring , providing hygiene, changing linens , changing brief or assisted in toileting, device care or use : central line, urinary catheter , feeding tube, tracheostomy/ventilator; wound care: any skin opening requiring a dressing. https://www.cdc.gov/long-term-care-facilities/hcp/prevent-mdro/PPE.html Review of the facility's policy (P) titled, 2025-2026 Annual Infection Prevention and Control Plan and Risk Assessment dated 12/2025, the P indicated Goals, Objectives, and Performance Measure:5. (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Increase PPE compliance. IP to monitor staff for appropriate PPE in relation to applicable precautions. 2. During an observation on 1/21/26 at 11:34 a.m., with LVN D, she was observed wearing the gown, mask, and gloves then she touched her nose with her clean gloves, took the glucometer, gauze and alcohol swab placed them at the overbed table without cleaning the table and not placing a paper barrier first to check the fingerstick blood sugar (FBS) for Resident 2. After doffing (a process of removing personal protective equipment), LVN D hand sanitized and prepared the insulin syringe then did the same sequencing of putting on PPE, LVN D took the insulin syringe and alcohol swab placed in the overbed table without cleaning the table and placing a barrier first. During an interview with LVN D on 1/29/26 at 4:31 p.m., LVN D verified that she did not place a barrier on the table before placing the glucometer and insulin syringe on Resident 2's overbed table before she used it, LVN D confirmed has runny nose and touched her mask with the clean gloves. LVN D confirmed she did not follow the sequencing of putting on PPE. During an interview with the SNF NM on 1/27/26 at 4:13 p.m., the SNF NM stated the LVN D should have cleaned the overbed table before and after placing the glucometer and the insulin syringe and placed a liner and not just placed in the table because of infection control. Review of the CDC's Sequence for Putting on Personal Protective Equipment (PPE), undated, indicated Use safe work practices to protect yourself and limit the spread of contamination: Keep hands away from face. https://www.cdc.gov/infection-control/media/pdfs/Toolkits-PPE-Sequence-P.pdf 3. During the medication administration observation on 1/22/26 at 9:26 a.m., LVN A was observed preparing the medication to be administered to Resident 5's. LVN A entered the isolation room and took the overbed table outside the two rooms. LVN A placed the cup of medication without cleaning and putting a barrier on the overbed table. During an interview with the SNF NM on 1/27/26 at 4:23 p.m., the SNF NM stated that any overbed table should be clean and should place a liner before putting anything in the table. A review of PharMerica Back to Basic Medication Administration, Documentation, and Medication Storage Nurse Consulting Services revised date 6/18/25, indicated Preparation and Safety of Medication Administration: Remember anything taken into a resident's room is considered potentially contaminated. Provide a barrier (paper towel/tissue/hand towel) on resident's bedside table before setting item down. Items should be cleaned before placing back in cart. 4. During a concurrent observation and interview with licensed vocational nurse D (LVN D) on 1/20/2026 at 11:15 a.m., inside Resident 38 and Resident 9's shared bathroom, the following was observed: two toothbrushes were stored in one cup without a label of resident's name; three used basins were stored on the bathroom floor under the sink, two of the basins had white substance build up and all three had no labels; and one basin was stored on the bathroom floor at the left side of the toilet. LVN D confirmed above observations and stated all resident's items should be labeled with either their names or room numbers. She stated the basins should be cleansed and labeled after use and she was not able to state where they should be stored. During an interview with the infection preventionist (IP) on 1/27/2026 at 3:00 p.m., the IP stated resident's used basins should be cleansed and labeled, and residents should not share basins. He also (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	stated resident's toothbrush should be labeled too and stored separately. 5. During dining observation on 1/20/2026 12:33 p.m., inside the facility's social dining room, CNA L was observed assisting Resident 17 with her lunch. CNA L was seated beside Resident 17 and feeding her with the use of spoon. CNA L stood up and went to another table, did not perform hand hygiene, and assisted Resident 41 in opening a cup of Jello. CNA L went back to continue assisting Resident 17 with her meals and did not perform hand hygiene. Further dining observation on 1/20/2026 at 12:36 p.m., inside the facility's social dining room, Resident 22 handed a used napkin and an empty small cup of plastic coffee creamer to the facility's volunteer. The volunteer threw the used napkin and the empty cup of plastic creamer to the nearest garbage container in the dining room and grabbed some more of the small plastic cup creamer, did not perform hand hygiene, then handed them to certified nursing assistant M (CNA M) who assisted Resident 41 with her lunch. During a follow up interview with the volunteer on 1/20/2026 at 12:40 p.m., the volunteer confirmed above observation and stated she forgot to use the hand sanitizer. The volunteer further stated she did not attend any hand hygiene in-services, but she was a volunteer at the facility for 18 years. During another follow up interview with CNA L on 1/20/2026 at 12:44 p.m., CNA L confirmed above observation and stated she did not realize that she did not perform hand hygiene. During an interview with the IP on 1/27/2026 at 3:30 p.m., the IP stated staff should perform hand hygiene when assisting two different residents. He also stated staff should perform hand hygiene after handling dirty or soiled napkins. During a review of the facility's policy and procedure titled, Hand Hygiene and Fingernails, date revised 4/2025, indicated, Hand Hygiene and skin antisepsis are critical components of infection prevention. Healthcare personnel are believed to be the mode of transmission for most preventable healthcare-associated infections and, in many outbreaks, hands of personnel have been identified as the probable means of cross-infection. Hand hygiene has been shown to eliminate or markedly reduce hand carriage of pathogenic organisms. The scope of this policy applies to all healthcare providers of MMHS [[NAME] Memorial Healthcare System] including the contract workers, volunteers and students.		

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to offer and administer pneumococcal vaccine (PV, immunization against bacteria that causes pneumonia [a lung infection]) for three of five sampled residents (Resident 3, 5, and 20,) requiring PV vaccines, and Resident 5's missing Flu vaccine (an annual seasonal flu vaccine is the best way to help reduce the risk of getting flu and any of its potentially serious complications) in accordance with the current Centers for Disease Control and Prevention (CDC) recommendations. This failure had the potential to compromise the resident's health. Findings: 1. During a concurrent interview and record review with the Quality Nurse Coordinator (QNC) on 1/29/26 at 4:58 p.m., the QNC reviewed Resident 3's admission and immunization records. The QNC confirmed Resident 3 was admitted on [DATE] and that Resident 3 had a history of getting the pneumococcal polysaccharide vaccine (PPSV23, a vaccine that can prevent pneumococcal disease) on 11/22/2013. The QNC confirmed Resident 3's was not offered the pneumococcal conjugate vaccine 20 (PCV 20, protects against 20 types of pneumococcal bacteria) or pneumococcal conjugate vaccine 15 (PCV 15, protects against 15 types of pneumococcal bacteria that commonly cause serious infection in adults), or pneumococcal conjugate vaccine 21 (PCV 21, protects against 8 types of pneumococcal serotypes that are not included in previously recommended pneumococcal vaccines [i.e. PCV15, PCV20, and PPSV23]) which should be administered at least 1 year after as recommended by CDC. The QNC further stated it will be offered to the Resident. 2. During a concurrent interview and record review with the QNC on 1/29/26 at 4:53 p.m., the QNC reviewed Resident 5's admission and immunization records. The QNC confirmed Resident 5 was admitted on [DATE] and had a history of getting the PPSV23, on 4/23/22. The QNC confirmed Resident 5's was not offered the PCV15, PCV20, or PCV21 at least 1 year after the last dose of PPSV23 as recommended by CDC. Further review with the QNC for Resident 5's immunization records, he received Flu vaccine on 10/11/24 and no record of current flu vaccine was offered for 2025. 3. During a concurrent interview and record review with the QNC on 1/29/26 at 4:48 p.m., the QNC reviewed Resident 20's admission and immunization records. The QNC confirmed Resident 20 was admitted on [DATE] and no history of getting any pneumococcal polysaccharide vaccine. The QNC confirmed Resident 20's does not have pneumococcal polysaccharide vaccine, nor education on the importance of having vaccine on his record, she stated it was not offered the medication. The QNC further stated the facility are working on it and would offer the vaccine to the resident. During an interview with the Infection Preventionist (IP) on 1/29/26 at 4:12p.m., the IP stated it was the staff responsibility to update and document if the resident refused the vaccine. The CDC's guidance titled Pneumococcal Vaccine Timing for Adults (https://www.cdc.gov/pneumococcal/downloads/Vaccine-Timing-Adults-JobAid.pdf), Last reviewed 3/2025, indicated for adults [AGE] years old complete pneumococcal vaccine schedules who have received prior vaccine None, the CDC recommend to give PCV20 or PCV21. Prior vaccine of PPSV23 only at any age, the CDC recommend to give PCV20 or PCV21 or option B to give PCV15 dose should be administered at least 1 year after the most recent PPSV23 vaccination. The CDC's guidance titled '2025-2026 Flu Season, reviewed date 1/17/26 indicated, Flu vaccines are available for use in people 6 months and older during the flu season. Getting a yearly flu vaccination is the best way to reduce the risk from flu and its potentially serious complications. https://www.cdc.gov/flu/season/2025-2026.html# Review of the facility's policy and procedure titled, Protocol for Administering Pneumococcal Vaccine to Adults, dated 12/2025, indicated, To reduce morbidity and mortality from pneumococcal disease by vaccinating all adult patient who meet the criteria established by the Centers for Disease and Control and Prevention's Advisory Committee on Immunization Practices and to maintain compliance with California Assembly [NAME] 106, chapter 378, section 120392.9, 2007 requiring general acute care hospitals to offer pneumococcal vaccine to inpatient 65 and older. 1. Identify adults in need of vaccination with pneumococcal polysaccharide (continued on next page)		

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	vaccine (PPV) based on the following criteria: a. All adults age [AGE] years or older with no or unknown history of prior receipt of PPV. 2. Identify adults in need of a second and final dose of PPV. Review of the facility's policy and procedure titled, Protocol for Administering Inactivated Influenza Vaccine to Adults, dated 12/2025, indicated To reduce morbidity and mortality from Influenza by vaccinating all adult patients aged 18 years or older who meet the criteria established by the Centers for Disease and Control and Prevention ?s Advisory Committee on Immunization Practices. To maintain compliance with California Assembly [NAME] 106, chapter 378, section 120392.9, 2007 requiring general acute care hospitals to offer an influenza vaccine to inpatients aged 65 years or older prior to discharge during the time frame of THE Influenza season. 1. Identify adults in need of vaccination with the Influenza vaccine based on any of the following criteria: a. All persons aged 18 years or older; d. Resides in a nursing home or other chronic care facility that houses persons or any age with who have chronic medical conditions.		

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to protect a resident's rights to confidentiality of protected health information (PHI, any information in the medical record that can be used to identify an individual and that was created, used, or disclosed in the course of providing a health care service such as diagnosis or treatment) for two of 12 residents' (Residents 3, and 40) clinical records, when Licensed Vocational Nurse (LVN) F computer screen was left open and unattended in the hallway near residents 3 and 40's room during medication pass. These failures had the potential to result in unauthorized access to the resident's health information. Findings 1a. During a medication administration observation on 1/22/26, at 11: 28 a.m., the Med cart CC containing an open laptop computer was left unattended in the hallway outside of Resident 40's room. The laptop computer was on, and the screen displayed residents' information and medication records when LVN F left to check the blood sugar of Resident 40's. Then LVN F prepared the insulin medication (any pharmaceutical preparation of the protein hormone insulin that is used to treat high blood glucose) to be administered with verification of another nurse then went inside Resident 40's room and administered the insulin leaving the laptop computer still open. 1b. During a medication administration observation on 1/22/26, at 11: 47 a.m., LVN F moved the Med cart CC for the next resident, Resident 3's room. LVN F left Med cart CC containing an open laptop computer on and the screen displayed residents information and medication records unattended in the hallway outside of Resident 3's room to check the blood sugar then LVN F went back and prepared and administered Resident 3's insulin leaving the laptop computer still open. During an interview with LVN F on 1/2/26 at 3:53 p.m., LVN F confirmed the laptop computer was left open, and the screen displayed information of the residents and was left unattended while administering the medication. LVN F stated the computer should be closed all the times, especially when away from the computer. During an interview with Skilled Nursing Facility Nursing Manager (SNF NM), on 1/27/26 at 4:02 p.m., SNF NM stated computers should not be left open, it should safeguard the resident information and block the med cart in the door. SNF NM further stated if the computer left open the staff had exposed the information of the residents. Review of the facility's policy and procedure (P&P) titled, Medication Administration General Guidelines. Medication Administration: 18. Resident's health information needs to remain private. The pages of MAR notebook containing resident health information must remain closed or covered when not in direct use. Review of the facility's purpose & policy (P&P) titled, Confidentiality Policy, dated 04/2024, the P & P indicated, The purpose of this confidentiality policy is to protect the patient, the clinical team and the facility from the inappropriate use and dissemination of individually identifiable health information. Safeguarding Confidential Information: Visual: Computer screens: All [NAME] Memorial Health System (MMHS) healthcare facilities will make every effort to ensure that confidential information on computer screens is not visible to unauthorized persons. A review of the title Health Insurance Portability and Accountability Act of 1996 (HIPAA), dated September 10, 2024, indicated, HIPAA Security Rule. To comply with the HIPAA Security Rule, all covered entities must ensure the confidentiality, integrity, and availability of all e-PHI. Detect and safeguards against anticipated threats to the security of the information. Protect against anticipated impermissible uses or disclosures that are not allowed by the rule. https://www.cdc.gov/php/php/resources/health-insurance-portability-and-accountability-act-of-1996-hipaa.htm		

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to ensure resident receiving dialysis (removal of waste and excess fluid from the body) treatment received care consistent with professional standards for one of 12 sampled residents (Resident 7) when the nursing facility/dialysis unit communication reports (NF/DUCR) were incomplete. This deficient practice had the potential for Resident 7's dialysis care not being properly communicated and could put Resident 7 at risk for complications. Findings: Review of Resident 7's clinical record indicated he was admitted to the facility on [DATE] with diagnoses including end stage renal disease (kidney failure, kidney's no longer functioning on a permanent basis), hypertension (high blood pressure), Anemia in chronic kidney disease, Aortic stenosis (narrowing of the aortic valve opening), Chronic Obstructive Pulmonary Disease (COPD - a progressive incurable lung disease - primarily caused by smoking - that causes inflammation, destroyed air sacs, and restricted airflow). Review of Resident 7's NF/DUCR, the form dated 1/19/26, and 1/21/26, the dialysis unit part of the NF/DUCR were incomplete. During a concurrent interview and record review with the Skilled Nursing Facility Nurse Manager (SNF NM) on 1/27/26 at 10:50 a.m., the SNF NM reviewed Resident 7's NF/DUCRs dated 1/19/26, and 1/21/26 and he confirmed the NF/DUCRs were incomplete. The SNF NM further stated the NF/DUCRs should be filled out completely before the Resident goes to the dialysis center. The SNF NM stated NF/DUCR's is a form of communication of transfer of care to the receiving transfer facility. Review of the NF/DUCR Instructions: Nursing Facility: Complete top portion of form and send with resident to dialysis unit.		

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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 interview, and record review, the facility failed to ensure the controlled substance (drugs with high potential for abuse or addiction) medications were fully accounted for on the electronic medication administration record (eMAR) to indicate they were given for one out of four residents (Residents 29) showed that medications were signed out of the Control Drug Record (CDR, an inventory sheet that keeps record of the usage of controlled medications). This failure had the potential for access to medications and supplies by unauthorized persons such as residents and visitors. Findings: During the review of the CDRs for one (1) random resident receiving PRN (meaning as needed) medications was requested for review during the survey. A review of Resident 29's eMAR indicated to give Acetaminophen -Codeine (used to treat severe pain) Oral tablet 300 MG -30 MG (milligram, unit of dose of measurement) by mouth three times daily as needed for severe pain with start date of 10/1/25. During a concurrent interview and record review with Licensed Vocational Nurse (LVN) D on 1/21/26 at 11:13 a.m., LVN D verified one tablet of Acetaminophen -Codeine was not accounted in the CDR and no signature of nurse on the CDR. During a concurrent interview and record review with the Skilled Nursing Facility Assistant Manager/Minimum Data Set Nurse (SNF AM/MDSN) on 1/26/26 at 10:42 a.m., a review of Resident 29's eMAR for Acetaminophen -Codeine dated 1/20/2026, reflected that nursing staff signed in the eMAR on 1/20/26 at 22:43 p.m., and did not sign out in the CDR (meaning they removed the medication from the locked controlled medication compartment in the medication cart) and did not document the respective administration. The SNF AM /MDSN stated the staff should follow the policy; the nurse should sign out in the CDR at once when the medication was taken out for administration. The SNF AM /MDSN also stated both the medication administration eMAR and the CDR should reflect the medication that was given. A review of the facility's policy and procedures (P&P) titled Controlled Medication Storage dated 01/23, the P&P indicated: #7. At each shift change or when keys are surrendered, a physical inventory of all Scheduled II controlled medications is conducted by two licensed nurses or per state regulation and is documented on the controlled substances accountability record or verification of controlled substance count report. The nursing care center may elect to count all controlled substance at shift change.		