STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	05A027	A. Building B. Wing	02/26/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sierra Vista	3455 East Highland Ave Highland, CA 92346

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure safe and sanitary food preparation and storage practices in the kitchen when: 1. The sink in the cook area which food service workers use to get tap water for residents, did not have an air gap (a vertical space between the end of a pipe and the top of a nearby sink that prevents the backflow of contaminated water). 2. The storage shelves in the walk-in refrigerator had a fuzzy white material and grime build-up. 3. Dust was found in several areas in the kitchen and equipment. 4. Chipped off/peeling paint found in janitor room and dry storage room. 5. Two frying pans were found with part of their black interior coating scraped off. 6. Two plastic scraping spatulas were found to have damage on their tips. 7. Five discrete brown dots/ spots grime were observed spread out on the ceiling above the holding cabinet. 8. The ice machine was found to have black substance inside the ice storage bin. 9. The microwave in the break room was found to have a brown substance splattered on the ceiling of the microwave. These failures had the potential risk to cause foodborne illness (stomach illness acquired from ingesting contaminated food) for 116 of 116 sampled residents who received food from the kitchen.Findings: 1. According to the Federal Food and Drug Administration (FDA) 2022 Food Code, A backflow prevention device (air gap) must be installed on the hose [NAME] to prevent the back siphonage of contaminated liquid into the drinking water system during occasional periods of negative pressure in the water line. During an observation on February 23, 2026, at 11:45 AM, Dietary Aide 2 (DA 2) was observed filling a pitcher with water from the sink in the kitchen by the prep counter which did not have an air gap, and then carrying the pitcher to an adjacent prep counter and using it to fill resident drinking glasses. During an interview on February 25, 2026, at 7:23 AM, with the Registered Dietician (RD), and the Certified Dietary Manager (CDM), the two acknowledged the need for the air gap in the sink. The CDM explained if the sink was contaminated with sewage water, when dietary staff put the pitchers in the contaminated sink and filled them water, it has potential risk to cross contamination residents drinking water. 2. During an observation on February 23, 2026, at 12:48 PM, in the walk-in refrigerator, four storage shelves inside were found to have a fuzzy white material and black and brown grime build-up underneath them. Foods like: gallons of milk, breads, [NAME] bell peppers and ground beef were observed stored on the shelves. During an interview on February 25, 2026, at 7:23 AM, with the Registered Dietician (RD), and the Certified Dietary Manager (CDM), the CDM admitted unsanitary kitchen storage shelves. The CDM stated dietary staff are just wiping the surface of storage shelves and not performing the deep cleaning. During a review of the facility's policy and procedure (P&P) titled, Equipment, dated September 2017, the P&P indicated, All foodservice equipment will be clean, sanitary. 3. During an observation on February 23, 2026, at 9:29 AM, in the kitchen, brown debris was observed on the rear guard of the fan blowing into the cleaned kitchenware. During an observation on February 23, 2026, at 9:37 AM, in the kitchen, brown debris was observed on a rack in the back of the kitchen where clean kitchenware is stored. During an observation on February 23, 2026 at 9:56 AM, in the kitchen, brown debris was observed on the half cylinder wall behind the ice machine and also behind the rack stored cleaned kitchenware. During an (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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	observation on February 23, 2026, at 9:58 AM, in the kitchen, brown debris was observed on the rack in the cooking area where clean kitchenware is stored. During an observation on February 23, 2026, at 10:01 AM, in the dishwashing room, brown debris was observed on the dishwashing room door frame. In a concurrent interview with the Certified Dietary Manager (CDM) regarding above findings, the CDM referred to the brown debris as dust. During an interview on February 25, 2026, at 7:23 AM, with the Registered Dietician (RD), and the CDM, the RD stated the risk of presence of dust in the kitchen is that it can contaminate the food. During a review of the facility's Policy and Procedure (P&P) titled, Environment, dated September 2017, the P&P indicated, All food preparation areas, food service areas. will be maintained in a clean and sanitary condition, and The Dining Services Director will ensure that the kitchen is maintained in a clean and sanitary manner, including floors, walls, ceilings, lighting, and ventilation. 4. During a concurrent observation and interview on February 23, 2026, at 8:54 AM, with the Certified Dietary Manager (CDM) in the kitchen, the door to the janitor's closet was observed to have two chips in the wood/ paint at the top of the door. CDM stated, it's not good, it's not a smooth surface, .not able to effectively clean the surface. During an observation on February 23, 2026, at 8:57 AM, in the dry storage room, wall paint was chipped off the wall exposing underlying layers in 4 locations. During an interview on February 25, 2026, at 7:23 AM, with the Registered Dietician (RD), and the CDM, the RD stated, You never know what it's getting into. Contamination one way or another. During a review of the facility's Policy and Procedure (P&P) titled, Safety, dated September 2017, the P&P indicated, The Dining Services Director will ensure that the environment will be maintained in good repair . During a review of the facility's P&P titled, Environment, dated September 2017, the P&P indicated, All food preparation areas, food service areas. will be maintained in a clean and sanitary condition, and The Dining Services Director will ensure that the kitchen is maintained in a clean and sanitary manner, including floors, walls, ceilings, lighting, and ventilation. 5. During an observation on February 23, 2026, at 9:12 AM, two frying pans on the kitchen storage rack were found with part of their black interior coating scraped off. During an observation on at February 23, 2026, 11:15 AM, [NAME] 1 (CK 1) was observed preheating one of the frying pans with scraped interior coating on the kitchen stove. During an interview on February 25, 2026, at 7:23 AM, with the Registered Dietician (RD) and the Certified Dietary Manager (CDM), the CDM stated in response to the frying pans with the scraped interior coating being used for cooking food for residents It can get in the food. It's going somewhere. During a review of the facility's Policy and Procedure (P&P) titled, Equipment, dated September 2017, the P&P indicated, All foodservice equipment will be clean, sanitary, and in proper working order. During a review of the facility's P&P titled, Food: Preparation, dated September 2017, the P&P indicated, Dining Services staff will be responsible for food preparation procedures that avoid contamination by potentially harmful physical, biological, and chemical contamination. 6. During a concurrent observation and interview on February 23, 2026, at 9:53 AM, with the Certified Dietary Manager (CDM) at the cook area, two plastic scraping spatulas were observed to have damage on their tips which did not have smooth surfaces. One was missing a piece, another had small chips along one edge. The CDM discarded the spatulas. During an interview on February 25, 2026, at 7:23 AM, with the Registered Dietician (RD) and the CDM, the CDM stated, the plastic can get in the food, resident can choke on it. Spatulas that do not have smooth surface area are not able to be cleaned properly, bacteria gets in the cracks. During a review of the facility's Policy and Procedure (P&P) titled, Equipment, dated September 2017, the P&P indicated, All foodservice equipment will be clean, sanitary, and in proper working order. During a review of the facility's P&P titled, Food: Preparation, dated September 2017, the P&P indicated, Dining Services staff will be responsible for food preparation procedures that avoid contamination by potentially harmful physical, biological, and chemical contamination. 7. During an observation on February 23, 2026, at 10:16 AM, five (5) discrete brown dots/ spots grime were observed spread out on the ceiling above the cook area. During an interview on February 25, 2026, at 7:23 AM, with the Registered Dietician (RD) and the Certified Dietary Manager (CDM), the CDM stated, Eventually it's (the brown (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	dots/spots grime) going to fall. It can attract flies, pests. It gets moldy, it gets nasty. During a review of the facility's Policy and Procedure (P&P) titled, Environment, dated September 2017, the P&P indicated, All food preparation areas, food service areas. will be maintained in a clean and sanitary condition, and The Dining Services Director will ensure that the kitchen is maintained in a clean and sanitary manner, including floors, walls, ceilings, lighting, and ventilation. During a review of the facility's P&P titled, Food: Preparation, dated September 2017, the P&P indicated, Dining Services staff will be responsible for food preparation procedures that avoid contamination by potentially harmful physical, biological, and chemical contamination. 8. During an observation on February 23, 2026, at 10:21 AM, in the kitchen, a white napkin was used to wipe inside of the ice storage bin of the ice machine, and the napkin was pulled out with a black substance on it. During an interview on February 25, 2026, at 7:23 AM, with the Registered Dietician (RD) and the Certified Dietary Manager (CDM), the CDM stated potential risks to be cross contamination of the ice stored in the ice storage bin. During a review of the facility's Policy and Procedure (P&P) titled, Equipment, dated September 2017, the P&P indicated, All foodservice equipment will be clean, sanitary. 9.During an interview on February 24, 2026, at 2:13 PM, with Primary Counselor 1 (COUN 1), COUN 1 stated the microwave in the vending machine room is used to heat residents' outside food. During an observation on February 24, 2026, at 2:18 PM, in the vending machine room, the microwave was observed to have a brown substance splattered on the ceiling of the microwave. During an interview on February 25, 2026, at 7:23 AM, with the Registered Dietician (RD) and the Certified Dietary Manager (CDM), the CDM stated potential risks to be cross contamination. During a review of the facility's Policy and Procedure (P&P) titled, Equipment, dated September 2017, the P&P indicated, All foodservice equipment will be clean, sanitary, and in proper working order. During a review of the facility's P&P titled, Food: Preparation, dated September 2017, the P&P indicated, Dining Services staff will be responsible for food preparation procedures that avoid contamination by potentially harmful physical, biological, and chemical contamination.

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Dispose of garbage and refuse properly. Based on observation, interview, and record review, the facility failed to dispose of garbage and refuse properly when three dumpsters on the side of facility outside of the hallway that leads to the facility's kitchen were filled beyond the brim with trash, and the lids of all three dumpsters were not closed properly. This failure had the potential to attract pests and rodents and comprise the health and safety of 116 residents who reside in the facility.Findings: During an observation on February 23, 2026, at 7:55 AM, on the side of the facility outside of the hallway that leads to the facility kitchen, all three dumpsters were filled above the brim with trash bags and the lids of the dumpsters were unable to fully close. During a concurrent observation and interview on February 23, 2026, at 8:38 AM with Certified Dietary Manager (CDM) outside by the dumpsters, CDM advised the state of the dumpsters is Horrible. CDM advised the lids are supposed to be able to close (and if they don't) they bring rodents and flies. During a review of the facility's policy and procedure (P&P) titled, Dispose of Garbage and Refuse, dated August 2017, the P&P indicated, All garbage and refuse will be collected and disposed of in a safe and efficient manner.

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to organize and participate in resident/family groups in the facility. Based on interview, and record review, the facility failed to respond to and act upon the grievances and recommendations of the Resident Council (a group of residents that acts as a formal body to improve quality of life, discuss concerns, and make recommendations to facility's administrator to improve the quality of daily living and care in the facility) regarding dietary services for seven sampled residents (Residents 12, 34, 45, 55, 60, 88, and 113) when the Resident Council requested to increase the frequency of snacks from once daily to three times daily and provide a greater variety of snacks, including more nutritious options, to address resident hunger; however, the facility failed to provide a written response or implement these requested changes. This failure had the potential to cause unmet nutritional needs, increased feelings of hunger and discomfort, decreased quality of life, and diminished the residents' dignity by not addressing residentˆvoiced concerns regarding dietary services.Findings: A combined Resident Council meeting (separate Resident Council meetings were held on Unit 1 and Unit 2) was conducted on February 24, 2026, from 10:00 AM to 10:35 AM with Residents 12, 34, 45, 55, 60, 88, and 113. Resident 60 identified himself as the Resident Council president for Unit 1, and Resident 45 identified herself as the Resident Council president for Unit 2. Resident 113 was the main spokesperson for the group.Resident 113 stated the facility provided only one nighttime snack per day, which was not enough, and that residents were hungry during the day. The group nodded in agreement and stated they needed more than one snack per day. Resident 113 explained that when residents asked for more snacks, they were told to speak with dietary because dietary staff made those decisions; however, they believed the dietary staff member was contracted with the facility, and residents did not know when that individual was present.Resident 113 asked, Can't we have more than one snack a day that we don't have to purchase with our own money? The group nodded again and murmured agreement. Resident 113 further stated the facilityˆprovided snacks were always the same items repeated, and when residents requested a greater variety of snack items, they were again told they would need to speak with dietary, though they did not know how to reach that person.Resident 45 stated she also wanted healthier, more nutritious snacks, such as a small chef's salad or something similar. The group again nodded and murmured agreement. The group collectively agreed they would appreciate receiving a snack between breakfast and lunch, another between lunch and dinner, and a bedtime snack.A review of a sign posted to a window outside the Dietary Supervisor's office indicated Snack List!!! Monday: [NAME] Krispie Treats, Fruit Punch, Tuesday: Cheezits, Ice Water, Fresh Fruit, Wednesday: Scooby Snacks, Fruit Punch, Thursday: Fresh Baked Chocolate Chip Cookies, Ice Water, and Fresh Fruit, Friday: Corn Chips, Fruit Punch, Saturday: . Fresh Fruit, Sunday: Lays Chips, Fruit PunchDuring an interview with the Administrator (Admin) and a Social Services Assistant (SSA) on February 26, 2026, at 9:46 AM, the Admin stated she was the grievance official responsible for ensuring a written response to grievances and requests from the Resident Council meetings within 30 days. The SSA stated she was the individual who took the notes at the meetings and assisted with the followˆthrough on grievances and complaints. The SSA stated she had not heard that the Resident Council members wanted more than one snack per day, but she did tell the residents that if they wanted different snacks, they needed to speak with the dietitian. The SSA stated she did not bring the snack issue to the Admin because she thought the council members needed to bring up the issue with the dietitian directly.The Admin provided teaching to the SSA during the interview, indicating the SSA should have filled out a grievance form for the snack issue and submitted it to her so it could be acted upon. The Admin stated that, regarding the increased number of snacks per day, she believed the regulatory requirement was being fulfilled by the one nighttime snack provided to all residents.The Admin reviewed the facility's policy and procedure titled Snacks, dated September 2017, which indicated, snacks will be provided for all residents. Additional snacks and beverages will be available upon request for all residents who want to eat at nonˆtraditional times.The Admin stated she had not been made aware of the request from (continued on next page)

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the Resident Council regarding the facilityˆprovided snacks; therefore, no written response was given and no action was taken.During an interview with the Registered Dietitian (RD) on February 26, 2026, at 2:00 PM, the RD stated that the snack list posted outside the Dietary Supervisor's office represented the snacks provided to all residents for their nighttime snack. The RD stated the snacks on the list did not change unless a specific request was made for a change. The RD stated she had not been informed of the Resident Council's request for three snacks a day instead of one, nor that they wanted a variety of snacks with healthier options. The RD stated that if she had known, she would have made the recommendations, but she did not have high confidence that the requests would be honored due to budget cuts and operating on a shoestring budget.A review of the facility's policy and procedure (P&P) titled, Resident Council, dated December 2025, indicated, Policy Statement: The facility supports residents' rights to organize and participate in the resident council. Policy Interpretation and Implementation: 1. The purpose of the resident council is to provide a forum for: . b. discussion of concerns and suggestions for improvement; . 6. The resident council may create its own tool for communicating with the facility regarding input, concerns and suggestions for improvement, or the facility can support the council in creating one . 7. All feedback and requests communicated from the resident council to the facility are addressed in writing to the council. While some requests or concerns may take longer, most responses should occur within 30 days of the facility receiving communication from the council. 9. The quality assurance and performance improvement (QAPI) committee reviews information and feedback from the resident council and addresses any quality issues accordingly.A review of the facility's P&P Snacks, dated September 2017, indicated, snacks will be provided for all residents. Additional snacks and beverages will be available upon request for all residents who want to eat at nonˆtraditional times.

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep residents' personal and medical records private and confidential. Based on observation, interview, and record review, the facility failed to protect residents' privacy and confidentiality by failing to secure personal information from public view for 45 sampled residents (Residents 1 to 45) when a whiteboard containing the full names and room numbers of all residents on Unit 1 was posted in a back room of the nursing station but remained clearly visible to unauthorized individuals and other residents walking in the common hallway. This failure had the potential to cause psychosocial harm by compromising the residents' dignity and their right to exercise control over their personal environment, creating an institutionalized atmosphere that devalues resident individuality and can lead to feelings of embarrassment, vulnerability, and a loss of self-worth.Findings: During an observation and interview on Unit 1 at Nursing Station 1, conducted with a Registered Nurse (RN 1) and the Director of Nursing (DON) on February 25, 2026, from 8:19 AM to 9:23 AM, a door with a nameplate indicating Chart Room was propped open. When walking through the Chart Room, one entered through a second door into the medication storage room. On the upper right wall upon entering the Chart Room a whiteboard was hung listing the first and last names and room numbers of all residents on Unit 1. The board was visible to passersby in the common hallway, where the resident names and room numbers could be read. RN 1 stated the Chart Room door was always propped open because it provided access to the medication storage room, where staff were coming and going all day. RN 1 further stated the Chart Room was not used as a chart room, but rather as a place to store items. RN 1 and the DON stood in the common hallway of Unit 1 at Nursing Station 1 and confirmed that the resident names and room numbers could be read from that location. The DON verified that the residents had a right to their personal privacy and privacy regarding their accommodations (room numbers).A review of the facility's policy and procedure (P&P) titled, Confidentiality of Information and Personal Privacy, dated February 2021, it indicated, Our facility will protect and safeguard resident confidentiality and personal privacy. Policy Interpretation and Implementation: 1. The facility will safeguard the personal privacy and confidentiality of all resident personal and medical records. 2. The facility will strive to protect the resident's privacy regarding his/her: a. accommodations; . 4. Access to resident personal and medical records will be limited to authorized staff and business associates.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide comprehensive pharmaceutical services by failing to ensure a medication error-free system and by lacking proper accountability, reconciliation, and witness documentation for the disposal of controlled substances, for 71 residents on Unit 2 (Residents 1 to 71) when:1. Resident 4 was administered two times the dose (400 mg-milligrams, a unit of measurement) of clozapine (an atypical antipsychotic medication used to treat schizoaffective disorder-a chronic mental health condition that is essentially a combination of two different types of illnesses: schizophrenia (which affects how a person perceives reality) and a mood disorder (which affects how a person feels), instead of the physician-ordered 200 mg dose. This failure had the potential to cause serious adverse outcomes, including severe respiratory depression, seizures, or significant hypotension, due to the administration of double the prescribed amount of a high-risk medication. 2. Two controlled medications (medications with a high potential for abuse or addiction) were found in individual, unlabeled plastic bags inside a double-locked, controlled medication drawer of a medication cart. Because neither bag was labeled with a resident's name or the medication's name and dose, the medications could not be identified or reconciled (the process of comparing and verifying medication records to ensure accuracy and ensuring every dose of a controlled medication is accounted for). This failure had the potential to cause medication errors, the administration of unknown substances to residents, and the undetected diversion or loss of controlled medications due to the lack of accountability and identification.Findings: 1. A review of Resident 4's face sheet (a document that gives a summary of resident's information), undated, indicated an admission date of February 29, 2016. Resident 4 had diagnoses that included schizoaffective disorder (a chronic mental health condition which causes hallucinations, delusions, depression, mania, and disorganized speech).During a medication administration observation with a Licensed Vocational Nurse (LVN 2) and Resident 4 on February 25, 2026, at 10:40 AM, LVN 2 withdrew a bubble pack of medication (a type of medication packaging where each individual pill is sealed in its own plastic bubble or compartment) from the medication cart. The pharmacy label on the pack indicated: [Resident 4's name] clozapine [ODT-Orally Disintegrating Tablet] 200 mg [milligrams-a unit of measurement] tab [tablets], take [two] tablets by mouth four times daily. [Fill date: February 10, 2026]. Two tablets were noted in each bubble. LVN 2 popped two tablets from the bubble into a pill cup marked with Resident 4's name and room number.During a continued observation on February 25, 2026, at 11:48 AM with LVN 2 and Resident 4, LVN 2 identified Resident 4 by asking him to state his name and room number; Resident 4 did what was asked. LVN 2 then handed Resident 4 the pill cup containing the two 200 mg tablets of clozapine and a glass of water. Resident 4 took the medication and drank the water independently.A review of Resident 4's physician's order dated February 10, 2025, indicated, clozapine Oral Tablet Disintegrating (Clozapine) Give 200 mg by mouth four times a day for Episodes of Paranoid Delusions that people want to touch him related to [schizoaffective disorder].During an interview with a Registered Nurse (RN 1) and LVN 2 on February 25, 2026, at 2:12 PM, RN 1 reviewed the pharmacy label on Resident 4's clozapine bubble pack and Resident 4's physician's order for clozapine dated February 10, 2026. RN 1 confirmed that Resident 4 had received 400 mg of clozapine instead of the 200 mg ordered by the physician. RN 1 noted that the bubble pack had a sticker with red lettering that indicated, Directions changed refer to chart. RN 1 stated that LVN 2 should have gone to Resident 4's chart and reviewed the physician's order before administering the medication. LVN 2 stated she thought each of the tablets in the bubble was 100 mg, not 200 mg. LVN 2 stated she should have followed the instructions on the sticker and reviewed the physician's order before administering the clozapine, but she had not.During an interview with the Administrator (Admin) and the Director of Nursing (DON) on February 26, 2026, at 2:52 PM, the DON stated she had (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	conducted an investigation into Resident 4's medication error. She found that the pharmacy had sent the wrong clozapine bubble pack with an incorrect label that did not reflect Resident 4's physician's order for clozapine. The DON stated the facility had procedures in place with specific medication checks to identify mistakes such as these and hopefully prevent a medication administration error; however, these checks had not been conducted, which led to Resident 4 receiving twice the dose of clozapine he should have.The DON described the checks that should have occurred: when a new medication was delivered by the pharmacy to the medication room, the LVN scheduled at that time was supposed to check the labeling on the bubble pack against the physician's order before placing the medication in the medication cart. The DON stated this check was not done, noting that if it had been, the wrong clozapine bubble pack would not have been available in the medication cart to give to Resident 4.The DON further stated that when the LVN was going to administer a medication, the medication bubble pack label was supposed to be checked against the order in the Medication Administration Record (MAR) before administering it to the resident. The DON stated this check did not happen, noting that if it had, Resident 4 would not have received a double dose of clozapine. The DON stated LVN 2 was required to follow the five rights of medication administration (a safety standard used by healthcare professionals to prevent medication errors): 1. Right Resident, 2. Right Drug, 3. Right Dose, 4. Right Route (the method by which the medication enters the body), and 5. Right Time. The DON stated LVN 2 had violated right number 3: Right Dose. The Admin stated she agreed with the DON's explanation and statement.A review of the facility's policy and procedure (P&P) titled, Medication Errors, dated June 28, 2022, indicated Purpose: To ensure the prompt reporting of errors in the administration of medications and treatments to residents. Policy: . b. Medication Error means the administration of medication: . At the wrong dose . Procedure: . g. The Director of Nursing Services or his/her designee will investigate the error to determine the cause. 2. During a medication storage observation and interview on Unit 2 in Medication Storage room [ROOM NUMBER], conducted with LVN 2 and the DON on February 25, 2026, from 2:19 PM to 2:44 PM, LVN 2 explained the procedure for wasting controlled medications that residents had refused. LVN 2 stated that when a resident refused a controlled medication, the tablet or capsule was placed in a plastic baggy and kept in the double-locked, controlled medication drawer until the DON arrived to waste the medication.LVN 2 retrieved two unmarked plastic baggies from the controlled medication drawer. One bag held a capsule with writing on it that had smeared, rendering it unreadable except for the date of January 24, 2025-over a year ago. The second bag contained a tablet with no attempt made to write anything on the bag. LVN 2 stated the two medications could not be reconciled or wasted properly because the medication, resident, and dose could not be determined.The DON stated that when the LVN notified her that there were controlled medications to waste and destroy, she would bring a specialized container for the medications and then pour water with a chemical powder into the container, rendering the controlled medications unusable and non-retrievable. The DON stated that before she destroys the medication, she performs a controlled medication reconciliation with the LVN to confirm there are no controlled medications unaccounted for; then, she and the LVN sign the medication disposition log to attest to that fact before she destroys the controlled medications.The DON stated the problem with this situation is that she cannot perform the following medication reconciliation steps:1. Count What You Have: Count the actual number of pills currently in the drawer or bottle.2. Check the Records: Look at the logbook or computer records to see how many pills should be there based on what was delivered and what was given to residents.3. Compare the Numbers: See if the number you counted matches the number in the records.4. Find the Difference: If the numbers do not match, you must investigate to find out why.5. Sign Off: Once the numbers match, the DON and LVN sign their names to confirm that everything is correct.The DON stated these steps were not possible because the capsule and tablet in the baggies were unidentified, the dosages were unknown, and the associated residents could not be determined.During an interview with the Pharmacist Consultant (PC) on February 26, 2026, at 11:49 AM, the PC stated that controlled medications refused by a (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	resident should be wasted immediately by two licensed nurses. The controlled medications should not be placed in a non-labeled bag to wait for the DON to waste them. This practice will lead to medication administration errors and possible drug diversion (when legal medications are taken for illegal use).During an interview with the Administrator (Admin) and the DON on February 26, 2026, at 2:52 PM, the Admin and DON stated they agreed with the statement made by the PC. The DON stated that controlled medications refused by residents should be wasted immediately by two licensed nurses.A review of the facility's policy and procedure (P&P) titled, Controlled Medication Storage, dated August 2014, indicated, Policy: Medications included in the Drug Enforcement Administration (DEA) classification as controlled substances are subject to special handling, storage, disposal and record keeping in the facility in accordance with federal, state and other applicable laws and regulations. Procedures: The director of nursing and the consultant pharmacist maintain the facility's compliance with federal and state laws and regulations in the handling of controlled medications. A controlled medication accountability record is prepared by the pharmacy or facility for all Schedule II-V medications. The following information is completed:1) Name of resident2) Prescription number3) Name, strength, and dosage form of medication4) Date received5) Quantity received6) Name of person receiving medication supply7) Dispensing pharmacy informationD. At each shift change, a physical inventory of all controlled medications, including the emergency supply is conducted by two licensed nurses and is documented on the controlled medication accountability record. E. Any discrepancy in controlled substance medication counts is reported to the director of nursing immediately. I. The director of nursing in conjunction with consultant pharmacist or designee routinely monitors controlled medication storage, records, and expiration dates during medication storage inspection.

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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 in an organized and safe manner for 45 sampled residents (Residents 1 to 45) when the Unit 1 medication storage room contained injectables, oral over-the-counter medications, liquid medications, tablets, sublingual medications, rectally applied medications, breathing treatments, eye drops and test kits that were intermingled and disorganized. This failure had the potential to cause significant medication errors, as the intermingling of products with different routes of administration increases the risk of nurses selecting and administering the wrong medication to a resident.Findings: During a medication storage observation and interview on Unit 1 at Nursing Station 1, conducted with a Registered Nurse (RN 1) and the Director of Nursing (DON) on February 25, 2026, from 8:19 AM to 9:23 AM, there were three cabinets in the medication room where medications were stored. On the shelves of each cabinet, medications were stored haphazardly; intermingled together on each shelf were injectables, oral over-the-counter medications, liquid medications, tablets, sublingual medications, rectally applied medications, breathing treatments, eye drops, and test kits. There was no apparent order or organization of the medications. RN 1 stated that the over-the-counter medications were in the cabinets, so staff did not have to go downstairs for more when they ran out. The DON reviewed the disarray of the medications in the three cabinets and confirmed that they were not stored appropriately or per the facility's policy and procedure (P&P).During an interview with the Pharmacist Consultant (PC) on February 26, 2026, at 11:49 AM, the PC stated the facility should store medications separated by route (the specific way or path a medicine takes to get into the body), with each route kept together on one shelf or in a specific container or drawer. The PC further stated that medications of different routes should not be intermingled, as it increases the likelihood of making a medication error.During an interview with the Administrator (Admin) and DON on February 26, 2026, at 2:52 PM, the Admin and DON stated they agreed with the statement made by the PC. They further agreed that the medications in the Unit 1, Nursing Station 1 medication room were not stored in accordance with the facility's policy and procedure.A review of the facility's Policy and Procedure (P&P) titled, Storage of Medications, dated January 2025, it indicated, Policy: Medications and biologicals are stored safely, securely, and properly, following manufacture's recommendations or those of the supplier. Procedures: . c. Orally administered medications are kept separate from externally used medications, such as suppositories [a solid piece of medicine that is inserted into a body opening-most often the rectum or the vagina], liquids, and lotions. D. Intravenously [through a vein] administered medications are kept separate from orally administered medications. E. Eye medications are kept separate from ear medications. F. Except for those requiring refrigeration, medications intended for internal use are stored in a medication cart or other designated area. G. Medications labeled for individual residents are stored separately from floor stock medications when not in the medication cart.

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F 0800 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs. Based on interview, and record review, the facility failed to ensure that snacks provided to residents (Residents 1 through 35) met their specific clinical and therapeutic needs for 35 residents receiving controlled carbohydrate diets (a consistent, set amount of carbohydrates at each meal and snack to stabilize blood sugar levels) when the facility failed to follow physician-ordered controlled carbohydrate diets by providing a uniform bedtime snack to the entire resident population without offering therapeutic alternatives. This failure had the potential to cause significant fluctuations in blood sugar levels, specifically acute hyperglycemia (high blood sugar) from excessive carbohydrate intake or nighttime hypoglycemia (low blood sugar) if the provided snack did not meet the resident's specific stabilization needs.Findings: A review of the facility provided Diet Type Report, dated February 23, 2026, indicated Residents 1 to 35 had a current physician's order for a controlled carbohydrate diet.A review of a sign posted to a window outside the Dietary Supervisor's office indicated, Snack List!!! Monday: [NAME] Krispie Treats, Fruit Punch, Tuesday: Cheezits, Ice Water, Fresh Fruit, Wednesday: Scooby Snacks, Fruit Punch, Thursday: Fresh Baked Chocolate Chip Cookies, Ice Water, and Fresh Fruit, Friday: Corn Chips, Fruit Punch, Saturday: . Fresh Fruit, Sunday: Lays Chips, Fruit Punch.During an interview with the Registered Dietitian (RD) on February 26, 2026, at 2 PM, the RD stated that the snack list posted outside the Dietary Supervisor's office represented the snacks provided to all residents for their nighttime snack. The RD stated that the snacks on the list did not change unless a specific request was made for a change. The RD stated there were no established substitutions for the snack items listed, and there were no established snack options for residents with physician-ordered controlled carbohydrate diets. The RD stated she had not provided a therapeutic alternative for residents receiving controlled carbohydrate diets.During an interview with the Administrator (Admin) and Director of Nursing (DON) on February 26, 2026, at 2:39 PM, the DON stated that residents with physician's orders for a controlled carbohydrate diet should have been offered a snack which aligned with the ordered diet. The Admin and DON stated that the facility's policy and procedure titled Snacks, dated September 2017, was not followed.A review of the facility's P&P titled, Snacks, dated September 2017, indicated, Policy Statement: Snacks and beverages will be provided as identified in the individual plans of care. Bedtime [also known as HS] snacks will be provided for all residents. Additional snacks and beverages will be available upon request for all residents who want to eat at non-traditional times. Procedures: 1. The Dining Services department will collaborate with the residents/patients, and nursing and management team to identify necessary beverage and snack items to be provided to each resident/patient. 2. The Dining Services department assembles on a daily basis snack items (food and beverages) for delivery to each resident/patient care area. 3. Snacks will be assembled, labeled, and dated in accordance with the individual plan of care for each resident and those items will be delivered to patient care areas in a timely manner. 4. The Dining Services department will assemble and deliver to each unit the individually planned snack items and bulk snack items to be offered at bedtime. 5. The Dining Services department provides a listing of the current diet orders and snacks for each resident to each care area. 6. Nursing Services is responsible for delivering the individual snacks to the identified residents and for offering evening snacks to all other residents. 7. All snacks will be properly stored for time and temperature control, as appropriate.

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. Based on observation, interview, and record review, the facility failed to ensure food services employees safely and effectively carried out the functions of food and nutrition services when:1. Cooks did not follow standard of practice Cleaning and sanitizing food contact surfaces by using three separate steps (wash, rinse and sanitize) to clean and sanitize work surfaces.2. Multiple food services employees did not follow manufacturer's guideline time length dipping the test strip into sanitizer (sanitizing solution used for sanitizing food contact surfaces) for testing the concentration of the sanitizer.3. Multiple food services employees did not know the concentration range of sanitizer (a solution used to reduce the number of germs on food contact surfaces to acceptable levels).4. Diet Aide 1 did not know the Dish machine sanitizing concentration.5. [NAME] 2 did not know how to calibrate thermometer. 6. [NAME] 2 unable to demonstrate cooling process for Tuna Salad. These failures had the potential to cause foodborne illness (stomach illness acquired from ingesting contaminated foods) for 116 out of 116 sampled residents who received foods from the kitchen. Findings: 1. During a review of the facility provided in service document titled, CLEANING AND SANITIZING, undated, the document indicated, PURPOSE: To educate all new hires and current employees on the importance of and proper method for cleaning and sanitizing to ensure safety for all staff and residents. PROPER CLEANING AND SANITIZING Resident safety in a healthcare environment is a top priority. Cleaning and sanitizing properly is one of the most important things we continually do in our kitchens to prevent harm.Cleaning: .To clean a surface .clean with a soapy towel; Rinse with clean cloth; Follow with proper sanitizing .During an interview on February 23, 2026, at 9:54 AM, with [NAME] 1 (CK 1), CK 1 was asked to demonstrate how to clean and sanitize soil food-contact work surfaces. CK 1 stated she cleaned soil food-contact work surfaces with soap and water and then sanitized with sanitizer.During an interview on February 23, 2026, at 12:30 PM, with [NAME] 2 (CK 2), CK 2 was asked to demonstrate how to clean and sanitize soil food-contact work surfaces. CK 2 stated he cleaned soil food-contact work surfaces with soap and water and then sanitized with sanitizer.During an interview on February 25, 2026, at 7:22 AM, with the Certified Dietary Manager (CDM). The CDM stated for standard of practice food service employees should wash the soil work surfaces with soap and water; then rinse away the soap; and the final step was sanitized with sanitizer. The CDM stated the soil food-contact work surfaces could not sanitize effectively by skipping rinse. The CDM explained failure to properly clean and sanitize food-contact work surfaces may result in growth of microorganisms which could cross-contaminate foods.2. During a review of the sanitizer manufacturer's guidelines poster, it indicated, Dip paper [test strip] in sanitizer solution for 10 secondsDuring a review of the facility provided in service document titled, CLEANING AND SANITIZING, undated, the document indicated, PURPOSE: To educate all new hires and current employees on the importance of and proper method for cleaning and sanitizing to ensure safety for all staff and residents.Sanitizing .How to test Sanitizer Solution 1. Remove test strip from container and place in the diluted sanitizer solution for 10 seconds.During an interview on February 23, 2026, at 11:34 AM, with Dietary Aide 1 (DA 1), DA 1 was asked to demonstrate how to check the concentration of sanitizer. DA 1 dipped the test strip into sanitizer for 1 second and then checked the concentration of sanitizer.During an interview on February 23, 2026, at 12:30 PM, with [NAME] 2 (CK 2), CK 2 was asked to demonstrate how to check the concentration of sanitizer. CK 2 stated he needed to dip the test strip into sanitizer for 1 minute.During an interview on February 25, 2026, at 7:22 AM, with the Registered Dietitian (RD) and Certified Dietary Manager (CDM), the RD stated the test strip needed to dip into sanitizer for 10 seconds to check the concentration of sanitizer. The CDM stated not following manufacturer's guidelines length of time dipping test strip could resulted false reading of the sanitizer. The CDM stated false reading concentration of sanitizer could lead to ineffective sanitizing food contact surfaces which may result in lack of removal of inadvertent growth (continued on next page)

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	on surfaces of microorganisms which may contaminate food and cause food borne illness.3. A review of the Sanitizer manufacturer's guidelines poster indicated, Testing solution (Sanitizer) should be between 150 - 400 parts per million (ppm - a unit of measurement).During an interview on February 23, 2026, at 11:34 AM, with Dietary Aide 1 (DA 1) in the dishwashing room, DA 1 was asked to demonstrate how to check the concentration of sanitizer. DA 1 stated the sanitizer concentration should be between 200 -500 ppm.During an interview on February 23, 2026, at 12:30 PM, with [NAME] 2 (CK 2), CK 2 was asked to demonstrate how to check the concentration of sanitizer. CK 2 stated the sanitizer concentration should be between 400 -500 ppm.During an interview on February 25, 2026, at 7:22 AM, with the Certified Dietary Manager (CDM), the CDM stated 150 - 400 ppm was the concentration of sanitizer per manufacturer's guidelines. The CDM stated food service workers should follow manufacturer guidelines. The CDM stated sanitizer with 500 ppm was too concentrate.During a review of the facility provided in service document titled, CLEANING AND SANITIZING, undated, the document indicated, PURPOSE: To educate all new hires and current employees on the importance of and proper method for cleaning and sanitizing to ensure safety for all staff and residents.Sanitizing .Sanitizer solution should be tested for correct PPM .Consult manufacturer's directions for proper dilution rate for the chemical in sue at your facility. How to test Sanitizer Solution. Follow manufacturer guidelines for correct dilution/PPM for the chemical in use at your facility .4. During an interview on February 25, 2026, at 11:34 AM, with Dietary Aide 1 (DA 1) in the dish washing room, DA 1 was asked to demonstrate how to check the Dish machine sanitizing concentration. DA 1 dipped the test strip into Dish machine sanitizing solution. The test strip indicated at 100 ppm. DA 1 stated the sanitizer concentration should be between 100 -200 ppm.During an interview on February 25, 2026, at 7:22 AM, with the Registered Dietitian (RD) and Certified Dietary Manager (CDM), the RD stated according to manufacturer guidelines dish machine sanitizing concentration should be 50 -100 ppm. The CDM stated sanitizing concentration between 100 -200 ppm was too strong. The CDM stated using too strong concentration sanitizing solution could result the cleaned kitchenware had strong chlorine odor.During a review of the facility provided document titled, Dish Machine log, undated, the log indicated, Manufacturer Recommended PPM: 50 -100.5. During an interview on February 23, 2026, at 12:30 PM, with [NAME] 2 (CK 2) in cook area, CK 2 was asked to demonstrate how to calibrate thermometer. CK 2 inserted thermometer into a cup of ice water. When the thermometer reached 32 degrees Fahrenheit (F - a unit of measurement). CK 2 stated he needed to calibrate thermometer at 40 F.During an interview on February 25, 2026, at 7:22 AM, with the Registered Dietician (RD). The RD stated the cooks should calibrate the thermometer at 32 F. The RD stated failure to calibrate thermometers may result in inaccurate reading thermometers.During a review of the facility provided in service education document titled, TIME AND TEMPERATURE CONTROL AND RECORDING, undated, the document indicated, PURPOSE: To educate all new hires and current employees on the importance of and guidelines for time and temperature control and recording procedures.Thermometers The first step in avoiding temperature abuse is to maintain a properly calibrated thermometer.Calibrate and testing Using Ice-Point Method: .if the temperature is at 32 F, .It is now ready for use.6. Potentially Hazardous Foods (PHFs) are those capable of supporting bacterial growth associated with foodborne illness PHFs. PHFs shall be cooled within four hours to 41 F or less if prepared from ingredients at ambient temperature, such as reconstituted FOODs and canned tuna. (Food Code, 2025).During an interview on February 23, 2026, at 12:30 PM, with [NAME] 2 (CK 2) in cook area, CK 2 was asked to demonstrate cooling process for making Tuna Salad. CK 2 unable demonstrated despite the Certified Dietary Manager (CDM) providing him with a copy of the cooling log.During an interview on February 25, 2026, at 7:22 AM, with the Registered Dietician (RD). The RD stated CK 2 should know the cooling process for making Tuna Salad. The RD stated the potential risk for CK 2 did not know the cooling process making Tuna Salad was foodborne illness outbreak.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. Based on observation, interview, and record review, the facility failed to ensure the Controlled Carbohydrate Diet (a meal plan for diabetic residents) lunch dessert was provided for 34 of 34 sampled residents who are on a Controlled Carbohydrate Diet (CC) when the 34 sampled residents received a regular dessert for lunch on February 23, 2026. This failure had the potential to negatively impact the residents' nutritional status and further compromising residents' medical status.Findings: During an observation on February 23, 2026, at 11:04 AM in the kitchen, Dietary Aide 3 (DA 3) was observed preparing dessert for the lunch service for the residents. DA 3 used a spatula to slice two of two sheet pans of cake into even portions. DA 3 then applied frosting to all slices of cake on both sheet pans and used a spatula to separate each cake slice portion and distribute them onto dessert plates. No additional or differing size chocolate cakes were prepared for lunch. During an observation on February 23, 2026, at 12:01 PM in the dining room, all residents, including residents who were on CC Diet were observed being served the same size chocolate cake with frosting as regular diet residents. During a concurrent interview and record review on February 23, 2026, at 12:30 PM with the Certified Dietary Manager (CDM), the therapeutic spreadsheet (the document used to guide dietary staff on food items, portions, and therapeutic diet) on February 23, 2026 was reviewed. The therapeutic spreadsheet indicated, Residents on CC diet were to receive a 1/2 portion of chocolate cake, plain (without frosting) for lunch. The CDM admitted DA 3 did not prepare CC dessert and CC diet Residents being served regular dessert. During an interview on February 25, 2026, at 7:23 AM with the RD, and the CDM, both of them stated food service employees should follow the spreadsheet when preparing and serving food. The RD stated in response to risks of giving CC residents regular dessert portion, Blood sugar can spike, because they get more carbohydrates. During a review of facility's Policy and Procedure (P&P) titled, Menus, dated September 2017, the P&P indicated, Menus will be planned in advance to meet the nutritional needs of the residents/patients in accordance with established national guidelines. During a review of facility provided diet definition titled, Controlled-Carbohydrate Diet, dated February 2025, the definition indicated, The controlled-carbohydrate diet incorporates the (menu company) regular menu with consistent amounts of carbohydrate meals and snacks. In this diet, priority is given to the total amount of carbohydrate consumed at each meal and snack rather than to the specific source of carbohydrate. Portion sizes on this menu must be followed.

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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. Based on observations, interviews, and record reviews, the facility failed to maintain a sanitary and orderly medication storage room for 45 residents (Residents 1 through 45) when:1. A tub containing various used personal care products-some labeled with resident names and others unlabeled-was stored in a cabinet alongside resident medications.2. A bag of discontinued prescription topical medications awaiting disposal was stored on the bottom shelf of a medication cabinet next to discarded items, disinfectant spray, and trash. This failure had the potential to cause cross-contamination and the transmission of infectious agents for 45 residents who reside in Unit 1 of the facility.Findings: 1. During a medication storage observation and interview on Unit 1 at Nursing Station 1, conducted with a Registered Nurse 1 (RN 1) and the Director of Nursing (DON) on February 25, 2026, from 8:19 AM to 9:23 AM, there were three cabinets in the medication room where medications were stored. In the third cabinet on the third shelf, a tub of personal care products was stored (10 different colognes, one electric razor, and one disposable razor).RN 1 stated that residents at the facility were not allowed to keep breakable objects, such as glass, or sharp objects, such as razors, in their rooms. Therefore, when residents wanted these items, they would come to the nursing station to request them, and a staff person would assist and monitor them to keep the residents safe. RN 1 acknowledged that not all items were labeled with a resident's name, causing a risk of giving an item to the wrong resident and increasing the risk of transmitting an infection. RN 1 further acknowledged that the personal care products were stored with the medications, increasing the risk for cross-contamination. Upon reviewing the storage of these items, the DON noted that the majority of the personal care products were unlabeled. The DON stated that all personal care products should have been labeled with the resident's name and should not have been stored with medications in the medication room.During an interview with the Pharmacist Consultant (PC) on February 26, 2026, at 11:49 AM, the PC stated that non-medication-related items were not to be stored in a medication room with resident medications. The PC stated that a medication room was strictly for medication storage.During an interview with the Administrator (Admin) and the DON on February 26, 2026, at 2:52 PM, the Admin and DON stated they agreed with the PC's statement. The DON agreed that not all personal care items had been labeled with a resident's name, creating a risk of giving an item to the wrong resident and increasing the risk of transmitting an infection. The DON further agreed that personal care products should not be stored with medications, as it increased the risk for cross-contamination.2. During a medication storage observation and interview on Unit 1 at Nursing Station 1, conducted with RN 1 and the DON on February 25, 2026, from 8:19 AM to 9:23 AM, there were three cabinets in the medication room where medications were stored. In the third cabinet on the fourth shelf, a bag of discontinued prescription topical medications awaiting disposal was stored on top of and next to discarded items, disinfectant spray, and trash. RN 1 acknowledged that this storage practice did not provide a sanitary environment for storing medications. The DON stated that discontinued medications should not be stored alongside discarded items, trash, or disinfectant spray.During an interview with the PC on February 26, 2026, at 11:49 AM, the PC stated that the facility should store medications awaiting disposal in an area dedicated solely to that purpose. The PC stated it was not appropriate to store prescription medications (whether discontinued or not) on top of discarded items, trash and next to a disinfectant chemical spray. The PC stated this creates an unnecessary risk for cross-contamination and was not an appropriate way to handle and separate waste from clinical items.During an interview with the Admin and DON on February 26, 2026, at 2:52 PM, the Admin and DON stated they agreed with the statement made by the PC. They further agreed that storing discontinued medications on top of discarded items, trash and next to a disinfectant chemical spray in the Unit 1 medication room was not acceptable.A review of the facility's policy and procedure (P&P) titled, Storage of Medications, dated January 2025, indicated, Policy: Medications and biologicals are stored safely, securely, and properly, following manufacturer's recommendations (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	of those of the supplier. Procedures: . F. Except for those requiring refrigeration, medications intended for internal use are stored in a medication cart or other designated area. H. Potentially harmful substances such as . household poisons, cleaning supplies; disinfectants are clearly identified and stored in a locked area separately from medications. M. Outdated, contaminated, or deteriorated medications and those in containers that are cracked, soiled, or without secure closures are immediately removed from stock, disposed of according to procedures for medication disposal, . N. Medication storage areas are kept clean, well-lit, and free of clutter and extreme temperatures. O. Medication storage conditions are monitored on a routine basis and corrective action taken if problems are identified.A review of the facility's P&P titled, Infection Prevention and Control Program, dated September 18, 2024, indicated, Purpose: An infection prevention and control program (IPCP) is established and maintained to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.

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	05A027	A. Building B. Wing	02/26/2026

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Keep all essential equipment working safely. Based on observation, interview, and record review, the facility failed to ensure the proper maintenance of essential equipment when: 1. The handwashing sink did not consistently maintained water temperatures in accordance with the standard of practice. This failure had the potential for inadequate water temperature which may result in ineffective handwashing putting residents at risk for food borne illness. 2. The Veggie reach-in freezer had ice condensation buildup. This failure had the potential to cause poor quality of food served to a population of 116 out of 116 sample residents who received food from the kitchen. Findings: 1. During a review of FDA (Food and Drug Administration) Food Code 2025, Section 5-202.12., the FDA Food Code indicated, A handwashing sink shall be equipped to provide water at a temperature of at least 85 degrees Fahrenheit (F - a unit of measurement) through a mixing valve or combination faucet. An inadequate flow or temperature of water may lead to poor handwashing practices by food employees. A mixing valve or combination faucet is needed to provide properly tempered water for handwashing. The International Plumbing Code (IPC) states that tempered water is having a temperature range between 85 F and 110 F. During an observation on February 23, 2026, at 8:50 AM, in the kitchen at the handwashing sink near dietary office, the surveyor turned on hot water to wash her hands. The water in the handwashing sink was cold. Surveyor let the water ran for approximate1 minute and checked the water with thermometer which indicated 63 F. An additional follow up observation on February 23, 2026 at 8:55 AM, revealed the water was too hot. Surveyor checked the water with thermometer which indicated 114 F. In a concurrent interview with the Certified Dietary Manager (CDM), the CDM stated handwashing water temperature supposed to be at least 85 degrees F. to 110 degrees F. During an interview on February 25, 2026, at 7:22 AM, with the Registered Dietitian (RD) and CDM. The CDM stated according to standard of practice and Food Code, handwashing temperature should be at least 85 F to 110 F. The RD explained if handwashing temperature too hot, it would be scalding food service employees. And if too cold, lower than 85 F, it may result in ineffective handwashing. 2. During a concurrent observation and interview on February 23, 2026, at 9:20 AM, with the Certified Dietary Manager (CDM), in the kitchen. inside the Veggie reach-in freezer had ice condensation buildup on the ceiling. The CDM stated the reach-in freezer not supposed to have ice condensation buildup on the ceiling. During an interview on February 25, 2026, at 7:22 AM, with the Registered Dietician (RD) and CDM. The RD stated it was an early sign of malfunction freezer with the ice condensation buildup. The RD stated malfunction freezer could affect the quality of foods stored in the freezer. During a review of the facility's policy and procedure (P&P) titled, Equipment, revised dated 9/2017, the P&P indicated, All foodservice equipment will be .in proper working order. Procedures: 1. All equipment will be routinely . maintained .

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. Based on observation, interview, and record review, the facility failed to ensure two of two resident's communal shower rooms (blue and green shower rooms) located on unit 1 were maintained in good repair and in a safe and sanitary condition, when the blue and green shower rooms were both observed to have cracked and stained tile surfaces. This failure had the potential to expose all 45 residents on unit 1 who utilize these shared showers to potential harm, contamination and transmission of healthcare-associated infections.Findings:During a concurrent observation and interview on February 25, 2026, at 9:01 AM with Infection Preventionist (IP), in the green and blue shower rooms, it was observed multiple cracked and stained tiles. The IP stated, I see there are multiple cracked and stained tiles within both shower rooms. The IP further stated, shower surfaces should be intact and cleanable to prevent infection control issues.During a concurrent observation and interview on February 25, 2026, at 9:42 AM with Maintenance Supervisor (MS), in the green and blue shower rooms, it was observed multiple cracked and stained tiles. MS, confirmed, the two showers have multiple cracked and stained tiles. He stated, I wasn't aware of the cracked and stained tiles but has been trying to get a remold for both shower rooms. He further stated, cracked tile surfaces doesn't meet the standards for a safe and sanitary environment.During a concurrent observation and interview on February 25, 2026, at 9:50 AM with Administrator, in the green and Blue shower rooms, Administrator verified both shower rooms have multiple cracked and stained tiles. The Administrator further stated, These two showers are old and need a remodel without a tile surface. During a concurrent interview and record review on February 25, at 11:20 AM, with Administrator, the facility's Policy and Procedure (P&P) titled, Maintenance Service undated, was reviewed. The P&P indicated, 1. The maintenance department is responsible for maintaining the buildings, grounds, and equipment in a safe and operable manner at all times.2b. maintaining the building in good repair and free from hazard. The Administrator stated the facility did not follow the P&P.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to develop and implement comprehensive care plans (an individualized plan based on assessment that identifies needs, sets goals, and outlines interventions for the medical care of a resident) for two of 35 sampled residents (Resident 14 and 34) when:1. For Resident 14, who had a documented history of falls, the facility did not create a fall risk care plan to address fall risk factors, individualized interventions, and preventive strategies.2. For Resident 34, who was identified as a smoker, the facility did not create a care plan that addressed smoking supervision, safety precautions, and risk mitigation. These failures had the potential to place Residents 14 and 34 at risk for injury, burns, fire hazards, and recurrent falls with injury.Findings: 1. During a review of Resident 14's admission Record (contains medical and demographic information), the admission Record, indicated, Resident 14 was admitted to the facility on [DATE], and had diagnoses which included schizophrenia (a mental disorder marked by disturbances in thinking, perception, and behavior, often including hallucinations, delusions, and impaired functioning), unspecified convulsions (episodes of involuntary muscle contractions or seizure-like activity that are not further defined or classified as a specific seizure disorder), and hypo-osmolality and hyponatremia (a condition where the sodium level in the blood is too low, causing the blood to become too diluted. This can lead to neurological symptoms like confusion, headaches, seizures, or changes in alertness.) During a concurrent observation and interview on February 23, 2026, at 12:22 PM, with Resident 14, Resident 14 was sitting on the edge of his bed and stated he had fallen in the facility but he could not remember when it occurred. During a review of Resident 14's Electronic Health Record (EHR), a progress note dated November 11, 2025, indicated, .resident had what appeared to be seizure activity while watching television with other residents in the rec [recreation] room. The seizing lasted about 2 min [minutes].staff worked quickly to assist him to the floor to prevent falls. During a review of Resident 14's EHR, a progress note dated November 13, 2025, indicated, At approx. [approximately] 0700 [7:00 AM] Resident tripped on his foot, fell on right knee when walking in hallway. During a review of Resident 14's EHR, a progress note dated November 14, 2025, indicated, .while on a community smoke break, resident had moved to an area that was not well lit while walking with peers. According to reports from peers, resident collapsed convulsing in what appeared to be a seizure. Peers alerted staff to the resident falling and staff called emergency services.resident was found on the ground convulsing and unresponsive to staff. During a review of Resident 14's EHR, a progress note dated November 18, 2025, indicated, .staff had heard the resident make a grunting noise and went to investigate. Resident was found by staff laying on the floor in front of roommate's bed, face down.it is unknown how the resident got onto the floor.staff was unable to wake resident. Resident soon sat up and was visibly disoriented.resident began to regain consciousness but then began having a seizure lasting approx. [approximately] 3 minutes. During a review of Resident 14's EHR, a progress note dated November 20, 2025, indicated, IDT (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	[interdisciplinary team] discussed resident on 11/20/25 d/t [due to] seizures resulting in falls.no complications d/t fall resident currently on Q15 monitoring [monitoring every 15 minutes]. Resident had medication adjustment for low sodium and seizures. During a review of Resident 14's HER, a progress note dated January 15, 2026, indicated, .resident had a witnessed fall without injury. During a review of Resident 14's EHR, there was no active care plan for falls or risk for falls. During a concurrent interview and record review on February 25, 2026, at 7:36 AM, with the Director of Nursing (DON), the DON stated Resident 14 had a history of seizures with falls and the resident should have a care plan for fall risk or fall history. The DON reviewed Resident 14's care plans and stated she was unable to find an active care plan for falls or fall risk and that she needed to create one for him. During a review of the facility's policy and procedure (P&P) titled, Fall Management, dated May 26, 2021, the P&P indicated, Purpose – To reduce risk for falls and minimize the actual occurrence of falls.Policy – Patients will be assessed for falls risk as part of the nursing assessment process. Those determined to be at risk will receive appropriate interventions to reduce risk and minimize injury.Procedure – 1. Identify patient's fall risk by reviewing the Nursing Documentation. 2. Communicate patients fall risk status to caregivers. 3. Develop individualized plan of care. During a review of the facility's P&P titled, Care Plan Comprehensive, dated August 25, 2021, the P&P indicated, Purpose – an individualized comprehensive care plan that includes measurable objectives and timetables to meet the resident's medical, physical, mental and psychosocial needs shall be developed for each resident. Policy – the facility's interdisciplinary team, in coordination with the resident and/or his/her family or representative, must develop and implement a comprehensive person-centered care plan for each resident, that includes measurable objectives and timeframes to meet a residents medical, physical, and mental and psychosocial needs. 2. A review of Resident 34's admission Record, (contains demographic and medical information), indicated Resident 34 was admitted to the facility on July18, 2025, with diagnoses which included, Schizoaffective disorder bipolar type (a chronic mental health condition that combines symptoms of schizophrenia (hallucinations, delusions) with severe mood swings of bipolar disorder (high mania, depression), and Vitamin D deficiency (not enough vitamin D in the body). During a review of Resident's 34 Minimum Data Set ([MDS] a standardized, core set of essential information collected to evaluate a person's health, needs, and capabilities) Section J dated July 24, 2025, indicated Resident 34 currently uses tobacco. During a record review of Resident 34's Smoking Evaluation (health assessment that looks at a person's smoking habits, their physical addiction to nicotine, and their health risks) dated January 20, 2026, indicated Resident 34 doesn't require special equipment during smoking and resident is independent for smoking. The facility's policy and procedure (P&P) require supervision during smoking. During a record review of Residents 34's comprehensive care plan dated January 12, 2026, indicated, there was no care plan to address Resident 34 smoking assessment, measurable goals, or (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	individualized interventions to safely manage the residents smoking. During an interview on February 25, 2025, at 8:31 AM, with the Director of Nursing (DON), the DON stated Resident 34 didn't not have a care plan for smoking but should to address his smoking needs and safety. During a concurrent interview and record review on February 25, 2026, at 8:50 AM with DON, the facility's Policy and Procedure (P&P) titled, Smoking, dated August 9, 2022, was reviewed. The P&P indicated, .I. Purpose: To provide a safe environment for resident, staff and visitors.III.Procedures: IDT will develop an individual plan for safe storage, use of smoking materials, assistance and required supervision, if necessary, for residents who smoke. This is documented on the resident's smoking evaluation, the residents plan of care and discussed with the resident and responsible party at the resident care conference meeting. DON stated the facility did not follow the policy.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure nursing staff followed physician's orders for one of five sampled residents (Resident 19) investigated for nutrition, when the facility did not have documented weights of Resident 19 in the frequency as ordered by the physician. This failure resulted in Resident 19 not being monitored as ordered by the physician for changes in weight and placed the resident at risk for undetected significant weight loss or gain.Findings: During a review of Resident 19's admission Record (contains medical and demographic information), the admission Record, indicated Resident 19 was admitted to the facility on [DATE], with diagnoses which included paranoid schizophrenia (a mental disorder characterized by intense paranoia, delusions, and auditory hallucinations), and vitamin D deficiency.During an interview on February 24, 2026, at 8:45 AM, with Resident 19, Resident 19 stated he had lost 60 pounds since he was admitted to the facility.During a review of Resident 19's care plan titled, Resident is at nutritional risk: overwt [overweight].wt loss planned; is desired w/o [without] sig [significant] changes.goal.gradual wt loss toward long term 166# [166 pounds] wt loss goal. interventions in the care plan included, Weekly weights for monitoring progress to assess for no more than loss of 2% per week or loss of 5% per month.weigh as ordered.During a review of Resident 19's physician's orders, an order dated February 24, 2025, indicated, Weigh weekly x 4 [for four weeks] post admission, then monthly.During a review of Resident 19's Electronic Health Record (EHR), Resident 19 did not have documentation of weights recorded by staff weekly as ordered by the physician. Weights were recorded as follows: 240 pounds (lbs) February 25, 2025, 238 lbs. March 4, 2025, but then there was no other weights recorded until March 28, 2025, at 236 lbs. There was no weights for the week of March 9, 2025, and March 16, 2025.During a concurrent observation, interview, and record review on February 25, 2026, at 2:20 PM, with the Director of Nursing (DON), the DON reviewed Resident 19's EHR and stated staff was supposed to weight the resident weekly for four weeks starting February 24, 2025, and then monthly as ordered by the physician but it was not done. The DON stated the resident did not have weights recorded in his medical record for the weeks of March 9, 2025, or March 16, 2025. The DON further stated the individual who was responsible for weighing and documenting resident weights was no longer at the facility and used to document weights on a paper chart sometimes. The DON then found the paper chart she was referring to and upon review it was blank for the weeks of March 9, 2025, and March 16, 2025, where Resident 19's name was indicated. The DON stated Resident 19 was not weighed weekly for four weeks as ordered by the physician.During a review of Resident 19's Minimum Data Set Assessment (MDS assessment - a federally mandated, standardized evaluation of a residents functional skills, medical conditions, cognitive and psychosocial status, which is used to guide care planning and quality monitoring) the MDS assessment indicated Resident 19 had significant weight loss and was not on a prescribed weight loss program.During a review of the facility's policy and procedure (P&P) titled, Weight Management, dated August 25, 2021, the P&P indicated, Purpose - To obtain baseline weight and identify significant weight change.Policy - Each individual's weight will be obtained and documented upon admission to the facility.Procedure.2. In nursing facilities, weights will be obtained weekly for 4 weeks after admission. Subsequent weights will be obtained monthly unless physician's orders or an individual's condition warrants more frequent weight measurements.4. Staff will follow acceptable procedure to obtain accurate weights.