| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 065299 | A. Building<br>B. Wing | 05/21/2026 |

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| Parkview Care Center | 3105 W Arkansas Ave<br>Denver, CO 80219 |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Provide and implement an infection prevention and control program.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews, the facility failed to maintain an infection control program designed to provide a safe, sanitary and comfortable environment to help prevent the development and transmission of diseases and infections in three of four hallways.Specifically, the facility failed to:-Ensure staff donned (put on) the appropriate personal protective equipment (PPE) for a resident requiring enhanced barrier precautions (EBP) during wound care for Resident #10;-Ensure housekeeping staff cleaned the residents' toilets in a sanitary manner;-Ensure sterility was maintained during tracheostomy care and suctioning for Resident #66; and,-Ensure staff performed hand hygiene while providing meal assistance.<br><br>Findings include:<br><br>I. Facility policy and procedure<br><br>The Infection Control and Surveillance policy, dated 7/28/23, was provided by the nursing home administrator (NHA) on 5/19/26 at 8:40 a.m. It read in pertinent part, 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.<br><br>Important facets of infection prevention include identifying possible infections or potential complications of existing infections; instituting measures to avoid complications or dissemination; educating staff and ensuring that they adhere to proper techniques and procedures; communicating the importance of standard precautions and cough etiquette to visitors and family members; enhancing screening for possible significant pathogens; immunizing residents and staff to try to prevent illness; implementing appropriate isolation precautions when necessary; and, following established general and disease-specific guidelines such as those of the Centers for Disease Control (CDC).<br><br>II. EBP failures<br><br>A. Professional reference<br><br>Implementation of Personal Protective Equipment (PPE) Use in Nursing Homes to Prevent Spread of Multidrug-resistant Organisms (MDROs), 4/2/24, was retrieved 5/25/26. It read in pertinent part, EBP expand the use of PPE and refer to the use of gown and gloves during high-contact resident care activities that provide opportunities for transfer of MDROs to staff hands and clothing. MDROs may be indirectly transferred from resident-to-resident during these high-contact care activities. Nursing home residents with wounds and indwelling medical devices are at especially high risk of both<br>(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 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | acquisition of and colonization with MDROs. The use of gown and gloves for high-contact resident care activities is indicated, when contact precautions do not otherwise apply, for nursing home residents with wounds and/or indwelling medical devices regardless of MDRO colonization as well as for residents with MDRO infection or colonization.<br><br>Examples of high-contact resident care activities requiring gown and glove use for EBP include: dressing; bathing/showering; transferring; providing hygiene; changing linens; changing briefs or assisting with toileting; device care or use: central line, urinary catheter, feeding tube, tracheostomy/ventilator; and, wound care: any skin opening requiring a dressing.<br><br>In general, gown and gloves would not be required for resident care activities other than those listed above, unless otherwise necessary for adherence to standard precautions. Residents are not restricted to their rooms or limited from participation in group activities. Because enhanced barrier precautions do not impose the same activity and room placement restrictions as contact precautions, they are intended to be in place for the duration of a resident's stay in the facility or until resolution of the wound or discontinuation of the indwelling medical device that placed them at higher risk.<br><br>B. Facility policy and procedure<br><br>The EBP policy, dated December 2024, was provided by the NHA on 5/21/26 at 3:45 p.m. It read in pertinent part, EBP are utilized to prevent the spread of MDROs to residents.<br><br>EBP refers to infection prevention and control interventions designed to reduce the transmission of MDROs during high contract resident care activities. EBP applies when: a resident is infected or colonized with a CDC-targeted MDRO but does not have a wound or indwelling medical device, and does not have secretions or excretions that cannot be covered or contained; a resident is not known to be infected or colonized with any MDRO, has a wound or indwelling medical devices and does not have secretions or excretions that are unable to be covered or contained; and, contact precautions do not otherwise apply.<br><br>Examples of secretions or excretions include wound drainage, fecal incontinence or diarrhea or other discharges from the body that cannot be contained and pose an increased potential for extensive environmental contamination and risk of transmission of a pathogen.<br><br>EBP employs targeted gown and glove use in addition to standard precautions during high contact resident care activities when contact precautions do not otherwise apply. Gloves and gown are applied prior to performing the high contact resident care activity (as opposed to before entering the room).<br><br>Examples of high-contact resident care activities requiring the use of gown and gloves for EBP include: dressing, bathing/showering, providing hygiene, changing briefs or assisting with toileting, transferring, changing linens, prolonged contact with items in the resident's room, device care or use and wound care.<br><br>C. Record review<br><br>Review of Resident #10's May 2026 computerized physician orders (CPO) revealed the following physician's order:<br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | EBP: staff to utilize gowns and gloves for high-contact resident care activities (wound), ordered 4/4/26.<br><br>Review of Resident #10's skin integrity care plan, initiated 9/29/24, revealed the resident had a right medial malleolus (ankle) diabetic ulcer. Pertinent interventions included following EBP including gowns and gloves for high-contact resident care activities such as dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care or use (central line, urinary catheter, feeding tube, tracheostomy/ventilator).<br><br>D. Observation<br><br>On 5/19/26 at 11:25 a.m. wound care for Resident #10's diabetic foot wound was observed with licensed practical nurse (LPN) #1. She donned a pair of gloves and placed a towel on the floor beneath the resident's right foot.<br><br>LPN #1 completed wound care according to the physician's orders.<br><br>-However, LPN #1 failed to don a gown while providing wound care to Resident #10.<br><br>E. Staff interviews<br><br>LPN #1 was interviewed on 5/19/26 at 11:45 a.m. LPN #1 said she did not know what EBP was. She said Resident #10 was not on any precautions and the sign and supplies might have still been up from a recent roommate. LPN #1 said she thought the MDS coordinator or the infection preventionist was responsible for making sure the isolation precaution signage were updated and accurate for each resident.<br><br>Certified nurse aide (CNA) #3 was interviewed on 5/21/26 at 10:52 a.m. CNA #3 said when a resident was on EBP she should wash her hands and wear gloves, a mask and a gown. She said she knew a resident should be on EBP because it was documented on the facility's documentation system and posted on the resident's door. CNA #3 said Resident #10 was on EBP for her foot wound. She said it was important to follow EBP so that she would not come in contact with any infections.<br><br>Registered nurse (RN) #2 was interviewed on 5/21/26 at 10:50 a.m. RN #2 said EBP was indicated when the resident had an infection, and EBP was documented in the resident's MAR as well as posted on the resident's door. She said if there was a change in isolation status it would be discussed in shift to shift report. RN #2 said Resident #10 was on EBP for a wound on her foot. She said it was important to follow EBP because the nurse would not want to get contaminated with bacteria while performing wound care. RN #2 said staff should wear the necessary equipment to protect themselves and others.<br><br>The clinical nurse consultant was interviewed on 5/21/26 at 12:51 p.m. The clinical nurse consultant said she was filling in for the infection preventionist. She said in order to determine if EBP should be implemented for a resident she would have to identify the organism. The clinical nurse consultant said quite a few residents at the facility were on EBP due to gastrostomy tubes (a medical device inserted through the abdomen directly into the stomach that delivers nutrition, hydration and medications to people who cannot safely eat or consume enough calories by mouth), tracheostomies (an opening in the neck to the trachea that provides an alternative airway for breathing and clearing lung secretions), catheters and wounds. She said the staff knew which residents were on EBP because there was<br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | signage outside the resident's door that told the staff which isolation precaution to use, and there were EBP supplies ready to go on the resident's door. The clinical nurse consultant said Resident #10 should be on EBP due to a chronic wound.<br><br>The assistant director of nursing (ADON) was interviewed on 5/21/26 at 2:04 p.m. The ADON said she was filling in for the director of nursing (DON) while she was out. The ADON said EBP was for when a resident had a wound, a foley catheter, a colostomy (a surgical procedure that brings a section of the large intestine to the outside of the abdominal wall to create an opening called a stoma), ileostomy (a stoma that connects the small intestine to the outside of the abdominal wall) or urostomy (a surgical procedure that creates an alternative pathway for urine to leave the body through a stoma). She said staff needed to wear a gown and gloves to provide resident care.<br><br>The ADON said Resident #10 was on EBP. She said the staff knew to wear the gown and gloves because it was posted on the resident's door. The ADON said it was important to follow EBP to prevent contamination of potential infectious organisms from resident to resident.<br><br>III. Housekeeping failure<br><br>A. Professional references<br><br>Assadian O, Harbarth S, Vos M, et al. Practical Recommendations for Routine Cleaning and Disinfection Procedures in Healthcare Institutions: A Narrative Review. The Journal of Hospital Infection, (July 2021) 113:104-114, was retrieved on 5/25/26 from https://www.journalofhospitalinfection.com/article/S0195-6701(21)00105-5/fulltext. It revealed in pertinent part,<br><br>High-touch surfaces, on the other hand, are usually close to the patient, are frequently touched by the patient or nursing staff, come into contact with the skin and, due to increased contact, pose a particularly high risk of transmitting pathogens (virus or microorganism that can cause disease) Healthcare-associated infections (HAIs) are the most common adverse outcomes due to delivery of medical care. HAIs increase morbidity and mortality, prolonged hospital stay, and are associated with additional healthcare costs. Contaminated surfaces, particularly those that are touched frequently, act as reservoirs for pathogens and contribute towards pathogen transmission. Therefore, healthcare hygiene requires a comprehensive approach. This approach includes hand hygiene in conjunction with environmental cleaning and disinfection of surfaces and clinical equipment.<br><br>The Centers for Disease Control and Prevention (CDC) Environment Cleaning Procedures, (revised 3/19/24) was retrieved on 5/25/26 from https://www.cdc.gov/healthcare-associated-infections/hcp/cleaning-global/procedures.html. It read in pertinent part,<br><br>Proceed from cleaner to dirtier areas to avoid spreading dirt and microorganisms. Examples include: during terminal cleaning, clean low-touch surfaces before high-touch surfaces, clean patient areas (patient zones) before patient toilets, within a specified patient room, terminal cleaning should start with shared equipment and common surfaces, then proceed to surfaces and items touched during patient care that are outside of the patient zone, and finally to surfaces and items directly touched by the patient inside the patient zone. In other words, high-touch surfaces outside the patient zone should be cleaned before the high-touch surfaces inside the patient zone and clean general patient areas not under transmission-based precautions before those areas under transmission-based<br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | precautions.<br><br>B. Observations<br><br>On 5/20/26 at 9:23 a.m. housekeeper (HK) #1 prepared to enter room [ROOM NUMBER], a double occupancy room. Before HK #1 entered the room, HK #2 came over to help HK #1.<br><br>HK #1 and HK #2 performed hand hygiene with sanitizer, donned a clean pair of gloves and entered the room together. HK #2 began spraying the Clorox fuzion disinfectant spray on high-touch surfaces, including side A's bedside table, bed remote and call light.<br><br>HK #1 entered the residents' bathroom with a toilet brush and toilet cleaner. HK #1 scrubbed the inside of the toilet bowl with the toilet brush, then used the toilet brush to scrub the toilet seat. Next, HK #1 raised the toilet seat and scrubbed the inside of the toilet bowl with the toilet brush again.<br><br>-HK #1 failed to clean the toilet in a sanitary manner from the cleanest area to the dirtiest area in room [ROOM NUMBER].<br><br>On 5/20/26 at 9:37 a.m. HK #1 was cleaning room [ROOM NUMBER], a double occupancy room. HK #1 entered the resident's room with clean rags and the Clorox fuzion disinfectant spray. At 9:39 a.m. she sprayed the light switch and side A's bedside table, call light, bed remote, the door handles to the resident's room and bathroom, all surfaces of the sink and the faucet, the toilet/toilet riser and the bathroom grab bars.<br><br>At 9:41 a.m. HK #1 used a clean rag to wipe the sink's surfaces before she wiped the toilet's pipes and flush handle, the toilet riser and the exterior of the toilet. HK #1 emptied the trash from the bathroom's trash can and placed a new trash bag in the can before she returned to the housekeeping cart at the entrance of the room.<br><br>-HK #1 failed to clean the inside of the toilet bowl with a toilet brush in room [ROOM NUMBER].<br><br>HK #1 disposed of the dirty rags in a plastic bag, doffed her gloves, performed hand hygiene with sanitizer and donned a clean pair of gloves.<br><br>At 9:43 a.m. HK #1 re-entered the room and was observed disinfecting side B's high-touch surfaces, sweeping and mopping the room.<br><br>-However, HK #1 did not return to the toilet to finish cleaning it in a sanitary manner.<br><br>C. Staff interviews<br><br>HK #1 was interviewed on 5/20/26 at 9:53 a.m. HK #1 said it was not bad to clean the inside of the toilet bowl before she cleaned the toilet seat in room [ROOM NUMBER]. She said she did not clean the toilet in room [ROOM NUMBER] because the toilet was already clean. HK #1 said the housekeeping staff used the toilet brush to clean when the toilet got very dirty. She said the housekeeping staff should clean the toilet everyday.<br><br>The clinical nurse consultant was interviewed on 5/21/26 at 12:51 p.m. The clinical nurse consultant said she was filling in for the infection preventionist. The clinical nurse consultant said the resident's<br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | toilets should be cleaned at least daily and with deep cleans. She said the toilet should be cleaned starting with the cleanest area and ending with the dirtiest area, so the inside of the toilet bowl should be cleaned last.<br><br>IV. Tracheostomy suctioning failure<br><br>A. Facility policy and procedure<br><br>The Tracheostomy Care policy and procedure, revised in October 2023, was provided by the NHA on 5/21/26 at 3:33 p.m. The facility policy read in pertinent part,<br><br>The purpose of this procedure was to guide tracheostomy care and the cleaning of reusable tracheostomy cannulas.<br><br>General guidelines dictate aseptic technique must be used during cleaning and during all dressing changes. Sterile gloves must be used during aseptic procedures.<br><br>After removing old trick dressings, pull soil gloves over the dressings and discard into appropriate receptacles and perform hand hygiene.<br><br>B. Observations<br><br>On 5/19/26 at 11:59 a.m. RN #3 turned on the suction machine and suctioned the Resident #66 via his tracheostomy. RN #3 suctioned the residents via his tracheostomy opening and then suctioned the resident's mouth with the same tubing. The resident began coughing during the suctioning procedure. The nurse proceeded to change the resident's trach dressing with a new clean trachestomy dressing.<br><br>-However, the nurse failed to change her gloves or perform hand hygiene prior to initiating the tracheostomy dressing change.<br><br>On 5/19/26 at 12:54 p.m. RN #3 entered Resident #30's room, donned sterile gloves to perform tracheostomy suctioning. The nurse used her left hand to turn on the suction machine. The nurse touched the bedside table with her left hand and her right (clean) hand while wearing her sterile gloves and moved the table closer to her. The nurse suctioned the residents' trach two times with a return of clear frothy sputum noted.<br><br>-However, RN #3 failed to change her gloves or perform hand hygiene after touching the non-sterile surface with her sterile gloves.<br><br>C. Staff interviews<br><br>LPN #4 was interviewed on 5/21/26 at 8:55 a.m. LPN #4 said he was trained by the facility regarding nursing technique for tracheostomy suctioning and care. LPN #4 said sterile gloves should always be used for tracheostomy suctioning to prevent infection. LPN #4 said if a nurse touched a non-storeal surface with sterile gloves, then the gloves should be removed and don a new pair of sterile gloves.<br><br>The clinical nurse consultant was interviewed on 5/21/26 at 1:05 p.m. The clinical nurse consultant said RN #3 should have changed her gloves and washed her hands after she touched the bedside table with her sterile gloves. The clinical nurse consultant said the gloves were no longer sterile after she<br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | touched a non-sterile surface. The clinical nurse consultant said RN #3 should have changed her gloves after suctioning Resident #66 before applying a clean dressing to his tracheostomy site. The clinical nurse consultant said her expectation was for the nursing staff to maintain sterility to prevent the residents from getting an infection.<br><br>V. Hand hygiene failures<br><br>A. Professional reference<br><br>According to The CDC Hand Hygiene for Healthcare Workers (2/27/24), retrieved on 5/27/26 from https://www.cdc.gov/cleanhands/<br><br>hcp/clinical-safety/index.html, included the following recommendations for hand hygiene, Hand hygiene protects both healthcare personnel and patients.<br><br>Cleaning your hands reduces the potential spread of germs, including those resistant to antibiotics.<br><br>Clean your hands immediately before touching a patient and after touching a patient or the patient's surroundings.<br><br>B. Observations<br><br>During a continuous observation of the lunch meal in the main dining room on 5/18/26, beginning at 11:17 a.m. and ending at 12:50 p.m., the following was observed:<br><br>At 12:30 p.m. certiCNA #6 was assisting two unidentified dependent residents with eating. CNA #6 alternated offering each resident a bite of food before offering a bite of food to the other resident using the same hand. CNA #6 continued alternating offering each resident a bite of food through 12:50 p.m.<br><br>-CNA #6 did not perform hand hygiene between offering bites of food to each resident, and no hand sanitizer was available at the table for CNA #6 to use.<br><br>During a continuous observation of the lunch meal in the main dining room on 5/19/26, beginning at 11:18 a.m. and ending at 12:28 p.m., the following was observed:<br><br>At 12:16 p.m. CNA #6 sat down between two unidentified residents before turning to one resident, preparing her straw in her cup of water, unwrapping her silverware and preparing a bite on the resident's fork. CNA #6 offered a bite of food to the resident, then turned to the other resident at the table and began speaking with him while unwrapping his silverware and offering him a bite of food. CNA #6 continued alternating offering each resident a bite of food using the same hand through 12:25 p.m.<br><br>-CNA #6 did not perform hand hygiene between offering bites of food to each resident, and no hand sanitizer was available at the table for CNA #6 to use.<br><br>C. Staff interview<br><br>The clinical nurse consultant was interviewed on 5/21/26 at 1:07 p.m. The clinical nurse consultant (continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | said if the nursing staff touched something such as a resident's clothing or wiped the resident's mouth they should get up and wash their hands prior to assisting the next resident with eating. The clinical nurse consultant said CNA #6 should have performed hand hygiene when alternating between the two residents. |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations and interviews the facility failed to ensure all drugs and biologics used in the facility were properly stored and labeled for one of four medication carts and one of one medication rooms reviewed for storage and labeling. Specifically, the facility failed to ensure prescription medications were discarded after the expiration date and after they were discontinued. Findings include:I. Professional referencesThe United States Food and Drug Administration (USFDA) Don't Be Tempted to Use Expired Medicines (revised 10/31/24), was retrieved on 5/27/26 from https://www.fda.gov/drugs/special-features/dont-be-tempted-use-expired-medicines. It read in pertinent part, Expired medical products can be less effective or risky due to a change in chemical composition or a decrease in strength. Certain expired medications are at risk of bacterial growth, and sub-potent antibiotics can fail to treat infections, leading to more serious illnesses and antibiotic resistance. Once the expiration date has passed, there is no guarantee that the medicine will be safe and effective. If your medicine has expired, do not use it.II. Facility policy and procedureThe Storage of Medication policy, revised February, 2026, was received from the nursing home administrator (NHA) on 5/21/26 at 3:33 p.m. It revealed in pertinent part, The facility stores all medications and biologicals in locked compartments under proper temperature, humidity and light controls. Only authorized personnel have access to keys. Multi-dose vials that are not opened or accessed are discarded according to the manufacturer's expiration date. The nursing staff is responsible for maintaining medication storage and preparation areas in a clean, safe, and sanitary manner. If the facility has discontinued, outdated or deteriorated medications or biologicals, the dispensing pharmacy is contacted for instructions regarding returning or destroying these items.II. ObservationsOn 5/21/26 at 10:33 a.m. medication cart #2 on the Santa [NAME] unit was observed with licensed practical nurse (LPN) #5. The following items were found:The drawer for Resident #17 contained the following:-Gabapentin (a medication used to manage nerve pain) oral tablets 300 milligrams (mg). The medication was discontinued on 3/1/26. The blister pack holding the pills contained seven pills. -Gabapentin oral tablets 300 mg. The medication was discontinued on 3/31/26. The blister pack holding the pills contained seven pills. -Gabapentin oral tablets 300 mg. The medication was discontinued on 3/1/26. The blister pack holding the pills contained 28 pills. The drawer for Resident #48 contained the following:-Oxycodone HCl (A medication used to treat severe and persistent pain) oral tablet 10 mg. The blister pack holding the pills contained 10 pills. -However, the resident was discharged from the facility on 5/19/26 (see interviews below).On 5/21/26 at 11:10 a.m. the medication room was observed with registered nurse (RN) #2. The shelf in the medication storage room contained the following:-Two vials of Daptomycin 600 mg intravenous (IV) (an IV antibiotic used to treat severe and complicated gram-positive infections) 1 gram (gm) that expired on 2/27/26. -Seven vials of Daptomycin 600 mg IV 1 gm, expired on 4/2/26. -Eight vials of Daptomycin 600 mg IV 1 gm. Expiration date 3/14/26. III. Staff interviewsLPN #5 was interviewed on 5/21/26 at 10:40 a.m. She said it was the responsibility of the nurses assigned to the individual medication card to ensure medications were removed after expiration date. She said the medications should have been discarded after the medications were observed to be expired. She said Resident #48 was discharged on 5/19/26. She said she notified her unit manager that the medication for Resident #48 needed to be removed from her medication cart. She said because the director of nursing (DON) was on vacation, the facility was unable to remove the medication. She said the DON had the keys to the locked disposal cabinet used for narcotics. She said she did not notice the medication for Resident #17 was in her medication cart. RN #2 was interviewed on 5/21/26 at 11:15 a.m. She said the vials of antibiotics in the storage room should have been removed after the expiration date was reached. She (continued on next page) |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | said the DON was responsible for ensuring that the medication storage room did not hold medications that were expired. The assistant director of nursing (ADON) was interviewed on 5/19/26 at 12:18 p.m. The ADON said she was the nurse assigned to work on the medication cart #2 on the Santa [NAME] unit yesterday. She said she should have discarded the medication for Resident #17, but she was too busy with other nursing tasks. The ADON said because the DON was on vacation the facility was unable to discard the medication for Resident #48. She said the DON had the keys to the locked disposal cabinet used for narcotics. She said all of the staff nurses on the unit were responsible for ensuring discarded medications were removed from medication carts and rooms after residents had either been discharged or the medication had expired or discontinued. |

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| F 0804<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.<br><br>Based on observations, record review and interviews, the facility failed to ensure residents consistently received food prepared by methods that conserved nutritive value and was palatable in taste, texture and temperature.Specifically, the facility failed to ensure the residents' food was palatable in taste, texture and temperature.Findings include:I. Facility policy and procedureThe Food Preparation and Service policy and procedure, revised November 2022, was received from the clinical nurse consultant on 5/21/26 at 3:27 p.m. It read in pertinent part, Proper hot and cold temperatures are maintained during food distribution and service. The temperatures of foods held in steam tables are monitored throughout the meal service by food and nutrition services staff.II. Resident interviewsResident #53 was interviewed on 5/18/26 at 10:02 a.m. Resident #53 said the food sucked in taste half the time. Resident #53 said she ate in her room and her food was always cold when it got to her room.Resident #52 was interviewed on 5/18/26 at 10:05 a.m. Resident #52 said his room meal trays were delivered cold, but said the facility staff would reheat it if he requested. Resident #52 said his meal trays were cold because he was the last room on the hallway to be served. Resident #52 said he had asked if the staff could alternate which hallways got served last, but said nothing ever came from his request.Resident #10 was interviewed on 5/18/26 at 10:45 a.m. Resident #10 said she usually ate in her room. Resident #10 said her room meal trays were consistently cold. Resident #10 said the kitchen staff often forgot to give her items she requested such as tomatoes or extra pickles.Resident #20 was interviewed on 5/18/26 at 2:22 p.m. Resident #20 said none of the food was ever spiced or seasoned and everything tasted bland. Resident #20 said she usually ate breakfast in her room and her breakfast meal tray was always cold. Resident #20 said she always had to send her breakfast meal tray back to the kitchen to have it warmed up.III. Resident group interviewA group interview was conducted on 5/20/26 at 11:23 a.m. with six alert and oriented residents (#43, #64, #2, #29, #21 and #1) who were deemed interviewable per the facility and assessment.Several residents said the facility's food was so-so, and said the food was often undercooked. Resident #2 and Resident #21 said they received a lot of the same food over and over. Resident #64 said there was not enough seasoning on the food.IV. Test trayA test tray for a regular diet was evaluated by four surveyors immediately after the last resident was served their room tray for lunch on 5/20/26 at 12:30 p.m.The test tray consisted of pork fried rice, sugar snap peas, mini egg rolls, sweet and sour sauce and fruited gelatin. Temperatures of the food items were taken immediately on arrival and were measured as followed:-The pork fried rice measured 118.4 degrees Fahrenheit (F);-The sugar snap peas measured 111.2 degrees F; and,-The egg rolls measured 119.1 degrees F.The test tray was sampled by each of the four surveyors and the following was noted:-The pork in the fried rice was not seasoned and the meat was chewy;-The rice was chewy and overcooked;-The contents of the egg roll were chewy/mushy; and,-The sugar snap peas were unseasoned, overcooked and slimy. V. ObservationsDuring a continuous observation of the 5/18/26 lunch meal room tray service, from 12:01 p.m. through 12:21 p.m., the following was observed:At 12:01 p.m. the meal tray cart was wheeled to the Pacifico nurse's station and the first tray was delivered. The meal tray cart was an open metal rack with no walls or insulation.At 12:21 p.m. the last meal tray on the unit was delivered.During a continuous observation of the 5/20/26 lunch meal service, from 10:35 a.m. through 12:51 p.m., the following was observed:At 11:30 a.m. the temperatures of each menu item were measured. These measurements were recorded as follows:-The pork fried rice measured 168 degrees F;-The beef fried rice measured 158 degrees F;-The sugar snap peas measured 180 degrees F;-The pureed beef fried rice measured 157 degrees F;-The pureed carrots measured 181 degrees F; and,-The diced carrots measured 145 degrees F.At 11:34 a.m. the covers for each of the food items on the steam table were removed and lunch service began.At 12:46 p.m. the dietary manager served one of the final plates to a resident in the dining room and said there was one more resident who they were waiting on to come to the dining room so they could serve them. Final menu item temperatures were assessed and<br>(continued on next page) |

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| F 0804<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | measured as follows:-The beef fried rice measured 133 degrees F;-The egg rolls measured 117 degrees F;-The diced carrots measured 109 degrees F;-The pureed eggroll measured 124 degrees F;-The pureed carrots measured 128 degrees F; and,-The pureed beef fried rice measured 106 degrees F.-All items measured, with the exception of the pork fried rice and the sugar snap peas, had fallen below the safe hot food holding temperature of 135 degrees F.VII. Staff interviewsThe dietary manager (DM) was interviewed on 5/21/26 at 1:38 p.m. The DM said one side of the steam table seemed to be running hotter than the other, which seemed to correlate with where the heating element of the table was located. The DM said safe hot food holding temperatures were to be maintained above 135 degrees F, and said they tried to hold their food at higher temperatures especially with their room trays. The dietary manager said she had not been told about any issues with any cold room meal trays and said it was not a concern brought up in their food committee meetings. The dietary manager said the kitchen had received a grievance about cold room trays back in October 2025, and when the facility completed an audit they found it had taken the certified nurse aides (CNA) a while to pass out the meal trays that day because they had been busy. The DM said the registered dietitian conducted a monthly audit to test the meal trays' palatability and time it took for the trays to be passed, and said she had not identified any issues in her audits.The DM said she had been emailing with the nursing home administrator (NHA) to see what options they could implement to improve room tray service. The DMsaid the kitchen did not have a plate warmer, so the hot food was served on a cold plate, and the room tray carts were not insulated. The DM said she had recently changed meal service to have three people working to plate food instead of one to make the process go faster. The DM said she had initiated that change starting 4/12/26.The DM said she had begun emailing the NHA in February 2026 about the different room tray improvement options. The DM said she and the NHA discussed switching to doing room tray service first, which they had implemented, and getting new thermal bases and tops for the room meal trays. The DM said the thermal bases and tops used on the current room meal trays looked pretty old and she was not sure how well they held in heat. The DM said they had been working on getting quotes for these options.With regard to the post-service temperatures on 5/20/26, the dietary manager said she thought the temperatures of the menu items had dropped throughout service because they were rushing around that day and had laid out the steam table bins differently from how they normally would.The NHA was interviewed on 5/21/26 at 2:29 p.m. The NHA said the facility had a food committee, through which she had heard from some residents the food was too seasoned or not seasoned enough. The NHA said she had not heard many complaints from residents about the food temperatures for their room meal trays. The NHA said the facility had been working on new systems to see if they could have drinks pre-poured on the room trays to see if they could reduce the amount of time between when the food was served and when it was delivered to the residents. The NHA said she and the dietary manager had been brainstorming options for plate warmers or new thermal containers for the room tray plates, but said it was difficult to decide on because the metal pellets in the thermal bases could get hot or be heavy. The NHA said these improvements were on her to-do list. |

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| F 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure services provided by the nursing facility meet professional standards of quality.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and interviews, the facility failed to ensure three (#66, #30 and #7) of five residents out of 45 sample residents were provided services that met professional standards of quality. Specifically, the facility failed to:-Ensure professional standards were used when nursing staff completed oral and tracheostomy suctioning for Resident #66;-Ensure Resident #30's head of his bed was elevated 30 to 45 degrees while administering a water flush through his gastrostomy tube (a small device inserted through the abdomen directly into the stomach); and,-Create and implement a comprehensive care plan for Resident #7's insomnia or his use of Trazodone (antidepressant with off label use of sleep aid), and failed to follow Resident #7's physician's orders to track his hours of sleep.<br><br>Findings include:<br><br>I. Tracheostomy failures<br><br>A. Professional reference<br><br>The Tracheostomy Care & Suctioning (revised in 2021), was retrieved on 6/2/26 from https://www.ncbi.nlm.nih.gov/books/NBK593189/. It read in pertinent part,<br><br>Oral Suctioning Standards is performed using clean technique for oropharyngeal suctioning, typically using a Yankauer suction tip. Safety with care must be taken to avoid penetrating deep into the throat to prevent gagging, aspiration, or trauma to sensitive tissues.<br><br>Tracheostomy suctioning standards require the maintenance of strict sterile technique (open or closed systems) to prevent respiratory tract infections. Pre/Post-Assessment: Nurses must assess ABCs (airway breathing and circulation) , lung sounds, and oxygen saturation before and after the procedure. Pre-oxygenation is strongly recommended for pediatric and adult patients.<br><br>B. Facility policy and procedure<br><br>The Tracheostomy Care policy, revised October, 2023, was received from the nursing home administrator (NHA) on 5/21/26 at 3:33 p.m. It revealed in pertinent part,<br><br>The purpose of this procedure is to guide tracheostomy care and the cleaning of reusable tracheostomy cannulas.<br><br>A suction machine, supply of suction catheters, exam and sterile gloves, and flush solution, must be available at the bedside at all times.<br><br>Tracheostomy care should be provided as often as needed, at least once daily for old, established tracheostomies, and at least every eight hours for residents with unhealed tracheostomies.<br><br>C. Resident #66<br><br>1. Resident status<br>(continued on next page) |

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| F 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Resident #66, age greater than 65, was admitted on [DATE]. According to the May 2025 computerized physician orders (CPO), diagnoses included sepsis, dementia, tracheostomy, muscle weakness and dysphagia (difficulty swallowing).<br><br>The 5/6/26 minimum data set (MDS) assessment revealed the resident was unable to complete the brief interview for mental status (BIMS) assessment. The assessment indicated the resident was fully dependent on staff for oral hygiene, bathing and shower hygiene, chair-to-chair transfers, toileting hygiene, and lower body dressing.<br><br>The MDS indicated the resident had a tracheostomy upon admission.<br><br>The facility indicated that the facility should not conduct a staff assessment. The delirium assessment indicated that there were no acute mental changes.<br><br>2. Observations<br><br>On 5/19/26 at 11:59 a.m. registered nurse (RN) #3 turned on the suction machine and suctioned Resident #66 via his tracheostomy. RN #3 then suctioned the resident's mouth with the same tubing. The resident began coughing during the suctioning procedure. The nurse proceeded to change the resident's tracheostomy dressing with a new clean trach dressing.<br><br>-RN #3 failed to switch her suctioning device from the sterile suction catheter used to suction device for his trach, to an oral Yankauer catheter for his mouth (a firm rigid oral suction tool used in medical and emergency settings).<br><br>3. Staff interviews<br><br>The clinical nurse consultant was interviewed on 5/21/26 at 1:05 p.m. She said RN #3 should have used a separate Yankauer catheter device after suctioning Resident #66's tracheostomy and before suctioning his mouth.<br><br>II. Gastrostomy failures<br><br>A. Professional reference<br><br>The Applying the nursing process guidelines (revised in 2023), was retrieved on 6/2/26 from https://www.ncbi.nlm.nih.gov/books/NBK594494/. It read in pertinent part,<br><br>The head of the bed (HOB) to be elevated to a minimum of 30 to 45 degrees during and for at least (30 to 60 minutes after administering tube feeds or fluids. This universally adopted standard aims to prevent aspiration and gastric reflux.<br><br>B. Facility policy and procedure<br><br>The Enteral Feedings and Safety Precautions policy, revised April, 2026, was received from the NHA on 5/21/26 at 3:33 p.m. It revealed in pertinent part,<br><br>The purpose of this is to ensure the safe administration of enteral nutrition. The facility will remain current in and follow accepted best practices in enteral nutrition.<br>(continued on next page) |

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| F 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Elevate the head of the bed (HOB) at least 30 degrees during tube feeding and at least one hour after feeding. If elevating the HOB is medically contraindicated, use the reverse Trendelenburg position.<br><br>C. Resident #30<br><br>1. Resident status<br><br>Resident #30, age greater than 65, was admitted on [DATE]. According to the May 2025 CPO, diagnoses included sepsis, dementia, tracheostomy, muscle weakness and dysphagia.<br><br>The 2/25/26 MDS assessment revealed the resident was unable to complete the BIMS assessment. The resident was dependent on staff for oral hygiene, bathing and shower hygiene, chair-to-chair transfers, toileting hygiene, and lower body dressing.<br><br>The MDS assessment indicated the resident had a feeding tube upon admission and was receiving 51% or more of his calories through a feeding tube.<br><br>The facility indicated that the facility should not conduct a staff assessment. The delirium assessment indicated that there were no acute mental changes.<br><br>2. Observation<br><br>On 5/20/26 at 10:11 a.m. Resident #30's bed was flat upon entering his room. RN #5 entered the resident's room and began providing care to the resident. RN #5 entered Resident #30's room. RN #5 disconnected the resident's gastronomy tube from the continuous feeding pump device. Resident #30 lying in bed flat on his back with the head of the bed not elevated 30 to 45 degrees. RN #5 proceeded to flush the resident's gastronomy tube with 60 milliliter (ml) of water without raising the residence head of the bed.<br><br>3. Record review<br><br>The enteral feeding care plan, revised 1/3/26, revealed Resident #30 required tube feeding to meet his nutritional needs. Pertinent interventions included ensuring the resident's head of the bed was to 45 degrees during and 30 minutes after tube feed (initiated 7/30/20) and monitoring/documenting/reporting any signs and symptoms of aspiration- fever, shortness of breath and tube dislodged. ( initiated 7/30/20)<br><br>Review of Resident #66's CPO revealed the following orders for his tube feed management:<br><br>-Resident is to be NPO (nothing by mouth), only tube feeds, ordered on 3/28/26.<br><br>-Enteral feed order every shift. Elevate head of bed 30 to 45 degrees during feeding and for 30 minutes following feedings, ordered on 3/28/26.<br><br>4. Staff interviews<br><br>RN #5 was interviewed on 5/20/26 at 10:11 a.m. She said when flushing a gastronomy tube for a resident, the head of the bed must be elevated 30 to 45 degrees to prevent possible aspiration (inhaling foreign substances into the lungs) of fluids. She said Resident #30's head of his bed was (continued on next page) |

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| F 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | usually elevated by the certified nurse aides (CNA) staff when he was in bed. She said she did not notice that the head of the bad was flat when she provided the flush to Resident #30. She said she should have ensured that the head of the bed was elevated prior to performing the task.<br><br>The clinical nurse consultant was interviewed on 5/21/26 at 1:05 p.m. She said RN #5 should have elevated the head of the bed for Resident #30 while administering the scheduled water flush. She said facility nurses were trained on the professional nursing technique in regards to the safest way to administer gastronomy tube water flushes.<br><br>III. Following and implementing physician's orders failures<br><br>A. Resident status<br><br>Resident #7, age less than 65, was admitted on [DATE]. According to the May 2026 CPO, diagnoses included schizoaffective disorder, anxiety disorder, insomnia, depression and chronic pain.<br><br>The 4/23/26 MDS assessment revealed the resident cognitively intact with a BIMS assessment score of 14 out of 15.<br><br>The assessment documented the resident was taking antipsychotic, antidepressant and opioid medications.<br><br>B. Record review<br><br>The antidepressant care plan, revised 4/2/26, revealed Resident #7 received an antidepressant medication to treat his schizoaffective disorder, depressive type. Pertinent interventions included monitoring, documenting and reporting any adverse reactions to antidepressant therapy including changes in mood or cognition, fatigue or insomnia.<br><br>The antipsychotic care plan, revised 6/19/25, revealed Resident #7 received an antipsychotic medication. Pertinent interventions included monitoring, documenting and reporting any adverse reactions to psychotropic medications including sedation, fatigue or insomnia.<br><br>-Review of Resident #7's comprehensive care plan did not reveal any care plan focus, interventions or monitoring specific to his diagnosis of insomnia.<br><br>A progress note, dated 4/1/26 at 11:41 p.m., revealed Resident #7 reported insomnia lasting the last three nights. Resident #7's physician was notified and new orders for Trazodone 50 milligram (mg) once a day at bedtime were received. Resident #7 was resting well in bed.<br><br>A progress note, dated 4/2/26 at 8:06 p.m., revealed Resident #7 was taking 50 mg of Trazodone at bedtime. Resident #7 reported he slept very well the night prior (4/1/26).<br><br>A progress note, dated 4/13/26 at 9:31 p.m., revealed Resident #7 complained he had not slept the three days prior and requested an extra dose of Trazodone. The nurse contacted Resident #7's physician and received orders for a one time additional dose of Trazodone 50 mg which was then administered to the resident.<br><br>A progress note, dated 4/21/26 at 9:43 p.m., revealed Resident #7 complained he had not been (continued on next page) |

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| F 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | sleeping well with the 50 mg Trazodone dose and requested the nurse reach out to his physician. The nurse contacted Resident #7's physician who gave new orders to increase his Trazodone dose to 75 mg.<br><br>-However, there was no documentation indicating the resident was not sleeping well or that a physician assessed the resident prior to increasing the medication.<br><br>A physician note, dated 5/5/26 at 5:57 p.m., revealed Resident #7 was seen by his physician due to Resident #7 reporting insomnia. Resident #7 had asked his physician to increase his Trazodone dose, but the physician did not want to oversedate him. The note documented he increased his Trazodone dose for a week with plans to return to the original 75 mg dose. The physician documented Resident #7 said he was not sleeping at all. The physician documented she did not see any sleep tracking data for the resident. The physician's plan included continuing with Trazodone 100mg at bedtime with plans to monitor sleep tracking and return to the 75 mg dose in a week if possible.<br><br>-However, review of Resident #7's electronic medical record (EMR) did not reveal the facility implemented sleep tracking.<br><br>A physician note, dated 5/12/26 at 10:17 p.m., revealed Resident #7 was seen by his physician. The physician documented she had increased Resident #7's Trazodone dose from 75 mg to 100 mg per dose at her last visit and did not see any sleep tracking data. Resident #7 said he was sleeping much better and did not report any daytime sedation. The physician's plan included continuing with Trazodone 100 mg at bedtime with plans to monitor sleep tracking.<br><br>-However, Resident #7's hours of sleep were not recorded from 5/12/26 through 5/21/26 (during the survey process).<br><br>Review of Resident #7's April 2026 CPO revealed the following physician's orders:<br><br>-Aripiprazole (an atypical antipsychotic medication) 5 mg, give 5 mg by mouth one time a day related to schizoaffective disorder, ordered 1/22/26;<br><br>-Hydroxizine (an antihistamine used to treat anxiety and itching) 25 mg, give one tablet by mouth in the morning every Monday, Wednesday and Friday for anxiety prior to dialysis appointments, ordered 3/4/26 and discontinued 5/5/26;<br><br>-Seroquel (an atypical antipsychotic medication) 25 mg, give 25 mg by mouth two times a day related to schizoaffective disorder, ordered 4/8/26;<br><br>-Oxycodone (an opioid pain medication) 10 mg, give one tablet by mouth every six hours as needed for hip and leg pain rating 7 to 10 on a scale of 10, ordered 1/22/26 and discontinued 5/4/26;<br><br>-Trazodone 50 mg tablets, give one tablet by mouth at bedtime for insomnia, ordered 4/1/26 and discontinued 4/21/26;<br><br>-Trazodone 50 mg tablets, give 1.5 tablets by mouth at bedtime for insomnia, ordered 4/21/26 and discontinued 5/5/26; and,<br><br>-Record hours of sleep each shift for 14 days, ordered 4/1/26 and completed 4/15/26.<br>(continued on next page) |

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| F 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of Resident #7's May 2026 CPO revealed the following physician's orders:<br><br>-Trazodone 50 mg tablets, give 1.5 tablets by mouth at bedtime for insomnia, ordered 4/21/26 and discontinued 5/5/26;<br><br>-Trazodone 50 mg tablets, give two tablets by mouth at bedtime for insomnia, ordered 5/5/26;<br><br>-Record hours of sleep each shift for insomnia, ordered 5/4/26 and discontinued 5/12/26;<br><br>-Sleep tracking for one week, ordered 5/6/26 and completed 5/12/26;<br><br>-Record hours of sleep each shift for insomnia, ordered 5/12/26 and discontinued 5/21/26 (during the survey process); and,<br><br>-Monitor hours of sleep every shift, ordered 5/21/26 (during the survey process).<br><br>Review of Resident #7's treatment administration record (TAR) from 4/1/26 through 4/30/26<br><br>revealed the following:<br><br>-Resident #7's sleep was monitored and documented three times per day beginning the evening shift on 4/2/26 through the afternoon of 4/15/26; and,<br><br>-From 4/3/26 through 4/14/26, it was documented Resident #7 slept an average of 11.25 hours per day.<br><br>-Resident #7's hours of sleep were not recorded from the evening of 4/15/26 through 4/30/26.<br><br>Review of Resident #7's TAR from 5/1/26 through 5/21/26 revealed the following:<br><br>-The number of hours Resident #7 slept was recorded each shift from the evening of 5/4/26 through 5/11/26;<br><br>-From 5/5/26 through 5/11/26, it was documented Resident #7 slept an average of 9.1 hours per day; and,<br><br>-The order to record hours of sleep each shift was marked completed nearly every shift from 5/12/26 through 5/21/26.<br><br>-However the number of hours Resident #7 slept each shift was not recorded in the TAR from 5/12/26 through 5/21/26.<br><br>-Additionally, Resident #7's hours of sleep were not recorded from 5/1/26 through the morning of 5/4/26.<br><br>-Review of Resident #7's electronic medical record (EMR) did not reveal any documentation of Resident #7's hours slept from 5/12/26 through 5/21/26.<br><br>C. Staff interviews<br>(continued on next page) |

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| F 0658<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | RN #4 was interviewed on 5/20/26 at 3:59 p.m. RN #4 said residents receiving antidepressant medications or medications for insomnia needed to be monitored for behaviors and side effects, including drowsiness or aggression, and needed to have their hours of sleep monitored and documented. RN #4 said the actual number of hours the resident slept were documented in the TAR, and it was not something the nursing staff could just check off. RN #4 said the nursing staff needed to monitor the number of hours a resident slept while on those medications to see if the medication was effective, if it needed to be removed or changed, or if it made the resident too drowsy.<br><br>Licensed practical nurse (LPN) #3 was interviewed on 5/21/26 at 12:49 p.m. LPN #3 said residents receiving medications to treat their insomnia needed to be monitored for the number of hours they slept. LPN #3 said the nursing staff would monitor the resident each shift for seven days after they started the medication to see how much they slept and if they had any drowsiness in order to determine if the medication was effective. LPN #3 said she also monitored the number of hours a resident slept if they were taking any psychotropic medications. LPN #3 said she documented the number of hours the resident slept in the TAR and did not just check it off.<br><br>The assistant director of nursing (ADON), who was filling in for the director of nursing (DON), was interviewed on 5/21/26 at 2:07 p.m. The ADON said for residents on psychotropic medications, the nursing staff monitored them for mood, isolation, weight gain, nausea and tics each shift. The ADON said if a resident was taking Trazodone for insomnia, the nursing staff would monitor the resident to see if they were too sedated, any mood changes, and monitor the number of hours the resident slept. The ADON said the nursing staff documented the number of hours the resident slept in the TAR, and needed to actually document the number, not just check it was done.<br><br>The ADON said she found Resident #7's order in his CPO to record the number of hours he slept each shift. The ADON said as long as the order was put in correctly it should have given the nursing staff the option to record the number of hours Resident #7 slept each shift. The ADON reviewed Resident #7's TAR and said there was only an option to check yes or no on the order, and did not have an option for the nursing staff to record a number for the hours slept. The ADON said it must have been a glitch in the system. The ADON said the nursing staff should have documented the number of hours Resident #7 slept in a progress note if they could not enter it in the TAR.<br><br>The clinical nurse consultant was interviewed on 5/21/26 at 3:26 p.m. The clinical nurse consultant said the DON was ultimately responsible for overseeing residents' medication orders and making sure their hours slept was being monitored. The clinical nurse consultant said if a resident was receiving a medication for sleep, the nursing staff needed to make sure they were monitoring the number of hours the resident slept.<br><br>D. Facility follow-up<br><br>The NHA submitted additional information via email after the survey process on 5/24/26 at 9:19 p.m. The information submitted included the progress notes from 4/1/26 and 4/21/26, the physician note from 5/5/26, and the April 2026 and May 2026 MAR (see record review above). Also included was a psychiatric physician note, dated 5/20/26 at 6:45 a.m. (during the survey), which revealed Resident #7 was seen by his psychiatrist. The physician note documented Resident #7 reported experiencing anxiety and poor sleep quality, which the psychiatrist noted could be related to adjustments in his other psychotropic medications.<br><br>-However, the facility did not provide any additional documentation of sleep monitoring for Resident #7 during the periods specified in the record review above. |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and interviews, the facility failed to ensure an environment free from risk of accidents and hazards for one (#7) of five residents reviewed for accident hazards out of 45 sample residents.Specifically, the facility failed to prevent a second-degree burn from food for Resident #7.Findings include:I. Facility policy and procedureThe Accidents and Incidents - Investigating and Reporting policy and procedure, revised July 2017, was provided by the clinical nurse consultant on 5/21/26 at 10:57 a.m. It read in pertinent part, All accidents or incidents involving residents occurring on [facility] premises shall be investigated and reported to the administrator. Incident/accident reports will be reviewed by the safety committee for trends related to accident or safety hazards in the facility and to analyze any individual resident vulnerabilities.II. Resident #7A. Resident statusResident #7, age less than 65, was admitted on [DATE]. According to the May 2026 computerized physician orders (CPO), diagnoses included schizoaffective disorder, type 2 diabetes, legal blindness, end stage renal disease, and second degree burn of abdominal wall.The 4/23/26 minimum data set (MDS) assessment revealed the resident cognitively intact with a brief interview for mental status (BIMS) assessment score of 14 out of 15. The resident required substantial to maximal assistance from staff for most activities of daily living (ADL), including eating.The assessment documented the resident's vision was severely impaired.B. Facility incident investigationThe facility incident investigation, dated 3/23/26 at 10:04 a.m., was received from the nursing home administrator (NHA) on 5/20/26 at 12:15 p.m The investigation included the following:A progress note, dated 3/17/26 at 9:30 a.m., documented licensed practical nurse (LPN) #3 was performing wound treatment on Resident #7 at approximately 9:30 a.m. that morning when she noted a new bruise/blister to his right upper quadrant on his abdomen which measured 12 centimeters (cm) by 5 cm. Resident #7 reported to LPN #3 that he had burned himself the morning prior with noodles. When the nurse asked if he had told anyone he said he had told the certified nurse aide (CNA). LPN #3 asked Resident #7's CNA who said she was not aware of the blister. Resident #7 denied any pain/discomfort at the time. The nurse notified Resident #7's physician, the NHA and the resident's representative. LPN #3 educated the CNA to ensure residents' noodles/food temperature was checked and was safe. The CNA expressed understanding and said she made sure she poured out the soup and it was not too warm that morning.An interdisciplinary team (IDT) note, dated 3/23/26 at 10:04 a.m., revealed Resident #7 was reviewed by the IDT for his burn on 3/17/26. The root cause of the incident was determined to be Resident #7's blindness/poor vision. The treatment required for Resident #7's burn was silvadene cream with a dry dressing. Interventions put into place included retraining all staff on putting cups of noodles or similar foods in an open bowl so it cooled down faster and was more stable, and ensuring residents were in proper position.The investigation included an action plan, undated, revealed an identified concern after Resident #7 was burned from hot liquids/fluids inside of food (a cup of noodles). The action plan included the following:-All staff education regarding safe food and beverage temperatures, completed 3/18/26;-Dietary staff education on how to heat noodles without being placed in the microwave or stovetop using the water from the coffee machine which was regulated at 155 degrees Fahrenheit (F), completed 3/18/26;-Identify/evaluate all residents for safety in regard to hot beverages/liquids, no date of completion;-Thermometers placed at the kitchen microwave, completed 3/18/26;-Microwave safety sign posted on coffee machine in dining room, completed 3/18/26;-Thermometer placed by the coffee machine in the dining room to record temperatures of coffee and hot water used to make drinks/food, completed 3/18/26;-Thermometer placed in the breakroom for the microwave for staff to use outside of kitchen hours, completed 3/18/26;-Sign created for the nurses' stations for how to properly heat items in the microwave and measure their temperature outside of dietary hours, completed 3/18/26; (continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | and,-The dietary manager/designee will report findings to the quality assurance and performance improvement (QAPI) committee monthly for 90 days. The QAPI committee will identify any trends and take corrective action as needed.-However, observations during the survey process revealed staff failed to monitor the resident's positioning or encourage him to sit up while eating (see observations below).The Hot Food and Hot Liquid Safety Policy education, dated 3/18/26, revealed facility staff had received education on hot food/liquid safety, which included ensuring foods and liquids were heated/held between 135 and 165 degrees F, but allowed to cool to a safe consumption temperature of 135 to 150 degrees F prior to being consumed by a resident.-However, interviews revealed the staff were not aware of the process included in the action plan (see staff interviews below).C. Resident interview and observationsResident #7 was interviewed on 5/20/26 at 8:13 a.m. Resident #7 said he sustained a burn a while ago, because he was eating ramen noodles and the cup tipped down too much and spilled on him. Resident #7 said the nursing staff had prepared the ramen noodles for him. Resident #7 said he was blind, but could still see some shadows. Resident #7 was lying in bed with the head of his bed elevated to approximately 30 degrees. Resident #7 was attempting to feed himself breakfast while lying down with his tray table over him. Resident #7 activated his call light and told LPN #3 he could not eat his breakfast due to his nausea. LPN #3 attempted to adjust Resident #7's tray table down so he could reach his tray more easily but she said his table could not be lowered.D. ObservationsOn 5/20/26 at 10:54 a.m. a sign was posted on the microwave in the kitchen which read in part, Got hot food or hot beverage? Safe food/fluid for food/fluid safety and burn prevention. Staff rules for mandatory safe microwave use:-Check temperature of warm foods/fluids-Use a thermometer every time-Sanitize the thermometer equipment with an alcohol wipe before and after every use-Heat/reheat all food/fluids to 165 degrees then cool to 150 degrees-Staff will check the temperature every time to be sure and safe and prevent possible burn occurrences or other injury to others.On 5/21/26 at 12:03 p.m. two microwaves were observed in the employee breakroom. Neither microwave had any visible postings related to safe serving temperatures. No thermometers were visible in the surrounding area.-However, interviews with staff revealed these microwaves were also used to reheat residents' food.At 12:59 p.m. the same sign observed posted on the microwave in the kitchen (see above) was posted on the coffee station in the dining room. Another sign was posted next to the coffee machine which read in part, For safety reasons, if you are adding hot water to noodle cups please place the noodles in a bowl after heating and before giving to the resident. Please make sure the temperature is 150 degrees F or lower. A thermometer is on the left side of the coffee machine.A thermometer was attached to the side of the coffee machine.At 2:40 p.m. the NHA and the clinical nurse consultant entered the staff breakroom and began looking on top of the microwave and through the breakroom cabinet drawers to try to find the safe reheating signage and a thermometer. The NHA found a sign which read cool food to 150 degrees F before serving to a resident under several papers and napkins on top of the microwave and placed it on the counter. It was not easily visible to staff using the microwave.-Neither the NHA nor the clinical nurse consultant were able to find a thermometer in the breakroom.E. Record reviewThe skin integrity care plan, revised 3/3/26, revealed Resident #7 was at risk for impaired skin integrity due to his chronic kidney disease. Pertinent interventions included evaluating Resident #7's skin for areas of blanching or redness and monitoring his bony prominences.Review of Resident #7's March 2026 CPO revealed the following order:Treatment for burn to the right side of abdomen: clean with wound cleanser and apply silvadene cream and cover with a dry dressing. Change daily and as needed, ordered 3/18/26 and discontinued 3/30/26.A weekly skin assessment, dated 3/20/26 at 10:56 a.m., revealed Resident #7 needed extensive assistance with ADLs including feeding himself. The skin assessment documented Resident #7 had old wounds to his left ankle, left heel and right heel, and that he was being followed by the WCP and facility wound nurse.-The assessment did not document the burn on Resident #7's abdomen that occurred on 3/16/26.The wound care physician notes, dated 3/23/26, revealed Resident #7 was being followed by the wound care physician for multiple wounds. The wound care (continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | physician documented Resident #7 had a right abdomen upper quadrant burn which had not healed. The wound measurements were 1.5 cm length by 0.8 cm width by 0.1 cm depth. There was a scant amount of serous (a thin, watery plasma) drainage noted. Resident #7 reported a wound pain level of 0 on a scale from 0 to 10.A physician note, dated 3/27/26, revealed Resident #7 had been seen by his physician. The physician documented Resident #7 had a burn on the right side of his abdomen after spilling hot noodles on it. The physician documented Resident #7's burn had previously had a small blistering area on it which had by then almost completely healed. F. Staff interviewsCNA #5 was interviewed on 5/20/26 at 3:54 p.m. CNA #5 said if a resident needed their food reheated there was a microwave in the kitchen to do so. CNA #5 said the facility staff needed to check the temperature of the item before serving it to the resident to make sure it was safe. CNA #5 said she thought the safe temperature would be at least under 80 degrees F, but was not sure what temperature exactly was safe.Registered nurse (RN) #4 was interviewed on 5/20/26 at 3:59 p.m. RN #4 said she usually worked on the night shift. RN #4 said during the day if a resident needed their food or beverage reheated she could bring it to the kitchen and they would reheat it for her. RN #4 said the kitchen was closed during the night, so if a resident needed something reheated she would use the microwave in the staff breakroom to reheat it there. RN #4 said she had recently been trained on what temperatures were safe for serving to residents, but said she could not remember the exact temperatures. RN #4 said there was a sign that said the temperatures on it. CNA #4 was interviewed on 5/21/26 at 12:43 p.m. CNA #4 said if a resident needed their food reheated the nursing staff could bring it to the kitchen to have the dietary staff reheat it. CNA #4 said she was not able to reheat a resident's food after the kitchen was closed, so she would just give them snacks instead. CNA #4 said the nursing staff were not allowed to use the staff breakroom microwave to reheat residents' food.LPN #3 was interviewed on 5/21/26 at 12:49 p.m. LPN #3 said if a resident needed their food reheated, she would bring it to the dietary staff and have them reheat it. LPN #3 said the dietary staff checked the food or beverage's temperature to make sure it was safe to serve. LPN #3 said she never used the breakroom microwave to reheat things since they did not have a thermometer in the breakroom to check to make sure the temperature was safe after heating. LPN #3 said she had told the administration they needed a thermometer at every nurse's station because the kitchen staff left at 8:00 p.m. and the night shift nursing staff needed to be able to reheat items for residents and check the temperature.The dietary manager (DM) was interviewed on 5/21/26 at 1:38 p.m. The DM said when the kitchen was open, the nursing staff brought in residents' food to be reheated. The DM said the residents' food would be heated up to 165 degrees F then cooled to 150 degrees F before serving. The DM said there was not really an option for nursing staff to reheat residents' food after the kitchen was closed at night. The DM said there was a microwave in the breakroom, but she did not want staff members to use that to reheat residents' food for cross-contamination reasons.The assistant director of nursing (ADON), who was filling in for the director of nursing (DON), was interviewed on 5/21/26 at 2:07 p.m. The ADON said after the incident involving Resident #7 on 3/18/26 came to light, the administration no longer allowed nursing staff to reheat residents' food in the microwave. The ADON said the nursing staff needed to use the water in the coffee machine to heat up food and make sure Resident #7 was sitting up when he ate. -However, observations revealed Resident #7 was not sitting upright when eating his meals (see observations above).The ADON said maybe at one point nursing staff were reheating residents' food in the breakroom microwave, but they were not doing so anymore.The NHA was interviewed on 5/21/26 at 2:29 p.m. The NHA said for Resident #7's burn incident, someone in the kitchen had heated up the cup of noodles. but not checked its temperature prior to serving it. The NHA said the staff member had instead followed the instructions on the back of the package. The NHA said after the incident they placed signs on the microwaves with the specific safe serving temperatures, had thermometers available, and had the nursing staff reheat all food during the day through the kitchen and dietary staff. The NHA said the nursing staff were allowed to use the microwave in the staff breakroom to reheat residents' food, and said there were safe temperature signs posted there as<br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | well as a thermometer for the staff to use. -However, the sign with the safe serving temperatures was inaccessible, and there was not a thermometer available in the breakroom to use (see observations above).G. Facility follow-upAdditional information was provided via email from the clinical nurse consultant on 5/21/26 at 4:25 p.m. (after the survey exit), which included the following information:A noncompliance concern, identified on 3/18/26, involved kitchen staff warming up a cup of noodles and serving hot food to Resident #7. Resident #7 then spilled the soup onto himself causing small blisters to his abdomen. Resident #7 was treated by nursing staff immediately upon report of the spill and was assessed by the nurse practitioner. The staff member who warmed the food was immediately reeducated by the Food and Nutrition manager and disciplinary action was taken. No other residents were affected.Systemic changes to ensure the deficient practice would not recur included:-Staff present on shift were educated on not serving liquids or food items to residents from the microwave until the temperature of the item was below 150 degrees F;-A sign was placed on all microwaves as a reminder;-A digital thermometer was placed near the microwave for use whenever food or liquids were being reheated;-All staff were educated on the proper use of the microwave to warm residents' food or liquids, including using a thermometer to check for proper temperature for food safety and allowing to cool to a safe servable temperature (heated to 165 degrees F and cooled to 150 degrees F prior to serving); and,-For prepackaged food or soups available in Styrofoam containers, the item would be heated then poured into a bowl or cup prior to serving.The plan to monitor for sustained compliance included the Food and Nutrition Manager or designee conducting weekly rounds to ensure food thermometers were in place at all microwaves and signs for safe food handling were posted. The results of the rounds would be reported monthly to the QAPI committee.-However, observations and interviews throughout the survey process revealed thermometers and signage were not available at all microwaves in the facility, and nursing staff were not aware of what temperature it would be safe to serve reheated food to a resident (see observations and staff interviews above). |

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
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| F 0759<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure medication error rates are not 5 percent or greater.<br><br>Based on observations, record review and interviews, the facility failed to ensure the medication error rate was not greater than five percent (%).Specifically, the facility's medication error rate was 7.69%, or two errors out of 26 opportunities.Findings include:I. Facility policy and procedureThe Administration of Medication policy and procedure, revised April, 2019 was provided by the nursing home administrator (NHA) on 5/21/26 at 3:33 p.m The policy read in pertinent part, Medications are administered in a safe and timely manner, and as prescribed. Medications are administered in accordance with prescriber orders, including any required time frame. The individual administering the medication checks the label three times to verify the right resident, right medication, right dosage, right time and right method (route) of administration before giving the medication. As required or indicated for a medication, the individual administers the medication records in the resident's medical record. The date and time the medication was administered, the dosage, the route of administration, the injection site (if applicable), any complaints or symptoms for which the drug was administered and any results achieved and when those results were observed.II. Observations On 5/20/26 at 8:05 a.m. registered nurse (RN) #1 prepared to administer medications to Resident #10. RN #1 dispensed the resident's medications into a medication cup, including one tablet of the glipizide (medication used to treat diabetes ) 10 milligram (mg) oral tablet, and refresh tears ophthalmic solution (an over the counter medication used to treat dry eyes).-However, Resident #10's May 2026 computerized physician's order (CPO) ) indicated the resident was to receive two tables of glipizide 10 mg (see physician's order below). RN #1 completed dispensing the medication, picked up the medication cup for the resident and locked the medication cart. RN #1 said he completed his five rights and was ready to administer the medications to the resident. RN #1 then took the medication cup, which contained one tablet of the glipizide 10 mg, to administer the medication to Resident #10. Upon prompting, RN #1 did not administer the medication after he was informed it was the incorrect dose. RN #1 went back to the medication cart and retrieved another tablet of the glipizide 10 mg.RN #1 administered the medications to Resident #10, including the refresh tears ophthalmic solution, and gave two drops into each eye.-RN #1 administered the incorrect dose of refresh tears ophthalmic solution to Resident #10 (see physician's order below).III. Record reviewReview of Resident #10's May 2026 CPO revealed the following physician's order:Glipizide oral tablet extended release 24 hour 10 mg, give two tablets, every day, ordered 8/28/25. Refresh tears ophthalmic solution one drop to each eye, ordered 7/1/25.IV. Staff interviews RN #1 was interviewed on 5/20/26 at 8:10 a.m. RN #1 said he looked at the resident's orders in the medication administration record (MAR) while dispensing medications to make sure he followed the five rights of medication administration: right name, right time, right dosage, right route and accurate documentation. He said it was important to compare the medication order to the medication he was dispensing because the orders changed frequently, and the nursing staff would not know if the dose had changed. He said he did not review the orders thoroughly for Resident #10.The assistant director of nursing (ADON) was interviewed on 5/19/26 at 12:18 p.m. The ADON said RN #1 should have reviewed the MAR for Resident #10 prior to administering the medications. The ADON said she planned to complete additional in person education as soon as possible for RN #1 and all of the facility nursing staff. The ADON said if nursing staff failed to review the residents MAR prior to administering medications, it could result in significant medication errors. |