STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056495	A. Building B. Wing	04/24/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Casa Coloma Health Care Center	10410 Coloma Rd Rancho Cordova, CA 95670

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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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures to prevent abuse, neglect, and theft. Based on interview and record review, the facility failed to ensure their abuse policy was operationalized and implemented properly to prohibit and prevent abuse (aggressive or violent behavior), ensure timely reporting, thorough investigation, and appropriate response to an allegation of resident-to-resident physical abuse when one of 32 sampled residents (Resident 2) report of being physically assaulted by another resident was not handled according to their policy and regulations when the facility staff were not aware of the reporting requirements of allegations of abuse.These failures had the potential for allegations of actual or suspected resident abuse to not be identified, reported and investigated placing residents' safety at risk.A review of the facility's policy titled, Abuse Prevention Program, dated 12/2016, indicated, As part of the abuse prevention, the administration will .Protect our residents from abuse by anyone including .other residents .Develop and implement policies and procedures to aid our facility in preventing abuse .or mistreatment of our residents .Require staff training .programs that include such topics as abuse prevention, identification and reporting of abuse .and handling verbally or physically aggressive resident behavior.A review of the policy titled, Resident-to-Resident Altercations, dated 12/2016, indicated, All altercations, including those that may represent resident-to-resident abuse, shall be investigated and reported.A review of the Abuse Investigation and Reporting policy dated 7/2017, indicated, As the facility is made aware, reports of resident abuse .mistreatment .shall be promptly reported to local, state and federal agencies (as defined by current regulations) and thoroughly investigated by facility management. Findings of abuse investigations will also be reported.A review of the admission record indicated the facility admitted Resident 2 in 2024 with multiple diagnoses which included heart disease and polyarthritis (inflammation, pain and stiffness on multiple joints).A review of Resident 2's Minimum Data Set (MDS, a federally mandated assessment), dated 3/13/26, indicated Resident 2 had intact cognition and intact ability to think, rationalize, and recall.A review of Resident 2's clinical record contained a document titled, SBAR Communication Form (Situation, Background, Appearance, and Review) dated 1/23/26 at 8:30 p.m. The SBAR indicated that Resident 2 reported to her nurse that her roommate's fist landed on her left forearm. The SBAR note indicated that Resident 2's report of alleged abuse was classified as fabricated statement toward her roommate. The SBAR note indicated that Resident 2 declined to report it [allegation] as SOC [SOC 341, a mandatory written State's report of suspected verbal or physical abuse or mistreatment of dependent adult.] Resident 2's clinical record did not contain any documented evidence that resident's report of alleged physical abuse by another resident was investigated by the facility.During an interview and concurrent record review on 4/23/26 at 10:10 a.m., the Director of Nursing (DON) acknowledged that the incident involving resident-to-resident physical contact was not reported to State licensing agency. The DON stated that Resident 2 had no redness or injury to the arm where she reportedly was hit by another resident and the entire incident was not witnessed by the nurse or certified nursing assistant (CNA). The DON stated she instructed Licensed Nurse (LN 9) to document the allegation was fabricated.During a continued interview and record review with DON and Administrator (ADM) on 4/23/26 at 10:15 a.m., the ADM stated he was the abuse coordinator for the facility. When the ADM was asked if the investigation of Resident 1's allegation of abuse was investigated, the ADM stated, (continued on next page)

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

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

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Investigation was done, I talked to both residents. The ADM stated that Resident 2's roommate denied hitting Resident 2. The ADM stated Resident 2 did not report to him that she was hit by her roommate when he asked the resident what happened. The ADM stated he did not ask Resident 2 if she was hit or had any injury. The ADM validated there was no documented evidence that the investigation of alleged physical abuse toward Resident 2 was documented and reported to appropriate agencies. The ADM explained, I can only report what I know or what I was told.Staff did not report to me about [Resident 2] being hit by her roommate.During a concurrent interview and record review on 4/23/2026, at 2:48 p.m., with Social Services Director (SSD), the SSD stated she was informed of Resident 2's allegation of being hit by her roommate. The SSD stated that during interview with Resident 2 the next day, Resident 2 explained that her roommate started with verbal aggression then hit her. The SSD stated, I informed resident [Resident 2] that I will be reporting incident to appropriate agencies, including Ombudsman and State and Resident 2 declined. The SS explained facility's protocol for reporting allegation of abuse and stated, If the resident is alert and oriented, cognitively intact, refuse that we complete the report, I do not report.Resident [2] has capacity to make decisions and is her own Responsible Party. So it was not reported.During an interview on 4/24/26 commencing at 9:55 a.m., and completed at 10:19 a.m., six (6) nurses were interviewed about resident-to-resident altercations which may indicate abuse reporting requirements. Six out of six nurses (LN 2, LN 3, LN 4, LN 5, LN 6, and LN 7 did not know that suspected or alleged abuse allegations were to be reported to the State licensing agency.During an observation on 4/24/26 at 12:30 p.m., a list of emergency contact numbers, including the State agency were observed posted at Nursing Station 1, Nursing Station 2, and Nursing Station 3. A review of the list indicated the phone number for the State agency listed was not accurate.During an observation on 4/24/26, at 12:50 p.m., the list of emergency contact information was observed posted in DON's office. The DON stated the posted list contained emergency contact information, including State agency's phone number to report abuse allegation. However, upon dialing the listed phone number for the State agency, it was determined that the number was not accurate. The DON validated that emergency contact information was not reliable for staff use to report abuse.During an interview with Director of Staff Development (DSD) on 4/24/26 at 12:58 p.m., the DSD stated that all staff received abuse training annually. The DSD described the facility's process for reporting abuse: We notify abuse coordinator, who is administrator. Complete SOC 341 as soon as possible and sent to ombudsman.via fax. Follow up with phone call to make sure she received the SOC 341. The DSD added, Normally the ombudsman does her own investigation and if needed more investigation she will forward the report to [name of the State licensing agency]. The DSD stated that the facility did not have any abuse allegations since September 2025.During a follow up interview with ADM on 4/24/26 at 1:10 a.m., the Department discussed that multiple interviewed staff were not aware of the requirements to report alleged or suspected abuse to the State licensing agency. The ADM stated, We have trained them all about abuse, including abuse reporting and that training include reporting to the State.Its in our abuse policy.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observation, interview, and record review, the facility failed to provide a safe environment, supervision, and equipment maintenance to ensure safety and prevent accidents for 3 of 32 sampled residents (Resident 164, Resident 7, and Resident 108) when: 1. Specimen collection tubes were left unsecured at Resident 164's bedside;2. The physician's order to apply and monitor padded side rails for Resident 7, who had a history of seizures (a condition in which abnormal electrical activity in the brain occurs causing changes in level of consciousness and jerking movements) was not implemented, and3. Resident 108's bed remote control cord had exposed frayed wires accessible to the resident. These failures resulted in Resident 164 ingesting chemical from specimen collection tube, placed Resident 7 at risk for injuries during seizure activity, and created a safety hazard for Resident 164, Resident 7, and Resident 108. 1. A review of the admission record indicated the facility admitted Resident 164 in March of 2026 with multiple diagnoses which included aftercare following the fracture of sacrum (triangular bone at the base of spine), anxiety disorder, hearing deficit, and macular degeneration in both eyes (incurable eye disease causing blurred and distorted vision). A review of Resident 164's Minimum Data Set (MDS, a federally mandated resident assessment) dated 3/11/26, indicated the resident scored 9 out of 15 in a Brief Interview for Mental Status (cognitive assessment), which indicated moderate cognitive impairment. A review of the care plan dated 3/18/26 indicated that Resident 164 had the incident of ingesting of preservative additives [chemicals designed to preserve urine specimens] from a BD Vacutainer [type of the tube] urine collection tube. The additives were identified as Boric Acid, Sodium Borate, and Sodium Formate (toxic substances if ingested). A review of Resident 164's clinical record contained a document titled, SBAR Communication Form (Situation, Background, Appearance, and Review) dated 3/18/26 at 7 a.m. The SBAR indicated that Resident 164 had a change in condition (COC) related to Consumption of unknown amount of hazardous toxins. The SBAR indicated that during morning rounds at approximately 5 a.m., Certified Nursing Assistant (CNA) reported to nurse that Resident 164 was observed opening biohazard specimen kit, removed the tube's lid and ate unknown amount of white contaminants inside.White material seen on lips/tongue. Increased confusion noted. A review of Resident 164's record indicated that the resident was monitored prior to be picked up by ambulance on 4/18/26 at 8:42 a.m. A review of the Resident 164's clinical record contained an Interdisciplinary Team (IDT, a team of different disciplines) note dated 3/25/26 for investigation of the incident dated 3/18/26. The IDT note indicated that IDT conducted a thorough investigation to determine how the specimen collection materials became accessible to the resident. The IDT note indicated that the nurse inadvertently left the urine specimen collection pack near the resident's bedside cabinet rather than securing it in the designated storage area per facility protocol. During a joint interview on 4/23/26 at 10:45 a.m., the incident with Resident 164 ingestion of preservative additives was discussed with Administrator (ADM) and Director of Nursing (DON). The DON stated that evening nurse was unable to collect urine and left the specimen collection tubes at Resident 164's bedside. The DON stated that night shift nurse was not able to collect urine and the specimen collection tubes continued to be at Resident 164's bedside unsecured. The DON explained (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	that per specimen tube's manufacturer's Safety Data Sheets (SDS, documents that provide detailed information about chemical substance and inform users about potential hazards), the Emergency Department physician determined that Boric Acid, Sodium Borate, and Sodium Formate were classified as low toxicity because it was ingested in small amount. The DON acknowledged that specimen collection tubes should not be left at bedside unsecured because it affected the resident's safety. A review of the facility's policy titled, Cultures and Specimens, dated 7/2014, indicated, When cultures [lab specimens] are ordered, they should be obtained and completed as soon as practicable. Cultures and specimens are to be kept in a secluded location. A review of the facility's policy titled, Safety and Supervision of Residents, 7/2017, indicated, Our facility strives to make the environment as free from accident hazards as possible. Resident safety and supervision and assistance to prevent accidents are facility wide- priorities. Resident supervision is a core component of the system's approach to safety. 2. A review of the admission record indicated the facility admitted Resident 7 earlier this year with multiple diagnoses which included epilepsy with seizures. A review of Order Listing Report for Resident 7 contained a physician order dated 2/22/26. The order directed nursing to monitor placement of side rails pads related to epilepsy every shift. A review of Resident 7's At risk for injury care plan initiated on 2/13/26 indicated that the resident was at risk for injuries related to seizure disorder. One of the care plan interventions directed nursing To monitor placement of side rails every shift. A review of Resident 7's Minimum Data Set (MDS, a federally mandated assessment), dated 2/27/26 indicated Resident 7 had intact cognition and intact ability to think, rationalize, and recall. During an observation on 4/22/26 at 8 a.m., Resident 7 was in bed. Resident 7 was pleasant and answered appropriately to all questions. Resident 7's bed had one side rail on each side of the bed and the side rails were not padded. During an observation on 4/23/26 at 9:23 a.m., Resident 7 was in bed with head of bed elevated. Resident 7's side rails were not padded. During a joint interview with Certified Nursing Assistant (CNA 4) and CNA 5 on 4/23/26 at 9:25 a.m., in Resident 7's room, CNA 4 and CNA 5 stated they were familiar with Resident 7 and her care needs. CNA 4 stated she had not seen the facility utilized foam side rails padding for Resident 7. CNA 4 stated, We have foam pads in other rooms, but not used for [Resident 7's name]. I was not aware she needed them. Resident 7 stated she had history of epilepsy and seizures and explained, I know I should have side rails padded to prevent injuries in case I have seizure, but nobody placed it. During a concurrent interview and record review on 4/23/26 at 9:50 a.m., with Director of Nursing (DON), the DON stated that facility utilized foam side rails pads for residents who were on seizure precautions. The DON further stated that the side rails must be padded for resident's safety, to protect residents from injuries if the resident had a seizure. The DON reviewed Resident 7's order and validated that nursing was to monitor placement of side rails pads every shift. The DON reviewed Resident 7's Medication Administration Record (MAR) for April 2026 and stated that nurses placed 'Y' (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	every shift validating that the side rails were padded, except 4/2, 4/10, 4/20, and 4/22 on the evening shift and 4/20 on the night shift. The DON reviewed MAR for March 2026 and validated that the MAR's had inconsistent documentation. The DON was unable to find non-compliance care plan indicating that the resident refused side rails padding. The DON stated her expectation was to follow physician's order and protect Resident 7 from potential injuries caused by seizure disorder. The DON added, Resident's safety must be protected. A review of the facility policy titled, Emergency Procedure- Seizure Management, dated 8/2018, indicated, Personnel will assist in safety measures for a resident who is having a seizure. A review of the facility policy titled, Charting and Documentation, dated 7/2017, indicated, All services provided to the resident. shall be documented in the resident medical record. Documentation in the medical record will be objective (not opinionated or speculative), complete, and accurate. 3. A review of Resident 108's admission Record indicated Resident 108 was admitted to the facility in August 2023 with multiple diagnoses including encephalopathy (damage or disease that affects brain functioning), dementia (loss of memory, problem solving and thinking abilities that interfere with daily life), epilepsy (seizure disorder), and diabetes (blood sugar is too high due to insufficient insulin or body does not use insulin effectively). A review of Resident 108's MDS, Cognitive Patterns, dated 3/19/26, indicated Resident 108 had a Brief Interview for Mental Status (BIMS- tool to assess cognition) score of 7 out of 15 that indicated Resident 108 had severe cognitive impairment. During a concurrent observation and interview on 4/21/26 at 8:35 a.m. with Resident 108, observed bed remote control next to Resident 108 in bed. Observed frayed exposed wires at junction of remote and cord and where cord was wrapped around bed rail. Resident 108 stated he is able to use the bed remote and was observed picking it up. During a concurrent observation and interview on 4/21/26 at 9:42 a.m. with Certified Nursing Assistant (CNA) 7, CNA 7 confirmed that Resident 108's bed control remote cord had frayed and exposed wires. CNA 7 stated, This should not be. When asked what could happen to the resident, CNA 7 stated, Could shock the resident if he touches the frayed wire. During a concurrent observation and interview on 4/21/26 at 9:47 a.m. with the Director of Maintenance (DM), the DM confirmed that Resident 108's bed remote control cord has frayed and exposed wires. The DM stated the remote still works but needed to be changed. The DM stated this was the first time he was notified of the frayed cord. A review of the facility's Policy and Procedure (P&P) titled Safety and Supervision of Residents, revised 7/17, indicated .Our facility strives to make the environment as free from accident hazards as possible. Resident safety and supervision and assistance to prevent accidents are facility-wide priorities . Safety risks and environmental hazards are identified on an ongoing basis through a combination of employee training, employee monitoring, and reporting processes .The care team shall target interventions to reduce individual risks related to hazards in the environment, including adequate supervision and adequate devices . A review of the facility's P&P titled Maintenance Service, revised 12/2009, indicated .Maintenance service shall be provided to all areas of the building, grounds and equipment . The Maintenance (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Department is responsible for maintaining the buildings, grounds, and equipment in a safe and operable manner at all times .

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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. Based on interview and record review, the facility failed to ensure accurate accountability of controlled medications (medications with high potential for abuse or addiction) for four of 32 sampled residents (Residents 32, Resident 27, Resident 21 and Resident 114) when random controlled medication audits of the Medication Administration Record (MAR) and Controlled Drug Record (CDR) did not reconcile to indicate the medications were given to Residents 32, Resident 27, Resident 21, and Resident 114.This failure resulted in the facility not having accurate accountability of controlled medications, the potential for abuse or misuse of these medications, and the potential for not meeting the residents' therapeutic needs or worsening of their medical conditions.During a review of Resident 32's physician orders indicated orders for Hydrocodone-Acetaminophen (Norco, used to treat moderate to severe pain) 5-325 mg (milligrams, a unit of measurement) two tablets by mouth two times a day for chronic pain, dated 9/8/25, and Norco 5-325 mg one tablet by mouth every 6 hours as needed for moderate pain, dated 9/3/25. The CDR indicated one tablet of Norco was signed out for Resident 32 on 4/14/26 at 4:30 a.m. and one tablet on 4/23/26 at 4:30 a.m. but the MAR did not indicate that the doses for Resident 32's Norco were not administered on these dates and times.During a review of Resident 27 physician order dated 2/11/26, indicated an order for Oxycodone (used to treat moderate to severe pain) 5 mg 1/2 tablet every 6 hours as needed for pain management. The CDR indicated oxycodone doses were signed out for Resident 27 on 3/16/26 at 12:06 p.m., 4/13/26 at 3 a.m., 4/13/26 at 10:45 a.m., and 4/22/26 at 5:03 a.m. but the MAR did not indicate that the oxycodone doses were administered to Resident 27 on these dates and times. The MAR also indicated the oxycodone for Resident 27 was signed as administered on 3/20/26 at 12:06 p.m. but the CDR did not indicate that the dose was signed out for Resident 27 on this date and time.During a review of Resident 21 physician order dated 3/9/26, indicated an order for Norco 5-325 mg one tablet by mouth every 8 hours as needed for moderate to severe pain. The CDR indicated one tablet of Norco was signed out for Resident 21 on 3/22/26 at 1:25 p.m. but the MAR did not indicate the dose of Norco was not administered to Resident 21 on this date and time. The MAR also indicated Norco was signed as administered for Resident 21 on 3/23/26 at 1:24 p.m. but the CDR did not indicate that Norco was signed out for Resident 21 on this date and time.During a review of Resident 114 physician order dated 3/12/26, indicated an order for Norco 5-325 mg one tablet by mouth every six hours as needed for moderate to severe pain. The CDR indicated one tablet of Norco was signed out for Resident 114 on 4/21/26 at 8:11 p.m. The MAR did not indicate Norco was administered to Resident 114 on this date and time.During a concurrent interview and record review on 4/23/26 at 4:45 p.m. with the Assistant Director of Nursing (ADON), the ADON confirmed the discrepancies with the count on the MAR and CDR for Resident 32, Resident 27, Resident 21, and Resident 114. The ADON stated the MAR and CDR should match and it could be a medication error if the MAR and CDR did not match and that there was a possibility of drug diversion (occurs when a medication is taken for use by someone other than whom it is prescribed ot for an indication other than what is prescribed).During an interview on 4/24/26 at 9:09 a.m. with the Director of Nursing (DON), the DON stated the MAR and the CDR should reconcile. The DON further stated if the MAR and CDR did not match, there could be an overgiving of narcotics to the residents and there was a possibility of drug diversion.During a review of the facility's policy and procedure (P&P) titled Controlled Substances, revised 4/2019, the P&P indicated, .8. Controlled substances are reconciled upon receipt, administration, disposition, and at the end of each shift.10. Upon Administration: a. The nurse administering the medication is responsible for recording:.(3) Time of administration;.(6) Signature of nurse administering medication.12. At the End of Each Shift:.b. Any discrepancies in the controlled substance count are documented and reported to the Director of Nursing Services immediately.c. The Director of Nursing Services investigates all discrepancies in controlled medication reconciliation to (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	determine the cause and identify any responsible parties, and reports the findings to the Administrator.

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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. Based on observation, interview, and record review, the facility had a 7.69% error rate when three medication errors out of 39 opportunities were observed during a medication pass for two of four residents (Residents 98 and Resident 162).This failure resulted in medications not given in accordance with the prescriber's orders and potential to affect the residents' clinical conditions.1a. During a medication pass observation on 4/22/26 starting at 7:53 a.m. with Licensed Nurse 1 (LN 1), LN 1 was observed administering the following medications for Resident 162:- Insulin Lispro (rapid-acting insulin used to control high blood sugar) 15 units subcutaneous (SQ, under the skin)- Glimepiride (used to lower high blood sugar) 4 mg (milligrams, a unit of measurement) two tablets by mouth- Metoprolol tartrate (used to treat high blood pressure) 50 mg one tablet by mouth- Enoxaparin sodium (used to prevent and treat harmful blood clots) 60 mg/0.6 ml (milliliters, a unit of measurement) one pre-filled syringe injection SQ- Jardiance (used to help control blood sugar levels) 25 mg half tablet (12.5 mg) by mouth- Digoxin (used to treat heart failure) 250 mcg (microgram, a unit of measurement) one tablet by mouth- Dilacor XR (used to treat high blood pressure) 240 mg one capsule by mouth- Furosemide (used to treat fluid retention) 40 mg one tablet by mouth- Methimazole (used to treat an overactive thyroid gland) 5 mg one tablet by mouth- Spironolactone (used to treat high blood pressure and heart failure) 25 mg one tablet by mouthA review of Resident 162's medical record indicated physician's orders for Insulin Glargine (long-acting insulin to improve blood sugar control) 28 units SQ twice a day and Glycolax Powder (used to relieve constipation) 17 grams once a day. These medications were omitted during the medication pass observation on 4/22/26 at 7:53 a.m.During a review of Resident 162's Administration History for Insulin glargine, dated 4/22/26, the history indicated Resident 162's insulin glargine was scheduled to be administered at 8 a.m. The history further indicated that Resident 162's insulin glargine was administered on 4/22/26 at 10:42 a.m. instead of 8 a.m.During an interview on 4/22/26 at 11:52 a.m. with LN 1, LN 1 confirmed that Resident 162's insulin glargine was not administered on the scheduled time at 8 a.m. and during the medication pass observation. LN 1 stated she went back to Resident 162 to give the insulin glargine at 10:42 a.m. because LN 1 did not want to give Resident 162's insulin glargine at the same time as the two other injections. LN 1 confirmed Resident 162's insulin glargine was scheduled at 8 a.m. and stated that medications were supposed to be given an hour before and an hour after the scheduled time. LN 1 stated it was important to give insulin on time for safety and so it can regulate the blood sugar, and Resident 162 would not have hyperglycemia. LN 1 also confirmed that Resident 162's Glycolax was not administered during the medication pass. LN 1 further stated it was important to give medications on time like Glycolax to control bowel movement.During a review of Resident 162's MAR for April 2026, the MAR indicated Resident 162's Glycolax was signed as administered at 8 a.m., contrary to the medication pass observation.During a review of Resident 162's Administration History for Glycolax Powder, dated 4/22/26, the history indicated Resident 162's Glycolax Powder administration on 4/22/26 at 8:14 a.m. was striked-out as incorrect entry on 4/22/26 at 12 p.m. and was coded as refused on 4/22/26 at 12:23 p.m.During a concurrent interview and record review on 4/22/26 at 3:23 p.m. with the Director of Nursing (DON), the DON reviewed Resident 162's administration history for insulin glargine dated 4/22/26 and confirmed that the insulin glargine doses were scheduled twice a day at 8 a.m. and 8 p.m. The DON also confirmed that Resident 162's insulin glargine was administered on 4/22/26 at 10:42 a.m., over two hours from the scheduled administration schedule. The DON stated medications should be given one hour before and one hour after the scheduled administration time, unless there was an emergency.1b. During a medication pass observation on 4/22/26 starting at 8:15 a.m. with LN 1, LN 1 was observed administering eight medications for Resident 98 including Glipizide (used to lower blood sugar) 10 mg 1 tablet by mouth. No meal trays were observed at bedside and Resident 98 stated he already had breakfast before the medication pass. A review of Resident 98's medical record indicated a physician's order for Glipizide (continued on next page)

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	056495	A. Building B. Wing	04/24/2026

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	10 mg one tablet by mouth in the morning 30 minutes before breakfast, dated 3/10/26.During a concurrent interview and record review on 4/22/26 at 11:52 a.m. with LN 1, LN 1 confirmed Resident 98's physician order was to give Glipizide 10 mg 30 minutes before breakfast. LN 1 further confirmed that Resident 98's Glipizide was administered after breakfast and stated that breakfast was already served when LN 1's shift started and it was already late for LN 1 to give the medication.During an interview on 4/22/26 at 3:23 p.m. with the DON, the DON stated it was important to follow the physician order because it can affect the condition of the residents.A review of DailyMed, a nationally recognized drug information resource, indicated, .In general, glipizide should be given approximately 30 minutes before a meal to achieve the greatest reduction in postprandial hyperglycemia [increase in blood sugar levels after eating a meal] . (dailymed.nlm.nih.gov, accessed 4/29/26).During a review of the facility's policy and procedure (P&P) titled Administering Medications, revised 4/2019, the P&P indicated, .Medications are administered in a safe and timely manner, and as prescribed.4. Medications are administered in accordance with prescriber orders, including any required timeframe.8. Medications are administered within one (1) hour of their prescribed time, unless otherwise specified.

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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 ensure medications were stored safely, for a census of 131, when:Medication and medical supplies were available for residents' use past their expiration dates; and,Resident 63's topical cream was stored at bedside.These failures had the potential for residents to receive medications with decreased strength or effectiveness and for residents who have confusion to accidentally ingest medications kept at bedside. 1.During a concurrent observation and interview on 4/21/26 at 3:46 p.m. with the Assistant Director of Nursing (ADON), an inspection of Station 3 Medication Storage Room identified the following expired and discontinued medications and medical supplies: -A bottle of Docusate Sodium Liquid (stool softener) 473 ml (milliliters, a unit of measurement), expired 7/2025 -StatLock Catheter Stabilization Device (securely anchors catheter tubings to prevent dislodgement), expired 2/28/26 -Intravenous (IV, through the vein) Administration Set, expired 3/4/26 The ADON confirmed the items identified in Station 3 Medication Storage Room were expired and should have been removed from the facility's stock. The ADON stated it was important not to keep expired medications and supplies in the medication storage room for patient safety because expired supplies could have adverse effects on the residents if used or administered. During a review of the facility's policy and procedure (P&P) titled Storage of Medications, revised 11/2020, the P&P indicated, .The facility stores all drugs and biologicals in a safe, secure, and orderly manner.Discontinued, outdated, or deteriorated drugs or biologicals are returned to the dispensing pharmacy or destroyed. 2. A review of the admission Record indicated Resident 63 was admitted to the facility May 2024 with diagnoses including hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) and hemiparesis (weakness or partial paralysis affecting one side of the body) following cerebral infarction (loss of blood flow to a part of the brain) affecting left non-dominant side and congestive heart failure (CHF- a heart disorder which causes the heart to not pump the blood efficiently). A review of Resident 63's physician order dated 4/14/26 indicated a treatment on coccyx superficial skin tear and to apply zinc paste every shift and as needed after incontinent brief change. During a concurrent observation and interview on 4/21/26 at 3:53 p.m., with Resident 63, inside his room, there was a packet of zinc oxide on top of resident's table. Resident 63 stated one of the nurses left the packet yesterday. During a concurrent observation and interview on 4/21/26 at 4:09 p.m., with Licensed Nurse 8 (LN 8) inside Resident 63's room, LN 8 stated there was a packet of zinc oxide on top of resident's table. The LN 8 further stated no when he was asked if it was acceptable to leave the packet of zinc oxide at bedside. The LN 8 added the packet had medication in it and it should be applied by nurses. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a concurrent observation and interview on 4/23/26 at 8:38 a.m., with the Treatment Nurse (TN), the Nurse Surveyor (NS) requested TN to show the supply of zinc oxide the facility use for treatment. The supply of zinc oxide packet in the treatment cart was the same zinc oxide packet found in Resident 63's bedside on 4/21/26. The TN stated Resident 63 currently has an order to apply zinc oxide every shift and as needed for incontinent brief change. The TN further stated the staff cannot leave the zinc oxide at the bedside since other residents might think it is food and they could eat it. The TN added they want to make sure residents are safe so staff cannot leave the packet of zinc oxide at the bedside. A review of the facility's policy & procedure revised November 2020 and titled, Storage of Medications indicated, The facility stores all drugs .in a safe, secure .manner .Drugs .used in the facility are stored in locked compartments .Only persons authorized to .administer medications have access to locked medications.

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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, and record review the facility failed to utilize proper personal hygiene practices (e.g., proper hand washing and dish washing) to prevent contamination of food when:1. Hot water was not available in the kitchen handwashing sink;2. Certified Dietary Manager (CDM) picked up a piece of ice from the floor, then touched food thermometers without performing hand hygiene; and,3. Dietary staff were observed preparing to serve resident's drinks with reusable lids that were still wet.These failures had the potential to spread food-borne illness to all 131 residents of the facility. 1. During an observation on 4/21/26, at 8:02 a.m., in the facility kitchen, no hot water was available in the handwashing sink after allowing the hot water faucet to run for approximately 60 seconds. During an interview on 4/21/26, at 8:32 a.m., with CDM, CDM stated, she just checked the handwashing sink in the kitchen and the water was only warm. During an observation on 4/22/26, at 10:14 a.m., in the facility kitchen, no hot water was available in the handwashing sink after allowing the hot water faucet to run for approximately 60 seconds.2. During an observation on 4/22/26, at 10:55 a.m., in the facility kitchen, CDM was observed to pick up a piece of ice on the floor with her bare hand, then touched both food thermometers with the same hand (right) without performing hand hygiene. CDM was noted to touch both food thermometers and did not sanitize the food thermometers prior to use by staff. During an interview on 4/22/26, at 10:55 a.m., with CDM, CDM stated oh yes when asked if she should wash her hands after touching something from the floor before touching anything.3. During an observation on 4/22/26, at 10:58 a.m., in the facility kitchen, kitchen staff were observed preparing nutritional drinks for residents. Multiple staff were observed placing wet lids (approximately 4-5) onto the cups of prepared nutritional supplement. The liquid was noted to drop into the drink. During an interview on 4/22/26, at 10:58 a.m., with CDM, CDM stated dietary staff should not serve nutritional drinks with wet lids. CDM stated, it's not sanitary.During a review of the facility's policy and procedure (P&P) titled, Handwashing/Hand Hygiene dated 2019, the P&P indicated, The facility considers hand hygiene the primary means to prevent the spread of infections.7. Use and alcohol-based hand rub containing at least 62% alcohol;or, alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situations: .before and after eating or handling food.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to maintain an effective infection control program for two of 32 sampled residents (Resident 99 and Resident 89) when: There was no Enhanced Barrier Precaution (EBP- an infection control strategy in nursing homes requiring staff to wear gowns and gloves during high-contact care for residents at risk of carrying multidrug-resistant organisms or MDRO) sign posted for Resident 99.There was no adequate Personal Protective Equipment (PPE) used by staff during Resident 89's care. These failures increased the risk for Resident 99 and Resident 89 to be exposed to infections that are hard to treat. 1.During a review of Resident 99's admission records, the records indicated Resident 99 was admitted to the facility in March 2026 with diagnoses that included urinary tract infection, acute kidney failure (sudden loss of kidney function), and obstructive and reflux uropathy (blockage and abnormal backward flow of urine). Resident 99's Minimum Data Set (MDS, a federally mandated resident assessment tool), dated 3/17/26, indicated Resident 99 had intact cognition. During a review of Resident 99's physician order, dated 4/8/26, the order indicated, CATHETER: Indwelling Urinary Catheter.Monitor placement every shift for Obstructive Uropathy. During a review of Resident 99's physician order, dated 4/9/26, the order indicated, EBP.Enhanced Barrier Precautions due to presence of foley catheter [a thin, flexible, indwelling tube used to drain urine into a bag] + Hx [history] MDRO in urine. During a review of Resident 99's care plan, revised 4/9/26, the care plan indicated, USE OF ENHANCED BARRIER PRECAUTIONS FOR USE OF:.-INDWELLING MEDICAL DEVICE: Indwelling Urinary Catheter.EDUCATE RESIDENT AND FAMILY ON NEEDS FOR ENHANCED BARRIER PREAUTIONS. During an observation on 4/21/26 at 8:52 a.m. in Resident 99's room, no signages posted requiring any personal protective equipment (PPE) before entering Resident 99's room. Resident 99 was observed lying in bed, eyes closed and did not respond to questions. Resident 99's foley catheter bag was observed hanging on left side of the bed. During an observation on 4/21/26 at 12:29 p.m. in Resident 99's room, there were no signages indicating EBP or any signages requiring any PPE before entering Resident 99's room. During a follow-up observation on 4/22/26 at 1:29 p.m. in Resident 99's room, there were still no signages posted indicating Resident 99 was on EBP. During an interview on 4/23/26 at 8:52 a.m. with the Assistant Director of Nursing (ADON), the ADON stated EBP signages were important so that staff were aware if they should be wearing PPEs before going inside a room to protect the staff and patient from getting infection. During a concurrent observation and interview on 4/23/26 at 4:05 p.m. with the Infection Preventionist (IP), Resident 99's room was observed having EBP signage posted by the door. The IP stated if a resident has any devices, such as foley catheter, EBP signage should be posted. The IP confirmed that Resident 99 had foley catheter and required to be on EBP. The IP confirmed Resident 99's room did not have an EBP signage and the EBP signage was posted in the afternoon of 4/22/26. The IP further stated it was important to have EBP signage for resident safety and to prevent the (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	spread of infection. During an interview on 4/24/26 at 9:09 a.m. with the Director of Nursing (DON), the DON stated residents that have foley catheters should be on EBP because of the possibility of transmission of infection. The DON further stated the EBP signage was necessary for the staff to know which kind of precaution a resident is on. During a review of the facility's policy and procedure (P&P) titled ENHANCED BARRIER PRECAUTION, updated 6/18/24, the P&P indicated, .Enhanced Barrier Precautions involve gown and glove use during high-contact resident care activities for residents known to be colonized or infected with a MDRO as well as those at increased risk of MDRO acquisition (e.g. residents with wounds or indwelling medical devices.PROTOCOL: 1. Implementation.When implementing EBP, it is critical to ensure that staff have awareness of the facility's expectations about hand hygiene and gown/glove use .and access to appropriate supplies. To accomplish this:.Post clear signage on the door or wall outside of the resident room indicating the required PPE (e.g. gown and gloves). For EBP, signage should clearly indicate the high-contact resident care activities that require the use of gown and gloves. 2. A review of the admission Record indicated Resident 89 was admitted [DATE] with diagnoses including end stage renal disease (ESRD- irreversible kidney failure) and dependence on renal dialysis (a treatment to cleanse the blood of waste and extra fluids artificially through a machine when the kidney(s) have failed). A review of Resident 89's physician order dated 1/9/26 indicated Enhanced Barrier Precautions due to history of Multidrug-resistant organisms (MDRO) in the blood & tunneled internal jugular port (IJ- a device placed under the skin connected to a tube that goes into the large vein in the neck for hemodialysis access) to right upper chest every shift. During an observation on 4/21/26 at 9:49 a.m., outside Resident 89's room, an EBP sign was posted by the door. During an observation on 4/21/26 at 9:51 a.m., Certified Nursing Assistant 4 (CNA 4) entered Resident 89's room holding a brief and wipes. During a follow up observation on 4/21/26 at 9:56 a.m., CNA 4 had a mask and gloves while in Resident 89's room. There was no observation of CNA 4 putting on a gown prior to providing care for Resident 89. During an interview on 4/21/26 at 10:02 a.m., with CNA 4, outside Resident 89's room, CNA 4 stated she cleaned up and helped Resident 89 to get dressed. The CNA 4 further stated Resident 89 was on EBP and she was supposed to use gown, gloves, and mask. The CNA 4 added she used mask and gloves, and she forgot to use a gown. During a concurrent interview and record review on 4/23/26 at 3:49 p.m. with the IP, reviewed Resident 89's physician order and care plan. The IP stated Resident 89 had an order and care plan for EBP, and these should have been followed. The IP further stated Resident 89 had a history of MDRO and tunneled IJ for dialysis. The IP added her expectation was for staff to put on the right PPE for high contact activities when providing ADL care such as changing resident's clothes and briefs for resident's on EBP. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the facility's policy and procedure updated 6/18/24 and titled, ENHANCED BARRIER PRECAUTIONS indicated, To provide guidance and recommendations for implementing Enhanced Barrier Precautions (EBP) to include the use of glove and gown during high-contact care activities for residents with .indwelling medical devices, regardless of their MDRO status .High-Contact Resident Care Activities .include activities such as .Dressing .Changing briefs .

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide a POLST (Physician Orders for Life-Sustaining Treatment-a medical order from physician that specifies what type of medical treatment a person wants during serious illness) that accurately reflects resident's wishes for 2 of 32 sampled residents (Resident 13 and Resident 19) when: 1. Resident 19's POLST in clinical record did not indicate the same treatment as the physician's order; and, 2. Resident 13's code status (a status indicating what should be done if the resident had no pulse and not breathing) indicated on Residents 13's physician order did not match Resident 13's POLST. These failures had the potential for Resident 13 and Resident 19 to receive treatment that did not follow their wishes. 1. A review of Resident 19's admission Record indicated Resident 19 was initially admitted to the facility in February 2023 and readmitted [DATE] with multiple diagnoses including failure to thrive (inability to sustain weight due to poor nutrition), left leg above the knee amputation, dysphagia (difficulty swallowing), mood disorder (mental health condition that affects emotional state), and protein calorie malnutrition (protein and calorie intake are inadequate due to decreased oral intake). The admission Record indicated Resident 19's Family Member was his Responsible Party (RP-person responsible for decision making for resident). A review of Resident 19's Minimum Data Set (MDS- federally mandated assessment tool), Cognitive Patterns, dated [DATE], indicated Resident 19 had a Brief Interview for Mental Status (BIMS- tool to assess cognition) score of 0 out of 15 that indicated Resident 19 had severe cognitive impairment. A review of Resident 19's POLST, dated [DATE], indicated .Attempt Resuscitation/CPR [emergency treatment that is done when someone's breathing or heart has stopped] .Full Treatment- primary goal of prolonging life by all medically effective means .Long term artificial nutrition, including feeding tubes [flexible tube that delivers liquid nutrition directly to the stomach] . A review of Resident 19's POLST, dated [DATE], indicated .Do Not Attempt Resuscitation/DNR (Allow Natural Death) .Comfort-Focused Treatment- primary goal of maximizing comfort .No artificial means of nutrition, including feeding tubes . A review of Resident 19's Order Summary Report indicated order dated [DATE], .POLST: Do Not Attempt Resuscitation/ DNR [Do Not Resuscitate]; Comfort-Focused treatment- see Pink form [POLST] . During a concurrent interview and record review on [DATE] at 1:05 p.m. with Licensed Nurse (LN) 6, LN 6 stated Resident 19's physician order indicated DNR and Comfort Focused Treatment but acknowledged the POLST that was scanned in the clinical record, dated [DATE], indicated to attempt CPR and provide full treatment. LN 6 stated the order conflicts with the POLST and could cause confusion about Resident 19's treatment in case of emergency. LN 6 stated Resident 19 is not currently enrolled in hospice services. During a concurrent interview and record review on [DATE] at 1:09 p.m. with the Director of Nursing (DON), the DON stated Resident 19 was admitted to hospice services on [DATE] and discharged from (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	hospice on [DATE]. The DON stated the POLST was changed when Resident 19 was admitted to hospice to reflect DNR and comfort focused treatment. The DON stated when Resident 19 was discharged from hospice, the RP wanted to continue order to not attempt CPR and comfort focused treatment. Reviewed with the DON Resident 19's POLST, dated [DATE], scanned in the clinical record that indicated to attempt CPR and provide full treatment. The DON stated the POLST does not match the current order and there should have been a new POLST scanned into the clinical record. The DON stated the new POLST may be in the hospice binder. During a subsequent interview and record review on [DATE] at 1:40 p.m. with the DON, the DON provided Resident 19's POLST, dated[DATE], that indicated do not attempt CPR and comfort focused treatment. The DON stated this POLST was located in Resident 19's hospice binder which was locked in the medical records office since Resident 19 was no longer on hospice. The DON acknowledged that the nursing staff would not have access to the hospice binder if it was locked in the medical records office. A review of the facility's Policy and Procedure (P&P) titled Physician Orders for Life-Sustaining Treatment (or POLST), updated [DATE], indicated .This facility will advise residents about their rights to make health care decisions and the facility will honor those wishes .Resident /Representative only needs to complete a new POLST if treatment wishes change .Because the POLST form is a physician order, emergency medical personnel are required to adhere to its instructions regarding CPR and other emergency medical care .Initiating a POLST form: .File the copy in the Advance Directive or legal section of the medical record .Add the POLST form to the resident's chart to ensure that the current original form is sent with the resident upon transfer or discharge from the facility .To void a POLST, draw a line through the entire Section A through D and write VOID in large letters. The original POLST marked VOID should be signed, dated and filed in the thinning files . A review of the facility's P&P titled Advance Directives, revised 12/16, indicated .The plan of care for reach resident will be consistent with his or her documented treatment preferences and /or advance directive . 2. During a review of Resident 13's admission records, the records indicated Resident 13 was admitted in [DATE] with diagnoses that included major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest), and severe sepsis (a life-threatening reaction to an infection). Resident 13's MDS, dated [DATE], indicated Resident 13 had intact cognition. During a review of Resident 13's physician order, dated [DATE], the order indicated, CODE STATUS: Full Code [Attempt resuscitation]/Full Treatment [primary goal of prolonging life by all medically effective means] per transfer order. During a review of Resident 13's POLST, dated [DATE], the POLST indicated, .If patient has no pulse and is not breathing.Do Not Attempt Resuscitation/DNR. The POLST further indicated, .IF patient is found with a pulse and/or is breathing.Selective treatment – goal of treating medical conditions while avoiding burdensome measures. During an interview on [DATE] at 8:54 a.m. with the Assistant Director of Nursing (ADON), the ADON stated staff review a resident's POLST upon admission and if there are changes, there should be a new POLST form. The ADON further stated the POLST form should match the physician order so that if there is an emergency, staff know what to do accordingly and respect the residents' wishes. (continued on next page)

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	056495	A. Building B. Wing	04/24/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Casa Coloma Health Care Center	10410 Coloma Rd Rancho Cordova, CA 95670

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on [DATE] at 9:15 a.m. with Licensed Nurse 2 (LN 2), LN 2 reviewed Resident 13's physician orders and confirmed Resident 13 had an order for Full Code and full treatment and in case of emergency, LN 2 stated staff will perform CPR (an emergency procedure that involves chest compression and artificial ventilation to maintain circulation and brain function) on Resident 13. LN 2 reviewed Resident 13's POLST form and confirmed that the form indicated Resident 13 wished to be DNR and have selective treatment. LN 2 confirmed that Resident 13's physician order was not updated based on the most recent POLST and that clarification was needed. LN 2 stated it was important for the physician order and the POLST to match for the safety of the residents and to honor and respect the residents' wishes during emergency. During a concurrent interview and record review on [DATE] at 9:32 a.m. with the Director of Nursing (DON), the DON stated that if there is an emergency, the nurse will check both the POLST form and the physician order. The DON stated the POLST and physician order should match because .the facility will be liable if we do CPR on a DNR resident. The DON reviewed Resident 13's physician order and confirmed that the order dated [DATE] indicated Resident 13 was full code and full treatment. The DON also reviewed Resident 13's POLST form dated [DATE] and confirmed POLST indicated DNR and selective treatment. The DON confirmed that Resident 13's physician order did not match the POLST and stated, .I don't know why we missed it. The DON further stated that the order for Resident 13's code status should have been updated with the DNR status when the POLST form was received. During a review of the facility's policy and procedure (P&P) titled PHYSICIAN ORDERS FOR LIFE-SUSTAINING TREATMENT (OR POLST), updated [DATE], the P&P indicated, .The facility will advise residents about their rights to make health care decisions and the facility will honor those wishes. The California POLST form will be utilized for end of life planning based on the resident's values, beliefs and goals for care.The POLST will be honored if received on admission and signed by both the resident and a physician in accordance with the guidelines.3. Documentation – Any communication with the resident or their representative that involves decisions regarding use of life-sustaining treatments must be documented in the resident's medical record.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure that allegation involving verbal and physical abuse (aggressive or violent behavior toward other) was identified, thoroughly investigated and reported to the appropriate agencies for one of 32 sampled residents (Resident 2), when Resident 2 reported that she was hit by Resident 31 and there was no documented evidence that the investigation and reporting were completed.This failure had the potential to place Resident 2 and other residents at risk for abuse and mistreatment and prevented timely investigations by oversight agencies. A review of the admission record indicated the facility admitted Resident 2 in 2024 with multiple diagnoses which included heart disease and polyarthritis (inflammation, pain and stiffness of multiple joints).A review of Resident 2's Minimum Data Set (MDS, a federally mandated assessment), dated 3/13/26, indicated Resident 2 scored 15 out of 15 on a Brief Interview for Mental Status (BIMS, evaluation of cognitive function), which indicated intact cognition and intact ability to think, rationalize, and recall. The MDS assessment indicated Resident 2 had no hallucinations, delusions, and no verbal and physical behavioral symptoms directed toward others.A review of Resident 31's admission record indicated the facility admitted Resident 31 in 2025 with multiple diagnoses which included anxiety, depression, and schizoaffective disorder (a mental disease characterized by hallucinations and delusions).A review of the physician order dated 6/15/25 indicated that Resident 31 was not capable of Understanding Rights, Responsibilities, and Informed Consents.A review of Resident 31's MDS assessment dated [DATE] indicated Resident 31 scored 12 out of 15 on BIMS, which indicated that the resident had mild cognitive impairment. Resident 31's MDS assessment indicated that the resident used manual wheelchair for mobility.A review of psychiatrist's (physician specializing in treating mental disorder) progress notes dated 1/21/26 for Resident 31 indicated, .Resident with schizoaffective disorder, anxiety, depression, and chronic psychotic symptoms.seen today for psychiatric follow-up.Per nursing staff, patient was noted to be screaming frequently.and was difficult to verbally redirect.A review of Resident 31's clinical record contained the Interdisciplinary Progress Notes (IDT, a team of different disciplines) dated 1/26/26 at 2:04 p.m., which indicated, [Resident 31's name] alleged Incident for physical and verbal altercation with another resident. The IDT note indicated that Resident 31's roommate [Resident 2] reported that Resident 31 hit her with closed fist on.left forearm.During an observation on 4/23/26 at 8:25 a.m., Resident 31 was observed in her bed. Resident 31 responded when her name was called but did not respond when asked about the incident when her roommate reported that she hit her in the shoulder. A review of Resident 2's clinical record contained a document titled, SBAR Communication Form (Situation, Background, Appearance, and Review) dated 1/23/26 at 8:30 p.m. The SBAR indicated that Resident 2 had a change in condition (COC) related to alleged fabricated statement towards [Resident 31]. The SBAR written by Licensed Nurse (LN 9) indicated that around 7 p.m., Resident 2 reported that Resident 31's closed fist landed on [Resident 2's] left forearm. LN 9 documented that Resident 31 denied that she hit Resident 2 and documented further, No witness during the incident.No redness or swelling noted. The COC note indicated that Resident 2's physician, Administrator (ADM), Social Services Director (SSD), and Director of Nursing (DON) were notified regarding Resident 2's alleged verbal and physical altercation.A review of SSD progress note dated 1/24/26 at 11:43 a.m., indicated, Resident [2] verbalized to the nurse that her roommate hit her.Per nurse there is no witness and no physical bruises. The SSD documented further, Asked if the resident wants to report it. Patient [Resident 2] refused to report.During an observation and interview on 4/21/26 at 8:14 a.m., Resident 2 was sitting on the edge of her bed. Resident 2 was pleasant, alert and oriented, and answered appropriately to all questions. Resident 2 stated that she used to have a loud roommate that was screaming all the time, non-stop. Resident 2 stated she knew that her roommate [Resident 31] had (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	impaired cognition and added I had hard time to sleep and rest with all the screaming. Resident 2 stated she asked social services and other staff multiple times to transfer her roommate to a different room, but she was told there was nothing they could do.During continued interview on 4/21/26 at 8:14 a.m., Resident 2 stated that one day in January she asked her roommate [Resident 31] to be quiet so she could rest. Resident 2 added, Next thing she wheeled herself up to me and hit me with her fist into my right shoulder cap. Resident 2 stated that she had pain all the time due to her arthritis and when Resident 31 hit her in the shoulder cap, The pain shot all over my body. Resident 2 stated she reported the incident to her nurse. When Resident 2 was asked if she declined to report the incident, the resident replied, I reported to them and they moved her to different room few days later .No clue what happened after, nobody talked to me after that, not sure if they reported the incident or not.During an observation and interview on 4/22/26, at 8 a.m., Resident 2 was observed sitting in her bed. When Resident 2 was asked about the incident with Resident 31, the resident validated the incident again and stated that she reported to nursing right away that Resident 31 hit her in the shoulder.During an interview on 4/22/26 at 4:25 p.m., Director of Staff Development (DSD) stated that if resident reported that the roommate hit him or her, it was considered a potential abuse and all allegations of abuse needed to be reported. The DSD stated, Physical abuse is reported immediately, other forms .the timeframe is within 24 hours. The DSD explained that if the incident was unwitnessed, it was hard to determine if the abuse occurred or not. The DSD added, I educate staff to report [the incident] right away even if unwitnessed. The abuse coordinator will investigate but if we did not report, we are in big trouble. The DSD provided a binder located in Station 3 with blank forms and instructions for reporting the allegations of abuse.During a concurrent interview and record review on 4/23/26 at 10:10 a.m., the DON stated she was aware of the incident between Resident 2 and her roommate, Resident 31. The DON explained, Resident [2] reported to her nurse that her roommate [Resident 31] yelled and hit her. The DON stated that Resident 31 had lots of screaming behaviors but was not violent. The DON added, I talked to both residents, [Resident 31's name] denied that she hit her roommate [Resident 2]. I talked to nurse and CNA immediately after the incident and they stated they were there and did not witness Resident 31 hitting Resident 2. [Resident 2's name] did not tell me at that time that she was hit. The DON searched Resident 2's clinical records and stated that she was unable to find any records that Resident 2 denied she was hit by Resident 31.During a continued interview with DON on 4/23/26 commencing at 10:10 a.m., the DON stated that LN 9 to whom Resident 2 reported that she was hit by Resident 31, was out of country and was not available for interview. The DON explained that she instructed LN 9 to report in SBAR communication that Resident 2's alleged allegation was fabricated because the incident was not witnessed. The DON acknowledged that neither the assigned nurse nor assigned CNA were present in Resident 2's room at all times, one-on-one observation, and did not reply that it was possible that Resident 31 hit Resident 2 when the staff were not present. The DON stated the administrator, who is abuse coordinator was notified of the incident of physical altercation between Resident 31 and Resident 2, but the incident was not investigated by the facility and explained, We tried to initiate investigation, but resident refused to report the incident.During a continued interview and record review with DON on 4/23/26 at 10:15 a.m., the Administrator (ADM) joined the interview. The ADM stated he was the abuse coordinator for the facility. The ADM described the abuse investigation process as following: After I receive a report of alleged abuse, I would talk to residents, investigate, and document investigation report. No documented investigation for this resident because resident did not tell me she was hit and the nurse did not report about physical contact .I can only report what I know or what I was told.I did not read the SBAR notification and progress note addressing the incident. I don't read all progress notes. The ADM explained further, Resident [2] declined to complete the SOC 341 report [a mandatory state's report of suspected verbal or physical abuse or mistreatment of dependent adult. The ADM was asked if the regulations directed facility not to complete SOC 341 if the resident declined reporting. The ADM stated, No. If the resident declines (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	report, we do, but sometimes residents did not want us to report saying they don't want anyone getting in trouble.During a concurrent interview and record review on 4/23/2026, at 2:48 p.m., with Social Services Director (SSD), the SSD stated she was informed by nurse about Resident 2's allegations that she was hit by her roommate with a fist into right shoulder. The SSD stated that Resident 31 denied hitting, and Resident 2 explained that Resident 31 started with verbal aggression then hit her. The SSD stated, I informed resident [Resident 2] that I will be reporting incident to appropriate agencies, including ombudsman and state and she [Resident 2] said, No, just get her [Resident 31] out of here. The SSD explained the facility's protocol for reporting allegation of abuse and stated, If the resident is alert and oriented, cognitively intact, refuse that we complete the report, I do not report.Resident [2] has capacity to make decisions and is her own Responsible Party. So it was not reported. The SSD stated she called Resident 2's Family Member (FM) and reported the incident.During an interview on 4/24/26 at 3:05 p.m., with Certified Nursing Assistant 1 (CNA 1), CNA 1 stated she was assigned to Resident 2 and Resident 31 on 1/23/26 on the evening shift. CNA 1 stated she heard loud yelling coming from the room and when she entered the room, she noticed Resident 31 in wheelchair in the middle of room. Resident 2 was sitting on the bed and looked angry. CNA 1 stated Resident 2 pointed at Resident 31 and yelled, She hit me, she hit me. CNA 1 stated, I did not see her [Resident 31] hitting [Resident 2], but she kept repeating that [Resident 31] hit her. CNA 1 stated she was not in the residents' room all the time, as it was a busy time and she had other responsibilities. CNA 1 did not provide the answer when asked if it was possible that Resident 31 hit Resident 2 in the shoulder prior to her entering the room. CNA 1 stated she reported Resident 2's allegations to the nurse.During a telephone interview on 4/24/26 at 3:32 p.m., Resident 2's Family Member (FM) stated Resident 2 called frequently and complained not able to rest because of her roommate's screaming behaviors. FM stated that he found out about the alleged incident from Resident 2. FM explained that back in January his sister, (Resident 2) called him and talked about the incident when her roommate hit her in the shoulder. The FM stated he was unable to recall if the facility's staff notified him about the incident. FM added, I know for sure that I have heard it from my sister.A review of the policy titled, Resident-to-Resident Altercations, dated 12/2016, indicated, All altercations, including those that may represent resident-to-resident abuse, shall be investigated and reported.A review of the facility's policy titled, Abuse Prevention Program, dated 12/2016, indicated, Our residents have the right to be free from abuse. this includes but is not limited to freedom from. verbal. or physical abuse.As part of the resident abuse prevention, the administration will. Protect our residents from abuse by anyone including. other residents. Identify and assess all possible incidents of abuse. Investigate and report any allegations of abuse within timeframes as required by federal requirements.A review of the facility's policy titled, Abuse Investigation and Reporting, dated 7/2017, indicated, As the facility is made aware, reports of resident abuse . Mistreatment. shall be promptly reported to local state and federal agencies (as defined by current regulations) and thoroughly investigated by facility management. All alleged violations involving abuse. will be reported by the facility administrator, or his/her designee, to the following persons or agencies: a. The state licensing/certification agency responsible for surveying/licensing the facility .b, The Local/State Ombudsman.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on observation, interview, and record review, the facility failed to ensure that residents received necessary services to maintain personal hygiene for one of 32 sampled residents (Resident 7), when showers or bed bath were not provided two times a week as scheduled.This failure affected Resident 7's dignity, self-esteem, and had the potential to affect resident's overall well-being. A review of the admission record indicated the facility admitted Resident 7 earlier this year with multiple diagnoses which included hemiplegia (paralysis of partial or total body function on one side of the body) and hemiparesis (one-sided weakness) following stroke affecting left side.A review of Resident 7's Minimum Data Set (MDS, a federally mandated assessment), dated 2/27/26 indicated Resident 7 scored 13 out of 15 on a Brief Interview for Mental Status (BIMS, evaluation of cognitive function), which indicated intact cognition and intact ability to think, rationalize, and recall. The MDS assessment of Resident 7's functional abilities indicated the resident was dependent on staff for personal hygiene, including showers.A review of Activities of Daily Living functioning care plan initiated 2/13/26 indicated Resident 7 required assistance with personal hygiene and the care plan goal indicated, Resident will be well groomed, clean daily.During an observation and interview on 4/22/26 at 8 a.m., Resident 7 was in bed. Resident 7 was pleasant and answered appropriately to all questions. Resident 7's hair appeared to have sticky greasy clumping. Resident 7 stated, Look at my greasy hair. I am smelly, and I don't feel well cared for. Makes me feel less than human. Resident 7 stated she preferred to have bed bath and added, I have not had a good bed bath and my hair washed for 2-3 weeks. Resident 7 stated she was scheduled to receive bath two times a week, but the bathing was inconsistent. During an interview with Certified Nursing Assistant (CNA 2) on 4/22/26 at 8:05 a.m., in Resident 7's room, CNA 2 validated that Resident 7's hair was greasy and needed to be washed. CNA 2 stated that she bathed Resident 7 a week ago. Resident 7 stated, You did not wash my hair, [you] just washed my body, for which CNA 2 did not provide any answer.During an interview with CNA 3 on 4/23/26 at 4:10 p.m., CNA 3 described Resident 7 as alert, oriented, and able to verbalize her needs. CNA 3 stated Resident 7 had a left-sided weakness and was dependent on staff for personal hygiene. CNA 3 explained that showers or bed bath were documented on paper forms and then entered into electronic charting.A review of the facility's undated shower schedule indicated Resident 7 was scheduled for showers on Wednesday and Saturday during the day shift. As per shower/bed bath schedule, Resident 7 was due for shower on 4/1, 4/4, 4/8, 4/11, 4/15, 4/18, and 4/22/26.A review of the weekly shower forms for April of 2026 indicated Resident 7 received bed baths on 4/1, 4/8, 4/15, and 4/18/26 and the forms were signed by the nurses. There were no shower forms indicating that Resident 7 had bed bath on 4/4/26 and 4/11/26. Resident 7's clinical record did not contain any documented evidence that the resident refused bed baths on 4/4/26 and 4/11/26.During a concurrent interview and review of Resident 7's clinical records on 4/22/26 at 4:25 p.m., with Director of Staff Development (DSD), the DSD stated that each resident was scheduled for shower or bed bath twice a week. The DSD stated shower and/or bed bath were documented on shower sheets and then entered into electronic records. Upon reviewing Resident 7's shower forms and electronic charting, the DSD validated there was no documentation to show that Resident 7 had showers or bed bath on 4/4 and 4/11/26 and no records indicating that resident refused showers or bed bath.During a concurrent interview and record review on 4/23/26 at 5:15 p.m., with Director of Nursing (DON), the DON stated that the expectation for showers or bed bath was to be done twice a week. The DON explained that if resident refused shower or bed bath, the refusal should be documented in the resident's records. The DON stated that Resident 7 refused personal hygiene and was non-compliant with care at times. The DON was unable to find documented refusals for showers or bed bath in Resident 7's clinical record. The DON stated if the resident was non-compliant with care, she should have a non-compliance care plan, but there was none for Resident 7.A review of the facility policy titled, Activities of Daily Living, Supporting, dated 3/2018, indicated, Residents will be (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	provided with care. and services as appropriate to maintain or improve their ability to carry out activities of daily living. Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain. grooming and personal. hygiene.A review of the facility policy titled, Bath, Shower/Tub, dated 2/2018, indicated, Purpose.To promote cleanliness, provide comfort to the resident. The policy directed staff to document resident's refusal for the shower or bed bath and notifying the supervisor.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. Based on observation, interview, and record review, the facility failed to provide catheter (a thin flexible tube to drain urine) care in a manner to prevent catheter related infections for 1 of 32 sampled residents (Resident 161) when Resident 161's urinary (catheter placed into bladder) drainage bag and nephrostomy (catheter inserted into the kidney) drainage bag were laying on the floor in the same privacy bag.This failure had the potential to result in urinary tract infections for Resident 161. A review of Resident 161's admission Record indicated she was admitted to the facility in April 2026 with multiple diagnoses including encephalopathy (damage or disease that affects brain function), tubulo-interstitial nephritis (inflammation that damages structures of the kidneys), urinary tract infection (an infection in any part of the urinary tract system), and hydronephrosis (swelling of the kidney when urine cannot drain out from the kidney due to blockage or obstruction). A review of Resident 161's Minimum Data Set (MDS- federally mandated assessment tool), Cognitive Patterns, dated 4/11/26, indicated Resident 161 had a Brief Interview for Mental Status (BIMS- tool to assess cognition) score of 11 out of 15 that indicated she was moderately cognitively impaired. A review of Resident 1's Order Summary Report indicated an order dated 4/5/26, .MONITOR FOLEY [type of urinary catheter] DRAINAGE BAG FOR PROPER PLACEMENT, NO KINKING OR COMPRESSIONTHAT COULD OBSTRUCT URINE FLOW and MUST BE PLACE BELOW THE BLADDER AT ALL TIMES every shift . A review of Resident 1's Order Summary Report indicated order dated 4/7/26, .NEPHROSTOMY: Nephrostomy tube: LEFT UPPER QUADRANT .Monitor placement of the tubing every shift . During an observation on 4/22/26 at 8:40 a.m. with Resident 161, observed Resident 161's indwelling urinary catheter drainage bag and nephrostomy drainage bag in the same black mesh privacy bag laying on the floor. During a concurrent observation and interview on 4/22/26 at 9:00 a.m. with Licensed Nurse (LN) 1, LN 1 confirmed Resident 161's indwelling urinary catheter drainage bag and nephrostomy drainage bag were in the same black mesh privacy bag and were laying on the floor next to the bed. LN 1 stated the drainage bags should be in separate privacy bags and should be hanging off the side of the bed. LN 1 stated the bags should not be on the floor. LN 1 stated if the bags are on the floor, it is a trip hazard for the resident and an infection control issue. During an interview on 4/22/26 at 1:09 p.m. with the Director of Nursing (DON), the DON stated urinary catheter drainage bags and nephrostomy drainage bags should be kept in privacy bags and should not be on the floor. The DON stated, Don't allow on floor. On the floor is noncompliant. A review of the facility's Policy and Procedure (P&P) titled Catheter Care, Urinary, revised 9/14, indicated .The purpose of this procedure is to prevent catheter-associated urinary tract infections .Be sure the catheter tubing and drainage bag are kept off the floor . A review of the facility's P&P titled Urinary Tract Infections (Catheter-Associated), Guidelines for Preventing, revised 9/17, indicated .The purpose of this procedure is to provide guidelines for the prevention of catheter-associated urinary tract infections (CAUTI) .Do not place the drainage bag on the floor .

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure respiratory care was provided in accordance with professional standard of practice when:The oxygen order was not followed for Resident 135;The oxygen tubing was not labeled, and oxygen in use signage was not in place for Resident 52 and,The oxygen titration order was not followed for Resident 121.These failures had the potential for Resident 135, Resident 121, and Resident 52 to experience respiratory distress, and an increased risk for fire hazards for Resident 52. 1. A review of the admission Record indicated Resident 135 was admitted [DATE] with diagnoses including asthma (chronic lung disease causing airways to become inflamed, narrow, making it hard to breathe) and obstructive sleep apnea (brief episodes of stopped breathing or restricted airflow reduce blood oxygen). Resident 135's Brief Interview for Mental Status (BIMS- an assessment tool to screen and identify memory, orientation, and judgement status of the resident) dated 3/9/26 indicated Resident 135 was cognitively intact with a score of 13. A review of Resident 135's physician order dated 4/18/26 indicated oxygen inhalation at 2-4 liters per minute via nasal cannula (NC- a small plastic tube which fits into the person's nostrils, for providing supplemental oxygen) continuously, every shift for shortness of breathing (SOB), chest pain (discomfort caused by reduced blood flow to the heart muscle) to maintain oxygen saturation (O2 sat- a measurement of how much oxygen the blood is carrying as a percentage) above 92 %. During an observation on 4/22/26 at 8:27 a.m., inside Resident 135's room, Resident 135 was lying in bed, resident opened her eyes briefly when her name was called. Resident 135's oxygen concentrator was set at 5 liters per minute, and the NC was off her nostrils. During a concurrent observation and interview on 4/22/26 at 8:37 a.m., inside Resident 135's room with Licensed Nurse 3 (LN 3), the LN 3 stated she was assigned to Resident 135. The LN 3 further stated Resident 135's oxygen was set at 5 liters per minute, and it should be set between 2-3 liters. During a concurrent interview and record review on 4/23/26 at 4:14 p.m. with the Assistant Director of Nursing (ADON), Resident 135's oxygen orders and Medication Administration Record (MAR) were reviewed. The ADON stated Resident 135's physician order indicated 2-4 liters of oxygen continuously and licensed nurses were signing the oxygen order in the MAR. The ADON further stated the physician order was not followed if Resident 135's oxygen was set at 5 liters per minute, and the physician should have been notified of Resident 135's episodes of removing NC or non-compliance. A review of the facility's policy & procedure dated 10/23/25 and titled, Supplemental Oxygen indicated, The purpose of this policy is to provide guidelines for safe oxygen administration .Oxygen therapy is administered by way of .nasal cannula .The nasal cannula is a tube that is placed approximately one-half inch into the resident's nose. It is held in place by an elastic band around the resident's head .Physician's order for oxygen administration should be in place for routine administration . 2. A review of Resident 52's admission Record indicated Resident 52 was initially admitted to the facility in April 2025 and readmitted in March 2026 with multiple diagnoses including epilepsy (seizure disorder), respiratory failure with hypoxia (respiratory system is unable to maintain adequate oxygen in the blood), heart failure (heart does not pump blood as efficiently as it should) and senile degeneration of the brain (progressive decline in cognitive function, impacting memory and ability to (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	perform activities of daily living). A review of Resident 52's Minimum Data Set (MDS- federally mandated assessment tool), Cognitive Patterns, dated 3/31/26, indicated Resident 52 had a BIMS score of 13 out of 15 that indicated Resident 52 was cognitively intact. A review of Resident 52's Order Summary Report indicated order .OXYGEN inhalation at 1-4 liters per minute [amount of oxygen delivered] via nasal [cannula-tube to deliver oxygen through a tube into the nose] continuously every shift . A review of Resident 52's Order Summary Report' indicated order . Oxygen &/or [and /or] Nebulizer [machine that turns liquid medication into mist to be inhaled] tube: change tube weekly & PRN [as needed] (label date on tube when changed) .Document if tubing set replaced . During an observation on 4/21/26 at 8:35 a.m. with Resident 52, observed Resident 52 using oxygen via nasal cannula at 4 liters per minute. The oxygen tubing was observed not labeled with the date changed. During a concurrent observation and interview on 4/21/26 at 10:11 a.m. with LN 1, LN 1 confirmed Resident 52's oxygen tubing was not labeled with the date changed. LN 1 stated the tubing should be changed weekly and the tubing should be labeled with the date it was changed. LN 1 confirmed there was not an oxygen in use sign at Resident 52's room and stated Resident 52's room should have sign to indicate oxygen being used in the room. During an interview on 4/22/26 at 1:09 p.m. with the Director of Nursing (DON), the DON stated oxygen tubing is changed every Friday on the night shift. The DON stated it is a standard order and there does not need to be a physician's order for tubing to be changed. The DON stated there should be oxygen in use sign at the door if oxygen is used in the room. The DON stated Resident 52 should have had an oxygen in use sign at the door and the oxygen tubing should have been labeled with the date tubing was changed. A review of the facility's Policy and Procedure (P&P) titled Supplemental Oxygen, dated 10/23/25, indicated .The purpose of this policy is to provide guidelines for safe oxygen administration .No smoking/Oxygen in use sign shall be placed outside the resident's room .Oxygen cannula and tubing is to be changed every seven (7) days or as needed . 3. During a review of Resident 121's admission record, record indicated, Resident 121 was admitted to the facility on [DATE] with diagnoses including but not limited to, Acute and Chronic Respiratory Failure with Hypercapnia (a long-term condition where the respiratory system cannot adequately remove carbon dioxide (C02: waste product from breathing)), Acute and Chronic Respiratory Failure with Hypoxia (a long-term, ongoing condition where the lungs cannot adequately transfer oxygen into the blood, resulting in a low arterial oxygen), Chronic Obstructive Pulmonary Disease (COPD- a progressive, incurable lung disease that obstructs airflow, causing chronic breathing difficulties), Acute Pulmonary Edema (a life-threatening medical emergency caused by rapid fluid accumulation in the lung's air sacs, often due to sudden left-sided heart failure.), and Morbid Obesity with Alveolar Hypoventilation (a condition where severe obesity leads to breathing difficulties, resulting in low oxygen and high carbon dioxide). During an observation on 04/21/26, at 11:23 a.m., in Resident 121's room, Resident 121's oxygen (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	concentrator (machine that provides oxygen) was set to 3.5 Liters (L-unit of measure). During an interview on 4/21/26, at 11:25 a.m., with LN 10, LN 10 stated, she looked at Resident 121's physician orders, and the order stated to give 2-4 liters to maintain 88-92% [sp02: measures the percentage of oxygen-saturated hemoglobin in the blood, healthy individuals should maintain 95-100, and those with COPD are expected to maintain 88-92%]. LN 10 stated, she believes the oxygen being given at 3.5 liters is okay because it is within the order. During a review of Resident 121's MAR dated 4/21/26, indicated, LN 10 charted Resident 121's oxygen as 96%. During a concurrent observation and interview on 04/23/26, at 9:12 a.m., with LN 3, in Resident 121's room, Resident 121's oxygen concentrator was observed to read 3.5 liters. LN 3 stated, Resident 121 was currently receiving 3.5 liters of oxygen. During a concurrent interview and record review on 4/23/26, with LN 3, Resident 121's MAR dated 4/23/26 was reviewed. MAR indicated, Resident 121 had an order to titrate (therapeutic process that adjusts the amount of supplemental oxygen (flow rate) to meet a patient's specific needs) oxygen to maintain 88-92%. LN 3 stated, as long as its above 90% it is good. LN 3 stated, his [Resident 121] oxygen was at 95% this morning. LN 3 stated, she did not need to adjust the oxygen based on this reading. During a concurrent interview and record review on 4/24/26, at 9:25 a.m., with the DON, Resident 121's MAR dated April 2026 was reviewed. The MAR indicated, from 4/1/26-4/22/26, there were 64 instances of licensed nurses charting Resident 121's oxygen above the required range per the MD order, which read OXYGEN inhalation at 2-4 liters per minute via nasal cannula continuously every shift titrate up or down to keep oxygen saturation 88-92% but no greater than 92%. DON stated, the licensed nurses did not follow this order according to the MAR. DON stated it is her expectation that licensed nurses follow all orders. DON stated, a possible outcome of giving a COPD resident higher than 92% oxygen level is a Pulmonary crash down [respiratory distress]. During a review of article published by the Mayo Clinic titled, Why Oxygen Saturation Is NOT the Only Thing That Matters in COPD dated 2026, article indicated, For most COPD patients, the ideal oxygen saturation range is around 88–92%. If oxygen is given excessively and saturation is pushed too high (for example close to 100%), it can sometimes reduce the drive to breathe and also worsen CO^ retention (hypercapnia).That's why we usually titrate oxygen carefully instead of trying to make the saturation 100%.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide pain management in accordance with professional standards and resident centered care plan for one of 32 sampled residents (Resident 74), when facility did not assess Resident 74's pain, did not offer non-pharmacological (strategies that do not involve use of pain medications) interventions, and did not offer pain medications. This failure had the potential for Resident 74 to be in pain and have ineffective pain management.A review of the admission record indicated the facility admitted Resident 74 in 2017 with multiple diagnoses which included osteoarthritis (pain, stiffness, and swelling of multiple joints) and inflammatory radiculopathy of lower back (pinched nerve, causing pain that goes down the leg (s).A review of Order Summary Report for Resident 74 contained a physician order to administer Tylenol 500 milligram (mg, unit of measurement) to administer for pain every 6 hours as needed.A review of Resident 74's Minimum Data Set (MDS, a federally mandated resident assessment) dated 3/27/26, the MDS indicated the resident scored 7 out of 15 in a Brief Interview of Mental Status (cognitive assessment), which indicated moderate cognitive impairment. Resident 74's MDS assessment addressing pain indicated that the resident was not offered and did not receive any as needed or scheduled pain medications, and did not receive any non-pharmacological interventions for pain. A review of Resident 74's care plan initiated 3/8/24 indicated that the resident had acute and chronic pain related to his multiple diagnoses, including osteoarthritis and inflammatory radiculopathy. The care plan goal indicated that Resident 74 will receive adequate relief of pain and will not have interruption in normal activities due to pain. The interventions directed nurses to monitor/record/report to nurse any signs and symptoms of non-verbal pain, including changes in breathing, vocalizations (moaning, yelling out, grunting), monitor/document for probably cause of each pain episode, anticipate the resident's need for pain relief, respond immediately to any complaints of pain, and administer pain medications as ordered.A review of Resident 74's clinical records, including Medication Administration Record (MAR) for April 2026 indicated that resident's pain was not addressed, not assessed, non-pharmacological interventions were not offered, and the resident did not receive any pain medications.During an observation and interview on 4/21/26 at 9:55 a.m., Resident 74 was observed in bed dressed in hospital gown. Resident 74 responded to all questions appropriately. Resident 74 was noted to have facial expression of pain; was moaning and rubbing her knees. Resident 74 stated, My knees hurt, and [I] have pain all over. I have arthritis in my joints. During a continued interview, Resident 74 added, Nobody asks me about pain and do not offer any pain medication.During an observation and interview on 4/22/26, at 10:15 a.m., Resident 74 was in bed. Resident 74 stated, My left knee hurts, but as long as I don't move, it's okay. Very painful when moved.During an observation and interview on 4/22/26, at 4:15 p.m., Resident 74 was in bed, grimacing and moaning. Resident 74 continuously rubbed her lower legs. Resident 74 stated she did not receive any pain medication or any non-medicated intervention for pain.During an observation and interview on 4/23/26, at 3:45 p.m., Resident 74 was in bed, grimacing and moaning. Resident 74 grimaced while rubbing her left knee and stated she was hurting.During an interview on 4/23/26 at 9:43 a.m., with Certified Nursing Assistant (CNA 4), CNA 4 stated she was familiar with Resident 74 and her care needs. CNA 4 stated, Sometimes she [Resident 74] complained of pain in her legs when we transfer her. CNA 4 stated she reported to nurses when Resident 74 was complaining of pain but was not sure if the resident received pain medications.During an interview on 4/23/26, at 3:54 p.m., CNA 6 stated that Resident 74 was forgetful lately but was able to verbalize when she was in pain. CNA 6 stated Resident 74 frequently complained of pain in her left knee and asked to be careful during repositioning or transferring to wheelchair. During an interview on 4/23/26, at 4:05 p.m., with Director of Nursing (DON), the DON described facility's process for pain management. The DON stated nurses were responsible for assessing residents' pain every shift using scale 1 to 10 if resident can verbalize (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	pain. If not, use facial expressions or moaning, crying as expressions of pain. The DON explained further, Non-pharmacological interventions are part of pain management and should be offered every shift prior to pain medication administration.During a continued interview and record review on 4/23/26, at 4:05 p.m., the DON acknowledged that Resident 74's underlying health conditions predisposed the resident to experience pain. The DON reviewed Resident 74's orders and stated, No order for pain assessment, no non-pharmacological assessments. It's a batch order but it's not there. The DON stated that Resident 74 had Tylenol ordered for pain and stated, If resident asked, they [nursing] would administer it [pain medication]. Upon reviewing resident's MARs for April 2026, the DON stated that the resident's MAR did not reflect that the resident was assessed for pain every shift, was offered non-pharmacological interventions, or was administered pain medications. The DON reviewed Resident 74's MARs for March, February, January of 2026, December and November of 2025 and stated that the resident had not been assessed for pain and was not offered non-pharmacological interventions every shift. Upon further review of Resident 74's clinical records, the DON stated that the resident went to hospital on [DATE] and after her return, pain assessment every shift and non-pharmacological interventions were not ordered. The DON stated that at the end of each month, nurses responsible for orders auditing, did not capture that Resident 74 had not been assessed for pain since 10/6/25. The DON stated that her expectation for nurses was to assess Resident 74's pain at least once a shift using scale from 1 to 10, offer non-pharmacological interventions, like heat, cold, reposition, distraction and if not effective offer medications, but it was not done.A review of the facility's policy titled, Pain Assessment and Management, dated 3/20, indicated, Purpose.Help the staff identify pain in the resident and develop interventions.The pain management program is based on a facility-wide commitment to appropriate assessment and treatment of pain, based on professional standards of practice, the comprehensive care plan, and the resident's choices related to pain management. The policy further indicated that nurses were to assess pain using a consistent approach appropriate to the resident's level.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. Based on observation, interview, and record review, the facility failed to provide services in accordance with physician order, plan of care, and assessment for one of 32 sampled residents (Resident 74), when the right sided bed rail utilized for Resident 74's bed was not correctly sized.This failure had the potential to affect Resident 74's safety.A review of the admission record indicated the facility admitted Resident 74 in 2017 with multiple diagnoses which included cognitive impairment, weakness, and history of falling.A review of Order Summary report for Resident 74 contained a physician order dated 1/4/26 which indicated, Side rails 1/4 [quarter size] x 2 for bed mobility (turning and repositioning).A review of Resident 74's Minimum Data Set (MDS, a federally mandated resident assessment) dated 3/27/26, the MDS indicated the resident scored 7 out of 15 in a Brief Interview for Mental Status (cognitive assessment), which indicated moderate cognitive impairment.A review of Resident 74's care plan initiated 3/8/24 indicated that the resident required assistance from staff for bed mobility related to weakness and decreased strength. One of the interventions indicated to educate resident regarding the risks of using side rail. The care plan did not specify the size or type of side rails to be utilized as indicated by a physician's order. The care plan lacked individualized interventions to ensure the facility implemented the correct size of bed rail.During an observation on 4/21/26 at 9:55 a.m., Resident 74 was observed in bed with head of the bed elevated. Resident 74's bed was next to wall on left side and had a quarter size bed rail in upright position. Resident 74's right side of the bed had half-length size bed rail in the middle of resident's bed in upright position. The right bed rail was in locked position.On 4/22/26 at 10:53 a.m., Resident 74 was observed asleep in bed with right side half-length size bed rail in the middle of the bed in upright and locked position.A review of Resident 74's Quarterly Bed Rail Review dated 1/6/26 indicated the bed rails were used for safety due to resident's history of falls, impaired cognition, joint pain, and weakness. The document indicated that that quarter size left and right upper bed rails were utilized for Resident 74.A review of Resident 74's Quarterly Bed Rail Review dated 3/27/26 indicated the bed rails were used for safety due to resident's history of falls, impaired cognition, joint pain, and weakness. The document indicated that that quarter-length size left and right upper bed rails were utilized for Resident 74.During an observation on 4/23/26 at 4:55 p.m., in Resident 74's room and concurrent interview with Assistant Director of Nursing (ADON) the right side of the bed was noted with half-length side rails in place. The ADON stated that the installed right side rail was half-length and validated that this did not match the physician order for quarter-length side rails.During an interview and record review on 4/23/26 at 5:01 p.m., the Director of Nursing (DON) reviewed Resident 74's order and acknowledged that physician order specified a quarter-length side rails for bed mobility and repositioning. The DON reviewed quarterly bed rail assessments dated 1/6/26 and 3/27/26 and indicated that per assessments, Resident 74 was to have right and left quarter-length side rails. The DON validated that installed right side rail was half-length and not in accordance with the physician's order and as indicated in the assessments.A review of the facility's policy titled Proper Use of Side Rails, dated 12/2016 indicated, The purpose of these guidelines are to ensure the safe use of side rails as resident mobility aids.The use of side rails as an assistive device will be addressed in the resident care plan.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. Based on observation, interview, and record review, the facility failed to ensure residents are free of any significant medication errors for one of 32 sampled residents (Resident 162) when Resident 162's Insulin Glargine (a long-acting type of insulin - a hormone that removes excess sugar from the blood, can be produced by the body or given artificially via medication) was not administered as scheduled per physician's order.This failure had the potential to result in uncontrolled blood sugar for Resident 162 and placed Resident 162 at risk for developing signs and symptoms of high blood sugar.During a review of Resident 162's admission records, the records indicated Resident 162 was admitted to the facility in April 2026 with diagnosis that included Type 2 Diabetes Mellitus (DM - a disorder characterized by difficulty in blood sugar control and poor wound healing). Resident 162's Minimum Data Set (MDS, a federally mandated resident assessment tool), dated 4/4/21, indicated Resident 162 had intact cognition.During a review of Resident 162's physician order, dated 4/20/26, the order indicated, Insulin Glargine.Subcutaneous [under the skin, between the fatty tissue and muscle].Inject 28 unit subcutaneously two times a day for DM 2.During a review of Resident 162's care plan, initiated on 4/21/26, the care plan indicated, Risk for hypo/hyperglycemia [low or high blood sugar] secondary to: DIABETES MELLITUS.ADMINISTER MEDICATIONS AS ORDERED:.INSULIN GLARGINE.During the medication pass observation on 4/22/26 starting at 7:53 a.m. with Licensed Nurse 1 (LN 1), LN 1 was observed administering 8 1/2 pills and two injections for Resident 162. Resident 162's insulin glargine was not included in the medications administered during the medication pass observation.During a review of Resident 162's Administration History for Insulin glargine, dated 4/22/26, the history indicated Resident 162's insulin glargine was scheduled to be administered at 8 a.m. The history further indicated that Resident 162's insulin glargine was administered on 4/22/26 at 10:42 a.m. instead of 8 a.m.During an interview on 4/22/26 at 11:52 a.m. with LN 1, LN 1 confirmed that Resident 162's insulin glargine was not administered on the scheduled time at 8 a.m. and during the medication pass observation. LN 1 stated she went back to Resident 162 to give the insulin glargine at 10:42 a.m. because LN 1 did not want to give Resident 162's insulin glargine at the same time as the two other injections. LN 1 confirmed Resident 162's insulin glargine was scheduled at 8 a.m. and stated that medications were supposed to be given an hour before and an hour after the scheduled time. LN 1 stated it was important to give insulin on time for safety and so it can regulate the blood sugar, and Resident 162 would not have hyperglycemia.During a concurrent interview and record review on 4/22/26 at 3:23 p.m. with the Director of Nursing (DON), the DON reviewed Resident 162's administration history for insulin glargine dated 4/22/26 and confirmed that the insulin glargine doses were scheduled twice a day at 8 a.m. and 8 p.m. The DON also confirmed that Resident 162's insulin glargine was administered on 4/22/26 at 10:42 a.m., over two hours from the scheduled administration schedule. The DON stated medications should be given one hour before and one hour after the scheduled administration time, unless there was an emergency. The DON further stated it was important to follow the physician order because it can affect the condition of the residents.During a review of the facility's policy and procedure (P&P) titled Administering Medications, revised 4/2019, the P&P indicated, .Medications are administered in a safe and timely manner, and as prescribed.4. Medications are administered in accordance with prescriber orders, including any required timeframe.8. Medications are administered within one (1) hour of their prescribed time, unless otherwise specified.During a review of the facility's P&P titled Insulin Administration, revised 9/2014, the P&P indicated, .Purpose.To provide guidelines for the safe administration of insulin to residents with diabetes.3. The type of insulin, dosage requirements, strength, and method of administration must be verified before administration, to assure that it corresponds with the order on the medication sheet and the physician's order.

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure therapeutic diets are prescribed by the attending physician and may be delegated to a registered or licensed dietitian, to the extent allowed by State law. Based on observation, interview and record review, the facility failed to follow prescribed therapeutic diets (Physician prescribed meal plans that modify nutrient, calorie, or texture intake to treat medical conditions, and manage chronic diseases) for three residents (Resident 95, Resident 99, and Resident 134), for a census of 131.These failures had the potential for negative health outcomes for Resident 95, Resident 99, and Resident 134. During an observation in the facility kitchen on 4/22/26, at 12:05 p.m., Resident 99's food tray ticket was observed to read Diet: 2gm [gram, unit of measure] Sodium. Kitchen staff prepared Resident 99's lunch meal. Kitchen staff prepared the regular entree item country fried steak for Resident 99, and placed the tray on the food cart.During an interview on 4/22/26, at 12:05 p.m., with Certified Dietary Manager (CDM) CDM stated, Resident 99 got the wrong entree item and should have received the beef patty.During a review of the Facility's Diet Spreadsheet dated 4/22/26, spreadsheet indicated, for the 2gm Sodium diet the lunch item was a beef patty instead of the country fried steak.During an observation in the facility kitchen on 4/22/26, at 12:27 p.m., Resident 134's meal tray ticket was observed to read Texture: Soft & Bite Sized. Kitchen staff prepared Resident 134's lunch meal. Kitchen staff placed the regular dessert item Tiramisu pudding with wafers, on Resident 134's meal tray, then onto the food cart.During an interview on 4/22/26, at 12:27 p.m., with CDM, CDM stated, Resident 134 received the wrong dessert item and should have received the Tiramisu without the wafers. During a review of the Facility's Diet Spreadsheet dated 4/22/26, spreadsheet indicated, for the diet Soft and Bite Sized the dessert item was Tiramisu pudding cup with no wafers. During an observation in the facility kitchen on 4/22/26, at 1:00 p.m., Resident 95's meal tray ticket was observed to read, Texture: Mechanical Soft Ground. Kitchen staff prepared Resident 95's lunch meal. Kitchen staff placed graham crackers on Resident 95's meal tray and placed the tray onto the meal cart. During an interview on 4/22/26, at 1:00 p.m., with Assistant Dietary Manager (AD) AD stated, Resident 95 did receive the graham crackers on their tray, and should not have received the graham crackers on their tray if they are on a mechanical ground soft diet.During an interview on 4/22/26, at 3:36p.m., with Registered Dietician (RD), RD stated it is her expectation that kitchen staff follow therapeutic diets for all residents. RD stated if a resident is on a textured diet it was a safety concern if they don't receive the correct texture.During a review of the Facility's Policy and Procedure (P&P) titled, Texture Modified Diets, dated 2023, the P&P indicated, Each resident receives and the facility provides-Food prepared in a form designed to meet individual needs.

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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 0906 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough power supply for lighting all entrances and exits; equipment for fire detection and alarm systems, and extinguishers. Based on observation, interview, and record review, the facility failed to ensure there was uninterrupted power supply for life sustaining equipment during a power outage, for a census of 131. This failure had the potential for vulnerable residents to experience life threatening situation during power interruptions. During an observation on 4/23/26 starting at 1:14 p.m., the facility had a power interruption. The facility staff were observed taking out extension cords and they were checking residents with oxygen concentrators and those with air mattress. The staff brought out flashlights and power cords to plug into the red emergency outlets to power the oxygen concentrators in Station 2. The staff stated the outlets were not working and they needed oxygen tanks.During an interview on 4/23/26 at 1:35 p.m., with the Social Services Director (SSD), the SSD stated the emergency outlets were not working. During an observation on 4/23/26 at 1:38 p.m., 24 minutes later, the emergency power kicked in.During an interview on 4/23/26 at 1:43 p.m., the Assistant Director of Nursing (ADON) stated the emergency generator was on.During an observation on 4/23/26 at 2:51 p.m., the normal power supply was restored.During an interview on 4/24/26 at 7:45 a.m. with the Director of Maintenance (DM) in the conference room, the DM stated the generator company installed the shutdown switch a year ago. The DM further stated when there is a power outage, the generator should kick in within 6-9 seconds (transferring time). The DM added the reason why the generator did not kick in within 6-9 seconds was because the switch was pushed in, which means the generator was shut down. The DM stated when he checked the generator when there was a power outage yesterday, he had to pull out the generator switch. The DM further stated somebody touched the switch, the DM had a hard time resetting the switch and it took 10 minutes for the generator to kick in. The DM said it happened in the past when someone pressed the generator switch and DM notified the Assistant Dietary Manager (AD) and kitchen staff to be careful to not touch the switch. The DM said this incident was brought to the attention of the Administrator (ADM). During an observation on 4/24/26 starting at 8:04 a.m., with the DM outside the facility kitchen back door, the generator switch was located to the right of the kitchen back door. The DM demonstrated how easily the generator switch button could be pressed. During an interview on 4/24/26 starting at 8:49 a.m. with the ADM inside the conference room, the ADM stated he was never told by anyone the location of the generator switch was a bad spot, and the DM never notified him regarding an incident related to the generator switch. During a follow up interview on 4/24/26 at 9:22 a.m. with the ADM inside the conference room, the ADM stated the generator should kick in within 10 seconds when there is a power interruption. A review of the facility's policy and procedure (P & P) revised April 2019 and titled, Emergency Generator or Alternate Energy Source indicated, The facility plans for alternate sources of energy in the event of a crisis or disaster situation .If there is a disruption in the normal power supply, alternate sources of energy will be used to maintain subsistence needs such as .medical supplies, emergency lighting .fire systems .Some examples of alternate sources of energy may include .a permanent generator .if there is a disruption of power. A review of the facility's P & P revised April 2019 and titled, Emergency Power indicated, The facility and facility partners maintain the generator in accordance with government regulations .Life-Saving Equipment and Oxygen Generating equipment will be required to be restored to back up power within 10 seconds of failure of normal power source.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056495	A. Building B. Wing	04/24/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Casa Coloma Health Care Center	10410 Coloma Rd Rancho Cordova, CA 95670

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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 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interview, the facility failed to ensure 32 resident rooms (rooms 21, 22, 23, 24, 25, 26, 27, 28, 29, 31, 32, 33, 34, 35, 36, 37, 38, 40, 42, 43, 44, 45, 46, 47, 48, 49, 53, 55, 56, 57, 58, and 59) met the required 80 square feet (sq. ft.) per resident.This failure had the potential for residents residing in these rooms to not have enough space for the provision of care and lack of privacy. The ADM provided the room measurements for 32 rooms with three residents. The room measurements for each room were as follows:room [ROOM NUMBER] at 218.4 with 72.8 sq. ft. per residentroom [ROOM NUMBER] at 218.4 with 72.8 sq. ft. per residentroom [ROOM NUMBER] at 218.4 with 72.8 sq. ft. per residentroom [ROOM NUMBER] at 218.4 with 72.8 sq. ft. per residentroom [ROOM NUMBER] at 218.4 with 72.8 sq. ft. per residentroom [ROOM NUMBER] at 218.4 with 72.8 sq. ft. per residentroom [ROOM NUMBER] at 218.4 with 72.8 sq. ft. per residentroom [ROOM NUMBER] at 223.9 with 74.6 sq. ft. per residentroom [ROOM NUMBER] at 218.4 with 72.8 sq. ft. per residentroom [ROOM NUMBER] at 219.6 with 73.2 sq. ft. per residentroom [ROOM NUMBER] at 220.8 with 73.6 sq. ft. per residentroom [ROOM NUMBER] at 219.6 with 73.2 sq. ft. per residentroom [ROOM NUMBER] at 220.8 with 73.6 sq. ft. per residentroom [ROOM NUMBER] at 219.6 with 73.2 sq. ft. per residentroom [ROOM NUMBER] at 220.8 with 73.6 sq. ft. per residentroom [ROOM NUMBER] at 226.9 with 75.6 sq. ft. per residentroom [ROOM NUMBER] at 226.3 with 75.4 sq. ft. per residentroom [ROOM NUMBER] at 230.2 with 76.7 sq. ft. per residentroom [ROOM NUMBER] at 217.2 with 72.4 sq. ft. per residentroom [ROOM NUMBER] at 220.8 with 73.6 sq. ft. per residentroom [ROOM NUMBER] at 217.2 with 72.4 sq. ft. per residentroom [ROOM NUMBER] at 220.8 with 73.6 sq. ft. per residentroom [ROOM NUMBER] at 217.2 with 72.4 sq. ft. per residentroom [ROOM NUMBER] at 220.8 with 73.6 sq. ft. per residentroom [ROOM NUMBER] at 217.2 with 72.4 sq. ft. per residentroom [ROOM NUMBER] at 220.8 with 73.6 sq. ft. per residentroom [ROOM NUMBER] at 218.4 with 72.8 sq. ft. per residentroom [ROOM NUMBER] at 218.4 with 72.8 sq. ft. per residentroom [ROOM NUMBER] at 218.4 with 72.8 sq. ft. per residentroom [ROOM NUMBER] at 218.4 with 72.8 sq. ft. per residentroom [ROOM NUMBER] at 225.7 with 75,2 sq. ft. per residentroom [ROOM NUMBER] at 225,7 with 75.2 sq. ft. per residentDuring the initial tour on 4/21/26 starting at 9:04 a.m., there were no complaints received regarding not having enough space from residents in the 20's hall.During observations on 4/22/26 at 10:15 a.m., there were no concerns with the space in rooms 42, 44, 51-59. The staff were observed entering and exiting these rooms without space constraints.During interviews on 4/22/26 with residents in room [ROOM NUMBER] A, 59 C, 55A, and 44C, residents had no concerns with the space.During an interview on 4/23/26 at 8:42 a.m., with Licensed Nurse 6 (LN 6), the LN 6 stated he was assigned to rooms 46-49 with 3 beds. The LN 6 further stated there was enough room to provide resident care and there were no complaints from residents or family. During an interview on 4/23/26 at 8:45 a.m., with Certified Nursing Assistant 9 (CNA 9), the CNA 9 stated he had no problems providing care for residents in rooms 46-49 with 3 residents. The CNA 9 further stated he had not received complaints from residents regarding the room size. During a concurrent observation and interview on 4/23/26 at 8:58 a.m., with Resident 108 in room [ROOM NUMBER] B, there was a nightstand and table next to the bed. Resident 108 stated there was no problem with the room.During an interview on 4/23/26 at 9:01 a.m., with Resident 137 in room [ROOM NUMBER] A, Resident 137 stated there was no concern with room size or having three people in the room.During an interview on 4/23/26 at 9:31 a.m., Resident 58 in room [ROOM NUMBER] stated there were 3 beds in the room and she had been in this room for a year. Resident 58 further stated the staff provides privacy by pulling the curtains and her wheelchair was on the side of the room. During a concurrent observation and interview on 4/23/26 at 11:09 a.m., with Resident 29, there were 3 residents in the room. Resident 29 stated staff pull the curtain to provide her privacy.During a concurrent observation and interview on 4/23/26 at 11:13 a.m., with Resident 134, (continued on next page)

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	056495	A. Building B. Wing	04/24/2026

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F 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	there were 3 residents in the room. Resident 134 stated she was comfortable, staff provides privacy and she had no concerns. During an interview on 4/23/26 at 11:16 a.m. with CNA 8, the CNA 8 stated she was assigned to rooms [ROOM NUMBER]. The CNA 8 further stated she used a mechanical lift for resident in room [ROOM NUMBER] B and she was able to provide care to the residents in these rooms. During an interview on 4/23/26 at 11:20 a.m., with CNA 4, the CNA 4 stated she was assigned to room [ROOM NUMBER] in the past. The CNA 4 further stated there were 3 residents in the room and she was able to provide care for all residents. The CNA 4 added she worked with Resident 58, and she would bring the wheelchair near the bed and resident had no problem opening the closet.During continued observations from 4/22/26 through 4/24/26, there were no concerns noted for space requirements on resident care in the affected rooms.