STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056463	A. Building B. Wing	08/28/2025

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Emmanuel Post Acute Care - Hayward	26660 Patrick Avenue Hayward, CA 94544

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure one of eight sampled Resident's (Resident 21) Responsible Party (RP; the party responsible for making health care decisions when the principal party is unable to make said health care decisions for him or herself) choice in Resident's hair cut was considered. This failure resulted in Resident 21 receiving an unwanted haircut and feeling terrible. During record review of admission record, printed on 8/28/25, Resident 21 was admitted on [DATE].During record review of Resident 21's Minimum Data Set (MDS, an assessment used to guide care) dated 5/25/25, indicated Resident 21's Brief Interview for Mental Status (BIMS, an assessment used to assess mental status) score was 12 out of 15, indicated Resident was mildly impaired. During record review of Resident 21's MDS, dated [DATE], section 'GG-Functional Abilities' indicated, Impairment on one side to upper and lower extremity, and Substantial/maximal assistance (Helper does MORE THAN HALF the effort, Helper lifts or holds trunk or limbs and provides more than half the effort) regarding personal hygiene (i.e. combing hair, shaving, applying makeup, washing and drying face and hands). During an observation on 08/25/2025 at 10:15 A.M. Resident 21 had knotted hair while laying on her back in bed.During an observation and interview on 08/27/2025 at 10:34 A.M. Resident 21 stated the facility cut her hair about 1 month ago against her wishes. Stated short hair makes her feel terrible because it is a cultural preference to have very long hair. Resident 21 stated she expressed to staff she did not want her hair cut and facility staff cursed at her and stated she had to cut her hair because it was too long, and she could not care for it herself. Resident 21 stated was unable to comb and maintain long hair due to right sided weakness. During an interview on 08/27/2025 at 2:11 P.M. Social Services Director (SS) 1 stated facility had a resident hair care stylist that comes on a regular basis to cut and color hair, which is extra. SS 1 stated activities check to see which residents need haircuts. SS 1 stated women haircuts depend on what they want, stated residents had the right to call outside stylist to come in and style how resident and family wish. SS 1 stated activities had a list of residents who gets/needs haircut. SS 1 stated residents can refuse haircuts and can have long hair if desired. During record review of document titled, Barber/ Beauty Invoice, it indicated Resident 21 had a haircut on 10/10/24 for $25 in facility.During record review of document titled, Beautician Services, it indicated Resident 21 was signed up for appointment dated 10/10/24.During record review of facility's policy and procedure (P&P) titled, Resident Rights, dated 5/2023, it indicated, Federal and State laws guarantee certain basic rights to all residents of this facility. These rights include the resident's right to a dignified existence.be supported by the facility in exercising his or her rights.exercise his or her rights without interference, coercion, discrimination or reprisal from the facility.During record review of facility's policy and procedure (P&P) titled, Dignity, dated 5/2023, it indicated, Residents shall be groomed as they wish to be groomed (hair styles, nails, facial hair, etc.).

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0551 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give the resident's representative the ability to exercise the resident's rights. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0551 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure one of eight sampled Resident's (Resident 21) Responsible Party (the party responsible for making health care decisions when the principal party is unable to make said health care decisions for him or herself) choice in Resident's hair cut was considered. This failure resulted in Resident 21 receiving an unwanted haircut and feeling terrible. During record review of admission record, printed on 8/28/25, Resident 21 was admitted on [DATE].During record review of Resident 21's Minimum Data Set (MDS, an assessment used to guide care) dated 5/25/25, indicated Resident 21's Brief Interview for Mental Status (BIMS, an assessment used to assess mental status) score was 12 out of 15, indicated Resident was mildly impaired. During record review of Resident 21's MDS, dated [DATE], section 'GG-Functional Abilities' indicated, Impairment on one side to upper and lower extremity, and Substantial/maximal assistance (Helper does MORE THAN HALF the effort, Helper lifts or holds trunk or limbs and provides more than half the effort) regarding personal hygiene (i.e. combing hair, shaving, applying makeup, washing and drying face and hands). During an observation on 08/25/2025 at 10:15 A.M. Resident 21 had knotted hair while laying on her back in bed.During an observation and interview on 08/27/2025 at 10:34 A.M. Resident 21 stated the facility cut her hair about 1 month ago against her wishes. Stated short hair makes her feel terrible because it is a cultural preference to have very long hair. Resident 21 stated she expressed to staff she did not want her hair cut and facility staff cursed at her and stated she had to cut her hair because it was too long, and she could not care for it herself. Resident 21 stated was unable to comb and maintain long hair due to right sided weakness. During an interview on 08/27/2025 at 2:11 P.M. Social Services Director (SS) 1 stated facility had a resident hair care stylist that comes on a regular basis to cut and color hair, which is extra. SS 1 stated activities check to see which residents need haircuts. SS 1 stated women haircuts depend on what they want, stated residents had the right to call outside stylist to come in and style how resident and family wish. SS 1 stated activities had a list of residents who gets/needs haircut. SS 1 stated residents can refuse haircuts and can have long hair if desired. During an interview on 08/27/2025 at 3:11 p.m. Activity Co-Director (ACD) stated knew who needed haircut by asking each Resident during Resident rounds, and the family decides for resident who are dependent. Stated Resident 21 never requested a haircut, has been offered and refuses hair cut when offered. During an interview on 08/28/2025 at 8:26 A.M. Responsible Party (RP) 1 stated was not informed of Resident 21 haircut before haircut and found out about hair cut when came to visit that weekend. RP 1 stated Resident 21 probably did not want her hair cut, as Resident 21 typically prefers her hair long. RP 1 stated when visits hair is sometimes tangled, unbrushed, and unwashed. RP 1 stated if facility would have considered her opinion before Resident 21's haircut she would have refused facility offered haircut treatment and/or services. RP 1 stated she maintains Resident 21 hair and color dye treatment on weekend visits. During an interview on 08/28/2025 at 9:34 A.M. Activities Staff Assistant (ACT 1) stated if Resident's cannot make decisions or cannot talk, activities staff will call Resident's Responsible Party or ask nurse if able to provide hair cut or nail care treatment (medical care, nursing care, and interventions provided to maintain or restore health and well-being, improve functional level, or relieve symptoms). During an interview on 08/28/2025 at 9:38 A.M. ACD stated asked Resident 21 if wanted haircut on today and Resident 21 refused. ACD stated she will ask Resident 21 later or will ask charge nurse and family if she can get a haircut. ACD stated Resident 21 had to get a haircut because her hair is long and had not had a hair cut in a long time. ACD stated Resident 21 had not had a haircut since 2024. ACD stated facility policy is Resident had right to have haircut, if Resident does not want a haircut, I won't cut it anymore. ACD stated should ask RP 1 for a second opinion from family, because sometimes Resident 21 is forgetful. ACD stated Resident 21 can make decisions for herself. ACD stated did not call Resident 21's to consent to haircut in October 2024, or after haircut. ACD stated it is important to contact Resident's RP about beautician treatments and services to make sure facility staff do the right thing.During record review of document titled, Barber/ Beauty Invoice, it indicated Resident 21 had a haircut on 10/10/24 for $25 in facility.During record review of document titled, Beautician Services, it indicated Resident 21 was signed up for appointment dated 10/10/24.During record review of facility's policy and procedure (P&P) titled, Consents, dated 5/2023, it indicated, In accordance with state and federal regulations, and in adherence with patient's bill of rights, facility shall obtain consent, whereby applicable and indicated, from resident and /or responsible party and/or family member for

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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 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. (continued on next page)

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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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Based on interviews and record review, the facility failed to ensure 3 out of 5 sampled residents (Residents 8, 9, and 51) were free from unnecessary psychotropic medications (drugs that affects brain activities associated with mental processes and behavior) when all three residents received psychotropic medications without documented evidence of behavioral (or non-pharmacological) interventions attempted.The employment of non-pharmacological/non-drug interventions allows the facility to minimize the need for psychotropic medications, use the lowest possible dose, or discontinue the medications. 1. A review of Resident 8's clinical record indicated he was admitted to the facility with diagnoses including schizoaffective disorder (mental illness that can affect your thoughts, mood and behavior) and bipolar disorder (a disorder associated with episodes of mood swings ranging from depressive lows to manic highs).A review of Resident 8's physician's orders indicated the following psychotropic medications:a. Lexapro (an antidepressant) 10 milligrams (mg, unit of measurement), give 1 tablet one time a day for depression manifested by sudden angry outbursts such as throwing meal tray, verbal aggressiveness towards staff and others, dated 7/11/25. b. Depakote (a medication for mood disorder) 125 mg, give 2 capsules by mouth three times a day related to bipolar disorder, dated 6/25/25. c. Seroquel (an antipsychotic medication) 300 mg, give 1 tablet by mouth at bedtime related to schizoaffective disorder manifested by inappropriate sexual behavior to female staff, dated 6/25/25.A review of Resident 8's clinical record indicated no documented evidence of non-drug interventions (such as redirection, activities, music therapy, emotional support, pain assessment, etc.) being implemented/attempted for the resident, or that they were contraindicated.During a concurrent interview and record review with the Infection Preventionist (IP 1) on 8/27/2025 at 1:06 p.m., she reviewed Resident 8's clinical record and stated, It's not there. She explained that the staff used to document these interventions on the medication administration record, but the previous director of nursing (DON) cleaned up the documentation and removed all these requirements.2. A review of Resident 9's clinical record indicated she was admitted to the facility with diagnoses including unspecified dementia (impaired ability to remember, think, or make decisions that interferes with doing everyday activities) and depression.A review of Resident 9's physician's orders included an order, dated 5/29/25, for mirtazapine (an antidepressant medication) 15 milligrams (mg, unit of measurement), 0.5 tablet at bedtime for depression manifested by poor meal intake.A review of Resident 9's clinical record indicated there was no documented evidence the facility implemented behavioral (or non-pharmacological) interventions (such as offering appetizing food or regular meal intervals, protein shakes, staff encouragement, emotional health support, etc.) before or during the use of mirtazapine. During a concurrent interview and record review with the DON and IP 1 on 8/28/25 at 1:16 p.m., IP 1 confirmed there was no documented evidence the facility implemented the non-drug interventions prior to today.3. A review of Resident 51's clinical record indicated she was admitted to the facility with diagnoses including anxiety and schizophrenia (a chronic, severe mental disorder that affects the way a person thinks, acts, expresses emotions, perceives reality, and relates to others).A review of Resident 51's physician's orders included the following:a. Risperidone (an antipsychotic) 1mg, give 1.5 tablet two times a day for schizophrenia manifested by screaming/yelling and seeing people not present that causing fear, dated 8/20/2025.b. Depakote 125 mg, give 6 capsules by mouth two times a day related to major depressive disorder, dated 8/15/25.A review of Resident 51's clinical record indicated there was no documented evidence that the facility employed non-drug interventions before or while the resident was receiving these medications or that they were contraindicated.During a concurrent interview and record review with the DON and IP 1 on 8/28/25 at 1:29 p.m., IP 1 stated the staff employed non-drug interventions such as getting the resident up on the chair, taking her to activities, leaving her be, assessing for pain, etc. whenever she exhibited behaviors, but acknowledged there was no documented evidence of any of these interventions by the staff.A review of the facility's policy and procedures titled Psychotropic Medication Use, dated June 2021, indicated: The facility should not use psychotropic medications to address behaviors without first determining if there is a medical, physical, functional, psychological, social or environmental cause of the resident's behaviors. Facility staff should take a holistic approach to behavior management that involves a thorough assessment of underlying causes of behaviors and individualized person-centered non-drug and pharmaceutical interventions. a. Facility should involve the resident or the resident's representative(s) in the discussion of potential non-drug and medication interventions to address management of behaviors and the involvement should be documented in the resident's medical record. b. Psychotropic medications may be

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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. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Based on interview and record review, the facility failed to ensure the nursing practices that met professional standards for 3 out of 31 sampled residents (Resident 49, 57, and 74) when:1.There was no blood pressure (BP) assessment prior to Lasix (a medication to treat high BP and other conditions) administration for Resident 49.2. Pain medication orders were not followed as prescribed for Residents 57 and 74.3. Elevated ammonia level (toxic waste product produced by the body's metabolism of protein) was not communicated with the physician for Resident 57.The failures resulted in medications not being given as ordered, and inadequately monitored or untreated medical conditions for the residents.1. A review of Resident 49's clinical record indicated he was admitted to the facility with diagnoses including congestive heart failure (CHF, long-term condition that happens when your heart cannot pump blood well enough to give your body a normal supply).A review of his physician's orders included an order for: Lasix 20 milligrams (mg, unit of measurement), give 1 tablet by mouth one time a day for CHF HOLD FOR SBP [systolic BP] <100. This indicated to hold the Lasix if the SBP was below 100 (normal SBP is 120).A review of Resident 49's August 2025 Medication Administration Record (MAR) indicated the nursing staff has been giving the medication daily; however, there was no corresponding BP each time they administered it.A review of the Vital Signs section in Resident 49's clinical record indicated the nursing staff only documented BP assessment 7 times from 6/8/25 to 8/18/25 (a period over 2 months): on 6/8/25, 6/11/25, 6/29/25, 7/6/25, 7/27/25, and 8/18/25. During an interview with Resident 49 on 8/27/25 at 4:31 p.m., when asked whether the nursing staff take his BP on a daily basis, Resident 49 stated, Yes. He further stated he would not take Lasix unless his BP was above 100.During a concurrent interview and record review with the Director of Nursing (DON) and the Infection Preventionist (IP 1) on 08/28/25 at 1:20 p.m., they verified there was no documentation that Resident 49's BP was obtained before Lasix administration. IP 1 explained that the order was not entered correctly for the BP to be input in the computer system. They acknowledged the computer system must require the input for staff to remember to take the BP before administering the medications, especially for those residents who could not speak for themselves.A review of the facility's policy and procedures (P&P) titled Medication and Treatment Administration, updated 5/2023, indicated, Licensed nurse shall perform tests and taking of vital signs, as indicated or required by specific medication administration or treatment administration. Results of test and taking of vital signs shall be recorded in the resident's clinical record.2a. A review of Resident 74's physician's orders indicated an order for morphine sulfate (a potent narcotic for pain) 20 mg/milliliters (mL, unit of volume), give 0.25 mL by mouth every 6 hours as needed for severe/breakthrough pain, dated 8/8/25.A review of Resident 74's August 2025 MAR indicated, on 5 occasions, the nursing staff administered the morphine when the resident's pain score was zero (scoring range, 0-10; 0 = no pain, 10 = worst pain possible).During a concurrent interview and record review with IP 1 on 8/27/25 at 12:02 p.m., she stated severe pain scale is from 7 to 10. She reviewed Resident 74's August 2025 MAR and confirmed the staff administered the morphine while the resident had zero pain, inconsistent with the physician's order.2b. A review of Resident 57's clinical record indicated he had a physician's order for Ultram (a controlled medication for pain) 50 mg, give 1 tablet every 6 hours as needed for moderate to severe pain, dated 7/2/25.A review of Resident 57's July 2025 MAR indicated the nursing staff administered the Ultram dose 15 times during this month. Of the 15 times, 9 had the pain score of zero and 1 had pain score of NA (not applicable). During a concurrent interview and record review with the DON and IP 1 on 8/28/25 at 12:57 p.m., both staff verified this finding and stated that the Ultram should not be given for a pain score of zero. They acknowledged the medication was not given as ordered.A review of the facility's P&P titled Medication and Treatment Administration, updated 5/2023, indicated, Medications and treatments shall be administered as prescribed.3. A review of Resident 57's clinical record indicated a physician's order for lactulose (medication for liver disease, to reduce ammonia level in the blood) 10 grams (gm, unit of measurement)/15 mL, give 45 mL by mouth three times a day, dated 11/17/24.Further review of Resident 57's clinical record indicated he had a physician's order to obtain an ammonia level on 5/27/25 and 6/23/25. During a concurrent interview and record review on 8/28/25 at 12:57 p.m. with the DON and IP 1, they were asked to show the ammonia laboratory results as per order. IP 1 reviewed Resident 57's clinical record and stated the ammonia level was 65 (normal value: 9-37) on 6/23/25. When asked whether the physician was notified of the elevated ammonia level, both the DON and IP 1 could not find any documentation the physician was notified. They acknowledged it should have been communicated with the physician.A review

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide necessary one to one (1:1; one staff to one resident) feeding assistance to seven out of 42 sampled residents (Residents 19,66, 67, 85, 62, 29 and 58). This failure resulted in Resident 19, 66, 67, 85, 62, 29 and 58 to be fed more than 15 minutes after meal trays were delivered to bed side.During record review of Resident 19's MDS, dated [DATE], section 'GG-Functional Abilities' indicated, Impairment on one side to upper extremity, and Dependent (Helper does ALL of the effort. Resident does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the resident to complete the activity.) regarding eating. During record review of Resident 66's MDS, dated [DATE], section 'GG-Functional Abilities' indicated, Impairment on one side to upper and lower extremity, and Substantial/maximal assistance (Helper does MORE THAN HALF the effort, Helper lifts or holds trunk or limbs and provides more than half the effort) regarding eating. During record review of Resident 67's MDS, dated [DATE], section 'GG-Functional Abilities' indicated, Impairment to both sides to lower extremity, and Dependent (Helper does ALL of the effort. Resident does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the resident to complete the activity.) regarding eating.During record review of Resident 85's MDS, dated [DATE], section 'GG-Functional Abilities' indicated, Impairment to both sides to upper and lower extremity, and Partial/moderate assistance (Helper does LESS THAN HALF the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort) regarding eating.During record review of Resident 62's MDS, dated [DATE], section 'GG-Functional Abilities' indicated, Impairment to both sides to upper and lower extremity, and Partial/moderate assistance (Helper does LESS THAN HALF the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort) regarding eating.During record review of Resident 29's MDS, dated [DATE], section 'GG-Functional Abilities' indicated, Impairment to both sides to upper and lower extremity, and Partial/moderate assistance (Helper does LESS THAN HALF the effort. Helper lifts, holds, or supports trunk or limbs, but provides less than half the effort) regarding eating.During record review of Resident 58's MDS, dated [DATE], section 'GG-Functional Abilities' indicated, Impairment to both sides to lower extremity, and Substantial/maximal assistance (Helper does MORE THAN HALF the effort, Helper lifts or holds trunk or limbs and provides more than half the effort) regarding eating.During an observation on 08/27/2025 at 12:26 PM Station two (2B; rooms 214-221) meal trays were delivered on the floor. Certified Nursing Assistant (CNA) 4 was passing meal trays to Station 2B.During an observation on 08/27/2025 at 12:33 CNA 4 placed Resident 85 meal tray at bedside but did not set-up Resident to eat.During an observation and interview on 08/27/2025 at 12:38 PM CNA 4 was delivering Station 2B Resident meal trays alone. CNA 4 stated was waiting for another CNA to return from the dining room to assist in delivering meal trays to Station 2B. CNA 4 stated Station 2B has 6 1:1 feeding Residents. CNA 4 stated she will begin 1:1 feeding with each Resident after delivering all Station 2B meal trays.During an observation on 08/27/2025 at 12:41 PM Resident 67 meal tray was placed at bedside, but Resident 67 not set up to eat. During an observation and interview on 08/27/2025 at 12:47 PM CNA 4 was feeding Resident 85. CNA stated will feed remaining five other dependent residents when complete with Resident 85.During an observation on 08/27/2025 at 12:51 PM Resident 29 was sitting up in bed with meal tray at bedside. Resident stated he was unable to feed himself and awaiting CNA assistance. CNA 4 stated resident is a 1:1 feeder. During an observation on 08/27/2025 at 12:53 PM Resident 19 meal tray was at bedside, but Resident 19 not set up to eat. During an interview on 08/27/2025 at 12:53 PM Licensed Vocational Nurse (LVN) 3 stated CNA are responsible to feed residents, and nurses assist when needed. LVN 3 stated dependent, 1:1 feeding Residents should be fed 10 minutes after their meal tray is delivered. LVN 3 Stated it is important to feed residents to help with healing.During record review of facility's policy and procedure (P&P) titled, Assistance with Meals, dated 5/2023, it indicated, Nursing staff and/or Feeding Assistants will feed those resident needing full assistance within 15 minutes of the delivery of food trays.During record review of facility's policy and procedure (P&P) titled, Assistance with Meals, dated 5/2023, it indicated, Residents who cannot feed themselves will be fed with attention to safety effort and dignity, for example.avoiding the use of labels when referring to residents, (e.g. 'feeders').During record review of facility's policy and procedure (P&P) titled, Providing Assistance with ADL Care, dated 5/2023, it indicated, Provide assistance with activities of daily living depending on the level of assistance needed and the number of person(s) needed to assist resident

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide necessary treatment and services to one of eight Residents (Resident 21) to increase and/or prevent a further decrease in range of motion (ROM; the full movement potential of a joint.). This failure resulted in Resident 21 not receiving physician ordered passive range of motion (PROM; the movement of a joint through the range of motion with no effort from the patient) exercises for two months and feeling weak.During record review of admission record, printed on 8/28/25, Resident 21 was admitted on [DATE].During record review of Resident 21's Minimum Data Set (MDS, an assessment used to guide care) dated 5/25/25, indicated Resident 21's Brief Interview for Mental Status (BIMS, an assessment used to assess mental status) score was 12 out of 15, indicated Resident was mildly impaired. During record review of Resident 21's MDS, dated [DATE], section 'GG-Functional Abilities' indicated, Impairment on one side to upper and lower extremity, and Substantial/maximal assistance (Helper does MORE THAN HALF the effort, Helper lifts or holds trunk or limbs and provides more than half the effort) regarding personal hygiene (i.e. combing hair, shaving, applying makeup, washing and drying face and hands). During an observation and interview on 8/25/2025 at 10:15 AM Resident 21 stated wants rehab, has not had it. Resident 21 stated felt weak laying in bed.During a record review of Resident 21 'Order Summary Report', dated 8/22/25, indicated RNA (restorative nursing assistance) PROGRAM for Active and Passive ROM (range of motion) on Bilateral UE/LE in all planes of motion 3x/week x 3 months to maintain CLOF and contraction prevention, dated 8/22/25. and PHYSICAL THERAPY EVALUATION AND TREATMENT AS INDICATED, dated 3/13/2025. During a record review of progress notes titled, RNA Progress Notes, dated from 06/23/25-08/25/25, indicated Resident 21 did not receive or refuse passive range of motion exercises to right extremity.During a record review of Resident 21' untitled care plan dated 08/22/25 indicated, RNA program for Active and Passive ROM on bilateral UE/LE in all planes of motion 3x/wk x 3 months to maintain contraction (structural changes to your soft and connective tissues that cause them to stiffen, tighten and contract) prevention.During an interview on 08/27/2025 at 1:27 PM Restorative Nursing Aide (RNA) stated placed Resident 21 right hand splint every day for 6-8 hour wear, and completed active ROM (the performance of an exercise to move a joint without any assistance or effort of another person to the muscles surrounding the joint) to left hand. RNA stated does not complete PROM exercises because Resident 21 cannot raise right hand. RNA stated she was aware Resident 21 had physician orders, dated 8/21/25, for active and passive ROM in all plane of motion three times per week for three months. RNA stated PROM exercises are important to help keep Resident's strength and prevent contractures. RNA stated Resident 21 never refused RNA or PROM. During record review of facility's policy and procedure (P&P) titled, Resident Mobility and Range of Motion, dated 7/2017, it indicated, Residents with limited range of motion will receive treatment and services to increase and/or prevent a further decrease in ROM.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. Based on observation, interview, and record review, the facility failed to provide care according to the facility's policy and procedures (P&P) for one of one resident (Resident 1) receiving medications via the gastrostomy tube (aka G-tube, a tube inserted through the abdomen that delivers nutrition and medications directly to the stomach). The nursing staff did not verify tube placement and check residual volume (the amount of fluid contents remaining in the stomach) prior to administering medications. In addition, the nursing staff administered the medications by pushing through the tube instead of allowing them to go down by gravity.The failures posed a risk for complications associated with enteral feeding, including aspiration (inhalation of foreign material into the lungs) due to undetected tube displacement, tube dislodgement from improper medication administration, and potential for gastrointestinal symptoms such as nausea, vomiting, and abdominal pain.During a medication pass observation on 8/26/25 at 8:55 a.m., Registered Nurse (RN) 1 was observed preparing 11 medications for Resident 1. The medications included 1 eye drop, 1 inhalation medication, 1 powder medication, and 8 solid medications that were prepared 10 cups. After finished, she brought all 11 medications along with 3 large cups of water and to Resident 1's bedside. On 8/26/25 at 9:31 a.m. at the resident's bedside, RN 1 was observed adding water to each medication cup to dilute the medications. She turned off Resident's 1's tube feeding pump, attached a 60-mililiter (mL, unit of measurement) syringe to the resident's G-tube, and started administering the medications. First, by filling the syringe with about 30 mL of water, she pushed it into the tube to flush the tubing, then she drew up each diluted medication into the syringe and pushed it into the tube with flushing of water in between the medications. RN 1 did a final flushing of the tube by pushing about 50 mL of water. During the process, water and medication liquid was observed seeping out of the tube and onto the resident's abdomen. RN 1 wiped the excess fluid off the resident's abdomen several times with tissues.During an interview on 8/26/25 at 10:03 a.m. with RN 1, when asked about checking tube placement and residual volume prior to medication administration, RN 1 responded, We have to check tube placement first, yes and check the placement with the stethoscope. She stated, I forgot. When questioned about the seeping of liquid from the G-tube and pushing water and diluted medications through the tube, RN 1 acknowledged she needed to pour in the fluids and diluted medications by gravity. During an interview with the Director of Nursing (DON) on 8/26/25 at 12:18 p.m., she stated nurses need flush and administer the medication via gravity. She added, If [the medications are] not prepared properly the tube may clog. The DON stated the nurses are to check tube placement with the stethoscope and check if there is residual volume before administering medications through the feeding tube.A review of Resident's 1, Medication Administration Record (MAR), on 8/26/25, indicated a physician's order, dated 4/2/25: Enteral Feed Order every shift verify tube placement before and after feeding and before administration of medications.A review of the facility's policy and procedure titled Administering Medications through an Enteral Tube, updated 5/2023, indicated, 8. This procedure is contraindicated if the tube is obstructed or improperly positioned, . or if bowel sounds are absent. The Steps in the Procedure are: 17. Confirm placement of the feeding tube. 18. If you suspect improper tube positioning, do not administer feeding or medication. Notify the Charge Nurse or Physician. 19. Check gastric residual volume (GRV) to assess for tolerance of enteral feeding. 20. When correct tube placement and acceptable GRV have been verified, flush tubing with 15-20 mL warm sterile water (or prescribed amount.) . 23. Reattach syringe (without plunger) to the end of the tubing. 24. Administer medication by gravity flow.a. Pour diluted medication into the barrel of the syringe while holding the tubing slightly above the level of insertion.b. Open the clamp and deliver medication slowly.c. Clamp tubing (or begin flush) before the tubing drains completely.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the provision of pharmaceutical services that included availability of medications, accurate administration of medications, safe medication storage, and accurate accountability of controlled substances (that can be easily abused and are under strict government control) when:1. Lovenox (an anticoagulant to treat blood clots) was not available for administration for Resident 34 on 6 occasions since May 2025. This had the potential for the resident to develop blood clots.2. Glipizide (a medication for diabetes) as not accurately administered as per manufacturer's specifications for 2 residents (Residents 9 and 51). This resulted in the residents not receiving the optimized therapeutic effect of the medication.3. Controlled medications were not reconciled when they were signed out of the controlled drug record (CDR, an accountability sheet of controlled medications) but not documented on the medication administration record (MAR) for 4 out of 5 residents (Residents 74, 65, 81, and 23). This resulted in facility not having accurate accountability and the potential for abuse/loss of controlled medications.4. Discontinued controlled substance medications for residents (Residents 41,74, 56 and 18) were not removed timely in 2 of 2 medication carts inspected. This failure had the potential for medication errors and abuse/loss of controlled medications.5. There were duplicate narcotic emergency drug kits (E-kit, containing scheduled II medications-controlled substance) in Station 1 Medication Room. This failure had the potential for drugs to be diverted.6. A total of 9 discontinued controlled medications for residents (Residents 6, 76, 53, 35, and 8) were stored in Station 1 Medication Room where they were accessible to multiple staff members. This failure had the potential for medication errors and loss/abuse of controlled substances. 7. Nursing staff did not consistently document E-kit checks between nursing shift changes. This failure had the potential for emergency medications to be unavailable to residents in need, and/or narcotic e-kits to be lost or diverted.8. An oral medication E-kit was opened but not replaced timely. This failure had the potential for medications not to be available to meet the needs of residents. 1. During a medication observation on 8/25/25 at 5:00 p.m., LVN 5 checked her medication cart and stated she did not have the Lovenox syringes for Resident 34; she stated it was last administered the day before, on 8/24/25. A review of Resident 34's clinical record indicated an order, dated 4/17/25, for Lovenox injection solution 40 milligrams (mg, unit of measurement), inject 1 time a day for long term deep vein thrombosis (blood clot in the deep vein) prevention. It was scheduled to be given daily at 9 a.m. On 8/26/25, a review of Resident 34's August 2025 MAR indicated the nursing staff placed a code 9 (meaning Other/See progress notes) in the entry for Lovenox administration on 8/25/25 and 8/26/25 at 9 a.m. A review of the corresponding progress notes, dated 8/26/25 at 10:31 a.m., indicated Medication in order. Another progress notes, dated 8/26/25 at 1:24 p.m., indicated in part, Resident missed Lovenox 40 mg Scheduled dose on 8/25/25 due to pharmacy delivery delay. During an interview with Resident 34 on 8/26/25 at 2:05 p.m., she stated she has not had the Lovenox injection for 2 days. She stated this has happened in the past, and it would take 2 days for the facility to order it. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 34's May 2025 MAR indicated the staff placed a 9 in the entry for Lovenox injection administration on 4 occasions: on 5/3/25, 5/6/25, 5/7/25, and 5/8/25. The corresponding progress notes on those days indicated: f/u [follow up] with pharm[[NAME]], f/u with pharm, no notes, and Not available, respectively. During a concurrent interview and record review with the Infection Preventionist (IP 1) on 8/27/25 at 11:47 a.m., she reviewed Resident 34's May and August 2025 MARs and stated a 9 code means not administered. She confirmed Resident 34's Lovenox was not available for administration on 6 occasions since May 2025 (as indicated above). A review of the facility's policy and procedures (P&P) titled Preparation and General Guidelines, dated 10/2017, indicated, Medications are administered in accordance with written orders of the attending physician. 2a. A review of Resident 9's clinical record indicated she had a physician's order, dated 5/28/25, for glipizide 5 mg, give 1 tablet two times a day before meals for diabetes. A review of Resident 9's August 2025 MAR indicated glipizide was scheduled to be administered at 8 a.m. and at 4 p.m. A review of the facility's meal schedule indicated breakfast was scheduled at 7:15 a.m. and dinner is at 5 p.m. Thus, the morning dose of glipizide was schedule after breakfast, not before meal, as ordered. During a concurrent interview and record review with the DON on 8/28/25 at 2:08 p.m., she stated glipizide is supposed to be given 30 minutes before a meal. She stated breakfast is between 7 a.m. to 7:30 a.m. She confirmed Resident 9's morning glipizide dose was scheduled after breakfast, contrary to the physician's order. A review of the 7-day administration history for Resident 9's morning glipizide dose indicated it was administered at the following times and days, all of which was after breakfast time: 9:03 a.m. on 8/28/25 8:10 a.m. on 8/27/25 8:26 a.m. on 8/26/25 8:19 a.m. on 8/25/25 8:44 a.m. on 8/24/25 8:35 a.m. on 8/23/25 8:14 a.m. on 8/22/25 (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2b. A review of Resident 51's clinical record indicated she had a physician's order, dated 2/16/24, for glipizide 10 mg, 1 tablet by mouth one time a day with meals for diabetes. It was scheduled daily at 7:30 a.m. since 2/16/24 (1.5 years ago). During a concurrent interview and record review with the DON on 8/28/25 at 2:08 p.m., she confirmed glipizide was not to be given with meals, but 30 minutes before a meal. She stated that the nurse who entered the order must have mistaken it for metformin (another antidiabetic medication). A review of the Package Insert (information about a drug and its use) for glipizide, dated 9/2008, indicated glipizide should be given approximately 30 minutes before a meal to achieve the greatest reduction in postprandial hyperglycemia [rise in blood sugar after meal]. A review of the 7-day administration history for Resident 51's glipizide indicated it was administered at the following times and days, all of which was after breakfast: 11:09 a.m. on 8/28/25 9:34 a.m. on 8/27/25 11:56 a.m. on 8/26/25 9:38 a.m. on 8/25/25 9:10 a.m. on 8/24/25 10:09 a.m. on 8/23/25 10:57 a.m. on 8/22/25 A review of the facility's P&P titled Medication and Treatment Administration, updated 5/2023, indicated, It is the policy of this facility to administer medication or treatment. within the scope of professional standards of practice. 3. During the survey, the controlled drug record (CDR, an accountability sheet of controlled medications) for 5 residents receiving as-needed medications were requested for review. During a concurrent interview and record review with IP 1 on 8/27/25 at 11:59 a.m., she stated any time a resident requests an as-needed medication, the nursing staff assesses the resident; reviews the medication order, and if within administration time frame, removes the medication from the medication cart; administers the medication; and documents the administration on the MAR. 3a. A review of Resident 74's clinical record indicated an order for morphine sulfate (a potent narcotic for pain) 20 mg/milliliters (mL, unit of volume), give 0.25 mL by mouth every 6 hours as needed for severe/breakthrough pain, dated 8/8/25. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 8/27/25 at 12:02 p.m., a review of Resident 74's CDR for morphine and August 2025 MAR with IP 1 indicated, on 6 occasions, the nursing staff signed out the morphine doses on the CDR but did not document the administration on the MAR: on 8/8/25 at 9 a.m.; 8/12/25 at 5 a.m.; 8/13/25 at 5 a.m.; 8/19/25 at 4 a.m.; 8/22/25 at 5 a.m.; and on 8/22/25 at 9 p.m. During the review, IP 1 confirmed this finding. - 3b. A review of resident 65's clinical record indicated she had a physician's order, dated 8/26/25, for lorazepam (a controlled medication for anxiety) 0.5 mg, 1 tablet every 4 hours as needed for anxiety for 14 days. On 8/27/25 at 12:15 p.m., a review of Resident 65's CDR for lorazepam and July 2025 MAR with IP 1 indicated, on 2 occasions, the nursing staff signed 1 tablet out of the CDR but did not document the administration on the MAR: on 7/7/25 at 4 a.m. and 7/24/25 at 4 a.m. IP 1 reviewed the records and confirmed the finding. 3c. A review of Resident 81's clinical record indicated a physician's order, dated 4/11/25, for lorazepam 0.5 mg, 1 tablet every 2 hours as needed for anxiety. On 8/27/25 at 12:25 p.m., a review of Resident 81's CDR for lorazepam and April and May 2025 MARs with IP 1 indicated, on 4 occasions, the nursing staff signed the medication out of the CDR but did not document the medication administration on the MARs: 4/12/25 at 5 p.m.; 5/1/25 at 5 p.m.; 5/9/25 at 4:30 p.m.; and on 5/24/25 at 5 p.m. During the review, IP 1 confirmed this finding. 3d. A review of Resident 23's clinical record indicated a physician's order, dated 5/8/25, for Dilaudid (a potent narcotic for pain) 1 mg/milliLiter (mL, unit of measurement), give 1 mL by mouth every 4 hours as needed for pain. On 8/27/25 at 12:29 p.m., a review of Resident 23's CDR for Dilaudid and August 2025 MAR with IP 1 indicated the nursing staff removed 1 dose on 8/9/25 at 5:34 p.m. without documenting the medication administration on the MAR. On 8/27/25 at 12:36 p.m., IP 1 confirmed the lack of documentation for all four residents above and stated the nursing staff need to document the medication administration on the MAR to account for these controlled medications. A review of the facility's policy and procedures (P&P) titled Controlled Medications in the Preparation and General Guidelines, dated 4/2008, indicated: When a controlled medication is administered, the licensed nurse administering the mediation immediately enters the following information on the accountability record and the medication administration record (MAR): 1) Date and time of administration. 2) Amount administered. 3) Signature of the nurse administering the dose on the accountability record at the time the medication is removed from the supply. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4) Initials of the nurse administering the dose on the MAR after the medication is administered. 4a. During an inspection of the 1B Medication Cart at 8/25/25 at 10:22 a.m. with Registered Nurse 2 (RN 2), the following 2 discontinued or expired controlled medications were found: 8 oral syringes (syringes containing, liquid medication for oral use) containing 0.125 milliliters (mL) of Morphine (a medication to relieve severe pain) 100 milligram (mg)/ 5 mL (unit of measure) for Resident 41. The pharmacy prescription label indicated, Drug Exp. (Expired) 5/21/25. 20 oral syringes containing 0.5 mL of Lorazepam (a medication commonly used for anxiety) 2 mg/ mL for Resident 41. The pharmacy prescription label indicated, Drug Exp. 6/01/25 RN 2 confirmed the finding and stated the nursing staff does not count them during shift changes, and they should have been given to the Director of Nursing (DON) right away. A review of the facility's P&P, titled Discarding and Destroying Medication updated 5/2023, indicated, . Disposal of controlled substances must take place immediately (no longer than three days) after discontinuation of use by the resident. A review of the facility's P&P, titled Controlled Substances updated 5/2023, indicated, .Nursing staff must count controlled medications at the end of each shift. The nurse coming on duty and the nurse going off duty must make the count together. 4b. During an inspection of 2A Medication Cart on 8/25/25 at 11:10 a.m. with Licensed Vocational Nurse 6 (LVN 6), the following 5 discontinued and/or expired controlled medications were found: - Two bottles of Lorazepam Intensol (liquid) 2 mg/mL, for Resident 74. One punch card containing 54 half-tablets (1/2) of Tramadol (a medication for severe pain) 50 mg, for Resident 56. A review of the pharmacy label, indicated, the medication expired (exp) 8/21/25 . One punch card containing 2 tablets of Lorazepam 0.5 mg tablets for Resident 74. . One punch card containing 20 tablets of Hydrocodone 5 mg-Acetaminophen, 325 mg (a combination medication to treat severe pain) for Resident 18. A review of the pharmacy label, indicated, the medication expired (exp.), 6/21/25. During the inspection, LVN 6 confirmed the findings. She acknowledged the controlled medications have been in the bin for a while and are to be surrendered to the DON at the end of the shift. 5. During an inspection of the Station 1 Medication Room with the DON on 8/25/25 at 2:33 p.m., two narcotic E-kits were identified in a locked drawer: one had two red seals, indicating it was unopened; the other had two yellow seals, indicating it was previously opened. The DON opened the yellow sealed kit which contained a log that indicated: One tablet of hydromorphone was removed 8/3/25 for Resident 53 One tablet of hydrocodone 5 mg/acetaminophen 325 mg was removed 8/13/25 for Resident 79. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During this inspection, the DON stated that only one narcotic kit should be stocked. She stated when the pharmacy brought a new E-kit, they did not pick up the used one. The DON stated nursing staff do not count the E-kits during shift change and acknowledged the potential for a lost/ diverted narcotic kit to go unnoticed. A review of the facility's P&P, titled Emergency Pharmacy Service and Emergency Kits, revised 1/2025, indicated, .An emergency supply of medications including emergency drugs. controlled substances.is supplied by the provider pharmacy.in limited quantities. and M. If exchanging kits, when the replacement kit arrives, the receiving nurse gives the used it to the courier for return to the pharmacy. N. If exchanging kits, the used sealed kits are replaced with the new sealed kits within 72 hours of opening. 6. During an inspection of Station 1 Medication Room with the DON on 8/25/25 at 2:44 p.m., the following 9 expired or discontinued controlled substances were in the locked drawer, co-mingled with the narcotic E-kits: One medication card containing 19 tablets of oxycodone (a medication to treat severe pain) 5 mg for Resident 6; A review of the prescription label, indicated the medication expired (exp.) 8/7/25. One medication card containing 30 tablets of hydrocodone 5mg/acetaminophen 325 mg for Resident 76. One medication card containing 28 tablets of Morphine ER (extended release) 15 mg tablets for resident 53. One bottle of Morphine oral liquid for Resident 35. One 15 mL bottle of lorazepam 2 mg/mL oral liquid for Resident 8. Pharmacy label indicated, medication expired: 6/10/25. One prescription bottle containing 9 tablets of hydromorphone 4 mg tablets for Resident 53. A total of three (3) medication cards containing half-tablets of hydromorphone (medication to treat severe pain) 2 mg for Resident 53; (1) card with 14 half-tablets (1) card with 30 half-tablets and (1) card with 25 half-tablets. During an interview with RN 3 in the presence of the DON, in Station 1 Medication Room, on 8/25/25 at 2:45 p.m., when asked if nurses count the discontinued controlled medications stored in the medication room drawer, RN 3 stated, No, we do not. During an interview with the DON on 8/25/25 at 2:51 p.m., she verified a total of 9 medication cards and bottles of controlled substances were in the locked medication room drawer. The DON stated the medications should have been given to her to store separately and not stored in the drawer where multiple staff had access and do not keep count. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	7. During an interview on 8/25/25 at 4:02 p.m. with LVN 7 in the presence of the DON, in the Station 1 Medication Room, LVN 7 stated, During shift change we check if it [E-kit] is sealed, she added it is documented in the narcotic binder. A review of the July and August 2025 logs in the station 1 medication room with the DON and LVN7, indicated some entries had circled (S) for sealed or (O) for opened and during many shift changes there were no circles, documenting the status of the kits. in July, there were 44 times where the staff did not check the E-kit during shift changes. In August 2025, there were 17 times the staff did not check whether the E-kits were opened or sealed. The DON confirmed the finding. 8. During a follow-up inspection of the station 1 medication room on 8/25/25 at 4:11 p.m. with the DON, one oral E-kit with a yellow seal, indicated the E-kit was opened. A review of the emergency kit pharmacy log (a log documenting, opened date, medication and quantity, obtained, name of the resident and provider ordering the medication) indicated the oral E-kit was opened 8/12/25 for a new order of Augmentin (an antibiotic) for Resident 101; and on 8/13/25 for a new order of doxycycline (an antibiotic) for resident 90. The DON stated the kit should have been replaced already. A review of the facility's P&P, titled Emergency Pharmacy Service and Emergency Kits, revised 1/2025, indicated, .the used sealed kits are replaced with the new sealed kits within 72 hours of opening.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. (continued on next page)

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	056463	A. Building B. Wing	08/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Emmanuel Post Acute Care - Hayward	26660 Patrick Avenue Hayward, CA 94544

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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 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility's consultant pharmacist (CP) failed to identify and report irregularities during the monthly drug regimen review (MRR) for 3 out of 31 sampled residents (Residents 9, 51, and 57) when Resident 57 received lactulose (medication to treat constipation and liver disease) for a wrong indication; and Residents 9 and 51 did not receive glipizide (medication for diabetes) as per manufacturer's specifications.The failure resulted in inadequate monitoring for effectiveness and adverse effects for Resident 57's lactulose; and Residents 9 and 51 not receiving the optimized therapeutic effect of glipizide.1. A review of Resident 57's medical record indicated Resident 57 was admitted to the facility with diagnoses that include: alcoholic liver disease (a condition of liver damage) and portal hypertension (elevated pressure in the portal vein, commonly caused by liver disease). Resident 57's Minimum Data Set (MDS, a federally mandated resident assessment tool), dated 5/29/25, indicated Resident 57 has no cognitive impairment.A review of Resident 57's medical record indicated Resident 57 had the following physician order: - Lactulose 10 grams (gm, unit of measurement)/ 15 milliliters (mL, unit of volume), give 45 mL by mouth three times a day for constipation Hold if more than 3 bowel movements daily, dated 11/17/24 (9 months ago).During an interview on 8/27/25 at 9:27 a.m. with Resident 57, when asked about the lactulose medication, Resident 57 said, Oh, that is for my liver. The resident added he has been on the medication for four years.During an interview and record review with the MDS Coordinator (MDS C) on 8/27/25 at 1:15 p.m., when asked about indication for Resident 57's lactulose, MDS C stated it is for constipation. Upon further review of Resident 57 ‘s clinical record, the MDSC stated the hospital Discharge summary, dated [DATE], indicated the lactulose was used for alcoholic cirrhosis with portal hypertension. She confirmed the facility had the wrong indication for Resident 57's lactulose. During a concurrent interview and record review on 8/28/25 at 12:57 p.m. with the DON and the Infection Preventionist (IP 1), when asked about the medication monitoring for lactulose (such as labs and liver disease), IP 1 stated monitoring had not been done as the lactulose had the wrong indication.During a telephone interview with the CP on 8/28/25 at 2:40 p.m., the CP stated the dose of 45 mL three times a day, is higher than usual for constipation; the medication is for hepatic encephalophagy (a condition of liver damage, associated with a buildup of toxins). When asked whether she identified this wrong indication as an irregularity and reported to the facility, she stated, No. She stated she just started servicing the facility in June this year, and her focus was on psychotropic medications and not on this.2. A review of the Package Insert (information about a drug and its use) for glipizide, dated 9/2008, indicated glipizide should be given approximately 30 minutes before a meal to achieve the greatest reduction in postprandial hyperglycemia [rise in blood sugar after a meal].A review of Resident 9's clinical record indicated she had a physician's order, dated 5/28/25, for glipizide 5 mg, give 1 tablet two times a day before meals for diabetes. A review of Resident 9's August 2025 MAR indicated glipizide was scheduled to be administered at 8 a.m. and at 4 p.m.A review of the facility's meal schedule indicated breakfast was scheduled at 7:15 a.m. and dinner is at 5 p.m. Thus, the morning dose of glipizide was schedule after breakfast, not before meal, as ordered.During a concurrent interview and record review with the DON on 8/28/25 at 2:08 p.m., she stated glipizide is supposed to be given 30 minutes before a meal. She stated breakfast is between 7 a.m. to 7:30 a. m. She confirmed Resident 9's morning glipizide dose was scheduled after breakfast, contrary to the physician's order.A review of the 7-day administration history, from 8/23/25 to 8/28/25, for Resident 9's morning glipizide dose indicated it was administered from 8:14 a.m. to 9:03 a.m. during these days, after breakfast time. A review of Resident 51's clinical record indicated she had a physician's order, dated 2/16/24, for glipizide 10 mg, 1 tablet by mouth one time a day with meals for diabetes. It was scheduled daily at 7:30 a. m. since 2/16/24 (1.5 years ago).During a concurrent interview and record review with the DON on 8/28/25 at 2:08 p.m., she confirmed glipizide was not to be given with meals, but 30 minutes before a meal. A review of the 7-day administration history, from 8/22/25 to 8/28/25, for Resident 51's glipizide indicated the earliest it was administered was 9:10 a.m. and latest at 11:09 a.m.During a telephone interview with the CP on 8/28/25 at 2:40 p.m., when asked whether she identified the wrong scheduled administration time for Resident 9's and Resident 51's glipizide as irregularities in her monthly MRR for the residents, the CP stated, It's something I would have caught this month, but haven't caught yet. It hasn't been the focus of my recommendations.A review of the facility's policy and procedures (P&P) titled Consultant Pharmacist Services Provider Requirements, dated 10/2017, indicated: The consultant pharmacist provides consultation

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident’s drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure one of 31 sampled residents (Resident 57) was free from unnecessary medications. Resident 57 received lactulose (a medication commonly used for liver disease) for a wrong indication for use.This failure resulted in an inadequate treatment plan and insufficient monitoring for medication effectiveness and adverse outcomes related to liver disease.A review of Resident 57's medical record indicated Resident 57 was admitted to the facility with diagnoses that include: alcoholic liver disease (a condition of liver damage) and portal hypertension (elevated pressure in the portal vein, commonly caused by liver disease). Resident 57's Minimum Data Set (MDS, a federally mandated resident assessment tool), dated 5/29/25, indicated Resident 57 has no cognitive impairment.A review of Resident 57's medical record indicated Resident 57 had the following physician order:Lactulose 10 gram (gm, unit of measurement)/ 15 milliliters (mL, unit of volume), give 45 mL by mouth three times a day for Constipation Hold if more than 3 bowel movements daily, dated 11/17/24.During an interview on 8/27/25 at 9:27 a.m. with Resident 57, when asked about the lactulose medication, Resident 57 said, Oh, that is for my liver. The resident added he has been on the medication for four years.During an interview and record review on 8/27/25 at 1:15 p.m. with the MDS Coordinator (MDS C) when asked about indication for Resident 57's lactulose, MDS C stated, it is for constipation. Upon further review of Resident 57 ‘s clinical record, the MDSC stated the hospital Discharge summary, dated [DATE], indicated the lactulose was used for alcoholic cirrhosis with portal hypertension. She confirmed the facility had the wrong indication for Resident 57's lactulose.During a concurrent interview and record review on 8/28/25 at 12:57 p.m. with the DON and the Infection Preventionist (IP 1), when asked about the medication monitoring for lactulose, IP 1 stated monitoring had not been done, as the lactulose had the wrong indication.During a telephone interview on 8/28/25 at 2:40 p.m. with the Consultant Pharmacist (CP), when asked about the lactulose indication for Resident 57, the CP stated the dose 45 mL three times a day, is higher than usual for constipation; the medication is for hepatic encephalophagy (a condition of liver damage, associated with a buildup of toxins). A review of the facility's Policy and Procedure titled Medication Administration-General Guidelines, effective date 10/17, indicated,.If a dose seems excessive considering the resident's age and condition, or a medication order seems to be unrelated to the resident's current diagnosis or conditions, the nurse calls the provider pharmacy for clarification prior to administration of the medication, or if necessary contacts the prescriber for clarification.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility had a medication error rate of 15.15% when five medication errors occurred out of 33 opportunities during the medication administration for three out of eight residents (Residents 62, 70 and 1).Resident 62 received an insulin (medication to lower blood sugar) dose via insulin pen without the pen being primed prior to administration. Resident 70 did not receive two medications as scheduled; and Resident 1 did not receive two medications as prescribed.The failures resulted in the residents not receiving medications as prescribed and had the potential for complications of their medical conditions (such as high/low blood sugar, breathing problems or blood clots). 1. During a medication observation on 8/25/25 at 4:38 p.m. with Licensed Vocational Nurse (LVN) 4, she was observed removing Resident 62's Humalog Kwikpen (a pre-filled insulin pen containing a short-acting insulin called insulin lispro, used to treat high blood sugar) from the medication cart. LVN B stated she will give 6 units of insulin lispro for a blood sugar reading of 256.On 8/25/25 at 4:41 p.m. at Resident 62's bedside, LVN 4 dialed the pen to 6 units and injected the Humalog into the resident's right abdomen. LVN 4 did not prime the pen prior to administering the insulin dose to the resident.During an interview on 8/25/25 at 4:54 p.m., when asked about priming the insulin pen, LVN 4 stated she did not know how and had not done it before.A review of Resident 62's clinical record indicated a physician order, dated 6/25/25, for insulin lispro solution, to inject per sliding scale (a set of instructions for administering insulin dosages based on specific blood glucose readings), to give 6 units for blood sugar between 250 - 299.During an interview on 8/26/25 at 12:07 p.m. conducted with the Director of Nursing (DON) regarding the priming of insulin pens, she stated to prime the needle first, pushing the liquid out before administering the pen. A review of the drug manufacturer's INSTRUCTIONS FOR USE HUMALOG ([NAME]-ma-log) KwikPen, dated 7/2023, indicated the following instructions for priming the pen:Prime before each injection, priming your Pen means removing the air from the Needle and Cartridge that may collect during normal use and ensures that the Pen is working correctly. If you do not prime before each injection, you may get too much or too little insulin.To prime you Pen, turn the Dose Knob to select 2 units .Hold your Pen with the Needle pointing up. Tap the Cartridge Holder gently to collect air bubbles at the top .Continue holding your Pen with Needle pointing up. Push the Dose Knob in until it stops, and '0' is seen in the Dose Window .Turn the Dose Knob to select the number of units you need to inject .A review of the facility's policy and procedures (P&P) titled Use of Prefilled Insulin, updated 2025, indicated, Attach a new, sterile needle for each use .Prime the pen (usually 2 units) to ensure proper insulin flow.2. During a medication pass observation on 8/25/25 at 5:02 p.m., LVN 5 was at the medication cart preparing six medications for Resident 70. LVN 5 stated the resident's Flovent inhaler (an inhaled steroid to reduce lung inflammation) and Xarelto (an anticoagulant) were unavailable at this time. She stated she will check the medication room later.On 8/25/25 at 5:30 p.m. in the medication room, LVN 5 looked for the medications and stated they are not here. A review of Resident 70's medical record indicated Resident 70 had the following physician orders:- Xarelto oral tablet 10 milligram (mg, unit of measurement), give one tablet by mouth for CVA (cerebral vascular accident, also known as stroke)/ DVT (deep vein thrombosis, also known as blood clots), dated 2/11/23. It was scheduled daily at 5 p.m. - Flovent HFA 110 microgram/actuation (mcg unit of measurement), 1 puff inhale orally two times a day for COPD (chronic obstructive pulmonary disease, damage to the lungs), dated 5/2/22. It was scheduled daily at 9 a.m. and 5 p.m.On 8/26/25 at 10:45 a.m., a review of Resident 70's August 2025 Medication Administration Record indicated LVN 5 placed a 9 (meaning the medication was not administered and other/ see progress notes) in the entry for 8/25/25 at 5 p.m. administration for Xarelto and Flovent HFA. A review of the nursing progress notes, written by the Infection Preventionist (IP 1) on 8/25/25 at 7:12 p.m., indicated Xarelto 10 mg and Flovent HFA . will be delivered to the facility between 7:30 to 9:30 tonight. Nurse Practitioner notified.During an interview with the DON on 8/26/25 at 12:07 p.m., the DON acknowledged Resident 70's Flovent HFA and Xarelto were not given on 8/25/25 at 5 p.m. as scheduled.3. During a medication pass observation on 8/26/25 at 8:55 a.m., Registered Nurse (RN) 1 was observed preparing 7 medications for Resident 1. The 7 medications were an inhalation unit dose for breathing treatment, a tablet of cholecalciferol 25 micrograms (mcg) (Vitamin D supplement), a tablet of docusate (a stool softener) 100 mg and four other medications in tablet form. RN 1 crushed each tablet form medication and put them in individual medication cups. During the preparation, RN 1 was unable to locate one medication, placed the prepared medications in the locked

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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. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Based on observation, interview and record review, the facility failed to ensure proper labeling and storage of medications according to the facility policy and procedures (P&P) and/or manufacturer specifications in two of two medication carts and two of two medication rooms when:Three unopen bottles of latanoprost (a medication for glaucoma) eye drops and an unopened insulin lispro (a pre-filled insulin pen containing a short-acting insulin called insulin lispro, used to treat high blood sugar) pen were found stored at room temperature.Two opened containers of glucose test strips and an opened vial of tuberculin purified protein derivative (PPD, protein substance used to diagnosis tuberculosis (TB), an infection in the lungs) were not dated with an open date.An opened bottle of fluticasone (an over-the-counter nasal spray, used for seasonal allergies) was without a label to indicate whom it was for.An opened, Advair (an inhaler containing medication to manage long-term breathing problems) for Resident 12, and a vial of PPD were found expired. These failures had the potential for medication errors and/or medications given beyond their effective dates, which would be ineffective for the residents. 1. During an inspection of 1B Medication Cart on 8/25/25 at 9:43 a.m., the following were identified and confirmed with registered nurse (RN) 2: a. Three unopened bottles of latanoprost eye solution bottles for Residents 36, 38 and 2 were stored at room temperature in the cart. The pharmacy labels indicated, Refrigerate. There was no date indicating when they were left at room temperature.During a review of the manufacturer's prescribing information for latanoprost, revised 9/24, indicated, Storage.store unopened bottle(s) under refrigeration at 36 to 46 degrees Fahrenheit (F) (temperature scale) .the bottle may be maintained at temperatures up to 104 degrees F for a period not exceeding 8 days. Once a bottle is opened for use, it may be stored at room temperature (77 degrees F) for 6 weeks.b. One unopen insulin lispro pen for Resident 36, stored at room temperature in the cart. There was no date indicating when it was left at room temperature. The pharmacy label indicated, refrigerate until used. Once in use, store at room temperatureDuring a review of the manufacturer's instructions for use for insulin lispro pen, revised 7/23, indicated, Storing your pen, Unused Pens, Store unused pens in the refrigerator at 36 degrees F to 46 degrees F.Unused pens may be used until the expiration date printed on the label if the pen has been kept in the refrigerator. In-use pens, store.at room temperature.throw away the .pen.after 28 days, even if it still has insulin left in it.c. One open bottle of glucose test strips (strips used to measure blood sugar level). There was no date indicating when the bottle was opened. A review of the manufacturer's label printed on the label with RN 2 indicated to use within 6 months after first opening. d. One open bottle of fluticasone nasal spray without any patient identifiers or labeling. RN 2 confirmed he did not know to whom the medication belonged. A review of the facility's P&P titled Medication Labels, effective 4/2014, indicated Nonprescription medications not labeled by the pharmacy are kept in the manufacturer's original container and identified with the resident's name. 2. During an inspection of the 2A Medication Cart on 8/25/25 at 10:54 a.m. with LVN 6, one Advair Diskus for Resident 12 was identified with the date open of 7/21/25. A review of the product labeling from the manufacturer with LVN 6 indicated to discard inhaler one month after opening the foil pouch. LVN 6 verified this finding and acknowledged the medication expired on 8/21/25. The inspection with LVN 6 also identified an open glucose test strip vial without open date. A review of the manufacturer's patient information for Advair Diskus, revised 6/2023, indicated, .throw away Advair Diskus.1 month after you open the foil pouch or when the counter reads 0, whichever comes first. 3. During an inspection of Station 1 Medication Room on 8/25/25 at 2:18 p.m. with the Director of Nursing (DON), an open PPD vial with an open date of 7/24/25 was identified in the refrigerator. A review of the product labeling with the DON indicated, Once entered, vial should be discarded after 30 days. The DON verified the PPD vial was expired. 4. During an inspection of Station 2 Medication Room on 8/25/25 at 4:18 p.m. with the DON, an open PPD vial without the open date was identified in the refrigerator. The DON confirmed the finding and acknowledged it should have an open date. A review of the facility's P&P titled Storage of Medications, updated 5/2023, indicated in part, 2. The nursing staff shall be responsible for medication storage. in a.safe. manner. 3. Drug containers that have missing, incomplete, improper, or incorrect labels shall be returned to the pharmacy for proper labeling before storing. 4. The facility shall not use.outdated.drugs. Medications requiring refrigeration must be stored in a refrigerator.

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. Based on observation, interview and record review, the facility failed to prepare one out of 42 (Resident 60) Resident meal tray according to resident preferences. This failure resulted in Resident 60 receiving lunch tray without double portion of protein, per Resident preferences. During record review of Resident 60's Minimum Data Set (MDS, an assessment used to guide care) dated 05/17/25, indicated Resident 60's Brief Interview for Mental Status (BIMS, an assessment used to assess mental status) score was 00 out of 15, indicated Resident 60 had severe cognitive impairment. During an observation on 08/26/2025 at 12:32 PM Resident 60 tray was prepared and placed on meal tray cart for delivery but was not given extra protein as listed on meal tray card. During an observation and interview on 08/26/2025 at 12:39 PM, the Registered Dietitian (RD) and Dietary Manager (DM) stated Resident 60 was not given double protein, per photo, as listed in Resident's preferences. DM stated it is important for Residents to receive meals they prefer because it is their right. During record review of Resident 60 meal tray card, it indicated Resident 60's 'likes' included, Extra protein, pickles, crackers and soup.During record review of facility's undated policy and procedure (P&P) titled, Resident Food Preferences, it indicated, The dietitian and nursing staff, assisted by the physician, will identify any nutritional issues or dietary restrictions that might affect the facility's efforts to accommodate resident preferences. Whenever possible, the staff and physicians will strive to minimize dietary restrictions in order to accommodate those preferences. In conjunction with the physician, the Dietitian or nursing staff will document reasons why restrictions are necessary and/or why the facility cannot accommodate resident preferences.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, record review, the facility failed to maintain walk in freezer temperature below zero degrees Fahrenheit. This failure had the potential to spread foodborne illnesses to all residents. During an interview and observation on 08/26/2025 at 10:04 AM the walk-in freezer in kitchen thermometer read 10 F. Dietary Manager (DM) placed a new thermometer. DM stated staff use the largest thermometer to document onto temperature log. Largest thermometer read 10 F. Touch tested ice cream, broccoli, donuts, chicken, fries, diced carrots, meat patties, all items frozen hard/solid. During an observation on 08/26/2025 at 10:10 AM walk-in freezer thermometer read 8 F on two separate thermometers. During an observation on 08/26/2025 at 11:34 AM the walk-in freezer temperature read 8 F on two separate thermometers. During an observation and interview on 08/26/2025 at 11:50 AM the Maintenance Director (MTD) stated freezer temperature felt fine. MD stated walk-in freezer temperature should be below zero to keep food frozen and keep food safe. The walk-in freezer temperature read 10 F on two separate thermometers. During an interview on 08/28/2025 at 8:46 AM MTD stated walk-in freezer in kitchen was serviced (perform routine maintenance) monthly but has not been serviced since February 2025 due to change in Maintenance Director.During an observation on 08/28/2025 at 8:51 AM walk-in freezer temperature was 8 F.During an observation on 08/28/2025 at 5:16 PM walk-in freezer temperature was 8 F on two thermometers and 2 F on one thermometer. DM stated MTD is aware and working on freezer temperature.During a review of facility's undated policy and procedure (P&P) titled, Refrigerators and Freezers, the P&P indicated, The supervisor will take immediate action if temperatures are out of range. Actions necessary to correct the temperature will be recorded on the tracking sheet, including the repair personnel and/or department contacted.During a review of facility's undated policy and procedure (P&P) titled, Refrigerators and Freezers, the P&P indicated, Supervisors will inspect refrigerators and freezers monthly for gasket condition, fan condition, presence of rust, excess condensation, and any other damage or maintenance needs. Necessary repairs will be initiated immediately. Maintenance schedules per manufacturer guidelines will be scheduled ad followed.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on observation, interview, and record review, the facility staff failed to employ appropriate infection control practices during the medication administration for 1 out of 8 residents (Resident 1) when:1. Registered Nurse (RN) 1 did not wear a protective gown while administering medications via the resident's gastrostomy tube (aka G-tube, a tube inserted through the abdomen that delivers nutrition and medications directly to the stomach), a practice inconsistent with the facility's enhanced barrier precautions (EBP) policy. 2. RN 1 did not change gloves and perform hand hygiene between care and after touching surfaces and going in and out of Resident 1's room. The failures had the potential to increase the risk of cross-contamination and infections, compromising patient safety.1. During medication pass observation on 8/26/25 at 9:20 a.m. RN 1 was observed putting Resident 1's medication in a plastic bag and individually crushing each oral medication. She prepared a total of 11 medications for Resident 1, including an eye medication called Artificial Tears (to lubricate the eye) and one inhalation medication.During this medication observation with RN 1, a large orange poster sign was observed affixed on Resident 1's room door indicating, ENHANCED BARRIER PRECAUTIONS EVERYONE MUST: Clean their hands, including before entering and when leaving the room. PROVIDERS and STAFF MUST ALSO: Wear gloves and a gown for the following High-Contact Resident Care Activities . Device care or use: .feeding tube.On 8/26/25 at 9:28 a. m. RN 1 entered Resident's room wearing only a surgical mask and gloves and no protective gown. RN 1 proceeded to administer the medications to the resident.During an interview on 8/26/25 at 10:02 a.m., when asked whether she should have worn a gown to administer medications for Resident 1 who received medications via the G-tube, RN 1 stated, I am not sure. She stated the EBP was for Resident 1's roommate. During an interview with the Director of Nursing (DON) on 8/26/25 at 12:18 p.m., the DON stated nurses need to use EBP for residents with feeding tubes.A review of the facility's policy and procedures (P&P) titled, Enhanced Barrier Precautions, dated 8/2024, indicated . 2. EBPs employ targeted gown and glove use in addition to standard precautions during high contact resident care activities when contact precautions do not otherwise apply. 3. Examples of high-contact resident care activities requiring the use of gown and gloves for EBPs include: .g. device care or use (., feeding tube .)5. EBPs are indicated (when contact precautions do not otherwise apply) for residents with wounds and/or indwelling medical devices regardless of MDRO colonization.b. Indwelling medical devices include . feeding tubes .11. Signs are posted in the door or wall outside the resident room indicating the type of precautions and PPE required. 2. During medication pass observation on 8/26/25 at 9:40 a.m. at Resident 1's bedside RN 1, wearing gloves was observed pushing diluted medications through the resident's feeding tube, excess liquid from the tube dripped on to the resident's abdomen. RN 1 used tissue to wipe up the excess fluid and continued accessing the tube, flushing the tube and administering medications without changing her gloves.On 8/26/25 at 9:42 a.m., RN 1 was observed exiting Residents 1, did not perform hand hygiene, went to the medication cart outside of the room, to obtain several spoons. She then came back into the room, without changing gloves or performing hand hygiene, mixed each medication with water, drew it up and pushed the medications through the resident's G-tube.On 8/26/25 at 9:50 a.m., RN 1 was observed leaving Resident 1's room with gloves on, did not engage in hand hygiene, and returned with two full cups of water. At 9:52 a.m., RN 1 was back at Resident 1's bedside, added water to mix MiraLAX (a powdered laxative) and another medication, and proceeded to push the medication down the tube with water flushes between while wearing gloves. Again, excess fluid was observed dripping from the tube onto the resident's abdomen, RN 1 wiped the excess fluid with a tissue. This process was repeated several times during the medication administration.On 8/26/25 at 9:55 a.m. at the resident's bedside, shortly after finishing with the medication administration via G-tube, RN 1 was observed adjusting the resident's tubing and pulling the resident's blanket to cover her chest while wearing the same gloves as before. She then pressed the bed remote to lower the head of the bed and proceeded to give the resident the Artificial Tears, into each eye without changing gloves or performing hand hygiene.During an interview on 8/26/25 at 10:02 a.m., RN 1acknowledged she used tissues to wipe up the fluids from the tube several times and she should have changed her gloves. She also acknowledged she came in and out of the room without changing gloves. RN 1 also confirmed she wore the same gloves between the G-tube and eye medication administration; she stated she should have performed hand hygiene and changed gloves before administering the resident's eye drops.During an interview on 8/26/25 at 12:18 p.m. with DON, the DON stated nursing staff are to perform hand hygiene before administering medications via G-tube and before