STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056483	A. Building B. Wing	03/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sherwood Oaks Post Acute Care, LLC	130 Dana Street Fort Bragg, CA 95437

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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 - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure one of thirteen sampled residents (Resident 16) received quality nursing care that was resident-centered, based on a comprehensive assessment, and in accordance with her goals of care, as indicated in her Nursing Care Plan (a document that contains essential information about a patient's condition, diagnosis, goals, interventions, and outcomes) when she experienced intermittent constipation (problem passing stool; associated with hardened feces [stool]; generally passing less than three stools per week) from 12/1/25 through 1/3/26, but nursing staff: 1. Did not treat her constipation with PRN (given as needed or requested) medication ordered by her physician; 2. Did not notify her physician when she was constipated despite receiving her regularly scheduled medication for constipation; and 3. Did not perform weekly nursing assessments (systematic, continuous collection of data to create a patient-centered care plan) after 8/31/2025 through 2/28/2026.These failures caused Resident 16: 1. To develop a large fecal impaction (hard stool that becomes stuck in the rectum [the final segment of the large intestine; primary function is to temporarily store feces] or colon [large intestine]), that placed her at risk for bowel (intestine) perforation (a hole or tear in the wall of the small or large intestine that allows intestinal contents to leak into the abdominal cavity, creating a life-threatening medical emergency); 2. To be transferred to the local hospital where she was admitted from 1/3/26 to 1/5/26; 3. To experience bladder (organ that stores urine) distention (an enlarged, stretched bladder caused when urine cannot empty properly) due to obstruction (blockage); this in turn necessitated placement of a Foley catheter (indwelling tube inserted into the bladder to continuously drain urine into a collection bag); and 4. To have her stool manually disimpacted (physical removal of hard, impacted stool from the rectum using a lubricated, gloved finger). Findings: A review of Resident 16's facesheet (front page of the medical record that contains a summary of basic information about the resident) indicated she was ninety years old and admitted on [DATE] with diagnoses of severe dementia (a progressive state of decline in mental abilities) with agitation, delusional disorders (having false or unrealistic beliefs), and fecal impaction.A review of Resident 16's Minimum Data Set (MDS- a federally mandated resident assessment tool), dated 9/24/25, indicated Resident 16 had severe cognitive impairment (a decline in mental abilities such as memory, reasoning, language, and judgment), was always incontinent (involuntary loss of bladder/bowel control, causing leakage of urine/feces) of urine and stool, and required substantial/maximal assistance from staff for toileting hygiene (the ability to maintain hygiene before/after voiding and bowel movements).Review of Resident 16's medical record revealed a document titled, Task: B&B - Bowel. Elimination. (CNA documentation of bowel activity), dated 11/3/2025 through 3/4/26, that indicated Resident 16 had nine bowel movements (BMs) in December 2025 (12/1/25, 12/10/25, 12/13/25, 12/14/25, 12/20/25 [two BMs],12/23/25, 12/27/25, and 12/28/25). The document indicated Resident 16 had no documented BMs for eight consecutive days (between 12/1/25 and 12/10/25) and no documented BMs for five consecutive days (12/29/25 - 1/3/26), immediately prior to her ED transfer.Review of Resident 16's medical record revealed Medication Administration Records (MARs; a daily documentation record used by a licensed nurse to document medications and treatments given to a (continued on next page)

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

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F 0684 Level of Harm - Actual harm Residents Affected - Few	resident), dated 12/1/25 - 12/31/25 and 1/1/26 through 1/3/26 (approximately five weeks prior to her hospital transfer), that indicated her physician ordered the following medication to be given on a scheduled/daily basis: Polyethylene Glycol 3350 Powder. give 17 gram by mouth in the morning for constipation. Start Date 8/8/24. and Seroquel [antipsychotic medication primarily used to treat psychosis and related mental health conditions] oral tablet. Give 25 mg [milligram] by mouth in the morning related to delusional disorder. Start date- 06/20/2025. Seroquel oral tablet. give 50 mg by mouth in the afternoon. Start date- 06/20/2520. Seroquel oral tablet 100 mg. give 1 tablet by mouth at bedtime . Start date- 09/05/2024 . D/C [discontinue] date-12/15/2025. Seroquel oral tablet 100 mg . give 1 tablet by mouth at bedtime. Start date- 12/15/2025. D/C date- 01/06/2026.Continued review of Resident 16's MAR, dated 12/1/25 - 12/31/25 and 1/1/26 through 1/3/26, indicated her physician ordered the following medication to be given on a PRN basis: Percocet [narcotic pain medication containing oxycodone] oral tablet 5-325 mg. Give 1 tablet orally every 6 hours as needed for severe pain -Start Date- 01/30/2024. Nursing staff documented Percocet was administered on 12/1/25, 12/2/25, 12/3/25, 12/5/25, 12/6/25, 12/8/25, 12/10/25, 12/12/25, 12/13/25, daily from 12/16/25 - 12/20/25, 12/21/25, 12/23/25, 12/26/25 and 12/27/25.Continued review of Resident 16's MAR, dated 12/1/25 - 12/31/25 and 1/1/26 through 1/3/26, indicated her physician ordered the following medications for constipation: Milk of Magnesia [MOM; liquid medication to treat constipation] suspension.30 ml. give 1 each by mouth as needed for NO BM x3 [for three] DAYS. Admin. [administrator] as ordered. If no results from MOM, proceed to Supp Tx. [suppository treatment with Dulcolax] as ordered . -Start Date- 01/30/2024. Dulcolax Suppository [medication to relieve constipation, inserted into the rectum] 10 mg. Insert 1 each rectally as needed for no results from MOM . -Start date- 03/07/2023. Fleet Enema [liquid medication to treat constipation, injected into the rectum] .Insert 1 each rectally as needed for no result from Supp TX. [Dulcolax suppository treatment] . If no BM, notify M.D. [medical doctor] immediately. Start date- 03/07/2023. Senna [laxative] Oral Tablet 8.6 mg. Give 1 tablet by mouth every 12 hours as needed for constipation -Start Date- 03/06/2023. Nursing staff did not document administration of MOM, Dulcolax Suppository, Fleet Enemas, or Senna from 12/1/25 through 1/3/26.Review of Resident 16's medical record revealed a MAR, dated 12/1/25 - 12/31/25 and 1/1/26 through 1/3/26, contained the following order: Monitor every shift for side effects of Seroquel: . constipation. -Start date- 03/07/2023.Review of Resident 16's nursing care plan, initiated 5/1/25 with target date 4/6/26, indicated, The resident is on pain medication therapy: Percocet. the resident will be free of any discomfort of adverse side effects from pain medication. The care plan interventions indicated, . Monitor/document side effects. Q-Shift [every shift] . Ask physician to review medication if side effects persist. Report [to physician] PRN adverse reactions . constipation.Review of Resident 16's nursing care plan, revised on 8/13/25 with target date 4/6/26, indicated, The resident uses psychotropic [drugs that affect behavior, mood, thoughts, or perception] medications [Seroquel.] . The resident will be/remain free of psychotropic drug related complications including . constipation/impaction. The care plan interventions indicated, . Monitor for side effects. Q-Shift. Monitor/document/report PRN [as necessary] any adverse reactions of Psychotropic medications.Review of Resident 16's medical record revealed a nurse progress note (documentation of a resident's clinical status, response to treatment, and care updates), dated 1/3/26 at 1:58 a.m., that indicated, . Pt [patient, Resident 16] was complaining of nausea and abdominal pain. projectile vomited onto the floor. proceeded to have more episodes of emesis [vomiting]. Send to acute [hospital] for further evaluation and treatment.Review of Resident 16's hospital History and Physical Examination, subtitled, History of Present Illness, dated 1/3/26 at 4:16 p.m. and written by Physician N, indicated, . Patient [Resident 16] has chronic constipation. she vomited once this morning. Nasogastric tube [tube inserted through the nose into the stomach for stomach decompression] was introduced [put into her stomach, through her nose] . The CT [CT scan] of the abdomen also demonstrated a very large fecal impaction which in turn is compressing the neck of the bladder [lower part of the bladder that controls urine flow] so that she has a very (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	distended bladder. Foley catheter was placed. I discussed the case with Physician P, our general surgeon. Under the subtitle, Assessment/Plan, the physician indicated, . 3. Fecal impaction. she will need manual disimpaction. 4. Distended bladder. I think this is due to the large amount of stool in her rectum compressing the neck of the bladder. A Foley catheter is in place and is draining (urine) well and we will continue that in place until [sic] get the fecal impaction resolved.Review of Resident 16's hospital Discharge Summary (outline of the key details of a patient's hospital stay), subtitled, Final Diagnosis, dated 1/5/26 at 9:40 a.m. and written by Physician O, indicated, 2. Fecal Impaction. 4. Chronic constipation. needs an aggressive regimen. 9. Distended bladder. Under the subtitle, Hospital Course. 1/4/26, the document indicated, . presents [came to the hospital] with. a large Boulder in her rectum causing obstruction (a giant stool ball) and causing mechanical issues causing bladder outlet obstruction [blockage]. She got disimpacted [of stool] yesterday. I think the patient is simply severely backed up [constipated].During an observation on 03/04/2026 at 8:35 a.m., Resident 16 was sitting in her wheelchair outside of her room, talking to another Resident. Resident 16 was confused and the ideas she expressed verbally were disorganized.During an interview on 3/05/2026 at 2:31 p.m., Certified Nursing Assistant A (CNA A) stated when Resident 16 had a bowel movement, she documented it with a check mark on the Task: B&B Elimination flowsheet; she stated she was unsure if the nurses looked at her documentation. CNA A stated Resident 16 did not have many bowel movements; she stated she had a lot of bowel movements when she returned from the hospital (1/5/26) but that has slowed down.During an interview on 3/05/2026 at 2:37 p.m., Licensed Nurse E (LN E) stated she was Resident 16's nurse when she was sent to the hospital on 1/3/26. She stated prior to Resident 16's hospitalization, she was taking Percocet and Seroquel and was not eating or drinking much. When asked if Resident 16 was constipated prior to sending her to the hospital, LN E stated she, never had much out and had very little bowel movement. LN E stated laxatives (medication to relieve constipation) didn't work; she stated Resident 16 did not have much of a bowel movement after Dulcolax was given. She stated some days they did not give her anything (for constipation) because she was not eating.During a concurrent interview and record review on 3/05/2026 at 4:29 p.m., the Director of Nursing (DON) reviewed Resident 16's Task: B&B - Bowel Elimination flowsheet dated, 12/1/2025 through 1/3/26 and stated the empty boxes that contained no check marks (by the CNAs) indicated Resident 16 had no BMs on those days. The DON confirmed the multiple days without check marks indicated Resident 16 had no BMs on those consecutive days. The DON also confirmed Resident 16 was taking Percocet and Seroquel, both medications which can cause constipation; he stated Resident 16 was also inactive, which increased her risk of constipation.During the same concurrent interview and record review on 3/05/2026 at 4:29 p.m., the DON reviewed Resident 16's MARs, dated 12/1/25 through 12/31/25 and 1/1/26 through 1/3/26. The DON stated nursing staff did not give Resident 16 PRN medication to treat her constipation (including MOM, Dulcolax, Fleet Enema or Senna) during that timeframe. He stated the nurses should have given MOM after two days of constipation; he stated they should have given a Fleets enema on the third day of constipation and if that did not produce a bowel movement, they should have called the physician. The DON stated the directions for the PRN constipation medications were located in the MAR.During the same interview on 3/05/2026 at 4:29 p.m., the DON reviewed Resident 16's weekly nursing assessments (that included bowel assessments) and confirmed they were completed 8/31/25 and 2/28/26. The DON stated the weekly nursing assessments were missing from Resident 16's medical record after August 31, 2025, through February 28, 2026 (approximately five months). He stated Resident 16's weekly assessments were scheduled to be completed on Saturday afternoons and they should have been done timely.During a telephone interview on 3/06/2026 at 10:05 a.m., Physician F stated Resident 16's constipation was not brought to his attention. Physician F stated his expectation for nursing staff was for them to manage a resident's constipation using the ordered PRN medication. He stated if the PRN medications were not working for Resident 16, nursing staff should have called him because Resident 16 was his responsibility. Physician F stated fecal impaction could lead to (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	hospitalization, could have created the inability to catheterize (insert a Foley catheter) Resident 16 (preventing her from urinating), and could potentially cause bowel perforation (a potentially life-threatening medical emergency).Review of facility policy titled, Charge Nurse, subtitled, Nursing Care Functions, dated 2003, indicated, . Consult with the resident's physician in providing the residents care, treatment. as necessary. Notify the resident's attending physician. when there is a change in the resident's condition. Implement and maintain established nursing objectives and standards. Under subtitle, Care Plan and Assessment Functions, the policy indicated, Review care plans daily to ensure that appropriate care is being rendered. ensure that your nurses' notes reflect that the care plan is being followed.Review of facility policy titled, Bowel (Lower Gastrointestinal Tract) Disorders - Clinical Protocol, subtitled, Assessment and Recognition, revised 9/2017, indicated, . 2. Examples of lower gastrointestinal tract [GI tract; a continuous hollow tube from the mouth to the anus that digests food, absorbs nutrients, and expels waste] conditions. include: . b. Fecal incontinence. 3. the nurse shall assess and document/report the following. d. presence of fecal impaction. f. Abdominal assessment. Under subtitle, Treatment/Management, the policy indicated, 1. The physician will identify and order pertinent. interventions: for example. institute a regimen to prevent constipation. Under subtitle, Monitoring and Follow-Up, the policy indicated, 1. The staff and physician will monitor the individual's response to interventions and overall progress; for example. frequency. of bowel movements.During an interview on 3/06/2026 at 2:40 p.m., the DON stated the facility did not have a policy for weekly nursing assessments.Review of facility policy titled, Administering Medications, revised 12/2012) indicated, . 3. Medications must be administered in accordance with the orders. Online record review of the Cleveland Clinic website indicated Percocet can cause constipation (https://my.clevelandclinic.org/health/drugs/21127-opioids) and online review of the Mayo Clinic indicated Seroquel can cause constipation (https://www.mayoclinic.org/drugs-supplements/quetiapine-oral-route/description/drg-20066912).

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. Based on interview and record review, the facility failed to ensure dietary staff possessed required competencies (a combination of skills, knowledge, abilities, and behaviors that an individual needs to perform a job successfully) and certifications (an official document awarded by a professional organization verifying an individual's specific knowledge/skills required for a job) when the acting Dietary Manager (Manager J) was not certified to function in that position and did not have documented competencies of a Dietary Manager located in their employee file.These failures potentially prevented dietary staff from providing nourishing, palatable, and well-balanced diets that meet the daily nutritional and special dietary needs of residents.During an interview on 3/03/2026 at 11 a.m., Manager J stated he had been the Dietary Manager for two years.During a concurrent interview and record review on 3/05/2026 at 2:30 p.m., Dietary Consultant K reviewed the prior Registered Dietitian's (RD Q) kitchen inspection documentation titled, Sanitation and Food Safety Checklist, subtitled, General Sanitation and Safety, dated 11/23/25, that indicated, . 29. F/T [fulltime] Qualified Manager credentials meet Title 22/CMS (State and Federal) regulations: posted. Under subtitle, Comments, RD Q documented, DM [dietary manager] needs to be CDM [Certified Dietary Manager] or facility needs full-time RD. Dietary Consultant K confirmed Manager J was not certified (as a dietary manager).During a telephone interview on 3/06/2026 at 9:13 a.m., Consultant RD stated she thought Manager J was qualified (to function as a Dietary Manager). She stated if the facility did not have a qualified manager, they needed to employ a fulltime RD.During a concurrent interview and record review on 3/06/2026 at 11:40 a.m., Dietary Consultant K reviewed Manager J's competencies titled, Verification of Job Competency Demonstration - Cooks, dated 2023, and Competency Test for Cooks and FNS [food and nutrition services] Staff, dated 4/10/25, and confirmed the competency assessments were for cooks, not Dietary Managers.During an interview on 3/06/2026 at 11:47 a.m., the Administrator confirmed Manager J was not certified (to work as a Dietary Manager); she stated he was working as a high-level cook, really. The Administrator stated their current Consultant RD worked approximately five hours per week (she was not employed on a full-time basis at the facility).Review of facility policy titled, Personnel Management, dated 2018, indicated, . A qualified FNS (Food and Nutrition Services) Director, chosen by the Administrator, is responsible for the total operation of the Food & Nutrition Services Department. All Food & Nutrition service is performed under their direction.Review of facility job description titled, Job Description, subtitled, Position: FNS [Food and Nutrition Service] Director [Manager], further subtitled, Qualifications, dated 2023, indicated, 3. Must meet the qualifications of a FNS Director as stated under State & Federal regulations.Review of facility document titled, Facility Assessment, subtitled, Facility Resources, dated 7/26/25, indicated the facility required the following positions: Dietitian [RD]. 1 [number needed] . Food Service Manager. 1 [number needed] .

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure infection prevention measures were implemented for a census of 32 when: 1. Enhanced [NAME] Precautions (EBP, an infection control intervention designed to reduce transmission of multidrug-resistant organisms [MDROs] in nursing homes) were not implemented for three of 15 sampled residents (Resident 4, Resident 29, and Resident 35) with an indwelling medical device. Resident 4 with a central venous catheter (long, flexible tube inserted into a large vein and threaded to the heart for long-term delivery of medication, fluids, blood products, or nutrition), Resident 29 with a urinary catheter (a flexible tube inserted into the bladder used to drain urine), and Resident 35 with a suprapubic catheter (SP, a thin, flexible tube inserted into the bladder through a small abdominal incision used to drain urine). Effective 4/01/24, the Centers for Medicare Services mandated EBP, requiring gowns and gloves for high-contact care activities for residents with indwelling devices and wound care, and2. The facility did not have a current Legionella (a type of bacterium that thrives in warm, stagnant water within large HVAC [heating, ventilation, and air conditioning] systems and plumbing]) Water Test Program to prevent an outbreak of a pneumonia called Legionnaires' disease. These failures had the potential to cause the spread of infection among a vulnerable resident population.Findings: A review of Resident 4's admission Record (a facility demographic), dated 3/03/26, indicated Resident 4 was admitted to the facility on [DATE] with diagnoses including end stage renal disease (final, irreversible stage of chronic kidney disease, occurring when kidneys can no longer support life), dependence on renal dialysis (artificial process that filters waste, toxins, and excess fluid from the blood when kidneys have failed), immunodeficiency (the immune system is weakened or absent, making the body unable to effectively fight infections, viruses, and diseases), and urinary tract infection (infection in any part of the urinary system, including the kidneys, ureters, bladder and urethra). A review of Resident 4's Minimum Data Set (MDS-a federally mandated, standardized clinical assessment tool used in U.S. Medicare/Medicaid-certified nursing homes to evaluate resident functional, medical, and psychosocial status), dated 2/21/26, indicated Resident 4's memory was intact, and he was attentive and able to make independent decisions about daily life. A review of Resident 4's Order Summary Report, dated 3/11/26, indicated Resident 4 had a 2-lumen dialysis catheter (an invasive medical device with two separate channels that withdraws blood from the patient's body for dialysis filtration, then returns cleaned blood back into the patient's bloodstream) requiring care and monitoring. During an observation on 3/03/26 at 11:53 a.m., outside Resident 4's bedroom, no enhanced barrier precaution signage was posted, and no clean personal protective equipment (PPE, gloves, gowns, face shields) was present immediately outside the bedroom door. During an observation on 3/03/26 at12:31 p.m., Resident 29 was lying in her bed. There were no infection control precaution signs inside or outside of Resident 29's room and no PPE was located outside of her room. A review of Resident 29's MDS, dated [DATE], indicated she had an indwelling catheter. A review of Resident 35's admission Record, indicated Resident 35 was admitted to the facility on (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	[DATE], with diagnoses which included neuromuscular dysfunction of bladder (loss of bladder control), and cystostomy (the surgical creation of an opening into the bladder, usually through the abdomen just above the pubic bone, to insert a catheter for urine drainage). Also known as a suprapubic (SP) catheter. A review of Resident 35's Order Summary Report, dated 3/2026, indicated Resident 35 had an order to change his SP catheter once every 2 weeks on Wednesday related to cystostomy status. The order indicated, Change Bi-monthly and if non-functioning or dislodged. May use 16Fr [French: size of catheter]/5-30ml [milliliter: balloon capacity for keeping catheter in place] size, start date, 12/31/25. A review of Resident 35's care plan, initiated on 10/24/25, indicated Resident 35 had recurring urinary tract infections related to abusive treatment and poor hygiene techniques of his SP catheter related to dementia (memory loss that gets worse over time). During an observation on 3/03/26 at 2:55 p.m., Resident 35 was transferring himself from his wheelchair to his bed. Resident 35's SP catheter bag was on the floor. Resident 35 stated he thought catheter bag was still hanging on his wheelchair. There was no signage outside Resident 35's room to indicate he was on EBP and no implementation of PPE setup outside Resident 35's room. During an observation on 3/05/26 at 2:14 p.m., Resident 35 had no EBP signage posted outside his room and no PPE cart set up. During an interview on 3/05/26 at 7:45 a.m., the Director of Nursing (DON) stated he was not familiar with EBP. The DON stated he did not know that the standard of practice was to have signage posted outside resident rooms and PPE carts set up for residents who had an indwelling medical device such as a SP catheter, [urinary] catheter, central line, feeding tubes (delivers essential nutrients, fluids, and medications directly into the stomach or small intestine for individuals unable to take adequate nutrition by mouth), and wound care. The DON stated that was a hole in the facility's Infection Control Practice. The DON stated nurses and Certified Nursing Assistants (CNAs) had not been in-serviced on EBP and the Infection Preventionist Nurse (IPN, a licensed nurse who helps prevent and identify the spread of infectious disease in the healthcare environment) had not been setting up the residents' rooms for EBP. During an interview on 3/05/26 at 4:30 p.m., the Administrator did not realize residents with indwelling medical devices and/or with wound care should have EBP implemented. The Administrator stated she did not know that EBP signage should be posted outside those residents' rooms and PPE carts set up so staff giving direct care not only used gloves but disposable gowns as well to prevent the spread of infections. During an interview on 3/05/26 at 4:45 p.m., Certified Nursing Assistant (CNA) A and CNA B both stated they had not heard of EBP. They stated they had never seen signage posted to indicate a resident was on EBP and were not aware they should be wearing a disposable gown in addition to disposable gloves when providing personal care to a resident with a [urinary] catheter or a resident with a wound such as a pressure ulcer (PU, a localized damage to the skin and underlying soft tissue caused by prolonged, unrelieved pressure). CNA A and CNA B both stated they had never seen an IPN employed at the facility. CNA B stated she had never met the facility's IPN consultant. During an interview on 3/06/26 at 8:45 a.m., the DON stated nurses did have to flush Resident 35's SP (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	catheter because of the buildup of sediment (appearing as cloudy, white particles, or sand-like grains) in Resident 35's urine, which could block the flow of urine through his SP catheter. The DON stated there was an order to change Resident 35's SP catheter routinely to prevent the blockage of urine flowing through his SP catheter. The DON stated because of Resident 35'd dementia, he would pull at his SP catheter, roll over the tubing with his wheelchair and even tie knots in the catheter tubing. The DON stated gloves were worn when Resident 35's SP catheter was flushed or changed but no disposable gown was worn. The DON stated he was not aware of the EBP recommendations that went into place. A review of the undated facility policy & procedure (P & P) titled, Enhanced Barrier Precautions – Policy Summary, indicated, Purpose: To reduce transmission of multidrug-resistant organisms and other epidemiologically important pathogens in the facility by implementing EBP during high-contact resident care activities. Guidance follows recommendations from the Centers for Disease Control and Prevention and regulatory expectations from the Centers for Medicare & Medicaid Services. EBP should be implemented for residents who: 1. are colonized [a person who carries multidrug-resistant organisms on or in their body without experiencing symptoms of illness] or infected with MDROs. 2. Have wounds, indwelling medical devices, or invasive lines and 3. Are identified by Infection Prevention as needing additional precautions. PPE – Staff must wear gloves and gown when performing high-contact resident care activities, including: 1. wound care, 2. dressing or bathing assistance, 3. transferring residents, 4. changing linens, and 5. device care [catheter, feeding tube, etc.]. Residents requiring EBP will have door signage indicating required PPE. 2. During a concurrent interview and record review on 3/04/26 at 10:54 a.m., with the Administrator (ADM), [Laboratory] Water Testing Results, dated 2/25/25, were reviewed. The ADM acknowledged testing for Legionella was not included in the test results and stated, I cannot find a place that does this testing. During a concurrent interview and record review on 3/06/26 at 2 p.m. with the Building Manager (Manager M), a binder containing water monitoring information was reviewed. The binder contained water temperature logs, emergency drinking water information, Legionella testing/emergency water management policy, and bacterial testing results of water for the year 2024. In the water management task log, it indicated the last facility water samples were sent for bacterial analysis in April 2024. In addition, this log indicated no other water management tasks had been completed since April 2024. Manager M did not provide any further documentation that any water management program activities took place in the facility after April 2024. A review of the facility P & P titled, Legionella Testing, Maintenance and Record Keeping, dated 8/01/20, indicated, At least annually Legionella specific testing will be completed by maintenance.at least annually every shower head and hose will be replaced.all sinks in resident bathrooms, kitchen, common bathrooms, and utility rooms will have aerators removed and cleaned with approved cleaner to kill Legionella bacteria.Ice machine will be cleaned and sanitized at least quarterly as per manufacturer's instructions.Water heaters will be drained and flushed at least annually.Maintenance supervisor will be responsible to maintain logs for the Legionella testing.

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F 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to employ an Infection Prevention Nurse (IPN, a nurse who helps prevent and identify the spread of infectious disease in the healthcare environment) from early 10/2026 through 3/06/26, leading to Enhanced [NAME] Precautions (EBP, an infection control intervention designed to reduce transmission of multidrug-resistant organisms [MDROs, bacteria and other germs resistant to three or more classes of antibiotics, making infections difficult to treat and highly contagious] in nursing homes) not being implemented for residents with indwelling medical devices including central venous catheters (long, flexible tube inserted into a large vein and threaded to the heart for long-term delivery of medication, fluids, blood products, or nutrition), urinary catheters (a flexible tube inserted into the bladder used to drain urine), and suprapubic catheters (a thin, flexible tube inserted into the bladder through a small abdominal incision used to drain urine).This failure had the potential to significantly increase the risk of spreading MDROs, leading to higher infection rates and increased resident morbidity. (Cross-Reference: F880).Findings:During multiple observations, interviews and record reviews (Reference Federal Tag F880) during the Recertification Survey from 3/03/26-3/06/26, residents were not set up for EBP because there was no IPN. During an interview on 3/05/26 at 4:50 p.m., the Administrator stated the facility did not have an IPN.During an interview on 3/06/26 at 8:45 a.m., the Director of Nursing (DON) stated he could not recall when there was a full-time IPN. The DON stated there had been a few IPN that had filled in once in a while over the past year, but never a fulltime IPN. During an interview on 3/06/26 at 9:15 a.m., the Administrator stated there had not been an IPN in the facility since early 10/2025. A review of the facility Policy & Procedure titled (P & P), Infection Control Overview, revised on 7/2014, indicated, Policy Statement: The Infection Control Committee shall take an active and effective role in preventing and managing communicable illnesses within our facility. The Infection Control Committee shall include the following individuals: . d. Infection Preventionist.A review of the facility P & P titled, Monitoring Compliance with Infection Control, revised on 7/2014, indicated, Policy Interpretation and Implementation: The Infection Preventionist or designee shall monitor the effectiveness of our infection control work practices and protective equipment. This includes, but is not necessarily limited too: a. Surveillance of the workplace to ensure that established infection control practices are observed and protective clothing and equipment are provided and properly used.A review of the facility job description titled, Infection Control Nurse, dated 2003, indicated, Purpose of Your Job Description: The primary purpose of your job position is to plan, organize, develop, coordinate, and direct our infection control program and its activities in accordance with current federal, state, and local standards, guidelines, and regulations that govern such programs, and as may be directed by the Administrator and the Infection Control Committee to ensure that an effective infection control program is maintained at all times. Serve on, participate in, and attend Infection Control Committee meetings .

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Keep all essential equipment working safely. Based on observation, interview and record review, the facility failed to ensure three dryers' lint traps located in the laundry room were cleaned out after two uses per the facility's policy.This failure resulted in dryer lint traps accumulating lint, thereby presenting a potential fire risk and creating a hazardous environment for residents, staff, and visitors.Findings:During a concurrent observation and interview on 3/06/26 at 10:48 a.m. with Laundry Staff C with the help of translator CNA D, in the laundry room, all three dryer lint trap screens were full and there were no logs to indicate how often the lint traps were being cleaned. Laundry Staff C stated she had already dried four loads of laundry in each dryer. Laundry Staff C stated she cleaned the dryer lint traps twice a day. Laundry Staff C stated she was just about to clean the lint out of the dryer lint traps and she would clean the lint traps one more time before leaving, which was around 3:30 - 4 p.m. Laundry Staff C stated the number of loads of clothes/linen she dried per day was based on the census. Laundry Staff C stated she was not aware of needing to log the time she cleaned out the three dryer's lint traps or how often she was supposed to clean out the dryer lint traps. Laundry Staff C stated she has worked in the Laundry Room for a year. Laundry Staff C stated the staff member who trained her quit after training her. Laundry Staff C stated she cleaned the dryer lint traps out twice a day. Laundry Staff C was asked what could occur if there was a build-up of lint in the three dryer's lint traps. Laundry Staff C stated the dryers could catch fire.During an interview on 3/6/2026 at 12:35 p.m., the Administrator stated the laundry staff should be cleaning out the dryer lint traps after two loads and logging the time they cleaned out the lint traps. The Administrator stated logging the times the dryer lint traps were cleaned out have not occurred for at least the past two months. There were no logs presented. The Administrator stated Maintenance should be deep cleaning the dryers once a month and logging when all the dryers were deep cleaned.A review of the undated facility policy/procedure titled, Laundry Dryer Operation and Lint Removal Policy, indicated: Purpose: To ensure safe operation of laundry dryers and prevent fire hazards by maintaining a routine schedule for lint removal and dryer maintenance. Policy: The facility shall maintain all laundry dryers in a safe and sanitary condition. Dryer lint traps and surrounding areas shall be cleaned regularly to prevent lint accumulation, which may present a fire hazard. Procedure: 1. Daily Lint Removal - Laundry staff shall remove lint from dryer lint traps: After two dryer load, and At the end of each shift. 2. Daily Area Inspection - Laundry staff shall inspect and clean: lint traps dryer door seals floor area round dryers nearby surfaces where lint may accumulate. Documentation - A Dryer Lint Removal Log shall be maintained in the laundry area documenting: date time staff initial. Logs shall be reviewed periodically by the Environmental Services or Maintenance Supervisor. Staff Responsibility - Laundry staff are responsible for: proper dryer operation lint removal according to schedule reporting equipment problems.

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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. Based on observation, interview and record review, the facility failed to store drugs and biologicals safely for a census of 32 residents when a medication cart and a treatment cart were left unlocked and unattended in the facility's lounge room, accessible to residents. Additionally, a second medication cart was observed locked in a hallway outside residents' rooms, with its keys left unattended on top of the cart.These failures could have resulted in unauthorized access to medications by residents leading to accidental ingestion of medications, risk of injuries, contaminated medications, and theft or misuse of controlled substances by residents and staff.During an observation on 3/04/26 at 7:14 a.m., Licensed Nurse L (LN L) was seen preparing morning medications at medication cart #1, in a lounge area containing a total of two medication carts and a treatment cart. The Director of Nursing (DON) entered the room, unlocked medication cart #2, placed some medications inside, and walked out without locking cart #2 again. LN L then locked cart #1 and walked out of the room as well. All three carts were left unattended, and it was noted that cart #2 and one of the treatments carts were left unlocked. During a concurrent observation and interview on 3/04/26 at 7:16 a.m., LN L returned to the lounge area, where it was pointed out that cart #2 and the treatment cart were both observed unlocked and unattended for a period of time. LN L stated residents were allowed to come into the lounge area if they wanted, to sit and, look out the windows. Upon inspection, the treatment cart contained several topical medications (external preparations for skin application) along with scissors and other sharp instruments and equipment. LN L explained that the DON forgot to lock cart #2 after placing medications inside. LN L further acknowledged that all carts should have been locked before staff left them unattended in any area accessible to residents.During an observation on 3/04/26 at 1:49 p.m. the treatment cart in the lounge area was again found unlocked and unattended. LN L stated this cart should always be locked because residents could open drawers and remove items that could harm them.During an observation on 3/05/26 at 10:30 a.m., in the facility hallway outside a Resident's room, a locked, unattended medication cart was seen. The medication cart keys, along with some medications and bandages were observed on top of the cart. After no nurses were present for about five minutes, the DON was notified. The DON confirmed that leaving keys on an unattended medication cart was unsafe and against facility policy.During a review of the facility policy and procedure (P & P) titled, Storage of Medications, dated 2007, indicated Compartments containing drugs and biologicals will be locked when not in use, and trays or carts used to transport such items will not be left unattended if open or otherwise available to others.only persons authorized to prepare and administer medications shall have access to the medication room, including the keys.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observation, interview and record review, the facility failed to ensure food was prepared in a manner to maintain nutritive value and palatability (food that has a pleasant, agreeable taste and is enjoyable to eat) for four of thirteen sampled residents (Resident 4, Resident 35, Resident 5, and Resident 27), in a census of 34, when vegetables were cooked for approximately one hour and held on a steam table (box-like table where food is kept warm by steam or hot water circulating beneath) for approximately one additional hour.These failures caused Resident 4 and Resident 35 to feel unhappy, Resident 5 to decrease her food intake and potentially lose weight, Resident 27 to experience diarrhea, and potentially decreased the nutritive value and palatability of foods being served, thereby negatively impacting heath status and quality of life for residents. During a concurrent observation and interview on 3/03/26 at 11:10 a.m., [NAME] H identified the food items located in the steam table as meat and vegetable lasagna prepared that day, green beans, mashed potatoes and gravy. She stated the food was set on the steam table at 11 a.m. and lunch service began at 12 noon. During an interview on 3/03/26 at 11:53 a.m., Resident 4 expressed her unhappiness with facility food, stating she was served runny eggs every day. Resident 4 also stated she was not offered substitutions after notifying the facility about this issue. During an interview on 3/03/26 at 12:53 p.m., Resident 35 stated the food was, institutional-like (refers to food served in public settings such as schools, hospitals, and senior living facilities) and the green beans were overcooked on that particular day. During a phone interview on 3/03/26 at 2:13 p.m., Resident 5's Responsible Party (RP) stated facility food had not been good since 2024, and Resident 5 doesn't eat much of it. In addition, Resident 5's RP stated he feared the resident might have lost weight because of the poor food quality. During an interview on 3/04/26 at 10:00 a.m., Resident 27 stated she was often served food she should not eat because of her medical conditions. Resident 27 stated facility food often gave her diarrhea, and when she complained to staff about her concerns she was not offered substitutions. During an observation on 3/05/26 at 9:35 a.m., mixed vegetables and green beans were placed in separate pots containing water and positioned over heat on the stovetop. At the time of the observation, neither pot had reached boiling point. During an observation on 3/05/26 at 9:50 a.m., the green beans were boiling. During an observation on 3/05/26 at 10 a.m., the green beans were boiling in their pot and the mixed vegetables were almost boiling. During an observation on 3/05/26 at 10:35 a.m., the mixed vegetables were taken off the stove, drained, and put onto the steam table. The green beans remained in their pot of hot water, but they were no longer boiling. During an observation on 3/05/26 at 11 a.m., [NAME] H drained the green beans and subsequently placed them on the steam table at 11:05 a.m. During an observation on 3/05/26 at 11:50 a.m., staff began plating the lunch meals for the residents. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent interview and observation on 3/05/26 at 12:15 p.m., Manager J, Dietary Consultant K and a surveyor performed a taste test of the lunch meal. Manager J conducted food temperature checks, recording the fish at 149 degrees F (Fahrenheit), the mixed vegetables at 146 degrees F, and the green beans at 132 degrees F. Dietary Consultant K stated the fish was a little fishy-tasting and it seemed like it was at room temperature. Consultant K also stated the green beans were cold. The surveyor stated the mixed vegetables were soggy while Consultant K did not offer additional comments regarding this observation. Manager J stated vegetables could be cooked for half an hour, but Consultant K stated they should be cooked for ten minutes. Consultant K stated that cooking vegetables for about one hour, followed by holding them on a steam table for another hour, was not okay. Consultant K stated overcooking vegetables and storing them for extended periods of time on the steam table could decrease the nutrition and flavor of food. Additionally, she stated cooks should follow the recipe. During a telephone interview on 3/06/26 at 9:13 a.m., the Consultant Registered Dietitian (RD) stated there was a good chance vegetables would be overcooked if they were cooked for one hour and then held on a steam table for another hour. She stated that this process might diminish the nutritional value of vegetables due to overcooking; negatively impact palatability and cause a loss of color and texture. The RD further clarified that her expectation was for food to remain on the steam table for no longer than thirty minutes. During a review of the facility's recipe titled, Green Beans with Red Peppers, dated 2026, the recipe indicated, . 1. Heat green beans and drain them well. 4. Serve on trayline at recommended temperature of 160 degrees F - 180 degrees F. A review of facility recipe titled, Stir Fry Vegetables, dated 2026, indicated, . 2.boil. until soft. 4. Serve on trayline at recommended temperature of 160 degrees F - 180 degrees F. A review of facility policy titled, Food Preparation, subtitled, Preparation of Vegetables, dated 2018, indicated, . 2. [NAME] vegetables in small amount of water for a short amount of time. 4. Serve vegetables promptly. Do not hold on the steam table for long periods of time.

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have a plan that describes the process for conducting QAPI and QAA activities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility Quality Assurance Performance Improvement/Quality Assessment and Assurance (QAPI/QAA, a program that involves a systematic approach to quality assurance and performance improvement designed to identify areas of improvement and develop strategies to improve the quality of care provided to the residents) program failed to identify system-wide problems to correct quality deficiencies when:Since 10/26 through 3/06/26 (see Cross Reference F880 and F882), the facility had not employed an Infection Prevention Nurse (IPN), responsible for overseeing potential infection risks, safeguarding residents' health, and providing staff education on infection prevention measures,2. Enhanced [NAME] Precautions (EBP, an infection control intervention designed to reduce transmission of multidrug-resistant organisms [MDROs] in nursing homes) were not implemented for three of 15 sampled residents (4, 29, and 35) who had indwelling medical devices (instruments placed inside the body to assist with diagnostic, monitoring, or therapeutic functions),3. The facility did not maintain an updated Legionella (harmful bacteria) Water Test Program, to prevent the occurrence of Legionnaires' disease (a form of pneumonia caused by Legionella bacteria that thrive in warm, stagnant water within large heating, ventilation, and air conditioning systems) posing a significant risk to the health of residents (See Cross Reference F880), and;4. The facility had not employed a qualified Dietary Manager (DM) for more than a year (Cross Reference 801). These deficient practices had the potential to negatively impact the residents' safety, care and outcomes. Findings:During a concurrent interview and record review on 3/06/26 at 1:19 p.m. with the Administrator, a review of the facility's QAPI action plans did not address the systemic issues of non-compliance identified during the survey. Specifically, there were no QAPI/QAA plans or programs to resolve the following concerns: 1) Absence of an IPN; 2) Insufficient staff in-service training regarding EBP; 3) Lack of implementation of measures to prevent Legionella growth; and 4) Absence of a qualified RD. The Administrator confirmed these findings.A review of the facility's document titled, Quality Assurance and Performance Improvement (QAPI) Plan, dated 7/26/25, indicated, Guiding Principles: #4: QAPI focuses on systems and processes, rather than individuals. The emphasis is on identifying system gaps rather than on blaming individuals. Guiding Principle #5: Our organization makes decisions based on data, which includes the input and experience of caregivers, residents, healthcare practitioners, families, and other stakeholders. Guiding Principle #6: Our organization sets goals for performance and measures progress toward those goals.

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F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly Based on interview and document review, the facility failed to comply with its Assurance Performance Improvement (QAPI, the process that will guide the nursing home's efforts in assuring care and services are continually improved upon) program by not having the mandated Infection Preventionist (IP, a licensed nurse responsible for designing, implementing, and managing programs that prevent the spread of infections within health care facilities) preset at the recert quarterly meeting, thereby, not meeting the required membership for the program.This failure could have resulted in the facility's inability to identify critical infection control issues, develop appropriate corrective plans, implement those strategies and monitor their effectiveness, all of which had the potential to negatively impact resident health and overall outcomes.Findings:During an interview on 3/05/26 at 4 :50 p.m., the Administrator (Adm.) stated the facility did not have an IP.During an interview on 3/06/26 at 9:15 a.m., the Adm. stated there had not been an IP in the facility since 10/2025. During an interview on 3/06/26 at 2:44 p.m., the Adm. stated she gave the surveyor a list of the QAPI Committee Members who should be attending the quarterly QAPI meetings. The Adm. stated the IP should have been attending the Quarterly QAPI Committee Meetings.A review of the QAPI document titled, QA/QAPI Committee Members: Quarterly, revised 3/01/26, indicated the IP was on the committee.A review of the Quarterly QA Meeting, sign in sheets, dated 4/29/25, 8/12/25, 12/9/25 and 2/24/26, indicated the IP was not in attendance for the 2/24/26 quarterly QA Meeting.

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to obtain signed consents for two of two sampled residents (Resident 2 and Resident 4), who were routinely administered psychotropic medications (also called antipsychotic medications used to treat mental health disorders), when:1. Resident 2's Seroquel (medication used to manage behavioral symptoms like agitation, aggression, or hallucinations [false perception of objects or events involving the senses]) dose went from 25 milligrams (mg) to 50 mg in the morning and 75 mg to 100 mg in the evening without Resident 2's consent, and;2. Resident 4 received trazodone (an anti-depressant used off-label for sleeplessness) to treat insomnia prior to her Responsible Party (RP, and individual designated to make certain decisions for a nursing home resident) giving written informed consent.These failures may have resulted in RPs receiving insufficient information regarding the significant risks associated with these antipsychotics, such as increased mortality among elderly dementia patients. As a result, RPs may have been unable to effectively make informed decisions, potentially allowing antipsychotics to be used for staff convenience instead of legitimate psychiatric indications.Findings: A review of Resident 4's admission Record (facility demographic) indicated Resident 4 was admitted to the facility on [DATE], with diagnoses including alcohol use, alcohol induced dementia, delusional (false beliefs) disorder, and bipolar (intense mood swings) disorder. During a concurrent interview and record review on 3/05/26 at 10:24 a.m., and at 1:10 p.m., with the Director of Nursing (DON), Resident 2's Informed Consent Verification, signed by the DON on 5/01/25 and by the physician on 5/20/25, indicated Seroquel 25 mg and Seroquel 75 mg were discussed with Resident 2. Resident 2's Medical Administration Record (MAR), and Order Summary Report, dated 3/20/25, indicated Resident 2 was to receive Seroquel 50 mg in the morning, starting on 10/29/25 and Seroquel 100 mg at bedtime, starting on 10/29/25. The DON acknowledged this information and stated he should have completed a new informed consent since Resident 2's Seroquel was increased on 10/29/25. A review of Resident 2's, Order Summary Report, dated 10/29/25, indicated, Patient has capacity to make medical decisions, order date, 12/03/19. A review of the facility document titled, Informed Consent Verification, indicated, This form is completed when initiating the use of, or increasing the dosage of a psychotherapeutic drug. 2. A review of Resident 4's admission Record dated 3/03/26, indicated Resident 4 was admitted to the facility on [DATE] with diagnoses including cerebral infarction (a condition when blood supply to part of the brain is blocked or reduced), borderline personality disorder (characterized by long-term instability in emotions, behavior, relationships, and self-image), and circadian rhythm sleep disorder (sleep disruptions occurring when your internal body clock misaligns with environmental cues or social schedules). A review of Resident 4's Minimum Data Set (MDS-a federally mandated, standardized clinical assessment tool used in U.S. Medicare/Medicaid-certified nursing homes to evaluate resident functional, medical, and psychosocial status), dated 2/21/26, indicated Resident 4's memory was intact, and she was able to independently make decisions about daily life. A review of Resident 4's MAR dated 3/05/26, indicated Resident 4 was administered Trazadone HCl (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	(trazodone hydrochloride, a prescription antidepressant used mainly to treat major depressive disorder and off-label for insomnia) oral (by mouth) tablet 50 mg (milligram-a unit of measure) nightly for insomnia. The start date for this medication was 2/26/26. During a concurrent interview and record review on 3/06/26 at 10:50 a.m. with the DON, the electronic medical record and hardcopy medical documentation binder for Resident 4 were reviewed. No informed consent document signed by Resident 4 or Resident 4's RP was found in either location, and the DON acknowledged it was not completed. During a review of facility undated policy and procedure (P & P) titled, Addendum to Psychotropic Drug Use Policy – Informed Consent, indicated, the facility's licensed nurse shall verify that the physician has obtained informed consent prior to the initiation of a antipsychotic or other psychotherapeutic medication; and prior to the increase in dosage of an antipsychotic medication.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056483	A. Building B. Wing	03/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sherwood Oaks Post Acute Care, LLC	130 Dana Street Fort Bragg, CA 95437

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to develop care plans for one of six sampled residents (Resident 4), who suffered insomnia (inability to sleep) and was being administered an antipsychotic medication (a medication to treat mental illness and used off-label for insomnia symptoms) which required closed monitoring.These findings had the potential to result in increased physical and psychological symptoms associated with insomnia, and inability to track or monitor possible harmful side effects of antipsychotics. A review of Resident 4's admission Record (facility demographic), dated 3/03/26, indicated Resident 4 was admitted to the facility on [DATE] with diagnoses including cerebral infarction (a condition where blood supply to part of the brain is blocked or reduced), borderline personality disorder (characterized by long-term instability in emotions, behavior, relationships, and self-image), and circadian rhythm sleep disorder (sleep disruptions occurring when the internal body clock misaligns with environmental cues or social schedules).A review of Resident 4's Minimum Data Set (MDS-a federally mandated, standardized clinical assessment tool used in U.S. Medicare/Medicaid-certified nursing homes to evaluate resident functional, medical, and psychosocial status), dated 2/21/26, indicated Resident 4's memory was intact, and she was able to independently make decisions about daily life.A review of Resident 4's Medication Administration Record, dated 3/05/26, indicated Resident 4 was administered Trazodone HCl (trazodone hydrochloride - a prescription antidepressant used mainly to treat major depressive disorder and off-label for insomnia) oral (by mouth) tablet 50 mg (milligram-a unit of measure) nightly for insomnia. The start date for this medication was 2/26/26.A concurrent interview and record review on 3/06/26 at 10:50 a.m. with the Director of Nursing (DON), Resident 4's care plans were reviewed. The DON acknowledged there were no nursing care plans initiated for the monitoring of Resident 4's psychotropic (antipsychotic) drug administration, including monitoring for signs and symptoms of overdose and/or unwanted side effects. In addition, the DON acknowledged there was no past or current care plan for the management and treatment of Resident 4's insomnia. The DON stated that these care plans should have been started to monitor Resident 4's treatment, to consider non-pharmacological interventions, and to prevent harm.A review of facility policy and procedure (P & P) titled, Care Area Assessments, dated 2011, indicated, decisions about the care plan.evaluate resident's goals.design interventions.establish which items need further assessment or additional review.document interventions.include recommendations for monitoring and follow-up timeframes.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to develop a comprehensive care plan for one of six sampled residents (Resident 5) addressing weight refusals within seven days of a resident assessment indicating this issue.This failure could have resulted in the inability for staff to identify underlying reasons for weight refusals, offer alternatives, and mitigate health risks related to weight fluctuations. This oversight could have resulted in missed detection of nutritional decline for Resident 5, potentially leading to significant clinical complications. A review of Resident 5's admission Record (a facility demographic), dated 3/03/26, indicated Resident 5 was admitted to the facility on [DATE] with diagnoses including depression, severe protein-calorie malnutrition (a life-threatening deficiency of protein, carbohydrates, and fats resulting in severe muscle wasting, fat loss, or extreme fluid retention), anemia (when low red blood cell levels reduce oxygen transport to tissues, causing fatigue, pale skin, and dizziness), delusional disorders (one or more persistent, fixed, false beliefs lasting at least one month), and muscle weakness.A review of Resident 5's Minimum Data Set (MDS-a federally mandated, standardized clinical assessment tool used in U.S. Medicare/Medicaid-certified nursing homes to evaluate resident functional, medical, and psychosocial status), dated 1/02/26, indicated Resident 5 had severe cognitive impairment, exhibited delusions, and had rejected treatment or care occasionally.A review of Resident 5's Progress Note, dated 2/04/26, indicated, patient again refused to be weighed. This is an ongoing issue for us.During a phone interview on 3/03/26 at 2:30 p.m., Resident 5's Responsible Party (RP) stated facility food was, really not that great, and that Resident 5, doesn't eat that much of it.During a concurrent interview and record review on 3/06/26 at 11:30 a.m. with the Director of Nursing (DON), the weight history and care plans for Resident 5 were reviewed. The DON agreed that Resident 5 had been refusing weights since last year. When asked if care planning had been implemented for these refusals, the DON replied, what should I have care planned? When asked if any education, counseling or family involvement had been documented as a possible solution, the DON replied, that could have been part of a care plan for this problem.A review of Resident 5's Weights and Vitals Summary, dated 3/11/26, indicated the last recorded weight for Resident 5 was 145 lbs. on 11/13/25.During a review of the facility policy and procedure (P & P) titled, Weighing and Measuring the Resident, dated 2011, indicated, the purpose of the procedure is to determine the height and weight, to provide a baseline and an ongoing record of the resident's body weight as an indicator of nutritional status and medical condition of the resident.documentation: if the resident refuses the procedure, the reasons why and interventions taken.notify the Nurse Supervisor if the resident refuses the procedure.A review of the facility P & P titled, Care Area Assessments, dated 2011, indicated, decisions about the care plan.evaluate resident's goals.design interventions.establish which items need further assessment or additional review.document interventions.include recommendations for monitoring and follow-up timeframes.

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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 monitor the side effects of a psychotropic medication (a medication that influences brain chemistry to help treat mental health conditions by affecting mood, thoughts, behaviors, and perceptions. These types of medications may be hazardous because they carry a significant risk of severe side effects) for one of six residents (Resident 4) despite recommendations from a pharmacist and a subsequent review by the facility physician.This finding had the potential to result in inability for staff to identify significant side effects of the medication which could have resulted in serious harm for Resident 4. A review of Resident 4's admission Record (a facility demographic) indicated Resident 4 was admitted to the facility on [DATE] with diagnoses including cerebral infarction (condition where the blood supply to part of the brain is blocked or reduced), borderline personality disorder (characterized by long-term instability in emotions, behavior, relationships, and self-image), and circadian rhythm sleep disorder (sleep disruptions occurring when your internal body clock misaligns with environmental cues or social schedules).A review of Resident 4's Minimum Data Set (MDS-a federally mandated, standardized clinical assessment tool used in U.S. Medicare/Medicaid-certified nursing homes to evaluate resident functional, medical, and psychosocial status), dated 2/21/26, indicated Resident 4's memory was intact, was attentive, and was able to independently make decisions about daily life.A review of Resident 4's Medication Administration Record, dated 3/5/26, indicated Resident 4 was administered Trazodone HCl (trazodone hydrochloride - a prescription antidepressant used mainly to treat major depressive disorder and off-label for insomnia) oral (by mouth) tablet 50 mg (milligram-a unit of measure) nightly for insomnia. The start date for this medication was 2/26/26.A review of Resident 4's facility Consultant Pharmacist Medication Regimen Review, dated 1/07/26, indicated, CURRENT ORDER: Trazodone 50 mg po qHS [at every bedtime] for insomnia.RECOMMENDATION: Please include monitoring for side effects and behaviors for psychotropic above.During a concurrent interview and record review on 3/05/26 at 12:30 p.m. with the Director of Nursing (DON), Resident 4's Medication Administration Record was reviewed. The DON agreed monitoring for behaviors and side effects of trazodone were not ordered and therefore this task could not be assumed to be completed by nursing staff. During a subsequent interview on 3/06/26 at 10:50 a.m. with the DON, he stated nurses should have been monitoring for side effects of trazodone, including serotonin syndrome (a potentially life-threatening chemical drug reaction in the brain; symptoms include shivering, diarrhea, and fever, severe muscle rigidity, seizures, and unconsciousness), constipation, and suicidal ideations (having ideas or ruminations about the possibility of dying by suicide).During a review of the undated facility policy and procedure (P & P) titled, Psychotropic Medication Policy and Procedure, indicated, Nursing: Monitors psychotropic drug use daily noting any adverse side effects such as increased somnolence or functional decline.will monitor for presence of target behaviors on a daily basis.