STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555016	A. Building B. Wing	11/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St John Kronstadt Convalescent Center	4432 James Avenue Castro Valley, CA 94546

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to: Ensure three of three sampled residents' (Residents 5, 6 and 9) Medication Regimen Review ([MRR]- a review of medications to identify problems/errors) was completed monthly. This deficient practice placed Residents 5, 6 and 9 at risk of not having medication irregularities identified.1. During a review of Resident 5's admission Record printed on 11/20/25, admission Record indicated Resident 5 was admitted to the facility on [DATE].During a review of Resident 5's Minimum Data Set (MDS - a federally mandated resident assessment tool) dated 8/19/25, indicated Resident 5 had a Brief Interview for Mental Status (BIMS - an assessment tool used by facilities to screen and identify memory, orientation, and judgement status of the resident) Score of 10/15. Meaning Resident 5's mental cognition was moderately impaired. The MDS revealed Resident 5 had multiple diagnoses that included Depression (feeling of worry, fear, or dread), Bipolar Disorder (sometimes called manic-depressive disorder; mood swings that range from the lows of depression to elevated periods of emotional highs) and Schizophrenia (a mental illness that is characterized by disturbances in thought). The MDS also showed, Resident 5 received antipsychotic (medications that help control symptoms of serious mental health conditions) and antidepressant (a prescription medication that help improve mood).During a review of Resident 5's Physician Order Report (POR) dated 11/1/25 - 11/30/25, order start date 2/26/25, indicated Resident 5 had the following medication orders (a) Invega Sustenna (paliperidone palmitate - an antipsychotic medication) 156mg/mL (milligram per milliliter) Give 1mL intramuscular, Once A Day on the 14th of the Month. Special Instructions: For schizophrenia manifested by episodes of yelling and screaming, (b) Depakote (divalproex - and mood stabilizer) tablet delayed release. 500mg 1 tablet oral Special Instructions: For bipolar disorder manifested by episodes of agitation. (c) Lexapro (escitalopram oxalate - antidepressant) tablet; 20 mg oral Special Instructions: For depression manifested by verbalization of sadness.During a concurrent interview and review of the facility's MRR binder, on 11/20/25 at 1:54 p.m. with the DON, the MRR dated April 2025 through November 2025 revealed, Resident 5 did not have an MRR documented for the months of April through November.2. During a review of Resident 6's admission Record printed on 11/20/25, admission Record indicated Resident 6 was admitted to the facility on [DATE].During a review of Resident 6's MDS dated [DATE] indicated Resident 6 had a BIMS score of 7/15. Meaning Resident 6's cognition was severely impaired. MDS revealed Resident 6 had multiple diagnoses that included, Anxiety disorder (feeling of worry, fear, or dread), Depression and Psychotic disorder (mental health condition that causes a person to have a loss of contact with reality). The MDS also showed, Resident 6 received antipsychotic medication.During a review of Resident 6's POR dated 11/1/25 - 11/20/25, order start date 8/28/25 indicated Resident 6 had medication orders for the following (a) Seroquel (quetiapine - an antipsychotic medication) tablet oral Special Instructions: for Anxiety. (b) Seroquel tablet 25mg 1 and 1/2 (total 37.5) Special Instructions: for Anxiety manifested by episode at night of seeing and hearing people, that are invisible to staff, fearful f being alone resulting in inability to sleep related to fears.During a concurrent interview and review of the facility's MRR binder, on 11/20/25 at 1:54 p.m. (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 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	with the DON, the MRR dated June 2025 through November 2025 revealed, Resident 6 did not have an MRR documented for the months of June, July, August, October and November.3. During a review of Resident 9's admission Record printed on 11/20/25, admission record indicated Resident 9 was admitted to the facility on [DATE].During a review of Resident 9's MDS dated [DATE], MDS indicated Resident 9 had a BIMS score of 12/15. Meaning Resident 9's mental cognition was moderately impaired. MDS revealed Resident 9 had multiple diagnoses that included Anxiety and Depression. MDS showed, Resident 9 received antidepressant medications.During a review of Resident 9's POR dated 11/1/25 - 11/20/25, order start date 10/24/25 indicated Resident 9 had medication order for duloxetine (antidepressant) capsule delayed release; 60mg and 30mg (total of 90mg) in the morning for depression manifested by crying.During a concurrent interview and review of the facility's MRR binder, on 11/20/25 at 1:54 p.m. with the DON, the MRR dated April 2025 through November 2025, revealed Resident 9 did not have an MRR documented for the months of May, June and August through November. During a telephone interview on 11/20/25 at 2:28 p.m. with the Pharmacy Consultant (PC), PC stated, the medication regimen review was not done monthly for each resident. PC added, per facility policy, regimen review was done for residents that were on psychotropic medications (drugs that affect the brain to help manage mental health conditions like depression, anxiety, and schizophrenia) are only done quarterly.During an interview on 11/20/25 at 3:51 p.m. with the DON, DON confirmed Residents 5, 6, and 9 did not consistently have monthly medication regiment review done by the PC. DON added, because the MMR was not done monthly, there was risk for Residents 5, 6 and 9 for not being monitored for efficacy of their antipsychotic medications.During a follow up interview on 11/20/25 at 3:56 p.m. with the DON, DON stated, the MRR should have been done monthly for Residents 5, 6 and 9 according to federal regulations and per facility policy.During a review of the facility's policy and procedure (P&P) titled, MEDICATION REGIMEN REVIEW AND REPORTING, dated January 2024, the P&P indicated Medication Regimen Review (MRR) or Drug Regimen Review is a through evaluation of the medication regimen of a resident, with the goal of promoting positive outcomes and minimizing adverse consequences and potential risks associated with medication. The P&P also indicated under PROCEDURES .2. The consultant pharmacist reviews the medication regimen and medical chart of each resident at least monthly to appropriately monitor the medication regimen and ensure that the medications each resident receives are clinically indicated.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure 2 out t of 2 residents did not have prefilled medication cups with ointment left at the bedside, expired medications were not available for use, best by date was printed on a medication box, internal and external medications were separated when in the same drawer, compromised medication bubble packs were returned to the pharmacy, and glucose monitoring device was separated from internal medications. The deficient practice had the potential for residents to receive medications with unsafe and reduced potency from being used past their discard date or best by date and medications with different routes of administration were not separated in accordance with facility policy and procedure (P&P). 9. A review of Resident 25's Minimum Data Set (MDS, an assessment tool used to direct resident care), dated 10/7/25, indicated Resident 25 was admitted to the facility in 2020, had diagnoses that included dementia (memory loss), and had severely impaired cognition. The MDS also indicated Resident 25 was totally dependent (helper does all the effort) on all activities of daily living (ADLs) with two or more-person assistance. A review of Resident 25's Physician Order Report, dated 11/01/25-11/30/25, indicated treatment order date 9/29/25, Apply Triad (hydrophilic paste used to help maintain a moist wound healing environment) to moisture-associated skin damage (MASD) to scrotum and scattered redness to bilateral groin until healed. During an observation on 11/18/25, at 10:44 a.m., inside Resident 25's shared room, there were two undated, unlabeled, pre-filled disposable plastic medication (med) cups, each with approximately two inch-sized (squeezed out from a tube) white paste/cream, left at Resident 25's nightstand. During a concurrent observation and interview on 11/18/25, at 10:53 a.m., with the Infection Preventionist (IP), IP stated the two unlabeled and undated med cups with white ointment on top of Resident 25's nightstand was for the resident's bottom. IP stated leaving the ointment at bedside was a potential hazard for a confused resident to take the ointment and put it in the mouth. IP further added the ointment should have been prepared and applied immediately to Resident 25's skin and not left unattended on the nightstand. During an interview on 11/20/25, at 2:14 p.m., with Certified Nursing Assistant 2 (CNA 2), CNA 2 stated he had requested the Triad ointment in the med cups from the Charge Nurse, but CNA 2 became pre-occupied with another resident and was unable to apply ointment on Resident 25. Charge Nurse/Registered Nurse 1 (RN 1) was unavailable for interview. A review of the facility's policy and procedure (P&P), titled Medication Administration General Guidelines, dated 2007, indicated, .Medications are to be administered at the time they are prepared. The person who prepares the dose for administration is the person who administers the dose. During a concurrent observation and interview, on 11/17/25 at 10:00 a.m. with Director of Nursing (DON) in Medication Storage room [ROOM NUMBER], the following were identified: 3 bottles of (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Vitamin B-12 (a crucial water-soluble vitamin for healthy nerve and blood cells, DNA production, and energy metabolism) were expired, dated 1/25, 5/25, 7/25 , and 1 opened box Veltassa (treat high levels of potassium in the blood in adults and pediatric patients) had no best by date on box. The DON confirmed the findings and stated the expired medications should have been thrown away on Saturday when the medication storage room was scheduled to be organized. DON confirmed the findings and stated all medications should have a best by date completed on the label, so the drugs full potency and safety are known before administering to residents. During an observation and interview on 11/18/2025 at 2:04 PM, with Medication Nurse, Registered Nurse 2 (RN 2) on station 2 medication cart, the following were identified: hearing aid cleaner stored was with 2 brown bags of nitroglycerine (to treat or prevent acute attacks of angina (chest pain) tabs 0.4 mg sublingual, Hyoscyamine used to treat conditions involving muscle spasms and excessive secretions in the gastrointestinal (GI) and urinary tracts) sublingual 0.125 mg expired 8/1/25, Linzess (treat chronic constipation) capsule, and Eliquis (blood thinner- used to prevent and treat blood clots) 2.5.mg, Calcium 600 mg + D 10 mg, and Fersol 25 mg had no date container was open Anoro had no date container opened printed on the container. The Anoro container label indicated discard after 6 weeks. RN 2 stated she did not know when the 6 weeks would end and the medication should have been thrown away. Amlodipine Besylate 10 mg section 1 in bubble pack had foil seal compromised (torn), Methocarbamol 500 mg tab section # 15 and # 16 in bubble pack had foil sealed broken, Omeprazole DR 20 mg capsule section #8 of bubble pack had foil seal broken. One drawer contained 15 oz Metamucil container, 2 bottles of Uni Stat 30 fluid oz, pain relief patch, retention tape, and hydrocortisone cream 1% items. Another drawer contained Ketoconazole shampoo in drawer with Assure blood sugar monitor and glargine. Drawers with internal, external medications and glucose monitoring device were not separated by dividers. RN 2 confirmed the findings and stated internal and external medications and glucose monitoring device should not be mixed together, but stored separately. RN 2 stated expired medications should be discarded when found. RN2 stated once a medication is opened, you need to print the date open on the label because some medications may break down and lose potency. RN 2 stated when a medication blister pack has been compromised (opened by mistake) the pharmacy is notified for replacement. During an interview with the DON on 11/19/25 at 2:02 p.m., the DON stated nursing staff were expected prior to administration of a medication to ensure the medications had an open date on the container. Nurses should audit weekly for expired medications and destroy expired medications. If the medication is not destroyed, the medication is given to the DON and logged in the pharmacy logbook for disposition. The DON stated the medication room is organized weekly on Saturdays, and the Medication carts are to be cleaned and organized weekly on Sunday. She stated the expired medications should have been thrown out. Medications administered through different routes should have been separated. DON stated the pharmacy should have been notified about the compromised blister packs. She stated that if the medication blister pack foil is broken, they usually call the pharmacy for a replacement. During a review of the facility policy and procedure titled Medication Administration dated 2007, the policy indicated : The nurse shall place a date open sticker on the medication if one is not provided by the dispensing pharmacy and enter the date opened. During review facility policy titled Storage of Medication dated 2007 indicated Medications should be stored so that various routes of administration are separated. Internally administered medications are stored separately from medications used externally such as lotions, creams, ointments and suppositories. Potentially harmful substances (such as cleaning supplies, disinfectants) are clearly (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	identified and stored in an area separate from medications. Outdated, discontinued 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 and reordered from the pharmacy. The medication storage and preparation areas should be kept clean , well lit, organized and free from clutter. Discontinued, outdated, or deteriorated medications drugs or biologicals are returned to the dispensing pharmacy or destroyed.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to store, prepare, and serve food under sanitary conditions when:1. (a) a stainless-steel pasta tong was dirty and was in poor condition. (b) two handheld can opener had rust and metal fragments on the blade and surrounding parts.2. water pitcher with thickened liquid was left at Resident 25's bedside for more than 24 hours.These failures had the potential to cause food contamination and food borne illness. 1. During the initial tour of the kitchen and concurrent interview on 11 at 9/18/25 at 9:44 a.m. with the Food and Nutrition Services Manager (FNSM), the following items were stored in the clean kitchenware storage drawer: (a) a stainless-steel tong had sticky white debris and rubber tip that holds food was ripped in half; (b) two handheld can openers with red-orange debris and metal fragments on its blades. The DM acknowledged the tong was dirty and two can openers were rusty. DM, stated these utensils should have not been stored because rusty and dirty utensils can contaminate food served to residents and can cause foodborne illness. DM then discarded all three kitchenware. During an interview on 11/19/25 at 10:59 a.m. with the Registered Dietitian (RD), RD stated, she did not know what the implications of rusty can opener to health and safety of residents. RD added, staff should not use rusty can openers due to potential for rust fragments to get into food and contaminate food that was served to the residents. A review of the Food and Drug Administration (FDA) Food Code 2022, under 4-204.19 Can Openers on Vending Machines, indicated, Since the cutting or piercing surfaces of a can opener directly contact food in the container being opened, these surfaces must be protected from contamination. 2. A review of Resident 25's admission Record indicated that resident was admitted to the facility in 2020 with diagnoses that included dementia (memory loss). A review of Resident 25's Minimum Data Set (MDS, an assessment tool used to direct resident care), dated 10/7/25, indicated Resident 25 had severely impaired cognition. The MDS also indicated Resident 25 was totally dependent (helper does all the effort) on all activities of daily living (ADLs), including eating (the ability to use suitable utensils to bring food and/or liquid to the mouth and swallow food and/or liquid once the meal is placed before the resident).A review of Resident 25's Physician Order Report, dated 11/01/25-11/30/25, indicated diet order date 10/13/25, Provide fortified diet, puree texture.mildly thick liquid. During an observation on 11/18/25, at 10:44 a.m., inside Resident 25's shared room, there were two water pitchers on top of Resident 25's nightstand. The blue-colored water pitcher was dated 11/17/25, pink-colored pitcher dated 11/18/25, and both pitchers contained thick-consistency liquid. During a concurrent observation and interview on 11/18/25, at 10:53 a.m., with the Infection Preventionist (IP), IP stated there were two color-coded water pitchers with thickened water (water of sticky consistency to help people with swallowing difficulties) on top of Resident 25's nightstand. IP stated the blue water pitcher was dated 11/17/25 and the pink water pitcher, 11/18/25. IP further added thickened water was good for 24 hours and should be removed from the resident's room once the new water pitcher has been delivered by night shift. IP also stated that old, thickened water had the potential for bacterial growth past 24 hours. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 11/20/25, at 2:14 p.m., with Certified Nursing Assistant 2 (CNA 2), CNA 2 stated night shift started at 11 p.m. and ended at 7 a.m. CNA 2 stated night shift should have removed the old water pitcher when the new water pitcher was delivered. CNA 2 also stated that the old, thickened water should not be offered to the resident because of risk of infection. CNA 2 stated he got busy and could not remove old water pitcher from the resident's room. A review of the facility's policy and procedure (P&P), titled Nutrition Care, dated 2023, indicated, Thickened foods and liquids are provided to residents with swallowing disorders to ensure a safe consistency for adequate nutrition and hydration to decrease the probability of aspiration.Thickened water and juices may be kept at bedside for up to 24 hours without danger of harmful bacterial growth.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure one of two sampled residents (Resident 7) had a completed Pre-admission Screening and Resident Review (PASRR, a federal requirement to screen individuals for mental illness, intellectual disability, or related conditions to determine if the resident required specialized services) assessment when resident was newly diagnosed with schizophrenia (a disorder that affects a person's ability to think, feel, and behave clearly).This failure resulted in the facility to not notify the State Mental Health Authority and caused Resident 7 to not receive an in-depth mental health evaluation and care appropriate to his needs. A review of Resident 7's admission Record, printed on 11/24/25, indicated Resident 7 was admitted to the facility on [DATE] with diagnoses that included dementia (memory loss), schizophrenia, and depression.A review of Resident 7's PASRR Screening, dated 11/1/21, indicated resident had a Level I Screening conducted in the facility on the 11/1/21, followed by a Level II Evaluation on 12/10/21. The facility received the results of the Level II Evaluation in the Determination Report, dated 12/15/21.A review of Resident 7's Comprehensive Minimum Data Set (MDS, a resident assessment tool used to provide care), dated 6/6/22, indicated resident did not have a diagnosis of schizophrenia. A review of Resident 7's Physician Orders, dated 6/14/22, indicated an order of Perphenazine 4 milligrams (mg) by mouth three times a day starting on 6/20/22 for schizoaffective disorder.A review of Resident 7's medical records indicated Resident 7 did not have a new PASRR Screening after resident was diagnosed with schizophrenia/schizoaffective disorder later in 2022. Facility was unable to provide documentation to show the exact date when the physician had officially added Resident 7's new diagnosis of schizophrenia.A review of Resident 7's History and Physical, dated 10/18/23, indicated resident was with schizoaffective disorder (a mental health condition that combines symptoms of both schizophrenia (like hallucinations [seeing, feeling, or hearing things that are not there] and delusions [holding on to false beliefs]) and a mood disorder (such as bipolar disorder [high energy, racing thoughts, and risky behavior] or depression).During a concurrent interview and record review on 11/20/25, at 11:20 a.m., with the Minimum Data Set Coordinator (MDSC), a review of Resident 7's Quarterly MDS, dated [DATE], indicated the resident had diagnosis of schizophrenia. MDSC stated this Quarterly MDS was Resident 7's very first MDS Assessment that showed resident had a new diagnosis of schizophrenia since the new physician order of Perphenazine was ordered for resident's schizoaffective disorder.During a concurrent interview and record review on 11/20/25, at 12:52 p.m., with the Administrator (ADM), Resident 7's electronic clinical records were noted without a new PASRR Screening. The ADM stated there should have been a new PASRR Screening initiated when a more sufficient diagnosis of schizophrenia was added to resident's list of health illnesses. The ADM stated State Mental Health Authority should have been informed so that a more detailed assessment for Resident 7's appropriate mental illness services was provided.

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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. Based on interview and record review, the facility failed to develop a comprehensive care plan for one of two sampled residents (Resident 25) with right hand contracture and use of palm protector.This failure resulted in the lack of information regarding care and had potential to result in unmet care needs for Resident 25. A review of Resident 25's admission Record indicated resident was admitted to the facility in 2020 with diagnoses of dementia (memory loss) and dysthymic disorder (chronic depression).A review of Resident 25's Minimum Data Set (MDS, an assessment tool used to direct resident care), dated 10/7/25, indicated Resident 25 was rarely/never able to make self-understood, rarely/never had the ability to understand others, and had severely impaired cognition. The MDS also indicated Resident 25 was dependent (helper does all the effort) on all activities of daily living (ADLs), with two or more-person assistance.A review of Resident 25's Physician Order Report, dated 11/01/25-11/30/25, indicated an order date 9/2/25, for Restorative Nursing Assistant (RNA) to apply resident's right palm protector to prevent contracture and maintain skin integrity daily for four hours during the day when up in the wheelchair.A review of Resident 25's Care Plan, titled Mobility and Safety, created date 11/18/25, indicated a goal that resident will maintain range of motion to right hand.During a concurrent interview and record review on 11/20/25, at 9:39 a.m., with the Director of Nursing (DON), Resident 25's clinical records showed there was no care plan developed for resident's right-hand contracture and/or use of right-hand palm protector. DON stated the care plan should have been created in a timely manner. DON also confirmed there was no order for range of motion (ROM) exercises to at least the right hand and upper extremities other than for the Certified Nursing Assistant (CNA) and/or RNA to do exercises during provisions of resident care during ADLs. A review of the facility's policy and procedure, titled Care Plans, undated, indicated, The resident care plan is the vehicle employed by the interdisciplinary team from achieving desirable resident outcomes.It addresses the actual and potential physical, environmental, and psychosocial needs and problems identified by the interdisciplinary team.The care plan identifies the individual needs and problems of the resident, states the resident's goal in measurable terms, and documents realistic approaches.A comprehensive resident care plan will be completed within seven days after the conclusion of the resident's assessment process.The care plan will be reviewed and revised as necessary to reflect the changes in the resident's status. Any professional who recognizes the need for changing the care plan will initiate the change.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the physician was notified that one of four sampled residents (Resident 1) had been refusing his medications for two weeks. The failure to notify the physician had the potential to delay effective treatment for the resident, allow the physician to prescribe alternative pain management and adjust the plan of care.During an observation on 11/20/25 at 9:00 a.m., Resident 1 was awake, alert, oriented and sitting on the side of his bed. RN 1 asked Resident 1 if he wanted the 4% Lidocaine patch, (a type of topical anesthetic used for temporary pain relief by numbing the area where they are applied). The resident stated the Lidocaine patch was being refused.During a review of Resident 1's Resident admission sheet, the Residents admission Sheet indicated Resident 1 was admitted to the facility on [DATE] with a diagnosis that included pneumonia (an infection/inflammation in the lungs), acute bronchitis (inflammation of the bronchial tubes) and Rhinovirus (viral infectious agent).During a review of Resident 1's Minimum Data Set (MDS, an assessment tool used to direct resident care dated 9/23,25, the MDS indicated a Brief Interview for Mental Status (BIMS, a scoring system used to determine the resident's mental status in regard to attention, orientation , ability to register and recall information) score of 15 (A BIMS score of 15 out of 15 indicate intact cognition). During an interview on 11/20/25 at 1:00 p.m. with License Vocational Nurse (LVN) 1, LVN 1 stated Resident 1 had refused the Lidocaine patch for 2 weeks and the physician was not notified. RN 4 stated the physician should have been notified when the resident initially refused. LVN 1 stated not notifying the physician does not allow the physician to evaluate the reason for the refusal or adjust the resident's treatment.During a record review of Resident 1's Medication Administration Record (MAR) dated 11/01/25 through 11/20/2025, the MAR indicated Resident 1 was to receive Lidocaine adhesive patch 4% topical to right lower back, on for 12 hours and off for 12 hours. Lidocaine patch on at 9:00 am and off at 9:00 p.m. The MAR dated 11/2/25 through 11/20/25 indicated the Lidocaine patch was not administered 26 times out of 26 scheduled times. The resident refused the Lidocaine patch 23 times out of 26 scheduled times. The MAR indicated 3/26 times the refusal was due to condition.During a record review of the facilities policy and procedure (P&P) titled, Medication Administration General Guidelines dated 01/24, the policy and procedure indicated If two consecutive doses of a vital medication are withheld or refused, the physician is notified.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure four of four sampled residents (Resident 27, 39, 5 and 9), received care when following was noted:1. Resident 27 had overgrown and dirty fingernails in both hands.2. Resident 39 had overgrown and dirty fingernails in both hands.3. Resident 5 had long and dirty fingernails in both hands.4. Resident 9 had long and overgrown dirty fingernails in both hands. 1. During a review of Resident 27's face sheet, undated, indicated Resident 27 was admitted to the facility on [DATE] with multiple diagnoses that included, Parkinson's disease (progressive brain disorder that affects movement and balance) and Type 2 Diabetes Mellitus (DM -when body does not use insulin properly, which can weaken immune system placing a person at high risk for respiratory infections like pneumonia). During a review of Resident 27's Minimum Data Set (MDS - a federally mandated resident assessment tool) dated, 10/27/25, indicated Resident 27 had a Brief Interview for Mental Status (BIMS -an assessment tool used by facilities to screen and identify memory, orientation, and judgement status of the resident) score of 4. Meaning, Resident 27 had severe cognitive impairment. The MDS revealed Resident 27 required substantial/maximal assistance with personal hygiene. During a review of Resident 27's care plan (CP - individualized guide developed to outline a person's health needs, goals and steps to achieve them), dated 11/3/25, indicated Resident 27's problem included decline in functional ADL (Activities of Daily Living) including personal hygiene. CP also showed Resident 27 required substantial to dependent assistance with ADL care and one of the approaches was for staff to provide assistance with ADLs as indicated. During a concurrent observation and interview on 11/18/25 at 10:31 a.m. in Resident 27's room with Certified Nursing Assistant (CNA) 4, CNA 4 agreed Resident 27 had dirty and long fingernails. CNA 4 added, regardless of medical condition, Resident 27's fingernails should be cleaned. 2. During a review of Resident 39's face sheet, undated, indicated Resident 39 was admitted to the facility on [DATE] with multiple diagnoses that included Cerebrovascular Disease (CVA- stroke). During a review of Resident 39's MDS dated [DATE], MDS indicated, Resident 39 had a BIMS score of 6, meaning Resident 39 had severe cognitive impairment. MDS revealed, Resident 39 required substantial/maximal assistance with personal hygiene. During a review of Resident 39's CP, dated 9/30/25, indicated Resident 39's problem included decline in functional ADL including personal hygiene. CP also showed Resident 39 required substantial maximum to total dependence assistance with ADL care and one of the approaches were for staff to provide assistance with ADLs as indicated. During a concurrent observation and interview on 11/18/25 at 10:33 a.m., CNA 3 was observed assisting Resident 39 with the transfer from bed to wheelchair. Resident 39 had black and brown matter underneath overgrown fingernails. CNA 3 acknowledged Resident 39's fingernails was long and dirty. CNA 3 stated, it looked like Resident 39 has not had her nails trimmed for a long time. 3. During a review of Resident 5's face sheet, undated, indicated Resident 5 was admitted to the facility on [DATE] with multiple diagnoses that included Type 2 Diabetes Mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing).During a review of Resident 5's MDS dated [DATE], indicated Resident 5 had a BIMS score of 10, meaning Resident 5 had moderate cognitive impairment. MDS revealed Resident 5 required substantial/maximal assistance with personal hygiene. During a review of Resident 5's CP, dated 11/17/25, indicated Resident 5's problem included decline in functional ADL including personal hygiene. CP also showed Resident 39 required partial to substantial assistance with ADL care and one of the approaches was for staff to provide assistance with ADLs as indicated. During a concurrent observation and interview on 11/18/25 at 10:36 a.m., with Resident 5, Resident fingernails were overgrown and dirty with black matter underneath in both hands. Resident 5 stated, CNA 1 did not offer to clean his fingernails. Resident 5 added, he preferred to keep fingernails cleaned. 4. During a review of Resident 9's face sheet, undated, indicated Resident 9 was admitted to the facility on [DATE] with multiple diagnoses that included, Type 2 DM and Systemic lupus (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	erythematosus (SLE-a chronic autoimmune disease where the immune system mistakenly attacks the body's own healthy tissues, causing inflammation and damage in multiple organs including the skin). During a review of Resident 9's MDS dated [DATE], MDS indicated, Resident 9 had a BIMS score of 12, meaning Resident 9 had moderate cognitive impairment. MDS revealed, Resident 9 required substantial/maximal assistance with personal hygiene. During a review of Resident 9's CP, dated 10/28/25, indicated Resident 9's problem included decline in functional ADL including personal hygiene. CP also showed Resident 9 required substantial to total assist with ADL care and one of the approaches was for staff to provide assistance with ADLs as indicated.During a concurrent observation and interview on 11/18/25 at 10:43 a.m., with Resident 9, Resident 9 had long overgrown with black matter underneath fingernails. Resident 9 stated, CNA 1 did not check her nails and did not offer to clean her nails whenever he was assigned to her. Resident 9 added she wanted her nails shorter and clean. During an interview on 11/18/25 at 11:06 a.m. with CNA 1, CNA 1 stated he did not check Resident 5 and Resident 9's nails during ADL care this morning. CNA 1 added, he was not the only one responsible for cleaning Resident 5 and Resident 9's nails. CNA 1 further stated, morning shift was busy so he did not have time to check resident nails. During an interview on 11/18/2025 at 2:40 p.m. w/ Infection Preventionist (IP), IP stated, direct care staff was responsible for ensuring nailcare was provided daily to Residents 5, 9, 27 and 39. IP added, overgrown nails can accumulate dirt and spread infection. IP also stated, it was important to keep fingernails trimmed and clean to prevent spread of infection. During a review of facility's policy and procedure (P&P) titled, GROOMING CARE OF THE FINGERNAILS AND TOENAILS, undated, the P&P indicated, Nail care is given to clean the nail bed and keep the nail trimmed. The P&P also indicated under Policy, I. Fingernails are trimmed by Certified Nursing Assistants (CNA's), except for residents with diabetes or circulatory impairments, this includes all toenails except for high-risk residents. Note: A licensed nurse will trim high-risk resident's nails.

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Post nurse staffing information every day. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure the census and direct care service hours per patient day (DHPPD) posting was complete and was not missing information. This failure resulted in the actual direct care service hours and DHPPD not readily available to residents and visitors at any given time. During an interview and observation with the Director of Nursing (DON) on 11/21/25 at 12 noon of the posted DHPPD. The DON stated the DHPPD forms are posted daily outside of nursing station 1. The information is posted by the night shift nurse in charge and updated by the dayshift DON or charge nurse. It was noted the 11/21/25 actual direct care service hours and DHPPD were not completed. The DHPPD form dated 11/21/25 did not show the daily census changes for 8:00 a.m., actual care service hours, average patient census, the actual DHPPD, the actual total Certified Nursing Assistant (CNA) direct, care services hours and actual CNA DHPPD. The Director of Nursing had signed the form indicating she had reviewed the patient census and direct care services hours information and acknowledged the information was true and correct. During an interview on 11/21/25 at 12:30 p.m. with the Medical Records Director (MRD), the MRD stated she had not completed the section for the actual care service hours, average patient census, the actual DHPPD, the actual total Certified Nursing Assistant (CNA) direct. The MRD stated the care service hours and actual CNA DHPPD information for each 24-hour patient day had not been completed since September 2025. During an interview on 11/19/25 with Resident 32, Resident 32 stated he did not feel the nursing care was rushed and he only had to wait a few minutes before someone answered his call light. During a record review of Resident 32's admission face sheet indicated the resident was admitted on [DATE] with a diagnosis of congestive heart failure (CHF-a heart disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling) and atherosclerotic heart disease (caused by plaque buildup in arterial walls and refers to conditions that include: conditions such as myocardial infarction, angina, and coronary artery stenosis). During a review of the Brief Interview for Mental Status (BIMS -an assessment tool used by facilities to screen and identify memory, orientation, and judgement status of the resident) dated 08/19/25 for resident 32 indicated the BIMS score was 15/15. A score of 15 indicates intact cognitive response. During an interview on 11/19/25 with Resident 36, Resident 36 stated they had not observed any delay in the staff responding to the call light and stated there was adequate staff to assist with requests. During a record review Resident 36's admission face sheet indicated the resident was admitted on [DATE] with a diagnosis of congestive heart failure (CHF-a heart disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling) and chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing). During a review of the Brief Interview for Mental Status (BIMS -an assessment tool used by facilities to screen and identify memory, orientation, and judgement status of the resident) dated 09/03/25 for Resident 36 indicated the BIMS score was 15/15. A score of 15 indicates intact cognitive response. During an interview on 11/19/25 with Resident 15 , Resident 15 stated there was no issue with the staff responding to his call light or delay in the staff responding to the call light. Resident 15 stated the staff did not appear to be limited on time and did not rush to get task completed. During a record review the resident admission face sheet indicated Resident 15 was admitted on [DATE] with a diagnosis of congestive heart failure (CHF-a heart disorder which causes the heart to not pump the blood efficiently, sometimes resulting in leg swelling) and chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing). During a review of the Brief Interview for Mental Status (BIMS -an assessment tool used by facilities to screen and identify memory, orientation, and judgement status of the resident) dated 11/11/25 for Resident 15 indicated the BIMS score was 15/15. A score of 15 indicates intact cognitive response. During a review of the census and direct care services hours per patient day (DHPPD) document dated September 2025 through November 2025, the DHPPD document (continued on next page)

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F 0732 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	indicated the actual care service hours, average patient census, the actual DHPPD, the actual total Certified Nursing Assistant (CNA) direct was not completed. The document indicated the actual direct care service hours and DHPPD section must be completed at the end of each 24-hour patient day.During a review of the Federal regulation titled Nurse Staffing Information 483.35(i)(1)(iii)(a)(b)(c)(iv) dated 4/25/25, the regulation indicated the facility must post the following information on a daily basis: (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses, (B) Licensed practical nurses or licensed vocational nurses, (C) Certified nurse aides and (iv) Resident census.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, for two of two sampled residents (Resident 25 and Resident 11), Certified Nursing Assistant 1 (CNA 1) failed to implement infection prevention and control practice when CNA 1 did not perform hand hygiene in between feeding residents in the Community Room (back dining room). This deficient practice had the potential to result in the spread of infection. A review of Resident 25's Minimum Data Set (MDS, an assessment tool used to direct resident care), dated 10/7/25, indicated Resident 25 was admitted to the facility in 2020 with diagnoses that included dementia (memory loss) and had severely impaired cognition. The MDS also indicated Resident 25 was totally dependent (helper does all the effort) on all activities of daily living (ADLs), including eating (the ability to use suitable utensils to bring food and/or liquid to the mouth and swallow food and/or liquid once the meal is placed before the resident).A review of Resident 11's MDS assessment, dated 9/30/25, indicated Resident 11 was admitted to the facility on [DATE] with diagnoses that included Alzheimer's Disease (a brain condition that causes a progressive decline in memory, thinking, learning, and organizing skills) and had severely impaired cognition. The MDS also indicated Resident 11 was totally dependent on all ADLs, including eating.During lunch dining observation on 11/18/25, at 12:55 p.m., in the back dining room, CNA 1 was seated next to Resident 25 and assisted resident with feeding. Resident 25 was up in his wheelchair, observed with eyes closed in between feedings, and after a few spoonsful of food, the resident refused to take any more feeding from CNA 1. CNA 1 stood up and walked towards the door where Resident 11 was situated. Resident 11 was up in her wheelchair and quietly waited for a staff member to feed her. Without performing hand hygiene, CNA 1 picked up the spoon from Resident 11's plate and began assisting feeding the resident. During an interview on 11/18/25, at 1 p.m., with CNA 1, in the hallway outside the dining room, CNA 1 stated he should have sanitized his hands in between feedings. He stated he forgot to do hand hygiene when he left Resident 25 to assist Resident 11 with her lunch tray. CNA 1 stated it was important to sanitize and/or wash hands in between feeding residents to minimize the spread of infection. During an interview on 11/18/25, at 2:06 p.m., with the Infection Preventionist (IP), IP stated Certified Nursing Assistants (CNAs), Licensed Nurses (LNs), and other staff members qualified to assist in feeding the residents should perform hand hygiene before assisting the residents to minimize spread of infection. A review of the facility's policy and procedure (P&P), titled Infection Control, undated, indicated, .Standard precautions are work practices required for the basic level of infection control. They include good hygiene practices, particularly washing and drying hands before and after patient contact.Wash hands immediately after gloves are removed, between patient contacts and when otherwise indicated avoid transfer of microorganisms to other patients or environments.A review of the facility's P&P, titled Procedure for Using Alcohol-Based Hand Rub, untitled, indicated, .When to Use Alcohol- Based Hand Rub - after contact with residents intact skin.After contact with inanimate objects.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide pneumococcal immunization for one of five sampled residents, when Resident 27 was not offered the pneumococcal immunization.This failure had the potential to not protect Resident 27 against serious illnesses like pneumonia (lung infection).During a review of Resident 27's face sheet, printed on 11/18/25, revealed Resident 27 was admitted to the facility on [DATE] with multiple diagnoses that included, Parkinson's disease (progressive brain disorder that affects movement and balance) and Type 2 Diabetes Mellitus (DM -when body does not use insulin properly, which can weaken immune system placing a person at high risk for respiratory infections like pneumonia).During a concurrent interview and record review on 11/18/25 at 2:10 p.m. with the Infection Preventionist (IP), Resident 27's vaccination record revealed, Resident 27 was administered pneumococcal vaccine on 11/9/17. IP stated, Resident 27 was due for revaccination in 2022, but she forgot to offer the pneumococcal vaccine to Resident 27. IP added, the risk to Resident 27 for not receiving pneumococcal vaccine was potential for exposure to respiratory infection. IP further added, Resident 27 was susceptible and at risk for any type of infection due to multiple co-occurring health conditions. During a review of facility provided immunization RESIDENT ROSTER, dated 11/18/25, revealed Resident 27 received pneumococcal vaccine (PCV 13) on 11/9/17. During a review of facility's policy and procedure (P&P) titled, RESIDENT IMMUNIZATION PROGRAM, dated 10/1/22 indicated, Residents will be immunized against vaccine preventable diseases that may be encountered in this facility. These vaccinations will be provided to residents at admission unless over-ridden by the resident's physician, medically, contraindicated, or if refused by the resident or his/her surrogate decision maker. The P&P also indicated under IMMUNIZATION SCHEDULE, the Pneumococcal Polysaccharide PPV23 was recommended for individuals [AGE] years old and above. Furthermore, schedule for routine and catch-up administration revealed, One time revaccination is recommended after 5 years for people at highest risk of fatal pneumococcal infection or rapid antibody loss and for people over [AGE] years old if the first dose was given prior to age [AGE] and more than 5 years has elapsed since previous dose. Review of the Center for Disease Control and Prevention's (CDC) Vaccine Information Statement, dated 5/29/25, provided to the surveyor by the facility, indicated Pneumococcal Conjugate Vaccine: What You Need to Know. Pneumococcal conjugate vaccine can prevent pneumococcal disease. Pneumococcal disease refers to any illness caused by pneumococcal bacteria. PCV was recommended for adults 50 years or older who have not previously received PCV should receive a PCV vaccine. Some adults in this group who have already received PCV might be recommended to receive another dose.

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F 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide at least 80 square feet for each resident for one of 23 rooms (room [ROOM NUMBER]). This deficient practice had the potential to result in inadequate space to provide necessary and safe nursing care and privacy for the residents.During a concurrent observation and interview on 11/18/25 at 10:33 a.m. Certified Nursing Assistant (CNA) 3 and CNA 1 was seen transferring Resident 39 from bed to wheelchair using a Hoyer Lift (a mechanical device used to lift and/or transfer a person from place to place). CNA 3 stated, there was plenty of space in Resident 16's room even when using Hoyer lift for transfer. There was no negative outcome in the delivery of nursing care and services. During a record review on 11/21/25 of the Client Accommodations Analysis (undated), the following Resident room was identified having below the required 80 square feet requirement per resident: room [ROOM NUMBER] had 4 beds and 77 sq.ft./bed